

The State of Delaware

Health Policy & Planning Subcommittee

Health Savings Account (HSA) Planning

February 7, 2019

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Today's discussion

- Background and timeline
 - HSA plan overview and design alternatives
 - Current GHIP offerings
 - Next steps
-
- Appendix
 - Supplemental information about HSA plans

Background

- A Health Savings Account (HSA) plan is a type of medical plan that meets certain IRS requirements and is offered with a tax-advantaged medical savings account
 - Also called an IRS-qualified high deductible health plan with a HSA
- The SEBC voted on August 20, 2018 to move forward with serious consideration of the adoption of a HSA plan option for the GHIP
 - Viewed as an attraction and retention tool, particularly among millennial GHIP participants
 - Tentative effective date of July 1, 2020 (or later)
- An RFP was released in September 2018 to evaluate Aetna and Highmark's abilities to provide Health Savings Account (HSA) administrative services for the GHIP
 - RFP was conducted as a supplement to the 2016 medical third-party administrator (TPA) RFP in which both Aetna and Highmark participated
 - Narrowed the set of bidding vendors to the State's current medical TPAs only
- Proposal Review Committee (PRC) for this RFP determined that both vendors met the minimum qualifications and criteria outlined in the RFP

Background (continued)

- PRC recommended the following to the SEBC and the Health Policy & Planning and Financial Subcommittees:

1. Evaluate the overall GHIP plan offerings available and goals associated with adding an HSA plan to the GHIP offerings (**SEBC**)
2. Develop the proposed plan design (including the amount of and schedule for employer funding of the HSA) and premium rates
3. Evaluate the current plan offerings and in particular, the feasibility of continuing the existing CDH Gold plan, including how members' account balances would be managed if a proposal included discontinuation of this plan
4. Fully understand the fiduciary responsibilities, if any, by the State for the investment accounts along with any fees to members and how the investment funds are structured
5. Determine the intensity of focus needed to communicate and educate members about a HSA plan
6. Re-evaluate how closely aligned each vendor is to the above considerations to determine which vendor may be the best fit to administer a HSA plan
7. Propose whether or not to offer a HSA plan and the effective date, including all of the above considerations as part of a proposal that will include a recommendation on which of the two TPAs is best suited to administer the HSA plan

Timeline

- Review options and provide feedback
- Discuss other subcommittee's feedback
- ◇ TPA capabilities presentations
- ✓ Finalize recommendations

Goal – Review and consider all key decision points associated with an HSA plan in order to be ready to present a complete proposal to the SEBC at the June 10, 2019 meeting

Task (PRC recommendation #)	Owner	February 7		March 7		April 4		May 2		June 6	
		Financial	Health P&P	Financial	Health P&P	Financial	Health P&P	Financial	Health P&P	Financial	Health P&P
Develop HSA plan design (2)	Health P&P		○	○ ■	■ ✓						
Develop premium rates (2)	Financial			○	○ ■	■ ✓					
Evaluate current plan offerings and feasibility of continuing CDH Gold plan (3)	Health P&P		○	○ ■	○ ■	○ ■	✓				
Review fiduciary responsibilities (4)	Financial			○		○		✓			
Determine intensity of focus for communication and education (5)	Health P&P				○		○		○		✓
Review TPA capabilities (6)	Health P&P						◇ ○		○		✓
Finalize HSA plan proposal and recommendations to SEBC (7)	Health P&P							○	○ ■	■ ✓	■ ✓

HSA plan – defined

Definitions

Consumer Directed Health Plan (CDHP)

A type of medical plan offered together with a personal account (i.e., health savings account or health reimbursement arrangement) that can be used to pay a portion of the medical expense not paid by the plan.

Also called a High Deductible Health Plan (HDHP).

IRS-qualified High Deductible Health Plan (HDHP)

A type of CDHP with a plan design that meets IRS requirements to maintain the tax-favored status of the Health Savings Account.

Health Savings Account (HSA)

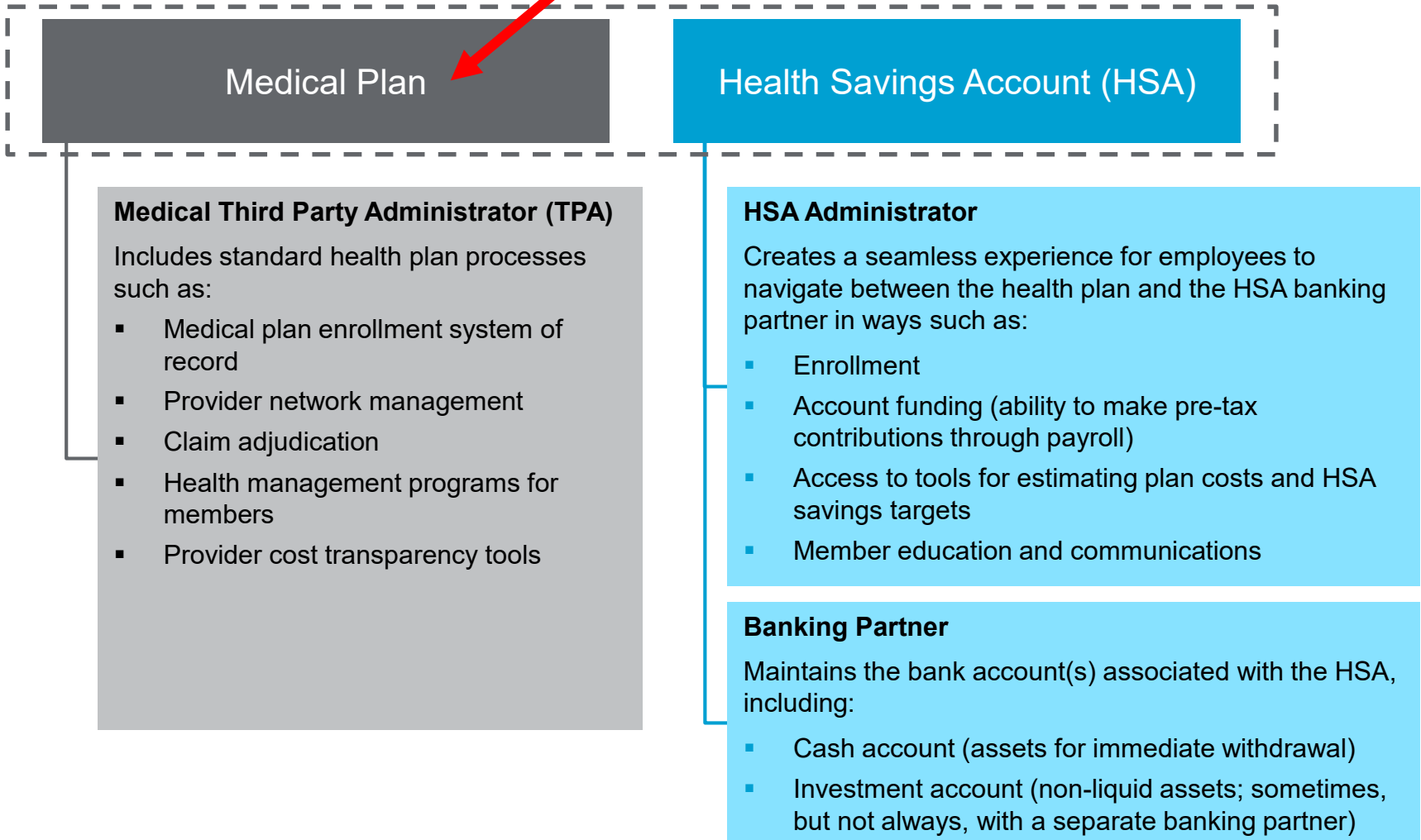
A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an IRS-qualified HDHP.

