Many employers are now looking to high-deductible health plans (HDHPs) paired with health savings accounts (HSAs) as a potential solution to rising health insurance costs. However, marketing a new plan to employees who are used to a traditional preferred provider organization (PPO) requires careful planning and extensive communication. This author recounts how one manufacturer introduced HSAs and enjoyed significant cost savings.

A Step-by-Step Approach to Introducing Health Savings Accounts

by J. Michael Vittoria

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When faced with a potential 37% premium increase for its traditional PPO plan, one manufacturer knew it had to start aggressively managing health insurance costs.

The year was 2004, and the company began a migration toward a consumer-driven health plan (CDHP) model. The move to the new plan design proved to be highly successful in controlling costs for the company and its employees. Since 2005, the company's annual health insurance increases have averaged less than 4% per year, and the cost of its plans are now $1,000 to $2,000 below national averages. Even though these particular employees live in some of the highest-cost states in the nation and have an average age of 45, employees' total health care costs are now 20% to 30% below community averages. It is estimated that the new plan design saved both the company and its employees a total of $7.7 million from 2004 to 2006. The company's U.S. health insurance expenditures are projected at approximately $8.8 million for 2007.

Significantly, these results were achieved without changing the overall cost-sharing formula between the company and its employees and while keeping employee payroll deductions for health insurance stable (or falling) during the entire three-year period.

The company, which manufactures personal protective equipment for firefighters, first responders and other workers, has 6,000 employees throughout North America, Europe and Asia.

The plan outlined in this article covers 1,300 employees and their family members at ten locations in nine states.

The company implemented the shift in design with the

assistance of a broker/ consultant/third-party administrator (TPA) that specializes in custom-designed CDHP solutions for midsized employers.

In 2006, after completing the initial transition to CDHPs, the next phase of the cost-saving strategy was launched with the introduction of HSAs to employees. Even though none of these employees had any prior experience with HSAs before this company introduced them last year, 23% selected the new plan over the more familiar PPO option. More remarkable was the fact that most of those who selected the HSA did not fit the usual profile of what conventional wisdom tells us a typical HSA enrollee looks like (young, healthy and wealthy):

- **Age:** 69% of these HSA participants are over age 40, and 33% are over age 50. (Only 9% are under age 30.)
- **Income:** 52% of these HSA participants earn less than $50,000 per year, and 34% earn less than $30,000 per year. (Only 26% earn more than $75,000 per year.)
- **Health Status:** 14% of these 2007 HSA enrollees had at least $1,000 in health claims in 2006 (compared with 16% of the company's total population), while 4% of these HSA enrollees had claims in excess of $5,000 (compared with 5% of the company's total population).

As these results show, it is possible to design an HSA plan that will control costs and have broad appeal to employees with diverse backgrounds. The key is to approach the design and introduction of HSAs to employees using the same methods that would be followed to introduce a new product to the marketplace. The steps to a successful HSA launch are essentially the same as a successful new product launch.

Step 1: Set Goals

With any project, the likelihood of success greatly increases once clear, measurable goals and a well-thought-out plan for achieving them are established. Regarding health plan design, this company found that striking a balance between employer and employee needs is critical to achieving long-term success. Here are three simple questions that employers beginning a similar transition might want to consider:

1. How much can the organization afford to spend on health care as a percentage of revenue?
2. How much can employees afford to spend on health care as a percentage of their hourly wages?
3. Will employees see their health plan's features and benefits as desirable, thereby enabling the organization to attract and retain the best people?

When this company's benefits administrators asked themselves these questions in 2003, they concluded that in order to keep the health plan affordable for the company and employees while still being able to attract and retain the high-quality people needed to grow the business, they needed to design a health plan that would keep the average annual increase in health insurance expenses to 5% or less. Since it became clear that cost shifting wasn't a viable long-term option, the only realistic solution was to design a plan that controlled cost for both the company and its employees. The decision makers therefore opted to maintain the longstanding cost-sharing formula in which the company paid 70% of total costs while employees paid the remaining 30%. But it was apparent that to do this effectively would require a migration from a traditional PPO plan design to a consumer-driven model that would get employees to become more engaged in health care cost control—and give them the opportunity to share in the savings if the change was successful.

Step 2: Introduce Consumerism a Little at a Time

In retrospect, one of the most important decisions the company made early on was not to introduce HSAs too quickly to the employees. Decision makers knew that changing a benefits culture does not happen overnight. From 2004 to 2006, the company followed a deliberate path of gradually transforming its traditional PPO plan into a consumer-driven model using a partially self-insured wrap design combined with a health reimbursement arrangement (HRA) that encouraged employees to assume more responsibility and control for their health care purchasing decisions. The plan was custom designed for the company by a major insurer. The insurer handled the nationwide claims administration for the insured part of the plan, while the TPA managed the self-insured HRA component.

