

Consumer Driven HEALTHCARE

Tips & tactics

Avoid the common pitfalls of open-enrollment season

Open-enrollment season has arrived for many companies, and despite their differences, many have something in common: They will make mistakes that will impair the success of their CDHP offerings.

CDH asked several experts to share the biggest CDH-related mistakes they've seen employers make during open enrollment. We collected quite a few, and we've narrowed them down to help make this open-enrollment period successful and (relatively) stress-free. The message from the experts? Don't treat CDHPs as just another plan design. To successfully drive enrollment, employees need to understand that CDHPs are different from HMOs and PPOs. And that requires communication and education.

A good place to start, says **Jay Savan**, principal at Towers Perrin in St. Louis, is to develop a thorough rollout effort, including town hall presentations, a plan selection tool, and an enrollment guide that explains the

program clearly. It should be engaging and easy to read and include specific examples.

Ruth A. Hunt, communication principal at Buck Consultants' Minneapolis office, offers the following ways for employers to address this challenge:

- ▶ **Recognize the challenge of convincing employees to take on more risk.** "That's not merely an educational effort," she says. "There's a 'change management' effort required—an effort that includes championing by senior leadership and the appropriate blend of communication tactics and plan design/incentives."
- ▶ **Invest in sufficient education at time of rollout.** That means creative strategies to get attention, face-to-face meetings to focus employees, and enrollment decision support tools that enable employees to model various scenarios for personal impact.
- ▶ **Be honest about the impact.** "Come clean—don't try to hide realities if this is mainly a cost shift," she says.

"There's no 'once and done' at open enrollment."

—Ruth Hunt



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Sander Domaszewicz, health consumerism national practice leader at Mercer Health & Benefits in Newport Beach, CA, offers another important, but often overlooked, design and positioning strategy:

- ▶ **Highlight the value of the employer contributions to the CDHP account and any savings on paycheck contributions.** Help employees understand how the "total cost of ownership" of a CDHP can often be less than other options. Go out of your way to repeatedly show and tell how the account and lower contributions reduce their deductible and out-of-pocket maximum, he says. The most daunting aspect of a CDHP is often the higher deductible,

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he says. When comparing CDHPs and traditional options, it is typically better to talk first about the deductible and then any coinsurance maximum, so the deductible isn't "counted twice as a negative" when looking at an out-of-pocket maximum (that often includes the deductible). This way, the plans are on a more level playing field. It's also important to point out the multiyear nature and long-term thinking needed when comparing CDHPs to traditional options—the out-of-pocket maximum and deductibles may be reduced or eliminated in future years as some employees accumulate funds.

Failure to communicate

Christine Miller, owner of Millerwood Communi-

cations in Bolton, MA, offers the following examples of how employee communication efforts often fall short:

- ▶ **Not providing adequate examples of how a CDHP works.** She advises walking an employee through a hypothetical example of how the CDHP works after a claim is submitted. **Cathy Tripp**, national practice leader for consumerism at Watson Wyatt Worldwide in Minneapolis, agrees. Increasingly, she's seeing employers and insurers using detailed scenarios to help employees understand how the plans work. Employees relate to the "like me" approach that has been popular in retail and other settings like Amazon.com. (For instance: Meet Martha, a 38-year-old woman with two children. She's scheduled for back surgery next month, and she's carrying over \$1,000 in her HSA. If she goes with plan design A, this is what she can expect. With B, etc.)
- ▶ **Using too many acronyms.** You may know the alphabet soup of ERISA, HIPAA, HSA, HRA, and CDHP, but they probably don't mean much to your employees, says Miller. Instead, use descriptions and terms employees can readily understand. (The exception, she says, are HIPAA and ERISA. For compliance reasons, she says it's best to spell out the name once and then use the acronym.) Tripp points to a related problem: jargon. Too often, benefits managers use arcane terms that they understand but are unfamiliar to most employees. ("What the heck is a limited-use FSA?") She points to the 2007 Watson Wyatt *Employee Perspectives on Health Care* study that indicates many employees are not comfortable with benefit terminology. (See **Figure 1**.)
- ▶ **Failure to include dependents.** Some employers distribute their information via e-mail or Intranet. "This makes it difficult for spouses to get the information they need to fully understand a CDHP or any other benefit," says Miller. Savan agrees. Spouses (or partners) should be included in the open-enrollment process. Ideally, this process should include in-person

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meetings, he says. And Tripp notes that RAND/Watson Wyatt research found that for employers launching CDHPs, face-to-face meetings were a critical component of a successful launch.