References to a ***Health Savings Account (HSA) plan*** are intended to describe an IRS-qualified High Deductible Health Plan with a Health Savings Account

Building blocks of a HSA plan

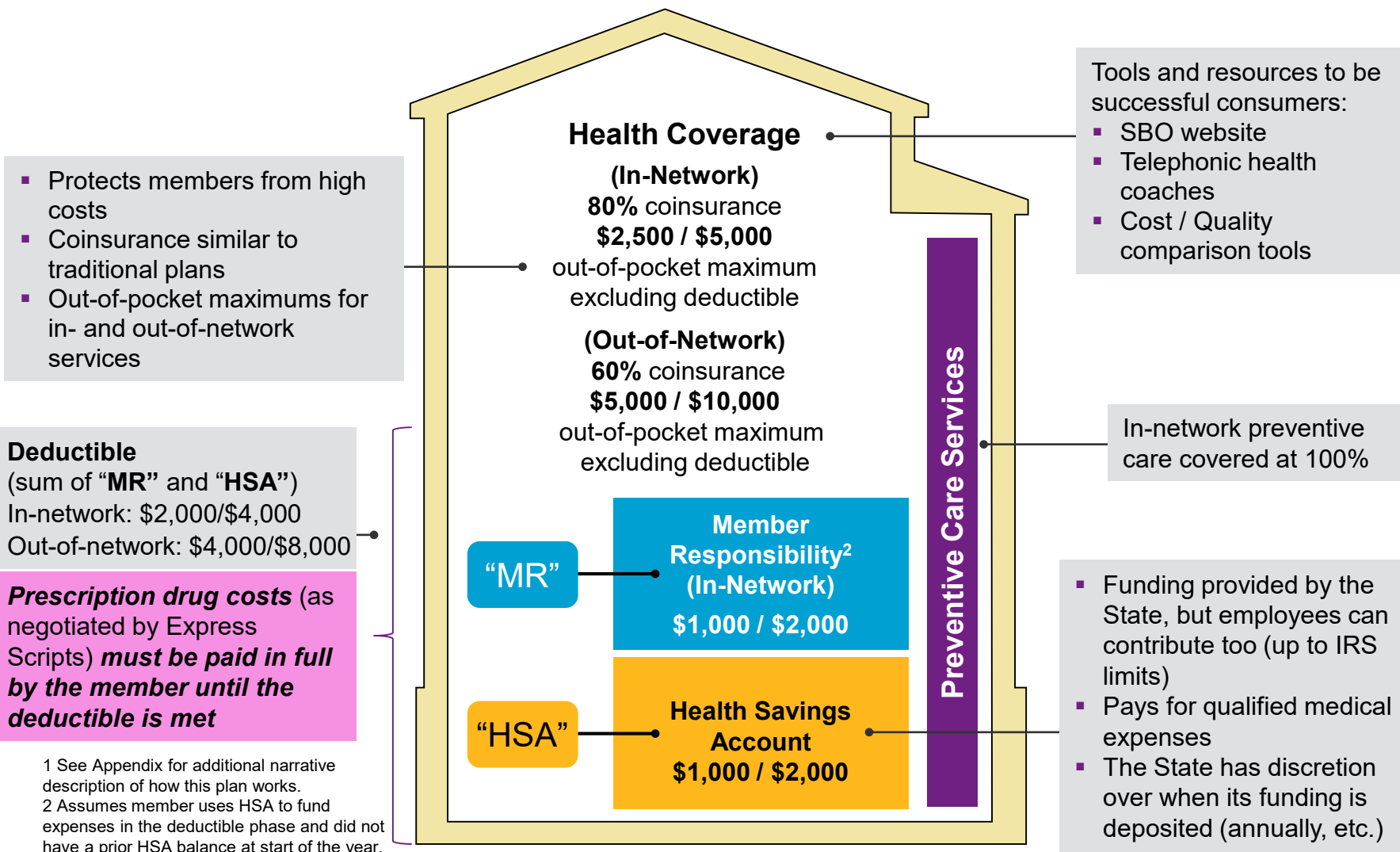
Two major components

Today's focus



How does a HSA plan work?

From the member's perspective – illustrative plan design¹



¹ See Appendix for additional narrative description of how this plan works.
² Assumes member uses HSA to fund expenses in the deductible phase and did not have a prior HSA balance at start of the year.

Plan design requirements for a HSA plan

- The IRS mandates certain plan design provisions to maintain tax-favored status of the HSA

Calendar Year 2019 Limits*	IRS-qualified HDHP / HSA
Minimum Deductible (Ind./Fam.)	\$1,350 / \$2,700
Maximum Out-of-Pocket Max (Ind./Fam.)	\$6,750 / \$13,500
Maximum Health Savings Account contribution (combined employer and employee, Ind./Fam.)	\$3,500 / \$7,000
Catch-up Health Savings Account contributions (for individuals attaining age 55 by 12/31 until enrolled in Medicare)	\$1,000