By the start of 2006, employees had a choice of three different PPO models, each with different coverage levels, deductibles and payroll deductions. This was the point at which it seemed the workforce was finally ready to seriously consider an HSA option. The key was to design an HSA that employees would want.

Step 3: Listen Before Launching

Even though the employees had become more comfortable with a consumer-driven model by early 2006, it was clear going from a PPO-type plan to a true HSA would still be a jump. Therefore, the company held a series of employee focus groups at key locations around the country in order to gain a better understanding of how employees might react to an HSA offering.

Each focus group was comprised of 12 to 15 employees who were carefully preselected to represent as broad a cross section of the organization as possible. Each had a mix of production, office and management employees who were representative of employees enrolled in all of the health plan options. Employees who weren't currently enrolled in any of the company's plans were also included. Each meeting lasted about three hours and helped the company gain an understanding of four things:

1. Why employees selected the health plan option that they currently had
2. Which attributes of a health plan were the most important to them
3. The process that they generally used to make major consumer purchases (such as buying a new car or a major appliance or planning a vacation)
4. How effectiveness of the current health plan communications could be improved.

The one thing that was not discussed in the focus group meetings was HSAs. That was by design. The goal was to understand what motivated employees' health care purchasing decisions, rather than the ultimate plan selection decision itself. The idea was that if the employees' decision-making process could be understood, the company would be able to design an HSA plan that would have broad-based appeal.

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When results from the different groups were pulled together, several common themes emerged:

- Most employees who selected the traditional PPO option described themselves as risk averse and willing to pay more out of their paycheck each week to limit their potential exposure to a large claim.
- Those who selected a higher deductible option with a lower payroll deduction described their plan as "being a good value."
- When asked what they would do with money saved if they selected a plan with a lower payroll deduction (but a higher deductible), most employees said they would save at least half of it—probably in their 401(k) plans. They would use the rest to supplement their household budgets.
- Generally, they were willing to spend hours researching a major consumer purchase and were able to engage in fairly complex decision making, but they typically spent much less than an hour on making their annual health insurance elections.
- Most health insurance communications were described as being too complex with too much detail. Simple side-by-side comparisons in plain language that could be quickly read and easily understood were more useful than brochures filled with legalese and fine print.

The most interesting information, however, came from an exercise referred to as "the four *C*s of health insurance" in which each participant was asked to rank the importance of four key attributes of a health insurance plan:

- **Coverage** (including access to the broadest possible network of health care providers with the least restriction on the types of services covered by the plan)
- **Cost** (including deductibles, copayments, coinsurance and the weekly payroll deduction)
- **Convenience** (the ease of use of the plan with minimal forms to fill out and records to keep)
- **Cash flow** (the ability to pay as you go for out-of-pocket health care expenses without unexpected surprises).

When the rankings from the five focus groups were compiled, a consistent pattern emerged. Fifty-nine participants (83%) ranked some combination of coverage and cost as first or second on their list of key attributes. Nearly the same percentage (80%) placed convenience as either third or fourth. An even higher percentage (86%) had cash flow as third or fourth on their list. Pulling all of this together and describing it in one sentence, we learned that: Employees wanted access to comprehensive coverage at a reasonable cost, and if it was necessary to trade off some convenience and deal with an occasional cash-flow issue in order to maintain coverage and cost, they would be willing to do so. Essentially this is a description of an HSA-type health plan.

Step 4: Design New Health Plan Options

Armed with the information from the focus groups, the company began the task of finalizing plan designs for 2006 open enrollment. The first decision was to offer, for the most part, only two nationwide plan designs. These were referred to as the "PPO option" and the "HSA option" for simplicity and ease of communication. (Employees in New York and California also had a third option of enrolling in a local health maintenance organization (HMO).) Both the PPO and HSA options used the same national network of physicians, hospitals and pharmacies and covered the same services so everyone had access to the same quality of care (the coverage issue). The issue of cost was addressed by balancing the weekly payroll deductions, plan deductibles and company contribution to each employee's HSA so that the employee's total cost came out about the same if a major expense, such as a hospitalization, was incurred under either the PPO or the HSA option. This gave HSA participants the security of knowing that they were protected against high-dollar claims under a worst-case scenario, while also giving them the opportunity to save money (when compared with the PPO plan) through lower payroll deductions and the company HSA contribution. Finally, the potential cash-flow issues were mitigated by scheduling the full company HSA contribution ($250) as a lump sum to be deposited during the first week of January. This left the convenience issue as the last hurdle to broad-based acceptance. (See Step 6 for the way this issue was addressed.)

