



# Benefit Insights

## **As Number of Chronically Ill Grows, So Does Their Impact on Health Care Spending**

The number of Americans with chronic health conditions continues to grow, so that today more than half of insured individuals are taking a prescription medication to treat at least one chronic health condition. With a health care system more attuned to treating episodes of illness rather than long-term chronic conditions, employers can find themselves especially challenged to come up with ways to moderate the health care costs and productivity losses that result from their employees' chronic illnesses.

Reports from various sources document the increase in the number of Americans with chronic health conditions, along with the costs associated with these long-term illnesses—

- According to a report from the Kaiser Family Foundation, the number of working age adults with at least one of seven major chronic conditions (heart disease, hypertension, stroke, diabetes, asthma, emphysema, cancer) grew 25% since 1997, to a total of 58 million by the end of 2006. Individuals with these conditions account for three-quarters of all personal medical spending in the United States. However, even at that rate of spending, these folks still may not be receiving the care and treatment they need to effectively manage their conditions: Among the insured with a chronic health condition, the share unable to meet their prescription drug needs doubled from 5% in 1997 to 9.5% in 2006.
- Pharmacy benefit manager Medco Health Solutions reports that, in 2007, 51% of insured Americans were taking prescription drugs to treat at least one chronic health condition, and 20% used three or more medications for chronic conditions. Though this trend was most pronounced among seniors, it also was seen among younger individuals. For example, 48% of women ages 20–44 are being treated for a chronic condition, with the most common

condition being depression. But, in general, prescription drug treatments for high cholesterol and high blood pressure were the ones most used by those with chronic health conditions, with more than 20% taking hypertensives and almost one in seven taking cholesterol-lowering drugs.

- According to a report from researchers at Johns Hopkins University, 65¢ of every health care dollar spent in the United States is for treatment of people with two or more chronic health conditions, and this group represents only 26% of the population. Individuals with at least one chronic condition have yearly health care spending more than five times greater than those with no chronic conditions.

After pondering this data, it's clear that employers will want to do what they can to moderate the impact of their employees' chronic health conditions on health care costs and workplace productivity. It's best to attack the problem on a number of fronts, and here are some approaches to consider—

- Since prescription drugs are a staple in the treatment of chronic health conditions, a prescription benefit with employee copayment pricing that strongly encourages use of generics will be important to cost management.
- Many chronic conditions are closely related to obesity (hypertension, high cholesterol, diabetes, osteoarthritis). Therefore, wellness programs that feature weight management tools can motivate and assist employees in their efforts to exercise, lose weight and develop eating habits that avoid the high fat/high sodium/high sugar foods that can exacerbate certain chronic conditions.
- Disease management programs can target individuals with chronic conditions and actively work with them to help them manage their diseases. Services can include

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## **Address Employee Concerns Head-On to Encourage Health Risk Appraisal Participation**

As health care costs have risen, employers have searched for ways to bring these costs under control. When cost shifting and plan redesigns did not bring about desired results, attention turned to ways to engage employees more actively in managing their health. Health risk appraisals (HRAs) are considered by many to be the first step in engaging employees in their health management.

An HRA is a tool for gathering information on various aspects of one's health and gauging appropriate interventions and follow-up care. An HRA usually consists of a questionnaire, frequently completed online through the health insurer's or wellness program provider's Web site, that gathers information on various health aspects: weight/body mass index, nutrition, exercise habits, lifestyle, personal and family medical history, etc. The HRA may be in conjunction with screenings for blood pressure, cholesterol and blood sugar levels. The HRA provides feedback to the employee on health status and suggestions on how to improve. These might include directing the employee into a disease management program, to a nutritionist, or for follow-up care with the employee's regular physician.

On paper, an HRA seems like a logical way to begin to become more involved in one's personal health management. Yet, many employees decline to participate when an HRA is available. This reluctance might result from concerns about the employer's motives in offering the HRA. Employees might wonder whether their answers to the questionnaire and any data gathered about their health will be kept confidential. They might be concerned that if health information is shared with their employer or insurer, they will suffer negative consequences, such as higher insurance rates or even a loss of coverage.

