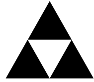
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ISSUE BRIEF
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Understanding Defined Contribution Health Plans

The current U.S. health care environment can be characterized by several features—rapidly increasing costs, employers' desires to control these costs, and consumers' desires for more choice, quality care, and information. These factors have led many employers to consider a shift from providing a specific health insurance benefit package (i.e., a "defined benefit" approach), to providing a specific contribution that workers can use to purchase the plan of their choice, perhaps from among a group of employer-selected options (i.e., a "defined contribution" approach).

A defined contribution health plan is not a particular type of health plan. Rather, it is a concept that gives rise to alternative approaches to financing and managing health care for employees. These approaches can be arranged along a continuum of alternatives that realign responsibility, or choice, from the employer or sponsor to the employee or participant.[1] *Primary differences among the approaches reflect the degree to which responsibility and choice are shifted.*

As the concept of defined contribution has evolved so has the terminology used to refer to this range of health plan approaches. The term "defined contribution," in its most literal interpretation, refers to approaches that provide a more predictable cost for the sponsors. However, since many of the approaches that satisfy this goal result in other changes—increased consumer role, use of the Internet to disseminate information—a number of other terms are used. Today, terms such as "consumer-driven," "consumer-directed," "e-health," and "self-directed" are used as much as the original "defined contribution" terminology, and often the terms are used interchangeably to refer to the same approach. We will use the term defined contribution health plans throughout this issue brief to refer generally to the various approaches that are associated with this concept.

This issue brief provides an overview of the defined contribution approach to health coverage. After a brief discussion of trends in health plan approaches and the factors contributing to the emergence of defined contribution health plans, the issue brief describes the characteristics and types of defined contribution health plans.

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The Evolution of Health Plans

Defined contribution (DC) plans are the latest development in the continuing evolution of health plans. Traditional fee-for-service (FFS) plans became popular during World War II, when national wage freezes induced employers to offer more health care coverage, which was deductible for employers and tax-exempt for employees. FFS plans defined the scope of services covered (with some services specifically excluded and maximum reimbursement specified for most if not all other services), but consumers were generally free to seek these services from the provider of their choice.

As health insurance costs grew dramatically, however, particularly in the 1980's and early 1990's, employers/sponsors sought ways to contain their costs. This led, in part, to the proliferation of managed care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Under these plans, insurers negotiate discounts with providers, who then aim to provide quality care more efficiently. Unlike FFS plans, most HMO plans cover services received from providers in the HMO network only. Utilization controls also help contain costs. PPO plans, which do cover services from out-of-network providers, but at higher cost-sharing to consumers, have grown in prominence, as consumers desire fewer restrictions on their access to care.

Although managed care helped control costs initially, substantial cost increases have returned. As a result, many plan sponsors are considering passing along a greater share of rising health care costs to their employees, through increased premiums and/or increased cost sharing. Plan sponsors, health plans, and consultants have been searching for other alternatives to control costs without negatively impacting the level or quality of care. The DC concept has appeal for those employers/sponsors who seek to control costs while encouraging informed consumption of health care. Advocates of DC plans believe that limiting available dollars but promoting access to available knowledge will lead to health care that is both more cost efficient and of higher quality.

Factors Contributing to the Emergence of DC Health Plans

Several emerging health trends make DC plans a potentially more attractive option to plan sponsors, and perhaps to other participants in the health care services process as well. It is not yet proven whether DC health plans will influence these trends.