- ▶ **Not branding the benefits program.** Branding communications with the employer's identity can help make the materials easier to identify, separating them from the clutter. And branding makes them more likely to be read, explains Miller. Interesting or fun branding is more likely to get someone's attention than the usual "Benefits Update" heading in corporate colors, she says. "In creating campaigns, I look at the demographics and company culture and try to come up with a unique way to present the information ['FlexMan and the Power of the Piggy Bank' and 'About You. About Life']," she says.
- ▶ **Lack of ongoing communication.** Employers

often curtail communication efforts after open enrollment. That's a mistake, says Miller. Several other experts raised this same issue, including Hunt. "There's no 'once and done' at open enrollment," Hunt says. (For more about this and how it relates to pre-enrollment education, see the sidebar below.)

The following are a few other common communication-related mistakes.

- ▶ **Not taking advantage of marketing staff expertise.** Often, the benefits staff is responsible for the open-enrollment materials, and, as Miller and Tripp noted earlier, it's often full of jargon and acronyms. What employees need is simple, clear, targeted information. And in many companies, the corporate communications or marketing staff is trained to provide just that.

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Plan now for 2009

Waiting until open enrollment to begin the communication process may be the most common employer mistake, says **Jay Savan**, principal at Towers Perrin in St. Louis. So, if you really want a successful open enrollment, start planning now for 2009.

If your company is making a dramatic change, you'll want at least six months lead time on your educational materials, says **Cathy Tripp**, national practice leader for consumerism at Watson Wyatt Worldwide in Minneapolis.

In addition, if the CDHP is going to be tied to certain other actions—for instance, if completing a health risk assessment means a reduced premium or an extra HSA contribution—you may need more time.

But don't start too early, she cautions. "People don't pay attention until they have to make a decision," Tripp says. You don't want to bombard them with data months before they have to take action.

Still, starting too early is less likely to be a problem than starting too late, says Savan. It's critically important to begin the education/communication process much earlier. "The simple fact is that the annual dump-a-bunch-of-enrollment-

material-on-them-at-once routine doesn't work anymore—not that it ever did," he says.

It's a year-round process, says **James Gandolfo**, senior director and vice president of global business development with Wilmington, DE-based PFPC. The point is to address different issues at different times. Gandolfo has a self-insured client who took the full-replacement route. For the seven months prior to open enrollment, the employee newsletter featured a series of articles about CDH in general. By the time it came to the nitty-gritty, employees had a basic understanding of the concept, and 96% signed up for the plan. That pre-enrollment information dovetails with information being sent to enrollees throughout the year, reminding them of the various tools and services available to them. In effect, it's year-round education, with different areas of focus at certain times.

It gets back to CDHPs being fundamentally different, says **Ruth A. Hunt**, communication principal at Buck Consultants in Minneapolis. "We're providing financial incentives and resources and tools to drive employees to be more engaged in not only their once-a-year benefit election but also their ongoing health-related decisions."

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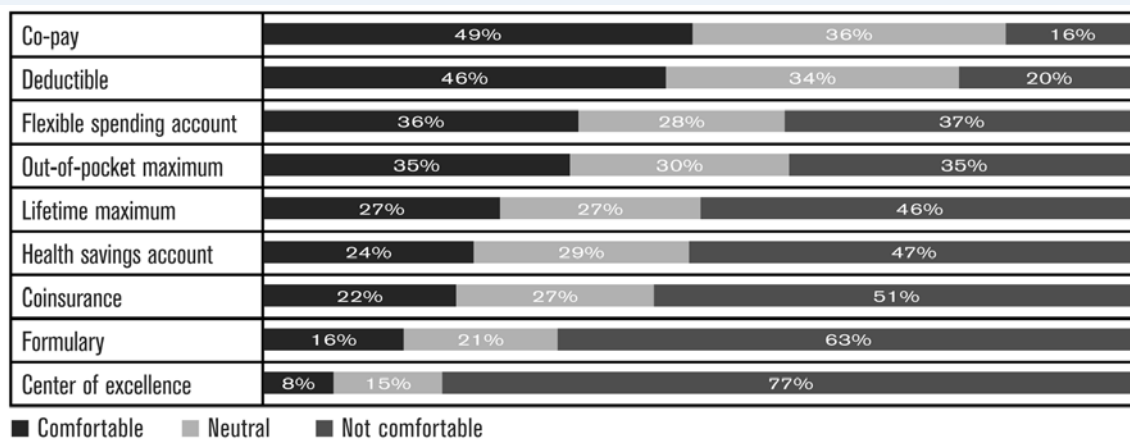
Its expertise can be particularly helpful when it comes to encouraging individuals to do things they aren't all that thrilled about doing—filling out a health risk assessment, exercising more, eating less, etc., Tripp says.

