

# DEFINED CONTRIBUTION PLANS

The Future of Healthcare for Employers and Employees



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Reynolds has more than 25 years of banking, healthcare, benefit consulting and payment technology experience. Prior to being named the CEO of CieloStar in August 2012, he managed Wells Fargo & Co.'s Global Trust & Custody business and Bryan, Pendleton, Swats & McAllister, LLC, an employee benefits consulting business with a national client base. He also managed sales and customer service within the Global Cash Management department of Mellon Bank Corporation in Pittsburgh, Pennsylvania.

A lifelong learner, Reynolds holds a bachelor's degree in economics, aeronautical engineering and speech communications from the University of Minnesota, a master's degree in management and administration from Metropolitan State University in St. Paul, Minnesota, and a Ph.D. in organization and management from Capella University in Minneapolis, Minnesota.

He has been a frequent speaker at national healthcare and financial services conferences and has published numerous articles on consumer directed healthcare, B2B healthcare payment technology, accountable care organizations (ACOs), treasury management, electronic commerce, customer loyalty and related topics.



**Pierce A. McNally**  
Chief Strategic Officer  
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Prior to joining CieloStar, McNally was a senior attorney at Gray Plant Mooty, practicing in the areas of business law and entrepreneurial services. He has also served on the Board of Directors for his family company, Midwest Communications, Inc., owner of numerous broadcast properties including WCCO-TV, WCCO-AM and WLTE in the Twin Cities. In 1989, he was subsequently elected an officer of the company. He served in both capacities until the company merged with CBS, Inc. in 1992.

McNally graduated in 1978 from the University of Wisconsin Law School, J.D., 1978 Order of the Coif, with an undergraduate degree from Stanford University.

McNally has worked with startup and early-stage companies, developing an advisory or management relationship. He has written and lectured on numerous topics pertaining to corporate governance issues including the Sarbanes-Oxley Act. McNally is very community-focused and serves on several community Board of Directors, including The Minnesota Opera and The Minnesota Historical Society.

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## Introduction: Change is Necessary

The United States healthcare system is broken. Employers can't afford rising health care premiums, and in order to stay competitive, cutting benefits for their employees is not a solution. Employers are looking for ways to change the rules and re-chart their own course.

The Affordable Care Act (ACA), signed into law by President Obama in March 2010, is the government's solution to the problem. Under the ACA, employers with 50 or more full-time workers must offer health insurance that meets standards of quality and affordability by Jan. 1, 2015 and provide detailed reporting on their health benefits plans. On an individual level, the ACA requires that virtually everyone in U.S. be enrolled in or covered by at least a minimum benefit set healthcare plan.

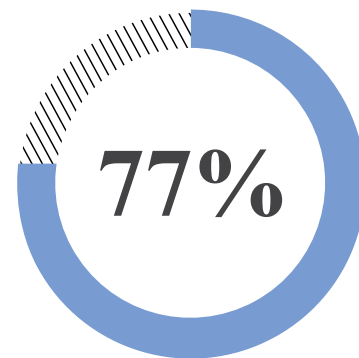
For many employers, however, this solution does not provide a viable alternative to the traditional defined benefits model which has dominated the U.S. healthcare system for decades.

Employers need to move away from the current model in favor of defined contribution healthcare – a system which infuses a measure of predictability into their health and benefits expenditures by allowing employers to set allocation levels and tailor the defined contribution to what is appropriate for their employees and their business. In this way, the defined contribution plan model represents a more efficient, employee-directed approach to healthcare.

Studies indicate that currently 77 percent of employer-provided healthcare is based on the defined benefit model, where an employer offers, for example, Plan A or Plan B from one or maybe two providers.