* Announced by the IRS on May 10, 2018

- **Deductible applies to all services** covered by the plan – i.e., medical *and* prescription drug
- HSA plan enrollee cannot have any other coverage that provides first-dollar coverage of medical expenses (e.g., dual coverage on a spouse’s plan) and cannot have a health care Flexible Spending Account (FSA) to pay for medical expenses (i.e., “limited purpose” health care FSA for dental and vision expenses only)
- The FY19 CDH Gold plan (administered by Aetna) meets the above plan design provisions but offers a Health Reimbursement Account (HRA) instead of a HSA
 - HRA is not tax-advantaged, is funded only by the State, and is forfeited by the employee upon disenrollment in the GHIP for any reason (i.e., is “notional” funding)
 - Additional details on the differences between HSAs and HRAs are provided in the next section

HSA plan design – illustrative scenarios

Feedback request:
Subcommittee member
thoughts on these designs

Plan Design (In-network)	CDH Gold w/HRA	HSA Scenario 1	HSA Scenario 2	HSA Scenario 3	State Employers Peer Benchmark HDHP+HSA ³
Deductible (Ind./Fam.)	\$1,500 / \$3,000	\$2,000 / \$4,000	\$1,500 / \$3,000	\$1,500 / \$3,000	\$2,100 / \$4,200
Account Funding (Ind./Fam.)	\$1,250 / \$2,500	\$1,000 / \$2,000	\$1,000 / \$2,000	\$1,000 / \$2,000	\$700 / \$1,400 ³
Coinsurance	90%	80%	80%	90%	80%, after ded.
Out-of-Pocket Max (Ind./Fam.)	\$4,500 / \$9,000	\$4,500 / \$9,000	\$4,500 / \$9,000	\$4,500 / \$9,000	\$4,500 / \$9,000
PCP Office Visit	90%	80%	80%	90%	80%
Specialist Office Visit	90%	80%	80%	90%	80%
Emergency Room	90%	80%	80%	90%	80%
Inpatient Care	90%	80%	80%	90%	80%
Prescription Drug¹					
Out-of-Pocket Max (Ind./Fam.)	\$2,100 / \$4,200	Combined with medical	Combined with medical	Combined with medical	Combined with medical
▪ Retail	\$8 / \$28 / \$50 after deductible	\$8 / \$28 / \$50 after deductible	\$8 / \$28 / \$50 after deductible	\$8 / \$28 / \$50 after deductible	85% / 80% / 75%
▪ Mail Order	\$16 / \$56 / \$100 after deductible	\$16 / \$56 / \$100 after deductible	\$16 / \$56 / \$100 after deductible	\$16 / \$56 / \$100 after deductible	85% / 80% / 75%
Relative Benefit Value (RBV)²	0.96	0.89	0.91	0.93	0.88

¹ Retail 30 day supply; mail order 90 day supply.

² RBV estimate includes Health Savings Account seed.

³ See appendix for further details about this benchmark.

HSA plan – employer seed considerations

Feedback request:
Subcommittee member thoughts
on timing of HSA seed money

- The GHIP has flexibility in the amount and timing of HSA seed money

Seed timing	Pros	Cons
Up-front lump sum	<ul style="list-style-type: none"> Employees have immediate protection against high claims early in plan year Administrative ease 	<ul style="list-style-type: none"> Employer seed vests immediately and money is portable; employees leaving employer during the year receive full value of the benefit The GHIP could forfeit \$100k in annual seed money for employees terminating during the year¹
Fixed per-pay contribution	<ul style="list-style-type: none"> Employer protection against employee turnover Employees “earn” seed money over course of plan year Minimizes budget impact 	<ul style="list-style-type: none"> Employees may have to pay for early claims with personal funds Administrative complexity for employer and employee
Periodic payments (quarterly, semi-annually, etc.)	<ul style="list-style-type: none"> Employer protection against employee turnover Employees “earn” seed money over course of plan year, with more money available initially Less complex than per-pay deposits 	<ul style="list-style-type: none"> Employees may have to pay for early claims with personal funds Administrative complexity for employer and employee

- Additional considerations:
 - Determination of the amount and timing of HSA seed money must be made as part of plan design and could impact overall plan costs/savings
 - Total deposits (employer + pre-tax employee contributions) are treated as employer contributions, and are subject to nondiscrimination testing
 - How to treat new hires during course of the year (i.e., make “whole” on date of hire, prorate, etc.)?

¹ Per 5% migration to HSA plan; assumes 5% annual turnover with uniform distribution throughout year, \$1,000/\$2,000 ind./family seed, and 40%/60% ind./family enrollment split

HSA plan – demographic considerations

- Employees enrolling in HSA plans tend to be younger and healthier than those electing other types of plans; millennials are the generation most likely to be enrolled in an HSA plan
 - Millennials are more likely to engage in consumerism behaviors targeted by HSA plans when seeking medical care, and are more interested in the tax-advantages and investment features of these plans than other generations¹
 - HSAs are important employer tools for attracting and retaining young talent
- Approximately 1/3 of GHIP enrollees are millennials² who are lower paid, more likely to waive/enroll in single coverage, and more likely to elect plans with low contributions (FSB, CDH) than other State employees

Demographics by Age Band			
Age Band	Average Salary	% Single Coverage	% Waive Coverage
< 26	\$36,724	51.2%	37.1%
26 - 29	\$41,879	65.9%	7.5%
30 - 39	\$51,402	32.0%	8.6%
40 - 49	\$59,423	19.1%	10.2%
50 - 59	\$55,108	29.2%	9.5%
60 - 69	\$54,766	40.7%	8.6%
70 and over	\$51,889	43.1%	12.5%

Plan Election by Age Band					
Age Band	CDH	PPO	FSB	HMO	Total Enrolled
< 26	9.0%	47.8%	19.2%	24.0%	676
26 - 29	7.1%	50.9%	14.6%	27.4%	2,250
30 - 39	5.4%	60.5%	7.2%	26.9%	7,277
40 - 49	4.5%	61.7%	4.7%	29.1%	8,269
50 - 59	4.8%	62.0%	4.7%	28.5%	8,467
60 - 69	3.9%	68.5%	4.2%	23.3%	3,839
70 and over	2.4%	79.9%	2.1%	15.5%	329

GHIP Millennials (10,203 enrolled, 33% of total)

- Offering a HSA plan will be more attractive to GHIP millennials than other State employees, allowing them to build HSA balances and save for retirement during lean utilization years

1 Source: EBRI 2017 Consumer Engagement in Health Care Survey.

2 EBRI 2017 Consumer Engagement in Health Care Survey defines millennial generation as the demographic cohort with birth years ranging from 1977 to 2000.