- ▶ **Failure to use plan tools.** Health plans provide an array of tools and services that can help employers communicate and employees better understand CDHP. But they often go unused, says **Tom Hricik**, principal and national director of HSA product distribution at ACS/Mellon HSA Solutions in Pittsburgh.
- ▶ **Not training HR and other field staff members on new offerings.** Those charged with communicating the CDHP need to understand it themselves, Hricik says. It may sound obvious, but it doesn't always happen.
- ▶ **Too much information.** Most employers provide too much information, says **Shawn Jenkins**, CEO of Charleston, SC-based Benefitfocus. This is especially true when they have attended a seminar or learned about some new CDH product. In attempting to educate, "they overload their employees with all the information they have collected, such as tax ramifications, pamphlets, booklets, presentations, multiple Web sites with confusing links, etc.," Jenkins says. Employees get frustrated, give up, and don't explore their choices.

Tripp has seen this happen frequently. Some employers simply hand employees a booklet the size of a phone book and expect them to read—and comprehend—it. Instead, make all of the information available but via a short and simple guide to what they must know and do to take full advantage of their health plan.

- ▶ **Too little information.** Some employers go in the opposite direction, notes Jenkins. They become so excited about providing an option that costs less that they roll out the new plan options without any strategy, leaving employees to figure out on their own what the new offerings mean to them. And, of course, many don't. At the point of decision, employers need to provide just the right amount of relevant information to help employees make an educated decision. One tactic he recommends is to explain both old and new offerings for comparison.
- ▶ **Inadequate use of available media.** Plan information needs to be developed in a variety of media and formats so those receiving it can digest the information in the format that works best for them, says Jenkins. For example, basic, easy-to-understand information that allows for the ability to drill down deeper and access additional resources

Figure 1: Employees are uncomfortable describing common benefit terms



Source: Watson Wyatt's Employee Perspectives on Health Care: Voice of the Consumer. Reprinted with permission.

reaches employees at a variety of levels, including the research-oriented analytical types. Video formats connect to the more visually oriented. Tripp agrees with using a variety of approaches but reminds employers not to ignore good old-fashioned paper. In *Employee Perspectives on Health Care*, Watson Wyatt found that the number one preferred method of healthcare communication is print materials sent to the home.

Failure to coordinate

Often, employers fail to link communications about the CDHP to other relevant information.

► **Omitting wellness and prevention information.**

Open enrollment is the time to discuss not just the plan itself, but the attendant wellness programs, says Miller. "I am always surprised at how much emphasis is put on how much a plan will pay, but how little emphasis is put on how employees can make a difference in how much they use a health benefit." Employers, she says, should devote more time to communicating about the link between healthy behaviors and reduced healthcare costs.

- **Overlooking the big benefits picture.** CDHPs, especially those linked to HSAs, are part of the larger financial planning picture, but employers sometimes forget to approach it that way during open

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HSA hits and misses

Successful CDHP adoption depends on proper use of the accompanying account, especially when that account is an HSA.

Contributing to an HSA is one of the best ways to promote CDHPs, says **James Gandolfo**, the senior director and vice president of global business development with Wilmington, DE-based PFPC and the chair of the American Bankers Association's HSA Council.

The contribution has both practical and symbolic value. It not only seeds the account and provides the employee with the confidence they can pay the deductible but, says Gandolfo, also demonstrates corporate commitment to CDH. That commitment by the employer, demonstrated with "their hard cold money," is very powerful, he says. "It says 'my company is dedicated to this.' "

Sander Domaszewicz, the health consumerism national practice leader at Mercer Health & Benefits in Newport Beach, CA, agrees, and says if a plan sponsor can afford to make the HSA-eligible plan \$100 per month less expensive for the employee, it is much better to put some of this money directly into the account instead of just lowering the employee paycheck contribution. Putting \$50 per month into the account yields \$600 annually, which can take a lot of edge off of a higher deductible, and the plan would still compare favorably at open enrollment

with \$50 per month less coming out of the paycheck.