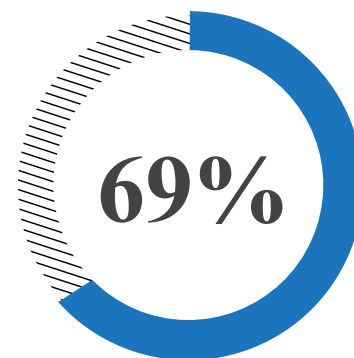
Studies indicate that within the next five years there will be an almost 180-degree flip, resulting in 69 percent of employers having moved to a defined contribution model. That would be a huge turnaround, a profound statement from employers on just how unworkable the current system is.

### CURRENTLY



Of employer-provided healthcare is based on the **defined benefit model**.

### IN THE NEXT FIVE YEARS



Of employers will have moved to the **defined contribution model**.

## Defined Contribution Plans: Why Now?

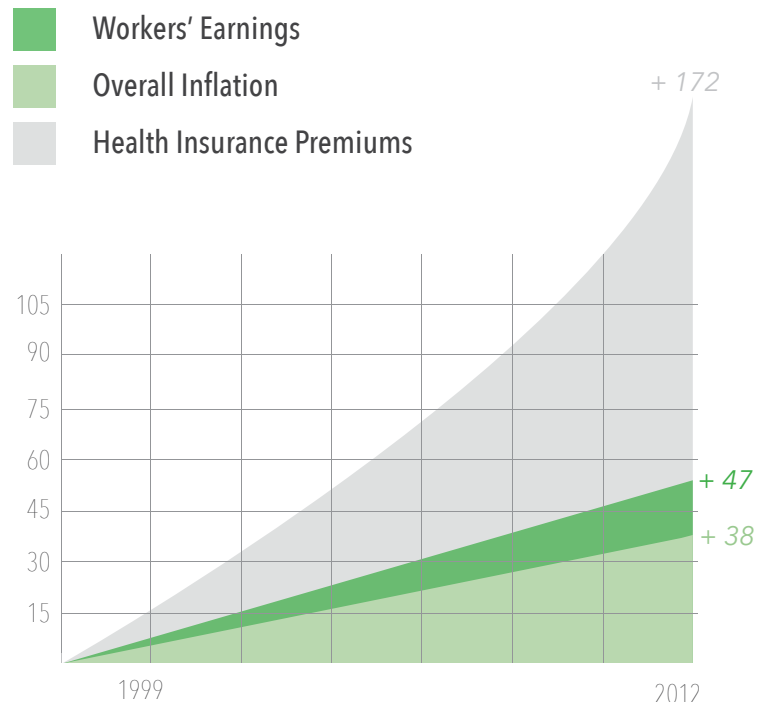
Defined contribution plans have been considered in healthcare since the success of the mid-1980s shift from defined benefit pension plans to 401K retirement plans. As early as 1998, 60 percent of human-resource executives at midsized companies wanted to enable employees to make their own health benefit decisions.<sup>1</sup> Around this same time, more than 62 percent of leaders in health-care predicted that defined contribution health plans would be the new norm by 2010.<sup>2</sup>

It is now 2013, though, and defined contribution plans are just becoming a serious consideration for employers. Prior to now, many employers shied away from this alternative because the employment-based system of healthcare did not necessitate change. Employees valued the health benefits offered by employers, and, as such, offering health benefits was a viable way for employers to acquire top talent. Moving to the defined contribution health model required too much risk from employers without a guaranteed reward. Furthermore, many employees lacked confidence that they would be able to effectively secure health coverage on the individual market.

However uncomfortable or unsettling the defined contribution model may be, the current U.S. healthcare system demands this change. Health insurance premiums are rising faster than wages and inflation.

**“From 1999 to 2012, while workers’ earnings and overall inflation have increased 47 percent and 38 percent, respectively, health insurance premiums have increased 172 percent.”<sup>3</sup>**

In an era where offering healthcare coverage is not only a smart business decision but also a legal mandate, it is clear that the existing system so long dominated by the defined benefit plan is unsustainable.