Current GHIP offerings

New hire enrollment patterns

- The below exhibit summarizes the distribution of plan elections made by new hires or rehired employees, at time of hire/rehire eligibility date
- New hires/rehires were more likely to waive coverage or elect First State Basic and CDH Gold options compared to the current GHIP State eligible population overall
 - In more recent years, new hires are increasingly likely to elect the lowest cost plan (FSB) or waive coverage; fewer new employees elected HMO and the CDH Gold options, though proportion in CDH Gold remains higher than GHIP overall

Hire Year	% Original Election by Plan ¹				
	PPO	Aetna/Highmark HMO	Aetna/Highmark CDH	FSB	Waive
CY 2014	37.8%	26.8%	7.6%	5.4%	22.3%
CY 2015	36.0%	28.2%	7.5%	6.1%	22.3%
CY 2016	32.6%	25.6%	8.4%	10.9%	22.5%
CY 2017	34.1%	20.8%	6.9%	13.9%	24.3%
CY 2018	32.7%	14.4%	5.1%	17.3%	30.4%
Overall GHIP² (current election)	55.2%	24.6%	4.5%	5.6%	10.1%

¹ Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018' provided to WTW by OMB on June 20, 2018

² Based on all full-time benefits eligible employees of the State per 'Ben Elig Ees April2018 wEarnings thru 041518' report provided to WTW by OMB on May 14, 2018. Includes 31,107 active State employees enrolled in GHIP. Excludes participating groups (waiver data not available)

CDH Gold plan – FY19 enrollment and HRA balances

- As of December 2018, there are 2,569 employees enrolled in the Aetna CDH Gold plan
- Total funds remaining in participant HRA balances are \$6.5M, with an average remaining balance of \$2,537
 - 315 employees (12% of total) have \$0 HRA balance
 - 55 employees (2% of total) have a balance in excess of \$10,000
- Offering an HSA plan alongside the existing CDH Gold option would erode potential GHIP savings
- If the State were to eliminate the CDH Gold plan and cause HRA balances to be forfeited, there is a potential for members with existing HRA balances to rush to spend remaining funds before forfeiture

HRA Balance (as of December 2018)	# of Participants (% total)
\$0	315 (12%)
\$1 - \$100	34 (1%)
\$100 - \$249	45 (2%)
\$250 - \$499	108 (4%)
\$500 - \$999	279 (11%)
\$1,000 - \$2,499	845 (33%)
\$2,500 - \$4,999	602 (23%)
\$5,000 and greater	341 (13%)
Total	2,569 (100%)

CDH Gold plan – options for employees with HRA fund balance

- For administrative and legislative simplicity, consider replacing CDH Gold plan with an HSA plan
 - Requires strategy for participants with existing Health Reimbursement Account (HRA) balances
 - Because the CDH Gold is a self-insured medical plan with the HRA funded entirely by the State, the SEBC has discretion over:
 - What HRA funds could be used for (e.g., payroll contributions, out-of-pocket expenses for covered services) and for which plans (i.e., medical, dental, vision)
 - How long those funds are available (e.g., 6 months, 1 year)
 - Rules/Restrictions regarding use of funds (e.g., employee must be currently enrolled in the State’s dental plan in order to be able to use HRA balance to offset out-of-pocket expenses for covered dental services)

HRA Options	Description	Pros	Cons
Premium Holiday HRA	Allow employees to use HRA funds to pay for coverage in lieu of payroll contributions in year one	<ul style="list-style-type: none"> ■ Could offer only if employee enrolls in HSA plan to encourage enrollment ■ Offers the most benefit to employees, especially if not limited to employees electing an HSA plan 	<ul style="list-style-type: none"> ■ May be expensive for the State, particularly if not limited to employees electing an HSA plan ■ Could be an administrative burden for the State to maintain
Limited-purpose HRA	Use HRA money to pay for “permitted insurance” (e.g., dental, vision) ¹	<ul style="list-style-type: none"> ■ Offers a small benefit to employees ■ Minimal cost to the State (relative to HRA use for medical expenses), especially if limited to out-of-pocket costs for “permitted insurance” 	<ul style="list-style-type: none"> ■ Communication could be difficult ■ If State allows HRA funds to offset dental and vision premiums, may need to review with those insurers for potential impact on premiums for those fully-insured plans
Post-deductible HRA	Pays for medical expenses after HSA plan deductible met	<ul style="list-style-type: none"> ■ Encourages HSA plan enrollment ■ Potential for moderate cost to the State 	<ul style="list-style-type: none"> ■ Would shield employees from some health care cost until HRA balance ran out
Retirement HRA	HRA used to pay for medical expenses ² in retirement	<ul style="list-style-type: none"> ■ Little cost to the State in the near-term ■ The State could chose to allow employees to keep HRA funds if they terminate before retirement 	<ul style="list-style-type: none"> ■ No immediate value to the employee ■ Could be an administrative burden for the State to maintain

¹ Potential compliance considerations related to allowing HRA use toward expenses not covered by the plan, and allowing employees continued access to HRA if they drop medical coverage.
² For non-Medicare eligible retirees enrolled in an IRS-qualified high deductible health plan, would need to be post-deductible medical expenses only to maintain eligibility for HSA contributions.

Feedback request

Current GHIP offerings

- Thoughts on feasibility of continuing the existing CDH Gold plan?
- Thoughts on options for managing members' account balances if CDH Gold were discontinued?

Next steps

- Subcommittee members to provide feedback to SBO on the following topics by no later than **Friday, February 15**:
 - HSA plan design scenarios
 - Amount and timing of employer HSA seed money
 - Thoughts on the feasibility of continuing the CDH Gold plan, including options for enrollees with a balance in their HRAs
- WTW to incorporate this feedback into the materials for the March 7 meeting of the Health Policy and Planning Subcommittee
- Feedback will also be shared with the Financial Subcommittee for their review and input

Timeline

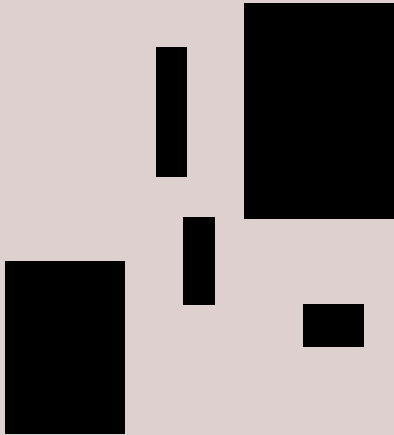
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Review fiduciary responsibilities (4)	Financial			○		○		✓			
Determine intensity of focus for communication and education (5)	Health P&P				○		○		○		✓
Review TPA capabilities (6)	Health P&P						◇ ○		○		✓
Finalize HSA plan proposal and recommendations to SEBC (7)	Health P&P							○	○ ■	■ ✓	■ ✓

Appendix

Supplemental information about HSA plans



How does a HSA plan work?