- *Rising Costs.* After a period of moderate increases in health costs, double-digit premium increases have returned—often as high as mid to upper teens, sometimes even at or above 20 percent.
- *Consumers' Desire for Choice and Involvement.* Consultants report that many consumers are expressing greater interest in becoming more personally involved with their health care choices and decisions. This is also seen in the consumerists' support for patient's rights legislation.
- *Providers Appear to Want to Regain "Control."* Under managed care, many providers feel they have had to relinquish some of their control over decisions regarding patient care. Providers appear to want, and perhaps may even need, to regain this control, at least with a greater ability to advise patients as they make more of the decisions. Although the shift to PPOs has helped providers regain control over their decisions, some providers feel even this is too constraining.
- *Patients' Rights and Liability.* Concerns regarding managed care have led to proposals for patients' rights, which include increased liability for health plans as well as employers who sponsor them. This additional risk to both health plans and employers, along with the new regulations regarding privacy of medical information, places additional burdens on plan sponsors and may lead to increased costs.
- *Information Expansion and Ease of Access.* Consumers' desires for more choice and involvement in their health care decisions have fueled the need for information, and the increased availability of this information has, in turn, fueled the desire for more choice. The Internet, in particular, has provided easy access to a broad range of medical information as well as a more refined and user-friendly approach to evaluating providers and health plans.
- *Quality Concerns.* Concerns about the quality of health care are a growing factor in health plan selection by plan sponsors. Employers/sponsors are hopeful that more consumer involvement will improve the quality of care and enhance the level of information available on the quality of health care.
- *Competition for Employees.* Small employers, in particular, are searching for a more feasible approach that would allow them to provide at least some form of health insurance benefit to their employees.

DC in the Context of Health Plans

Defined contribution, a common approach to retirement plans, has recently become a more appealing option to employers who provide health care coverage. Before discussing DC health plans in more detail, it is useful to first review the defined benefit (DB) and DC approaches to providing retirement benefits. Under DB retirement plans, employers promise employees a specific benefit at retirement—the employer defines the benefit to be received by the retiree (e.g., a monthly pension of *x* dollars per year of service with the employer, or *y* percent of the salary earned in the last year working for the employer). The employer contribution required to properly fund the promised benefit is calculated using various assumptions about what might happen between the present day and the time when benefit payments are actually received.

In contrast, under DC retirement plans, employers make no promises about the level of benefit available to future retirees. Instead, they commit to fund a retirement plan that *defines* a specific *contribution* to be made on behalf of each employee (e.g., a contribution of *x* dollars each year, or *y* percent of salary earned in a year). The employee's retirement benefit consists of the funds accumulated over his or her working lifetime from those employer contributions.

Traditionally, employer-sponsored health plans have followed a DB approach. Under this approach, an employer promises a specific package of health benefits, and the premium, or contribution rate, is calculated based on the expected cost of those benefits. The insurer, or the employer in self-insured plans, bears the risk of any funding shortfall. (If the premiums are too low, the insurer or employer is still required to provide the promised benefits.)

Under a DC approach to health care, however, employers promise to provide a specific contribution that workers can use to purchase the plan of their choice, perhaps among a group of employer-approved options providing a variety of benefit designs. In addition, or alternatively, some DC health plans may involve setting up a medical savings/spending account. In contrast to DC retirement plans, DC health plans are focused on immediate health benefits (current consumption) rather than long-term capital accumulation. The intended use of the funded account balance (if one exists) is for immediate non-catastrophic health care expenses. DC health plans have an insurance component that protects the participant from catastrophic events. Therefore, the benefits from DC health plans are not limited to accumulated contributions and investment return.

Characteristics Common to DC Health Plans

Health plans using a DC approach can vary greatly in their specifics. Nevertheless, many DC health plans share many common characteristics, which are discussed below. A health plan is not required to have all of these characteristics to be considered a DC health plan, and many of these features exist in other types of health plans as well.

Participant choice

One of the goals of DC health coverage is to give participants greater flexibility in making benefit decisions. Participant choice arises in three benefit decisions:

- *Plan choices.* The number of benefit choices that a sponsor offers can vary widely. A limited set of high benefit and low benefit options may be offered or the sponsor may allow a large array of options that may include more than one health plan.
- *Care choices.* A participant may be able to choose which providers make up his or her network during enrollment. Other plans allow the participant to choose the network provider at the time of service or episode of care. Some plans have no network restrictions.
- *Opt-out.* Some plans allow participants to opt out of coverage. In these plans, the employer must address whether and how to compensate workers who choose to opt out.