## Defining the Defined Contribution Model

The defined contribution gives the employee flexibility with and control over their healthcare coverage. A defined contribution health plan, in its most basic form, “hands the employee money to buy insurance from any insurer he or she wants, and the employee - not the employer - is the policyholder.”<sup>4</sup> Because he or she is the policyholder, the employee is not forced to change health coverage upon switching employers.

Newer versions of defined contribution plans, commonly implemented as “consumer-directed healthcare benefits” feature financial accounts, in conjunction with a scaled down traditional healthcare plan - typically a high deductible, catastrophic plan, on which the beneficiary can draw.

## Limitless Design Possibilities

The possible variations of defined contribution plans are endless.

As it mentioned previously, defined contribution plans can feature financial accounts, such as the following:



### DEFINED CONTRIBUTION PLANS



## FSA

#### Flexible Spending Account

Allows an employee to set aside a portion of earnings to pay for qualified expenses, such as medical expenses or dependent care. Money deducted from an employee's pay into an FSA is tax-exempt. Unused funds do not roll over from year-to-year.



## HSA

#### Health Savings Account

An account in which employees set aside their own pre-tax money to cover expenses of designated sorts, including healthcare. The individual owns the HSA, and funds roll over year-to-year if not spent.



## HRA

#### Health Reimbursement Account

IRS-sanction, employee-funded, tax-exempt employer health benefit plan that reimburses employees for out of pocket medical expenses and individual health insurance premiums.



## C

#### Combination

Some combination of these spending account types.

Within this spending account approach, employees can simply purchase a conventional health plan or buy individual services and products to cobble together a health plan to suit one's preferences.

A basic approach involves the employee using some of the funds to purchase a high deductible insurance plan, and then draws on the remainder to pay for individual expenses that arise throughout the year. In cases where enrollees spend all the money in their spending account and still need care, or where they use out-of-area services, traditional insurance coverage takes over. That coverage might begin immediately, or enrollees might be required to spend some of their own money as a "bridge" before catastrophic insurance begins.

More generally, in addition to access to plan, medical, and provider information and facilitating consumer enrollment into their chosen defined contribution plan, some plans also help enrollees keep track of expenditures as they draw on their spending account for various services and plan for future needs.

In sum, self-directed plans permit enrollees to become their own health advocate, benefits manager, and utilization reviewer, deciding which services are worth purchasing at what price and from whom.

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## Ten Advantages of Defined Contribution Plans

For employers, the obvious advantage of defined contribution is the ability to limit expenditures at the outset, rather than promising a level of benefits and then hoping to find an affordable price.

At the same time, beneficiaries face an obvious (potential) disadvantage. Because the employer no longer accepts increased costs to support a given level of care, beneficiaries may end up with whatever lesser level of care the defined sum will buy.

However, that downside is hardly the final analysis. For one thing, even defined benefit plans do not ensure a given level of benefits. Worsening economic conditions have prompted many employers to make marked cuts from one year to the next, and even within a given year, enrollees cannot be sure that their benefit levels will remain intact. So long as healthcare contracts provide only vague promises to cover "medically necessary" services, defined benefit health plans can steadily erode the actual level of coverage simply by declaring this or that service to be unnecessary.

On the other hand, the advantages of defined contribution plans - particularly the spending account versions - can be substantial.



## Availability

When patients pay for the daily mundane healthcare expense out of a dedicated account they face no significant financial barriers to accessing care. Assuming that the dedicated health account is sufficient to cover most routine expenses plus purchase a catastrophic plan, even an otherwise impecunious patient need not forego ordinary care on account of cost. Reciprocally, patients themselves enjoy the financial savings of prudent purchasing. In conventional plans, when coverage for a service is refused as “unnecessary,” it is plans, employers or governments – not patients – who pocket the savings.

## Accountability

Patients have virtually complete control over which services they receive, at least for routine expenses covered directly by the personal savings account. HMO or other health plans do not dictate which tests, treatments or drugs patients may receive and cannot deny coverage for nonstandard services such as acupuncture or laser vision correction. Rather, patients cover these directly from their own account. Self-control replaces external control.