From the member's perspective – *based on HSA plan design scenario 1*

- **Employees' ability to enjoy these plan benefits is predicated on enrolling in the State's HSA plan¹**
- Members would receive an annual contribution from the State to fund the HSA, and can also deposit their own money, up to IRS limits
- The HSA can be used to pay for qualified medical expenses², including during the deductible period, or can be used as a savings vehicle for future expenses (beyond the current plan year)
- Members must meet a deductible before the plan begins paying toward covered services – for in-network services, the deductible is \$2,000 for an individual plan / \$4,000 for a family plan (the IRS requires minimum deductibles of \$1,350 / \$2,700 in 2019)
- Once the deductible is met, the member has the security of knowing that the plan pays a set amount for services – 80% for in-network services
- There are limits to the amount of out-of-pocket expenses a member can pay in a plan year – in-network, that's \$4,500 for an individual plan/\$9,000 for a family plan (2019 IRS maximum out-of-pocket expenses \$6,750 / \$13,500)
- Once the out-of-pocket maximum is reached, the plan pays at 100%
- Prescription drugs count toward deductible and out of pocket maximums – until the deductible is met, members must pay the State plan's negotiated rate for prescriptions
- Unused HSA funds will carryover to the next year, regardless of whether or not employee remains enrolled in the State's HSA plan
- However, employee will need to remain enrolled in an IRS-qualified consumer-directed health plan in order to continue making contributions to a HSA

¹ Would be designed as an IRS-qualified consumer directed health plan.

² Term generally means "medical care" including medical, Rx, dental, vision and long-term care services. IRS Publications 502 (<https://www.irs.gov/publications/p502>) and 969 (<https://www.irs.gov/publications/p969>) provide guidance on IRC §213(d) qualified medical expenses. Withdrawals for any other expenses (prior to account holder reaching age 65) are subject to a tax penalty.

Health Savings Account – member access to funds

- HSA funds are available for use as soon as they appear in the account, similar to a checking account
 - Timing of the availability of funds following deposit varies by account administrator
- HSA administrator determines how account holder can access funds
 - Most administrators provide access via a HSA debit card
 - Paper checks and online bill payment options are also common
- Members have complete discretion over how to use their HSA
 - Account holder is responsible for determining whether use is for “qualified medical expense”¹
 - No claim substantiation requirement, but must save receipts for all HSA distributions (in the event of an IRS audit)
 - Employers and HSA administrators **are not required** to determine whether HSA distributions are used exclusively for qualified medical expenses
- Members are also responsible for ensuring they do not have “other health coverage” (as defined by the IRS²) that could disqualify them from making or receiving HSA contributions

¹ Term generally means “medical care” including medical, Rx, dental, vision and long-term care services. IRS Publications 502 (<https://www.irs.gov/publications/p502>) and 969 (<https://www.irs.gov/publications/p969>) provide guidance on IRC §213(d) qualified medical expenses. Withdrawals for any other expenses (prior to account holder reaching age 65) are subject to a tax penalty.

² See IRS Publication 969 (<https://www.irs.gov/publications/p969>).

Health Savings Account – member access to funds (continued)

- Examples of “permitted coverage”¹ that **would not** disqualify an individual from eligibility to make or receive HSA contributions

Permitted Coverage

- ✓ **Dental insurance**, if stand-alone plan
- ✓ **Vision insurance**, if stand-alone plan
- ✓ **Accident insurance**
- ✓ **Disability insurance**
- ✓ **Long-term care**
- ✓ **Dependent care FSA**
- ✓ **Insured supplemental health benefits**, such as workers’ comp or critical illness, as long as principle health coverage is provided by the Health Savings Account plan
- ✓ **Discount card** for health care services or products
- ✓ First-dollar coverage for **preventive medical and prescription drugs**

Permitted Coverage (with limits)

- ✓ **Limited purpose health care FSA or HRA** – limited to dental and vision expenses
- ✓ **Post-deductible health care FSA or HRA** – only provides benefits after the minimum annual deductible under an IRS-qualified Health Savings Account plan has been satisfied
- ✓ **EAP, disease management and wellness programs** – as long as the program doesn’t provide “significant” medical care or treatment benefits
- ✓ **Onsite/Near-site clinic** – limited to first aid, unless member is charged fair market value for services

Health Savings Accounts vs. Health Reimbursement Arrangements

Feature	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Available for GHIP participants in FY19?	No	Yes – as the CDH Gold plan
Taxability of account	Provides triple-tax advantage for employees – contributions, interest and reimbursements (when used for qualified medical expenses)	Not applicable (not employee's money)
Account ownership	Is a custodial account, owned by employee and is portable	Employer owned and not portable
Obligations to open account	Voluntary, the employee does not have to open the account	Mandatory, the employee must have an account
Account contributions	Can be made by the employee and/or the employer	Can be made solely by the employer
Governing of accounts and plan	IRS rules dictate account funding limits and qualifying medical plan design	Not governed – employer has discretion over account funding amount and plan design
Account ownership at employment termination	Account stays with employee	Account is forfeited unless retiring from the company and employer allows retiree to retain access to funds

Advantages of a HSA plan

For current employees

- There are multiple advantages to offering a HSA plan that are not available in the current GHIP plans

Employee savings vehicle	<ul style="list-style-type: none"> A HSA allows employees to save for future medical expenses, including but not limited to retiree medical Employees decide when and how to use HSA funds, or whether to save them for future qualified medical expenses, including after retirement Employees can start, stop, or adjust HSA contributions at any time Funds can be invested once the HSA balance exceeds a certain threshold
No “use it or lose it” rule	<ul style="list-style-type: none"> Unused funds carry over from year to year and are always the employee’s to keep, unlike employee contributions to a health care Flexible Spending Account (FSA)
Triple tax incentives	<ul style="list-style-type: none"> No federal taxes (or state taxes, except in NJ and CA)¹ on the funds the employee deposits, the employer-provided funds, the interest earned, or the funds spent on qualified medical expenses Taxes and penalties do apply if HSA funds are used to pay for anything other than qualified medical expenses Important note – per IRS guidelines, the HSA accountholder (i.e., the employee), <u>not</u> the HSA administrator, is responsible for tracking whether the HSA is used for qualified medical expenses
Competitive position	<ul style="list-style-type: none"> The marketplace has been moving in this direction, with 73% of all large employers and 63% of public sector and education employers offering a consumer directed health plan (with either HSA or Health Reimbursement Arrangement) in CY2017² New hires may have a HSA from a prior employer and may want to continue contributing to that account; they can also roll over funds from a prior HSA into one offered by the State

1 HSA contributions made by the State or by the employee via pre-tax payroll deductions are not eligible for tax-favored treatment for state tax purposes in NJ and CA. In AL, pre-tax contributions are tax-free, but any post-tax employee contributions to the HSA are taxable by the state.