When given choices, participants generally make decisions that are to their own advantage, consistent with what they know about their health conditions. These decisions may result in adverse selection, which should be included in any planning for such choices, especially in DC plans that provide a savings/spending account.

Increased participant cost-sharing

To facilitate more efficient health care consumption, participants are expected to assume an increased financial role. The hope is that by giving participants a financial stake in the outcome, they will be encouraged to spend money more effectively. The most straightforward way to increase the financial stake is to increase the plan's cost-sharing provisions (e.g., deductibles, copayments, coinsurance). Another method is to establish a medical savings/spending account.

Participant education

DC health plans allow participants to become more involved in managing their health care. Sponsors frequently provide information and various tools to enable the participant to make effective and informed decisions. The sponsor may provide information on the benefit plans as well as information to help consumers control and manage their health outcomes. Participant education regarding benefit options and their related costs becomes particularly important if the participant has a large financial stake in the outcome.

The type of information provided is varied, and it can include data on provider quality, best practice guidelines, health care management, provider cost information, and medical records (electronic). The information can be delivered to the participant in many ways, and the sponsor may provide multiple sources for information including Internet sites, brochures, flyers, publications, personal health care advocates, or telephone hotlines. As an alternative to setting up its own information delivery mechanism, a sponsor may choose to subcontract with one or more vendors.

Internet enabled systems capability

Many plans use the Internet as one of the information delivery mechanisms because it provides a cost effective way to deliver a large amount of information to the target population. In addition to information delivery, the Internet may be used for other administrative functions including billing and eligibility, enrollment, claims processing and information, sales and marketing, and savings/spending account tracking.