Admittedly, the control exerted by managed care organizations (MCOs) over specific health benefits has loosened in recent years. And yet that loosening has come at the cost of substantial premium increases that employers are unlikely to shoulder much longer. Therefore, MCOs, wanting to stay in business, will be forced to reinitiate significant control over medical/spending decisions, to place pervasive monetary caps on various kinds of services or to find some other way to clamp down once again on the rising costs of care. If costs must be contained and patients are not incentivized to do it for themselves, someone will do it for them.

## Consistency

Patients, likewise, control which providers they see because the patient, not the plan, directly incurs the expense. Patients can choose any physician or specialist at any without begging for gatekeeper approval. More importantly, patients are free to continue in a physician-patient relationship of their choosing.

Frequent change in provider networks flawed the mid-1990s managed care. These frequent changes occurred when employers shifted employees to a new health plan with a different provider network or when health plans discontinued contracts with particular providers or provider groups. Either way, many patients and physicians were deeply distressed by being forced to sever longstanding relationships simply because that year’s plan had changed. Such disruptions can be medically and economically counterproductive. Studies show that continuity of relationships yields better outcomes, lower costs and greater satisfaction for patients and physicians alike.

Health plans, too, can benefit when patients remain with a particular plan over time. When patients frequently shift from one plan to the next, plans that provide excellent care for chronic diseased such as diabetes can suffer significant financial losses because years in the future, some other plan will enjoy the financial rewards of this plan’s forward-looking preventative care. However, once patients have the power to choose their own health plan, including choosing the same plan from one year to the next, plans have an incentive to please the patient rather than the employer to attract that patient’s continued business. Ultimately, such relationships might even make multi-year contracts possible, thereby enhancing plans’ ability to improve service and control long-range costs.



## Integrity

Once patients are financially free to contract directly with the physician of their choice to buy the services they want, the physician-patient relationship can be on a sounder ethical footing than in many MCOs. Physicians need not labor under odious external micromanagement nor spend endless hours begging and haranguing permission to provide the simplest interventions. Neither do health plans need to pay physicians insidious incentives for withholding care.

In the routine care covered by a spending account, the only financial relationship is between the physician who recommends an intervention and the patient who receives and directly pays for it. If the physician says, "You don't need the costly brand-name drug," the patient need not wonder about ulterior motives. And if the physician says, "You really do need this test," that patient knows the only incentive is the traditional fee-for-service incentive encouraging physicians to do more than is needed. However, when the physician knows any excess comes from the patient's own account and not from a rich, distant insurance company, the professional ethics of personal fidelity are far more likely to shape his recommendations. Moreover, patients who are spending from their own account are more likely to ask whether something is really needed, whether it can wait or whether there is a more conservative alternative.

## Accuracy

Opportunities for fraud are greatly reduced. When third parties cover the expenses and the bills are breathtakingly complex, patients have little reason to scrutinize bills to ensure every entry is correct. Indeed, third-party payment encourages providers to continue their inscrutable billing practices so that errors are not readily noticeable. In contrast, when patients pay

their own bills immediately after services, they know whose financial account is being drained and they know (or can immediately ask) whether they are being properly charged.

## Efficiency

Spending accounts can yield administrative cost savings. When patients are empowered to make their own decisions, there is no need for costly claims processing procedures, eligibility determinations, utilization review or appeals following denials of coverage. Patients can simply present a debit card to the physician, pharmacist or whomever and payment is instant. In the process, providers need not wait weeks or months nor file multiple claims before they are paid.

## Choice

Patients who want extravagant or nonstandard care are not imposing on other people, at least within the ambit of the spending account. If patients want the costliest drugs, they pay out of their own funds, not common resources. At the same time, the fact that the patient pays more means that most decisions will be considered more carefully than they are at present. It is easy to demand antibiotics for a viral illness or insist on the expensive new drug advertised on television when others bear the costs. It is another thing when the cost of that drug comes directly out of one's own funds. By the same token, with more prudent decision-making, it may even be possible to avoid some of the problems of medical excess, such as the emergence of resistant organisms that result from the overuse of antibiotics.