Tom Hricik, principal and national director of HSA product distribution at ACS/Mellon HSA Solutions in Pittsburgh, also agrees that failure to contribute to an HSA is a common misstep employers make. He offers three other related mistakes:

- Rushing the HSA decision
- Not devising an account contribution strategy
- Not offering an HSA option at all

Hricik's colleague, **Lee Barson**, director of business development for ACS/Mellon HSA and Medicare MSA solutions in Philadelphia, offered a few insights along the same lines. Among the potential mistakes:

- **Failure to pay maintenance fees.** Employers see higher employee satisfaction when they pay the monthly maintenance fee, as opposed to this fee coming directly out of the employee's HSA.
- **Failure to allow payroll deductions.** "Employers who do not allow payroll deduction of HSA contributions make the HSA contribution process more difficult for employees," Barson says. Moreover, he adds, the employers may miss out on an opportunity to reduce FICA taxes.
- **Failure to communicate that the HSA is owned by the employee, not the employer.**

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enrollment. Savan encourages employers to include financial planners, who can help employees make decisions about their entire benefit program and answer key questions, such as “Should I contribute to my HSA or 401(k) first?” Tripp agrees, and sees some companies starting to combine “health and wealth messaging.” As HSA balances build, and as retiree health becomes a more critical issue, coordinating these messages will be more crucial and, ideally, more commonplace. Single statements that reflect all of the benefits are starting to catch on, she says. For instance, she says that The Principal Financial Group, which handles both 401(k)s and CDHPs, provides consumers with access to all of their accounts through a single screen.

- ▶ **Failure to explain how an FSA fits the new design.** Many employers are not explaining how an FSA can cover an expense once the HSA is depleted, says Miller. The only way employees can make wise decisions is if they can calculate their total expense. One way to help them do this, says Savan, is to provide an interactive plan selection tool that allows participants to model care utilization scenarios and observe how the various plan options affect them.
- ▶ **Inadequate attention to consumerism.** Teaching employees about a CDHP should include information about how to “shop,” says Miller. “What questions should they ask when getting a prescription? What should they do when tests are ordered? What questions should they ask a doctor when treatment is prescribed?” For a CDHP to be successful, employees must become good consumers, and employers need to help educate them in this area. Hunt agrees, adding that employers need to realize it may be a challenge to get employees to fully grasp the concept of incentives for staying well (making wise lifestyle decisions) and managing health (making wise healthcare purchasing decisions). “Tools and just-in-time support, when employees have health-

care needs, are vital,” says Hunt.

- ▶ **Too much, too soon.** Many employers talk to or read about other CDHP sponsors who have added unique or interesting features to their programs over time and may be tempted to add too many “bells and whistles” to their programs too fast, says Domaszewicz. Having matching HSA contributions, incentive-based account contributions, special coverage for preventive drugs, and salary-based accounts, paycheck contributions, or designs all may be appealing, “but to do them all out of the gate could confuse even savvy benefits professionals,” he says. It’s smarter, he says, to stage program elements over time as part of a multiyear strategy.

Why it matters

Mistakes during open enrollment can be costly. Not only do you risk low enrollment, but you may need to double back later to correct misunderstandings, says Hunt. Employees routinely identify healthcare coverage as the most valuable benefit they receive, so a poorly implemented CDHP can lead to negative employee perceptions and lower morale. “Not thoughtfully preparing people for enrollment can result in employees making poor decisions about their plan choices [including whether they should opt for a spouse’s plan, enroll in an FSA, etc.] and, ultimately, can reflect poorly on and engender mistrust of the employer,” says Savan. ■

Online questionnaire

HCPPro is collecting data for our *2008 Disease Management and Wellness Directory & Guidebook*. This year, we have made it easier for you by producing an online questionnaire. Just go online and fill out the survey, and tell the world about your organization and accomplishments this year. The information will be published in the *2008 Disease Management and Wellness Directory & Guidebook*. To fill out the online survey, go to www.hcpro.com/DMquestionnaire.