DC Health Plan Continuum

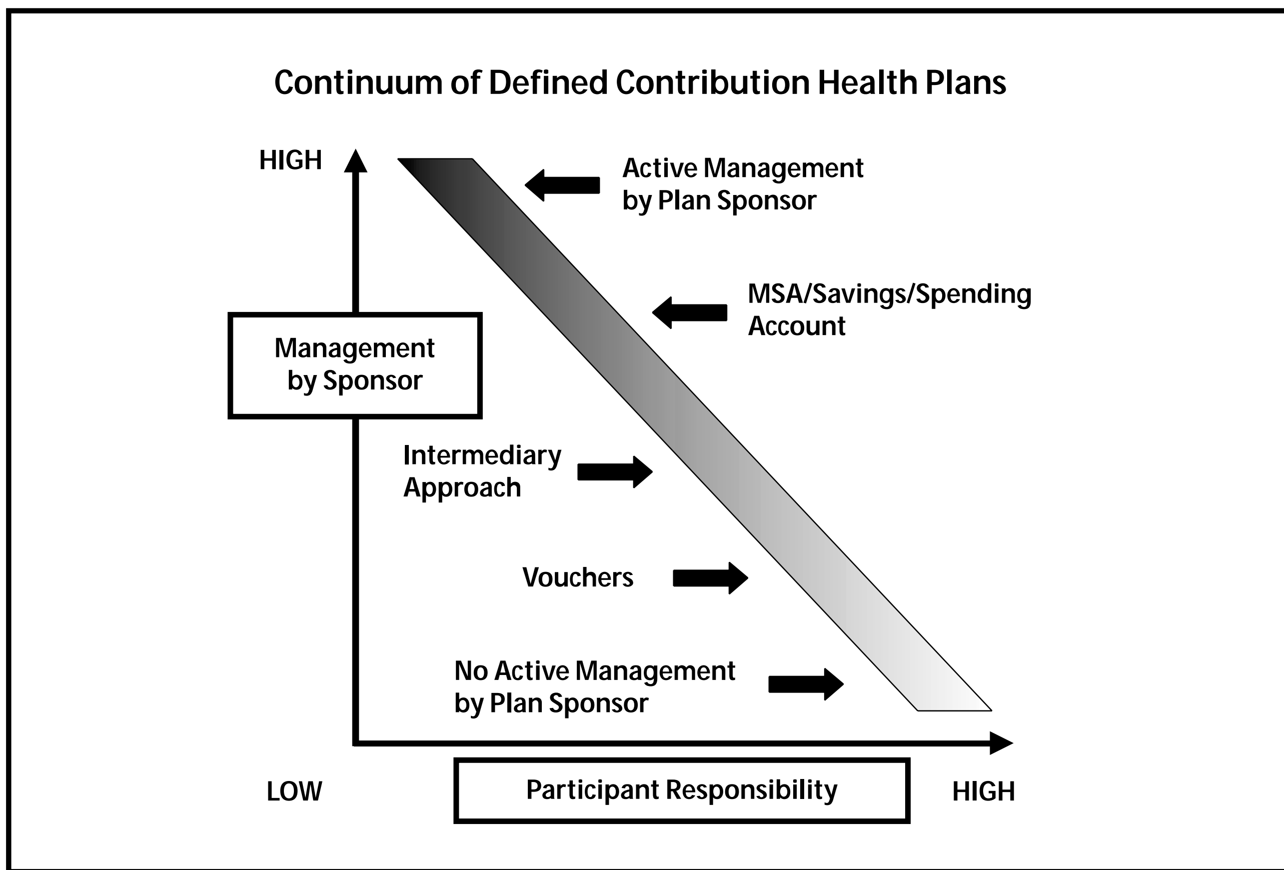
There are several ways to array the vast range of DC plans, including the level of employer management, the market in which coverage is purchased, and the degree of financial risk born by the employer. This issue brief presents a continuum of DC health plans according to the level of employer management. When adopting a DC approach to providing health benefits, the plan sponsor moves away from active management and toward a more passive approach. The responsibilities for choosing a plan and/or bearing the financial risk are shifted from the sponsor to the participant, mostly by incentives and occasionally by mandate.

There are many different types of plans along the DC continuum. One extreme of the continuum can be viewed as an extension of the current DB model—employers continue to actively manage the plan. At the other extreme, employers simply provide funds to participants to purchase health benefits on their own.

The following DC health models provide some conceptual points along the continuum of potential DC health plans that are intended to help define the DC concept. Moving along the continuum, the sponsors' role in managing the program gradually changes from active to passive. The examples provided are not intended to be an exhaustive list of all types of DC plans, but rather reflect the range of options available. Not all points along the continuum are fully viable in today's marketplace and regulatory environment. Only time will tell which approaches will successfully evolve in each marketplace.

Active management by the plan sponsor

An actively managed DC health plan looks similar in many ways to a DB plan. The plan sponsor takes a fairly active role, and the participant's role is relatively passive. The sponsor offers a limited number of benefit plan options to the participant. Although participant choice among these plans is generally allowed, the range and number of these choices are still determined by the sponsor. This structure is somewhat similar to a Section 125 cafeteria plan, which allows participants to have some choice in designing their own benefit packages, including non-health benefits.



The sponsor establishes a maximum contribution it will make for participant health benefits, with the participant funding the difference between the price of benefits chosen and the amount funded by the sponsor. Plan sponsors may structure the plan contributions to correspond to a pre-determined budget or the cost of the lowest-cost plan, or may vary contributions based on tenure, family status, or salary. The sponsor may also vary the relative plan contributions to encourage the selection of certain plans.

Rather than offering a limited number of plans, the sponsor may instead offer participants a list of recommended plans. The sponsor may have arranged for a discounted premium rate for its recommended plans for participants. The recommendation may also be a result of the sponsor's review of the plans' service, premium rates, or some quality measures. In some cases, participants may choose from some plan options that are not on the list of recommended plans, although it may cost more or have reduced benefits.