## Advances

When health plans no longer need to govern myriad small expenses, they are free to focus on the important realm: costly care for people with serious illness or injury, i.e., the people who dip into their catastrophic coverage. As of 1996, 1 percent of patients consumed 27 percent of total health expenditures, while the top ten percent consumed nearly 70 percent, and the top 30 percent consumed 90 percent (See [Chart to the Right](#)). This picture has not changed significantly over several decades.<sup>6</sup> Plans need to stop niggling over minor matters and take the lead in assessing costly new technologies and innovative interventions to ensure that evidence-based approaches will make the best possible uses of the great majority of common funds.

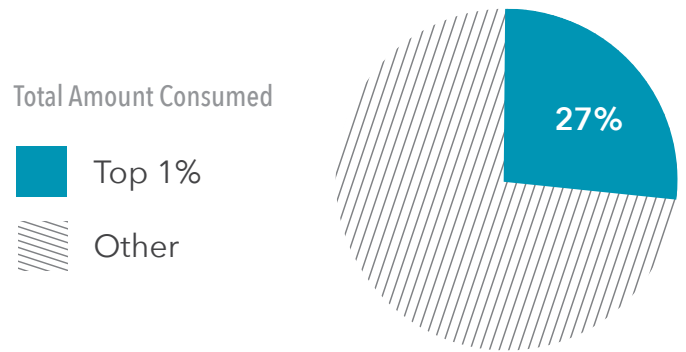
## Portability

Defined contribution approaches are considerably more portable than most current health plans. Particularly when self-insured employers establish their own distinctive set of benefits and provider networks, workers who change jobs usually begin a completely new plan, often with new providers. In contrast, because defined contribution plans generally permit enrollees to choose their own providers and treatments, at least at the lower levels within the deductible range, they offer considerably more continuity across job changes.

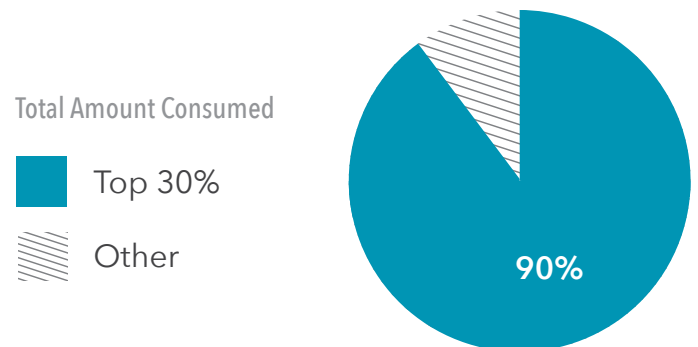
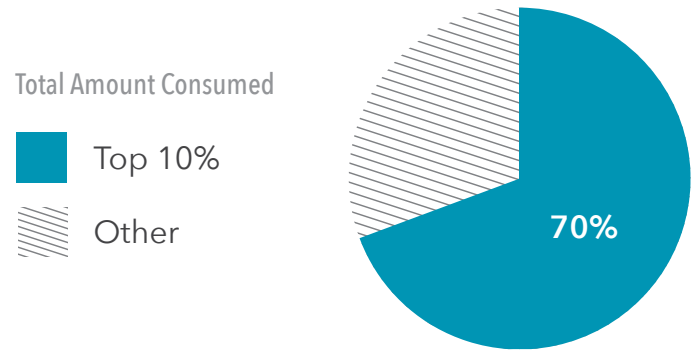
## Participation

Patients who control their own dollars have considerably greater reason to be informed participants in their own care. When employers choose the health plan, and when plans determine which care is “necessary” from what kind of provider in which setting, patients have relatively little reason or opportunity to become full partners in their care. Active participation in one’s care can, in itself, be medically beneficial.<sup>7</sup>