2 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Sample: Companies with at least 1,000 employees.

Advantages of a HSA plan

For former employees

- There are also advantages to having a HSA for former employees, including COBRA participants and retirees
- Accumulated HSA funds can be used to pay for qualified medical expenses
- Former employees can continue to make tax-advantaged contributions to a HSA, if still enrolled in an IRS-qualified consumer directed health plan **and if not accepting Social Security payments after becoming eligible for Medicare¹**
- This group can use HSA funds to pay for the following:
 - COBRA premiums
 - Health coverage while receiving unemployment compensation
 - Qualified long-term care insurance contracts, within statutory limits² (even if HSA contributions were made on a pre-tax salary reduction basis under a cafeteria plan)
- Individuals over age 65 can also use the HSA to pay for:
 - Health premiums for Medicare Part A, Part B, and Part D, Medicare Advantage premiums, and coverage under an employer's self-insured retiree health plan
 - **Note:** Premiums for Medigap/Medicare Supplement plans are not qualified medical expenses
 - Non-health related withdrawals without tax penalty (still subject to ordinary income tax) – just like an Individual Retirement Account (IRA)

1 Medicare Part A premiums are automatically removed from the Social Security benefit payments for Medicare-eligible individuals; it is not possible for those individuals to opt out of Medicare Part A. This automatic enrollment in Medicare Part A disqualifies any Social Security recipient from being eligible to make or receive Health Savings Account contributions.

2 See next page for further details.

Qualified long-term care insurance contracts

- A qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. The contract must¹:
 1. Be guaranteed renewable,
 2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed,
 3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits, and
 4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes per diem or other periodic payments without regard to expenses.

- Qualified long-term care premiums up to the following amounts (2018 per person limits) may be considered as qualified medical expenses²:
 - Age 40 or under – \$420
 - Age 41 to 50 – \$780
 - Age 51 to 60 – \$1,560
 - Age 61 to 70 – \$4,160
 - Age 71 or over – \$5,200

¹ Source: <https://www.irs.gov/publications/p502>, accessed 5/29/18.

² Source: IRS Revenue Procedure: 2017-58; limits are subject to change as the IRS updates publications such as this from time to time.

HDHP with HSA plan design benchmarking

State employers peer group¹

Key Provisions (In-Network)	GHIP CDH Gold with HRA	State Employers Peer Benchmark HDHP+HSA ^{1,2}
Deductible (Ind./Fam.)	\$1,500 / \$3,000	\$2,100 / \$4,200
Account Funding (Ind./Fam.)	\$1,250 / \$2,500	\$700 / \$1,400 ³
Coinsurance	90%	80%, after ded.
Out-of-Pocket Max (Ind./Fam.)	\$4,500 / \$9,000	\$4,500 / \$9,000
PCP Office Visit	90% after ded.	80%, after ded.
Specialist Office Visit	90% after ded.	80%, after ded.
Emergency Room / Urgent Care	90% after ded.	80%, after ded.
Inpatient Hospital	90% after ded.	80%, after ded.
Prescription Drug ^{4,5}	After ded.	After ded. ⁶
▪ Retail	\$8/\$28/\$50	85% / 80% / 75%
▪ Mail Order	\$16/\$56/\$100	85% / 80% / 75%
▪ OOP Max (Ind./Fam.)	\$2,100 / \$4,200	Combined
Relative Benefit Value	0.96 ⁷	0.88 ⁸

- 26 (53%) of 49³ state employers offer one or more health savings account (HSA) qualified high deductible health plan (HDHP) options
 - 4 (8%) state employers provide access to both HDHP+HSA and HDHP+HRA plan options
 - Of the 26 states benchmarked, none offers an HDHP+HSA as their only medical plan option
- Of the 26 State employers in the HDHP+HSA peer group, 12 (38%) provide HSA funding^{1,3}
 - 37 HSA-qualified plans evaluated; subscribers in 16 HDHP+HSA plans receive plan sponsor account funding
 - The individual and family deductibles in the average HDHP+HSA peer benchmark design is higher than the FY19 CDH Gold plan, however, OOPMs align
 - Dependent HSA plan sponsor funding is generally 2-times individual funding across all peers
 - Prevalent coinsurance-only medical and Rx cost sharing, after deductible; however, 15 of the 37 plans evaluated include pharmacy coverage with combined copayment plus coinsurance design
 - On average, non-formulary prescription drugs are covered at a lower coinsurance
 - Prescription drug individual and family deductibles and out-of-pocket maximums are combined with medical across all HDHP+HSA plans evaluated
- Kansas (KS), Nevada (NV) and South Dakota (SD) state employers provide wellness incentives through HSA contributions⁹

Note: Refer to the appendix for a list of the state employers evaluated

1. 26 state employers; 37 HDHP+HSA plans; 12 state employers provide account funding to 16 HSA-qualified plans; excludes the State of Delaware's Group Health Insurance Program (GHIP) CDH Gold plan
 2. Provisions shown are averages of 37 HDHP+HSA plans in place in 2018 (CY2018 and FY2019) corresponding to 26 state employers evaluated
 3. KS, NV and SD HSA seed incentives for wellness participation not included in the account funding individual/family averages (see footnote #9. The State of Kansas (KS) provides HSA funding to plans C and N, however, funding for plan C is contingent on employee contributions to HSA
 4. Deductible must be satisfied before coinsurance applies; coinsurance waived for preventive drugs and services
 5. Retail 30 day supply; mail order 90 day supply
 6. For prescription drug purchase, 15 of the 37 HDHP+HSA plans benchmarked apply a copayment in addition to coinsurance, after the deductible has been met; retail generic avg. copay: \$10, formulary avg. copay: \$40, non-formulary avg. copay: \$80; mail-order avg. copays approximately 2x retail; Indiana, Utah and Wisconsin drug plans are coinsurance-based with minimum and/or maximum copays in place
 7. CDH Gold plan RBV of 96.3% (including HRA seed)
 8. RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only
 9. KS provides additional \$500 employee or \$1,000 employee+spouse annual HSA funding for completing wellness-related activities; NV provides additional \$200 in HSA contributions to employees only (regardless of coverage level), \$100 for participating in preventive care exams and \$100 more for completing registration with Doctor on Demand and a guided tour using the Healthcare Blue Book (HCBB) program; in FY19, SD provides additional \$250 individual / \$500 family HSA contributions if employee or employee and spouse complete a health screening, a health assessment and earn 100 wellness points during plan year (by March 31, 2018); methodology for earning points not outlined in plan documents or website. Additional plan sponsor HSA contributions excluded from average account funding.