MSA/Savings/Spending account approach

In this approach, the participant has an "account" to use to purchase health care. There is also an insurance component. In most instances, the account is used to cover high-incidence, low-severity health services. High-severity, low-incidence health services are intended to be covered by the insurance component. An objective of these plans is to provide participants the incentive to more actively participate in the health care purchasing process, thereby leading to more efficient health care decisions.

The three types of accounts[2] vary by whether cash or notional dollars are used, and whether they are tax advantaged:

- MSA accounts use cash dollars and are tax advantaged.[3]
- Savings accounts use cash dollars but currently are not tax advantaged.
- Spending accounts credit notional dollars instead of cash dollars and their use may be tax advantaged.

There are many issues that need to be addressed when considering this type of structure. Among them are:

- Is the account funded or is it a notional account? If it is funded, who funds the account—the employer and/or the employee?
- What tax issues need to be addressed? Specifically, what are the tax implications to the sponsor or participants regarding deposits, distributions, or interest earned to and from the account? Are tax advantages related to health care benefits portable beyond the year of coverage, and do they carry into new employment situations or into retirement?
- What expenses are eligible for reimbursement from the account?
- For funded accounts, what are the investment options for the account?

Intermediary approach

Under this approach, the sponsor transfers its management role by adopting a group purchasing mechanism through an intermediary (insurance carrier, employer coalition, or independent organization). One or multiple sponsors serve as "bankers" through the intermediary, which sets rules and offers choices. Examples of some intermediary models include:

- One carrier offering multiple benefit choices (products).
- An intermediary that offers or facilitates the offering of a number of health plan options.
- An intermediary that contracts with or facilitates access to individual providers.

These intermediaries may provide tools that allow the participant to compare costs, quality of care, and the benefits offered under various options.

Vouchers

The sponsor grants vouchers to participants for purchase from among a pre-defined selection of participating benefits/plans, which could be either group or non-group health plans. The selections may be from one or more than one health plan. The participant pays the difference between the actual cost of the plan and the voucher amount. Unused voucher balances are forfeited.

No active management

The sponsor pays a pre-determined dollar amount to the participant to purchase individual health insurance in the local marketplace. This pre-determined dollar amount is taxable to the employee as if it were part of the regular salary or wages, though some deductibility may apply for the employee depending on expenses incurred for health care.

Conclusion

With recent health care trends including increased health care costs, concerns with health care quality, and the desire for more consumer involvement and education, employers are considering a shift from the traditional DB health plans to DC health plans. The combination of cost management and a decreased employer role distinguishes DC health plans from the DB type of plan and makes DC health plans an attractive option for employers.

DC health plans can be described along a continuum of health plans with varying degrees of employer/sponsor and employee/participant responsibility. One end of the continuum can be considered an extension of the DB model with active management by the employer, while at the other end of the continuum, the employer simply provides funds to the participant, who manages his/her own health benefits. Although there are different types of DC health plans, they have the common objectives of reducing and stabilizing costs, allowing an increased consumer role, and providing more consumer education.

This issue brief is the first in a series of issue briefs that will be published by the American Academy of Actuaries on issues related to DC health plans. Future issue briefs will address the impact of a shift to DC type plans on insurance, employer groups (particularly employee equity issues), health care costs, adverse selection, and employer/employee control, as well as implementation issues such as consumer education, health care quality, and administrative concerns.

[1] The terms employer or sponsor, and employee or participant, are used interchangeably throughout this issue brief.
[2] Note that these accounts are not the same as flexible spending accounts, which allow participants to use pre-tax dollars to cover cost-sharing requirements.
[3] MSAs, as defined by the Health Insurance Portability and Accountability Act of 1996, are subject to various restrictions.

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