### 1996: Overall Healthcare Expenditures



### Present: Overall Healthcare Expenditures



## Defined Contribution Health Plans Empower Patients

Admittedly patients can make mistakes, such as foregoing useful care in order to save money. However, it is not clear that patients' decisions about what care is necessary or unnecessary will be any worse than the denials now issued by health plans, often for medically dubious reasons. Moreover, it is not always so clear when a given intervention is actually useful or "necessary." The science behind the guidelines and recommendations issued by plans and by providers is often scanty in both quality and quantity, and one day's gospel becomes the next day's heresy with surprising facility.

However, when patients are restored to a mutually trusting relationships with their physicians and given increasing access to solid medical information, they may be more amenable to persuasion about which care is most important and thereby worthy of dipping into their medical spending account.

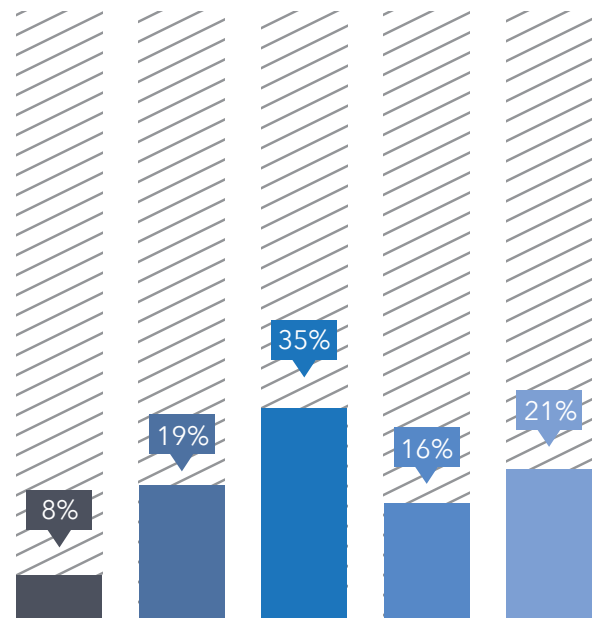
Also, because defined contribution funds can be

dedicated to healthcare and made immediately available, patients have far less reason to forego important care than in standard plans requiring patients to pay deductibles out of pocket for first-dollar health expenses.

As conversations of change continue, this caveat must be considered: according to Employee Benefit Research Institute's 2002 "Health Confidence Survey," only 8 and 19 percent of employees were extremely confident or very confident, respectively, that they would be able to choose the best health insurance plan for themselves. Conversely, 35 percent were somewhat confident and 16 percent and 21 percent were not too confident and not at all confident, respectively. ([See Chart Below](#))