CDH beyond CDHPs

More than a fad, retail clinics promote consumerism through transparency, choice, and convenience

Are convenient care clinics the new face of CDH?

Listen to some consumer healthcare experts and you may find that the hottest trend in CDH has nothing to do with plan design. Retail clinics—also called convenient care clinics (CCC) by their trade association—are small healthcare facilities located inside high-traffic retail outlets with pharmacies. They offer convenience, extended hours, and price transparency, and their presence is expanding dramatically.

There are about 400 clinics in the country, and supporters say they represent a form of healthcare that is truly consumer-driven.

Tine Hansen-Turton, executive director of the Convenient Care Association (CCA), estimates that through July, retail clinics have logged about 700,000–800,000 visits this year, and the association expects to reach one million by December. She predicts that there will be about 700 clinics by then.

These clinics, usually staffed with nurse practitioners, provide routine, nonemergency services to walk-in patients seven days a week.

“They are everything we need in the CDH space,” says **Roy Ramthun**, president of HSA Consulting Services in Silver Spring, MD. Ramthun, a former White House advisor and one of the brains behind the HSA, cites transparent pricing, convenient locations, accessible hours, quick service, and low cost—many of which, he says, are missing from traditional providers—as advantages.

What makes the clinic phenomenon significant to those following CDH isn’t just the rate of growth, it’s how this trend is driving consumer empowerment in the system at large, says **David Nash, MD, MBA**, chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia. He sees clinics as a disruptive innovation in healthcare—that is, an innovation that ultimately transforms the status quo.

As more consumers use these clinics, explains Nash, they see extended hours and price lists—things they want from their other providers. This increases the pressure for changes elsewhere in the healthcare system. He calls CCCs “the leverage point, pushing the whole marketplace toward transparency and accountability.”

It’s the start of a trend, says **Cathy Tripp**, national practice leader for consumerism at Watson Wyatt Worldwide in Minneapolis. She also points out that the first health plan to provide that level of transparency for a broader set of services is going to be very popular with consumers. “For consumers, it’s really easy to understand when you see a list of services is posted right outside the door with a price next to each one, just like you see at a fast-food restaurant.”

Sander Domaszewicz, health consumerism national practice leader at Mercer Health & Benefits in Newport Beach, CA, likens clinics to other consumer-focused innovations that encourage active consumers to try to find the best value in healthcare. He places CCCs in a larger context of on-site clinics, near-site and retail clinics, urgent-care centers, structured Web visits, telephonic visits, high-performing provider networks, centers of excellence, and even overseas sourcing of care.

The evolution of retail clinics from a cash-only business to one that accepts most major plans is a recent development, says Hansen-Turton. And it occurred, she adds, at the behest of consumers who wanted to be able to use their insurance coverage. Although the numbers are still small, more customers are using their HSAs to pay for services, and the cost of the visit counts toward their deductible.

Even at clinics not set up to debit funds directly from an HSA, the consumer only has to write a check on the

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Retail clinics

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account or pay out of pocket and reimburse him- or herself from it. All of the costs apply to the deductible, making it a good match for individuals with CDHPs, says Tripp.

Employers are paying attention, says Domaszewicz. They see CCCs as a convenient and cost-effective option for employees to stay healthy and to maximize their healthcare dollar. In fact, says Nash, employers will be bringing these clinics on site as part of that effort.

Consumers want convenience

Convenience, even more than transparency, seems to be driving much of the popularity. *Retail Clinic Revolution*, a survey of 600 retail clinic users and 900 potential users by Livonia, MI-based Market Strategies International (www.marketstrategies.com), found that 12% of retail clinic patients with a primary care physician agree with the statement "Retail clinics have mostly or completely replaced my primary care physician for the type of treatments offered at retail clinics."

The survey also asked what the primary care practices could do to win them back. The top responses aren't surprising to anyone who has heard patient complaints:

- Guarantee a wait time of 15 minutes or less
- Extend office hours
- Offer same-day appointments

Patients want convenience and access, and they will forego traditional primary care providers in exchange, explains **John E. Thomas**, vice president of Market Strategies International (MSI), a research and strategic consulting firm in Livonia, MI. "It's important to note that it matters less to them whether they see an MD or a PA [physician assistant], but they want to be seen." The trend, he says, addresses the consumer's need to be more directly involved in his or her own healthcare. It "gives them what they want, when they want it."