HDHP with HSA plan design benchmarking

Peer list - State employers¹

Peer #	Peer State Employer Name	Region ²	Plan Year Effective Date	Account-Based High Deductible Health Plans (HDHPs) ¹	HSA Employer Funding ³ Ind./Fam.
1	Arizona (AZ)	West	1/1/2018	●	No
2	Arkansas (AR)	South Central	1/1/2018	●●●●	No ⁴
3	Colorado (CO)	South Central	7/1/2018	○●	HDHP UHC & HDHP Kaiser: \$720 / \$720
4	Florida (FL)	South East	1/1/2018	○●	HDHP PPO & HDHP HMO: \$500 / \$1,000
5	Georgia (GA)	South East	1/1/2018	●●●●	No
6	Indiana (IN)	North Central	1/1/2018	●●	No
7	Kansas (KS)	North Central	1/1/2018	○●●●	Plan C: \$1,000 / \$1,250 ^{5,6} Plan N: \$500 / \$625 ⁵
8	Louisiana (LA)	South Central	1/1/2018	●●	No
9	Mississippi (MS)	South East	1/1/2018	●	No ⁴
10	Missouri (MO)	North Central	1/1/2018	○	HSA Plan: \$300 / \$600
11	Nebraska (NE)	North Central	7/1/2018	●	No
12	Nevada (NV)	West	7/1/2018	○	CDHP: \$700 / \$900 ^{5,7}
13	New Jersey (NJ)	North East	1/1/2018	○	HD1500: \$300 / \$300 ⁸
14	North Dakota (ND)	North Central	7/1/2018	●	No
15	Oklahoma (OK)	South Central	1/1/2018	●	No
16	Rhode Island (RI)	North East	1/1/2018	○	Choice Plus: \$1,500 / \$3,000
17	South Carolina (SC)	South East	1/1/2018	●	No
18	South Dakota (SD)	North Central	1/1/2018	○	HDHP: \$250 / \$500 ^{5,9}
19	Tennessee (TN)	South East	1/1/2018	○●	CDHP State & Higher Educ.: \$250 / \$500 ¹⁰
20	Texas (TX)	South Central	9/1/2018	○	Consumer Direct: \$540 / \$1,080
21	Utah (UT)	South Central	7/1/2018	○●	STAR: \$792 / \$1,584 Basic Plus: \$1,825 / \$3,650
22	Virginia (VA)	South East	7/1/2018	●●	No
23	Washington (WA)	West	1/1/2018	○●	UMP CDHP: \$700 / \$1,400 ¹¹
24	West Virginia (WV)	South East	7/1/2018	●	No
25	Wisconsin (WI)	North Central	1/1/2018	●●	No
26	Wyoming (WY)	North Central	1/1/2018	●	No

- 26 of 49 U.S. state employers offer one or more health savings account (HSA) qualified high deductible health plans (HDHP) options; 37 HSA-qualified plans evaluated. 6 of 49 state employers offer access to health reimbursement arrangement (HRA) HDHP plans (AK, GA, KS, KY, LA and VA), however, only 4 provide access to both HDHP+HSA and HDHP+HRA plan types
- HDHP+HSA plans distribution by region (# of state employers / # of plans): North Central – 8 / 11; North East – 2 / 2; South Central – 6 / 11; South East – 7 / 9; West – 3 / 4
- Of the 26 State employers in the HDHP+HSA peer group, 12 provide HSA funding to a total of 16 plans. AR, ID, IN, MN, MS, ND, VA, WA, WI and WY, assumed do not provide HSA funding to one or all of their plans as HSA funding information was not publicly available
- State employer does not offer/administer HSA accounts, however, subscribers are advised to secure an account independently
- KS, NV and SD state employers provide wellness incentives through HSA contributions
- KS state employer provides HSA funding to plans C and N, however, funding for plan C is contingent on employee contributions to HSA; KS state employer also provides additional \$500 employee or \$1,000 employee+ spouse annual HSA funding for completing wellness-related activities
- NV state employer provides \$500 base HSA funding for employee only coverage and additional \$200 for each dependent
- NJ state employer offers an HDHP+HSA (HD4000) to Local Government and State employees and an HDHP without account option (HD1500) to all Local government, Education and State employees
- SD state employer provides base account contribution amounts based on coverage level and additional FY 2019 \$250 individual / \$500 family HSA contribution, if the employee and covered spouse complete a Health Screening, a Health Assessment, and earn 100 Wellness Points during FY18; plan sponsor contribution rules and methodology for point assessment not disclosed in plan documents or website
- TN state employer offers 2 HDHP+HSA plans. CDHP State and Higher Education subscribers receive \$250 ind./\$500 fam. annual account funding. Plan sponsor account funding is not available for CDHP Local Education and Local Government subscribers
- WA state employer offers 2 HDHP+HSA plans. Plan sponsor account funding is not available for Kaiser CDHP subscribers

Health Savings Account plan designs – surrounding states¹

2018 Plan Design (In-network)	NJ HD4000 ²	NJ HD1500 ²
Deductible (Ind./Fam.)	\$4,000 / \$8,000	\$1,500 / \$3,000
Account Funding (Ind./Fam.)	N/A	\$300 / \$300
Coinsurance	80%	80%
Out-of-Pocket Max (Ind./Fam.)	\$5,000 / \$10,000	\$2,500 / \$5,000
PCP Office Visit	80%	80%
Specialist Office Visit	80%	80%
Emergency Room	80%	80%
Inpatient Care	80%	80%
Prescription Drug³		
Out-of-Pocket Max (Ind./Fam.)	Combined with medical	Combined with medical
▪ Retail	80% after deductible	80% after deductible
▪ Mail Order		
Relative Benefit Value (RBV)⁴	0.78	0.88⁵