Step 5: Communicate and Educate

The insights gained from the focus groups resulted in a complete redesign of benefits communications leading up to the open enrollment period, but there were three things that had the biggest impact on HSA enrollment in this case.

1. The term "high-deductible health plan" was eliminated from company personnel's benefits vocabulary.
2. The company turned making a health insurance election into a consumer purchasing decision.
3. The protection provided by the HSA design was emphasized rather than the tax savings.

It was apparent that the first thing that had to go was the term "high-deductible health plan." Instead, it was replaced with the term "up-front deductible," which seemed to convey more accurately how the HSA plan actually works and makes for more straightforward and understandable communication to employees. When employees were told that they would pay an up-front deductible of $1,100 (and the plan would then pay 100% of their remaining expenses), they knew exactly how much they were going to be expected to pay and when they would have to pay it.

Rather than rely on the printed material provided by the health insurer, the company worked with the TPA to design a series of colorful one-page communication pieces that grabbed the attention of employees and got them thinking about the financial decision involved in choosing a health plan. Using eye-catching headlines such as "Did You Get Your Money's Worth From Your Health Plan Last Year?" and "It's Your Money to Keep, Spend or Save," the goal was to get employees to start thinking about their choice of health plans just as they would with any other major purchase costing thousands of dollars. The company wanted employees to make their decision in terms of the *total value* of their plan (the four key attributes identified in the four *C*s exercise by the task forces).

The last thing the company did differently was to emphasize the protection offered by an HSA plan, rather than focusing on the tax savings. That's not to say the tax benefits of HSAs were ignored in communications; it's just that the tax considerations were kept in proper perspective. Tax

savings are a big benefit for those with higher incomes, which is probably how HSAs got the reputation that they are only good for the rich. But, the average person buys health insurance for protection rather than for tax breaks, and this is one area where an HSA can really shine if it is properly presented. A big advantage of this HSA plan design is that it pays for 100% of covered expenses once the up-front deductible is satisfied. As explained to employees, this meant that they always knew with absolute certainty what their worst-case scenario would be. The idea that the deductible gave them a "not-to-exceed cost" for health expenses had powerful appeal for many employees, especially those who described themselves as "risk averse" and normally inclined to pay the higher weekly PPO premiums for the peace of mind that was provided.

Step 6: Make Sure "Service" Is Part of the Plan

Several recent surveys have concluded that a large percentage of current HSA participants are unhappy with their plans and would prefer to return to a more traditional PPO model if the option was available to them. Based on what was learned from the employee focus groups, it could be concluded that a major source of this dissatisfaction stems from the convenience factor or rather the lack of it. For all of the benefits of CDHPs in general, and HSAs in particular, the big criticism of these plans is that they require more work on the part of a participant than simply walking into a doctor's office, plunking down a membership card and a small co-pay and not caring after that what gets done or how much it will cost. As employers modify their plans to increase employee engagement and responsibility, the initial employee reaction is often, "My new health plan is no good, it's too hard to use."

In most businesses, "service after the sale" can be a key product differentiator. This is especially true when introducing a new product to the market. New product launches rarely go off flawlessly. The same is true for a new HSA launch. There will be a learning curve as employees try to understand how to use their new plan. There will be billing issues with the provider community, especially if the providers do not already have a large number of patients with HSAs.

In this case, employees were told, "You will be the first one on your block to have an HSA, so don't be surprised if your doctor hasn't seen one yet." Plan designers fully expected that, with hundreds of employees and their family members using an HSA across the United States, the company would face its share of problems, especially in the first few months. Those who designed the plan also knew that they did not want those problems to be handled by the company's local HR departments.

The solution was to set up what the TPA now calls *concierge service.* Borrowing from the model of the hotel concierge, the TPA has one person (her name is Sara) who does nothing but work with this company's employees to help them manage their plans. If an employee's doctor doesn't understand how to bill for a particular service, Sara will call the doctor's office and walk their staff through it. The same thing is true for hospitals, pharmacies, etc. If an employee (or family member) contacts the company's HR staff with a problem, the first thing asked is, "Have you talked to Sara?"

One employee actually asked if "Sara" was an acronym for some type of automated customer service system (as in "SARA"). He was pleasantly surprised when he learned that Sara was a real person whose only job was to help make his health plan work for him. But ultimately, that's what a good health plan is all about—making it work for employees, one person at a time. **B&C**

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J. Michael Vittoria has more than 25 years of human resources (HR) management experience with organizations of all sizes. He is director of HR at Sperian Protection. Vittoria received a B.S. degree in business administration from Marquette University, an M.B.A. degree from Providence College and a J.D. from Suffolk University Law School.

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