Such attention to the patient's needs holds tremendous appeal, explains **Kenneth T. Hertz, CMPE**, senior consultant at the MGMA Health Care Consulting Group

in Alexandria, LA. And it's something traditional providers need to pay attention to. If customers want more immediate access, perhaps practices should examine and, if necessary, reengineer current processes, he says.

AMA resistance, physician acceptance

But right now, the AMA isn't focused on competing or collaborating with retail clinics. The association has raised objections in a variety of areas, including the potential conflicts of interest posed by joint ventures between clinics and pharmacy chains.

Regardless of what's happening at the association level, the relationship between physicians and the clinics isn't necessarily adversarial. For instance, of the MSI survey respondents who visited a retail clinic and needed a referral, 48% were referred to a specific group or physician. Most clinics have contractual relationships with primary care practices, says Nash. And, adds Hansen-Turton, clinics are trying to direct patients to these doctors—especially the 30% of clinic patients who lack a primary care provider. "We want to connect people to a primary care home."

Hertz points to another potential source for resistance: the nature of the physician-patient relationship. To many physicians, both "retail" and "customer" sound pejorative. But they shouldn't, he says. "If it means that we are focusing on the patient, is that such a bad thing?"

Nash expects resistance to continue over the short term. But as evidence emerges, he anticipates greater acceptance. He says the currently unpublished research shows that the quality of care at CCS is as good as, if not better than, that of primary care. He expects the studies that support these findings to be published this year in the *American Journal of Medical Quality* (<http://ajm.sagepub.com>). "The evidence ought to remind the AMA: In God we trust; all others bring their data," says Nash.

Continuity and coordination

The AMA has also expressed concern about

coordination and continuity of care. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care, according to the medical association. However, that's already part of the CCA standards. CCA members are expected to use electronic health records, and "members are committed to providing all patients with the opportunity to share health information with other providers electronically or in paper format," according to the standards found at www.convenientcareassociation.org/QSS.htm.

In addition, CCA member clinics are expected to:

- ▶ Build relationships with traditional providers
- ▶ Encourage patients to establish a relationship with a primary care provider
- ▶ Make appropriate referrals for follow-up care and for conditions outside the scope of the clinic's services.

In fact, according to Nash, most clinics follow up with a next-day phone call to patients. And when possible, someone from the clinic e-mails the primary care physician with information about the visit.

Transforming healthcare?

MSI's findings—and the projected growth of the industry—indicate that a consumer-driven transformation of healthcare is under way, and retail-based clinics are part of that transformation.

An interesting finding of the MSI study is that the primary reason patients said they didn't use retail clinics is that they didn't know they existed. As more people find out about them, more will use them, says Thomas.

Moreover, the business model may expand. Currently, these clinics generally treat cough-and-cold type conditions. But the MSI survey suggests consumers want more. Those who have used retail clinics are open to receiving treatment there for a wider range of conditions, such as migraines, high cholesterol, and hypertension. Nearly 30% of all respondents said they believe retail clinics should compete with primary care physicians by offering a broader variety of more complex care and diagnostic services.

Clinics are unlikely to usurp the role of the primary care physician. Some clinics may offer more services than they do now, but it's improbable they will ever become full-service practices. After all, says Thomas, CVS probably doesn't want someone with a highly infectious disease wandering down the candy aisle.

Nash expects the service to expand, most likely in the preventive care space. Over the long term, these clinics will provide increasingly sophisticated preventive care services, including cancer screenings, hemocult cards, urine protein tests, and glucose monitoring, he predicts. "They are going to turn into the leading edge of prevention and wellness."

Just how these clinics will evolve may be determined by economics, consumer demand, and a variety of other factors. But they have carved out a niche—which appears to be widening. And, at least according to some observers, they "disrupt" the standard approach to healthcare by putting the consumer, not the provider, first. "It's about meeting the needs of the patient, not the needs of the healthcare organization," says Thomas. ■

Pediatric patients and retail clinics

A recent University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health found a growing trend in the use of retail clinics. It found that 10% of U.S. children have used such a clinic for healthcare, and 15% of children are expected to use a retail clinic in the future.