- The State of NJ provides two HSA-qualified high deductible health plans (HDHPs) alongside several other traditional plan options (5 PPOs, 5 HMOs with RBVs ranging from 0.87 – 0.98) with varying levels of eligibility
 - The State of NJ \$300 annual Health Savings Account funding is available to HD1500 plan subscribers only
- The State of PA offers an CDHP with a Health Reimbursement Account for permanent part-time and temporary employees
- MD has not implemented an HSA-qualified HDHP from 2016 through 2018
- From 2016 through 2018, none of the states evaluated, implemented and then eliminated HSA-qualified HDHPs

1. Maryland (MD), Pennsylvania (PA) and New Jersey (NJ) state medical programs evaluated; MD and NJ 2016 through 2018 medical programs; PA 2017 and 2018 medical programs

2. HD1500 plan available to all Local government, Education and State employees; HD4000 plan available to Local Government and State employees only

3. Retail 30 day supply; mail order 90 day supply

4. RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only

5. NJ HD1500 plan RBV estimate shown includes HSA funding (annual funding dollars are \$300 Individual/\$300 Family); NJ HD1500 estimated RBV without seed is 0.86

State employer peer benchmarking

HSA seed amounts¹ and overall plan relative benefit values²

State employer peer HSA plans	Minimum	25 th Percentile	Median	75 th Percentile	Maximum	Average
Individual HSA Seed	\$250	\$450	\$620	\$738	\$1,825	\$694
Family HSA Seed	\$300	\$619	\$950	\$1,288	\$3,650	\$1,177
Relative Benefit Value (Without Seed)	0.65	0.78	0.83	0.84	0.88	0.80
Relative Benefit Value (With Seed ³)	0.73	0.86	0.90	0.92	0.95	0.88

1 KS, NV and SD HSA seed incentives for wellness participation not included in the account funding individual/family seed amounts or RBV average with seed.

2 RBVs shown are rough estimates developed using WTW proprietary actuarial tools and provided for reference only. RBVs with seed based on averaged individual and family seed amounts.

HSA plan financial impact – GHIP

- Financial impact of an HSA plan will vary based on:
 - Which participant groups are offered this plan
 - Availability of other plan options and/or changes to existing plan options
 - Final plan design and employer HSA contribution (“seed”)
 - Employee contributions relative to existing plan options

Estimated FY20 GHIP Savings ¹	HSA Scenario 1	HSA Scenario 2	HSA Scenario 3
Per 5% Migration to HSA plan	\$3.0M (\$1.9M General Fund)	\$2.2M (\$1.4M General Fund)	\$1.2M (\$0.7M General Fund)
Full Replacement (100% enrollment in HSA plan)	\$59.2M (\$37.2M General Fund)	\$43.1M (\$27.1M General Fund)	\$23.7M (\$15.0M General Fund)

- The richest HSA plan design permissible under IRS mandate includes a \$1,350/\$2,700 deductible (ind./family), followed by 100% plan cost-sharing
 - Relative Benefit Value: 98.7% (assumes \$1,000/\$2,000 Health Savings Account seed)
 - Estimated GHIP **Cost**¹: \$0.8M (\$0.5M General Fund) per 5% migration, up to \$16.7M (\$10.5M General Fund) at 100% migration

¹ Savings assumes migration from current plans (if offered alongside) or full-replacement of active employees and pre-65 retirees enrolled in the First State Basic, CDH Gold, HMO, and PPO plans; this does not include post-65 retiree Medicfill participants. Savings based on reduction in GHIP claims due to difference in actuarial value between current plan and HSA scenarios 1, 2 and 3.

New hire enrollment patterns

Distribution by age

- Average age for new hires/rehires is typically in the mid to late 30s
- Difference in age of new hires/rehires who enroll in a medical plan compared to those who waive coverage is minimal (on average, less than 1 year)
- Largest proportion of new hires/rehires is consistently from the 26-34 age band

Hire Year	Average Age by Plan					
	PPO	HMO	CDH	FSB	All Plans	Waive
CY 2014	38.2	38.1	39.0	35.6	38.1	37.6
CY 2015	41.2	38.9	41.1	36.9	40.0	38.8
CY 2016	39.4	37.8	38.2	36.0	38.3	37.5
CY 2017	38.5	37.7	39.3	35.3	37.8	36.6
CY 2018	39.3	39.1	38.2	36.6	38.5	38.2
Average	39.3	38.3	39.1	36.1	38.5	37.7

Hire Year	% of New Hires/Rehires by Age Band						Total
	Less than 26	26-34	35-44	45-54	55-64	65+	
CY 2014	3%	45%	25%	17%	9%	0%	100%
CY 2015	8%	36%	23%	18%	12%	2%	100%
CY 2016	13%	37%	22%	18%	9%	1%	100%
CY 2017	18%	33%	22%	17%	9%	1%	100%
CY 2018	17%	29%	22%	19%	11%	1%	100%
Average	12%	36%	23%	18%	10%	1%	100%

¹ Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018

New hire enrollment patterns

Enrollment by age and by plan

- Nearly half of new hires/rehires under age 26 waive coverage
- Of those who enroll in coverage, new hires/rehires under age 35 are more likely to enroll in FBS compared to older new hires, and less likely to enroll in PPO and HMO plans

Hire Year	% Original Election by Plan				
	PPO	HMO	CDH	FSB	Waive
Under Age 26					
CY 2014	33.3%	7.4%	3.7%	7.4%	48.1%
CY 2015	19.6%	25.6%	5.4%	7.1%	42.3%
CY 2016	23.8%	19.5%	5.4%	9.0%	42.2%
CY 2017	27.7%	12.5%	4.2%	13.2%	42.4%
CY 2018	23.3%	10.3%	3.9%	16.4%	46.1%
Age 26-34					
CY 2014	37.8%	26.1%	8.0%	6.3%	21.9%
CY 2015	34.9%	29.3%	7.3%	7.6%	21.0%
CY 2016	29.6%	27.6%	10.2%	15.1%	17.5%
CY 2017	32.7%	23.5%	6.4%	18.7%	18.6%
CY 2018	34.6%	15.1%	5.6%	23.3%	21.3%
Age 35+					
CY 2014	38.1%	28.8%	7.6%	4.5%	21.0%
CY 2015	39.2%	27.8%	7.9%	4.9%	20.3%
CY 2016	37.0%	25.7%	7.9%	8.3%	21.1%
CY 2017	37.5%	22.1%	8.2%	10.8%	21.4%
CY 2018	34.8%	15.4%	5.2%	14.4%	30.3%

¹ Based on all full-time benefits eligible employees of the State hired or rehired between 2014 and 2018 per 'PHRST_Hires_Rehires_ConHires_FY15-18_medical election_6.20.2018.xls' provided to WTW by OMB on June 20, 2018