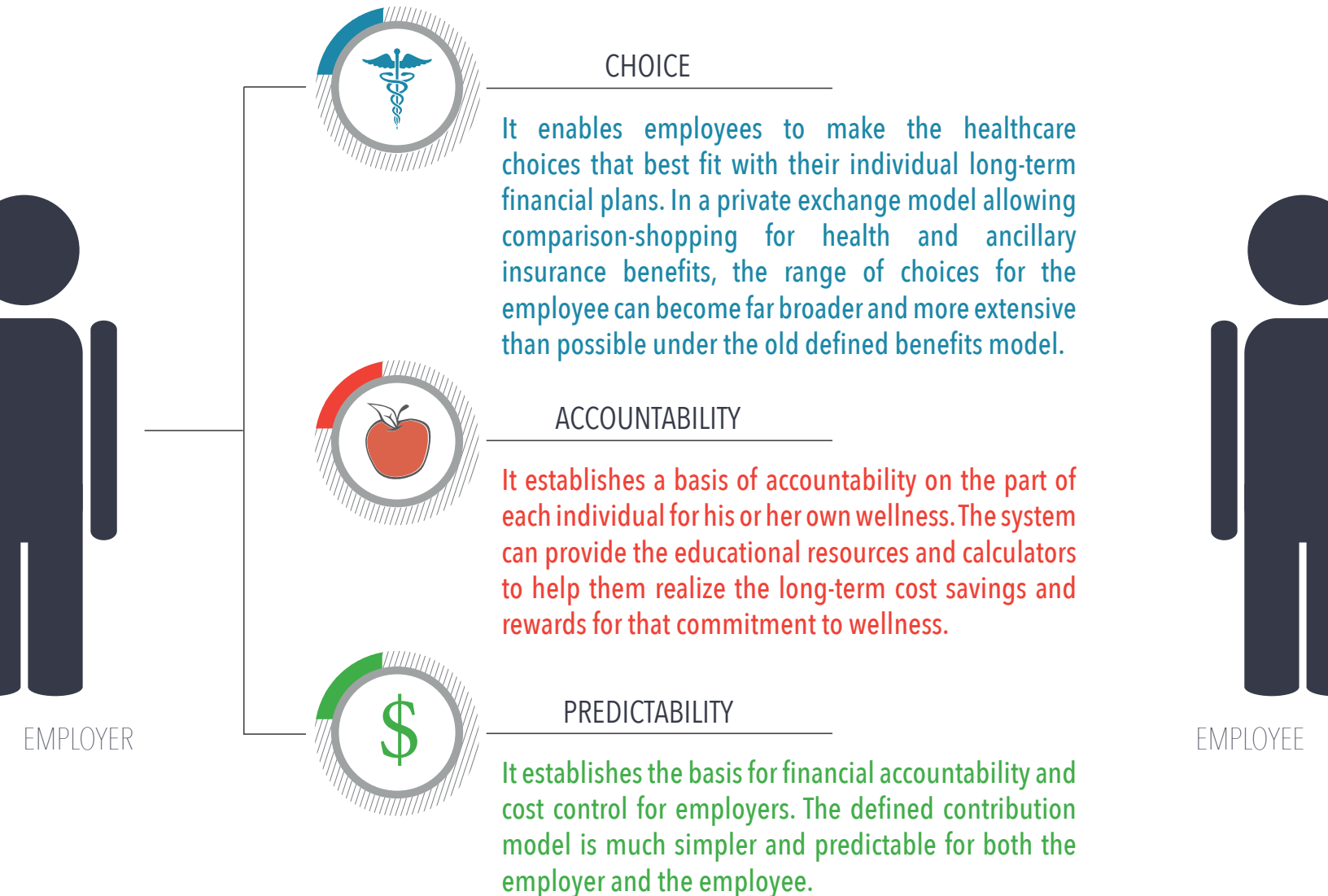
Changing the health insurance paradigm in the United States is no easy task, and employee confidence and knowledge must be a top concern during the switch to the defined contribution health model.

### Employee's confidence in choosing the best health insurance plans for themselves.



## Conclusion: Consumer-Centric Healthcare is the Future

In the final analysis, the three significant benefits of the defined contribution model for employers and employees are:



The past decade's extraordinary turbulence has taught some important lessons. It has been a time of trial and error in which the medical community's failure to constrain its spending gave way to a business orientation that failed to appreciate clinical realities. Doctors did not make good business people, and business people did not make good doctors. Still, the transition is hardly complete, and we may yet see a happier ending. The time has arrived to integrate patients into the picture and restore to them the power and responsibility of the purse that can, in turn, permit them the freedom to shape their care according to their own values.

## End Notes

<sup>1</sup> Employee Benefit Research Institute, July 2012

<sup>2</sup> et al.

<sup>3</sup> Kaiser Family Foundation/Health Research & Educational Trust, 2013 Employer Health Benefits Survey

<sup>4</sup> Plan Sponsor

<sup>5</sup> Barr, Ferber, Roulidis and Schulman

<sup>6</sup> Berk and Monheit

<sup>7</sup> Kaplan et al. and Kaplan, Greenfield, and Ware

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