Among the other findings:

- ▶ Children who have used retail clinics are less likely to have a regular doctor than children who have not used one. Among the children who had used a retail clinic, 89% have a regular physician, compared to 97% of children who had not.
- ▶ More than half of parents reported their child's last visit to a retail clinic was covered in full by insurance.
- ▶ Parents with annual household incomes of \$30,000 or less were more likely to use a retail clinic and are more likely to use them in the future than parents with higher incomes.

Medicare MSAs report modest success in 2007 despite late launch; some anticipate dramatic growth rates in 2008

MSA plans designed to bring CDH to the senior market

Medicare's version of the HSA is getting ready to enter its second year, and despite the first year's relatively low numbers, these MSAs may become a small but significant niche within Medicare. (Statutorily, Medicare can't allow insurers to offer HSAs.)

Lee Barson, director of business development for ACS/Mellon HSA and Medicare MSA solutions in Philadelphia, expects the rate of growth of these MSAs between January 1, 2007, and January 1, 2008, to exceed that of HSAs for the same period.

Of course, the key concept is "rate of growth." These MSAs got off to a slow start last year, so the 2007 update is low—around 2,300. As in 2007, next year insurers will be able to offer either a Medicare MSA or a Medicare MSA demonstration plan. The latter more closely resembles an HSA. (For details about the demonstration project, see the August 2006 issue of **CDH**.)

Although CMS had made no announcements as of presstime, Barson expects more insurers to offer Medicare MSAs for 2008, which means more publicity for the accounts and, ideally, greater enrollment. In 2007, the lead-up time was so short that employer groups didn't have the opportunity to sign on; the MSAs were marketed only to individuals. He expects that to change in 2008.

Barson also expects growth because the concept itself is appealing. As with HSAs, "there's something to be said for someone putting money into your account," he says.

Ideally, giving Medicare Advantage members access to CDHPs would promote individual choice and control as well as cultivate more careful use of the health-care dollar. "It definitely encourages consumerism," says Barson. (The demonstration MSA, in particular, is focused on consumerism.)

Year one

Medicare MSAs were first authorized in 1997 and reauthorized in 2003, but insurers weren't interested and didn't develop any products for the market. However, with the Bush administration promoting CDH and Congress making changes to conform the Medicare MSAs with Medicare Advantage rules, Medicare MSAs got a new life and were relaunched late last year for 2007 coverage.

Unfortunately, the lost time proved costly. As HSAs were gaining traction in the commercial market, MSAs weren't moving at all, says **Jean LeMasurier**, director of the employer group practice at the Gorman Health Group in Washington, DC. And whereas CDH was evolving on the commercial side, it was stagnant in the Medicare

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arena. MSAs did not keep up with all of the changes in the commercial marketplace, she explains.

So, when the Bush administration wanted to bring CDH to Medicare, it decided to buff up the MSA and, thus, the demonstration project. However, the 2007 demonstration project didn't take off. Only one company, American Progressive, offered such a plan, and according to LeMasurier, only a handful enrolled. The problem, she explains, is CMS didn't have the marketing and materials together in time for insurers considering the program.

The conventional Medicare MSA fared better, accounting for almost all of the approximately 2,300 enrollees. Still, only one company—WellPoint, through its Unicare and Blue Cross of California brands—offered these plans, says Barson. (Barson's firm, ACS/Mellon, administers these accounts, he explains.) Given that this was the first year for the product, WellPoint was pleased with the response, says **Richard White**, WellPoint's vice president of product management and innovation in the senior business division.

The basics

The Medicare MSA plans cover all Medicare Part A and Part B benefits. Members in an MSA plan will receive an annual deposit into an interest-bearing account from CMS to help them cover their healthcare costs.

Members can use these funds to pay for medical service, just as with an HSA. Medicare MSA plans cannot cover Part D drugs, but MSA enrollees can join a stand-alone prescription drug plan. And, although MSA funds cannot be used to pay the Part D premium, they can be spent on copayments, coinsurance, and deductibles for Part D drugs. They can also be used (without penalty) to pay for long-term health insurance premiums, says LeMasurier.

Leftover funds can be rolled over into the next year. (However, HSA funds cannot be rolled into an MSA.)

Despite pending changes to Medicare Advantage, the earliest MSA changes would occur after the 2008 elections. But, notes LeMasurier, if the MSA is successful, "there will be a number of legislative changes to make it more up to date." One change she'd like to see is allowing HSA funds to be rolled over into the Medicare MSA.

Consumer-driven demo

The demonstration MSA has a few distinctive elements that make it more similar to an HSA. The following are among the most important:

- ▶ Cost-sharing after deductible (a standard Medicare MSA plan pays 100% after the deductible)
- ▶ Reduced cost-sharing permitted for in-network services
- ▶ Predeductible coverage for preventive services.

The demonstration model also places strong emphasis on transparency.

Participating plans must provide their enrollees with cost and quality information about healthcare services—and tools to help them use this information. At least through 2008, both the demonstration MSA and the standard Medicare MSA will be permitted.

The market

These products can appeal to both the individual and employer markets. It makes particular sense for employers who already have CDHPs in place and plan to offer retiree health coverage.

Barson, too, thinks seniors who have had positive CDHP experiences would be well-suited for a Medicare MSA.

"It is a great way for an employer to keep older workers on a CDH plan while reducing their cost," says former White House advisor **Roy Ramthun**, president of HSA Consulting Services in Silver Spring, MD, and one of the brains behind the HSA.

He sees these plans as a particularly good fit for any senior with expenses below the CMS contribution to the MSA. In addition, the fact that the plans (other than the demonstration ones) must pay for 100% of covered Medicare benefits after the deductible is met should appeal to all seniors, he says. "To get that kind of coverage today, you have to pay an arm and a leg."

At this point, Medicare MSAs are just a "footnote" to CDHPs, says LeMasurier. But they may provide

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Medicare MSAs

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carriers with the opportunity to get in on the ground floor with new products as Baby Boomers start to enroll in Medicare, she notes.

Challenges and outlook

Despite the anticipated growth rate, the following are challenges to overcome if the CDHP model is going to work in the Medicare space:

- **Education and communication.** As in the commercial market, CDH success depends on educating enrollees about how their plan works. This may be especially difficult for retirees who have never encountered CDHPs, says Barson. White agrees, identifying this as one of the most important lessons learned in 2007.
- **Disenrollment and death.** The MSA is fully funded at the start of the year, but the enrollee owns only a prorated share of the current year's contribution if the enrollee leaves the plan during the year, says Barson. If the enrollee dies or disenrolls midyear, what happens to the funds allocated for the rest of the year, he asks? Technically, they revert to CMS. But how

practical will it be to collect? Will health plans go after the estate? (The amounts previously accumulated stay with the estate, he adds.)

➤ Calculating the penalty for nonqualified expenditures.

But perhaps the biggest hurdle is the same one that faced HSAs not that long ago: newness.

"Since we were the first plan to introduce MSAs to the marketplace, there were no protocols on how to administer the product," says White. "We worked collaboratively with CMS to develop processes and procedures to implement the product and are pleased with the result."

That newness brings with it another challenge to overcome: fear of change.

"People are resistant to change," says Ramthun. Overall in Medicare, he says, there's only a 20% adoption of private-plan alternatives to the traditional fee-for-service program. But as CDHPs catch on in the commercial market, they will gain traction in the Medicare market, he says. "Over time, people with HSAs will want the MSA option, I believe." ■

News in brief

HSAs near 5% penetration

HSAs are approaching 5% penetration, according to an analysis by Ridgefield, NJ-based Information Strategies, Inc. Among the states with the highest penetration (5%–7%) are Wisconsin, Texas, Georgia, Florida, Illinois, Ohio, Tennessee, and Kentucky. Among the lowest (below 2%) are New York, New Jersey, Rhode Island, Hawaii, and Vermont.

Premera offers bill estimator

Some Washington state consumers

can now get an estimate of what their portion of the bill will be, thanks to a new online tool offered by Premera Blue Cross to hospitals in Washington. The Out of Pocket Estimator (OPE) tool enables hospitals (and soon, clinics) to provide an estimate to patients of their out-of-pocket costs for hospital services, based on their specific benefit package. Providence Everett Medical Center went live as a beta site in early February, with other hospitals and major clinics targeted for the OPE by year end. The OPE tool is a Web appli-

cation that is compatible with virtually all systems used by hospitals in the state, according to Premera (www.premera.com).

New broker tool offered

HSA Clearing Corp. and brokersXpress have announced an agreement with HSA Financial, a turnkey HSA brokerage solution. HSA Financial is available to those banks and credit unions that wish to offer stock, mutual funds, and options brokerage capabilities within HSAs. ■