Though these fears are unfounded, employers need to address them head on in order to convince employees of the privacy of the information contained in the HRA. Be sure employees are aware of their HIPAA privacy rights, that personal health information is protected from disclosure, and that

the information gleaned from the HRA is for their use and benefit, not for that of the employer or insurer.

Beyond addressing employee concerns about privacy, probably among the most effective communications involving HRAs answer the employee question, "What's in it for me?" Make sure that your HRA communications include these messages—

- Completing an HRA will give you important information about your health, and knowledge is one of the best tools you can have in staying healthy.
- What you learn from an HRA can alert you to any health issues that you may be prone to or that are in their early stages. This information can lead you to appropriate screenings, preventive care and disease management programs.
- If you stay healthier your health care costs will probably be lower over time. By dealing with a health issue at an early stage your treatment options are likely to be wider and less expensive.

Many employers take the additional step of offering incentives for participation in health risk appraisals. In a survey from Watson Wyatt Worldwide and the National Business Group on Health, more than half of the firms responding (53%) offered employees financial incentives for completing an HRA. Premium or deductible credits were more effective than cash at boosting HRA participation—73% of companies that offered premium credits and 67% that offered deductible credits had at least half of their workforce participate in an HRA, compared with 17% that offered cash and 12% that offered no incentive.

An HRA is an important first step toward engaging employees in their health management and can be the entry point for other wellness programs. By encouraging employees to participate in an HRA, you'll be helping them to maintain better health and likely saving them, and your company, health care costs down the road.

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monitoring prescription drug compliance and sending refill reminders, educating members on their chronic condition, providing information on self care, and making sure that individuals are seeing a physician as is appropriate for their condition.

With any of these approaches, the goal is that better management of a chronic condition will reduce hospitaliza-

tions and emergency room visits—which are among the costliest forms of health care—and decrease the times that a chronically ill employee must miss work on account of the illness. Realizing these goals can help to control health care costs and improve employee productivity, while enhancing the quality of chronically ill employees' lives.

## IRS Notice Allows Transfers From IRAs to HSAs

Individuals will have the opportunity to transfer funds from an individual retirement account (IRA) to a health savings account (HSA) under the terms of an Internal Revenue Service (IRS) notice that implements a 2006 amendment to HSA legislation. Notice 2008-51 provides for a “qualified HSA funding distribution,” a one-time transfer from an individual’s IRA to an HSA. Such a distribution generally will be excluded from income and not subject to the 10% early distribution penalty that otherwise applies when IRA funds are withdrawn before age 59½.

The amount contributed to the HSA in a qualified HSA funding distribution cannot be deducted by the individual, but it does count toward the individual’s maximum HSA contribution for the year.

According to the notice, qualified HSA funding distributions can be made only from traditional IRAs and Roth IRAs, and not from ongoing SIMPLE IRAs or SEP IRAs. The latter two types of IRAs are considered to be “ongoing” if an employer contribution is made for the plan year ending with or within the IRA owner’s taxable year in which the qualified HSA funding distribution would have been made.

The notice limits the amount of the qualified HSA funding distribution, based on the individual’s age at the end of the taxable year and whether the individual has self-only or family high-deductible health plan (HDHP) coverage. For example, an individual under age 55 with self-only HDHP coverage would be allowed a maximum qualified HSA funding distribution of \$2,900 for 2008, while an individual over age 55 with family HDHP coverage would be allowed a maximum qualified HSA funding distribution of \$5,800, plus the \$900 catch-up contribution. As noted above, a qualified HSA funding distribution is a one-time opportunity, but the notice specifies that if an

individual changes from self-only to family HDHP coverage in the course of a taxable year, a second qualified HSA funding distribution may be made during that year.

If an individual owns multiple IRAs and wants to transfer funds from more than one of the IRAs, he or she first must make an IRA-to-IRA transfer, and then make the qualified HSA funding distribution from a single IRA. The transfer from the IRA to the HSA must be a direct transfer, but the notice specifies that a check made payable to the HSA trustee or custodian that is delivered by the IRA account holder is considered a direct transfer.

As noted above, qualified HSA funding distributions generally are excluded from income and not subject to the 10% early distribution penalty. However, in order for this general rule to apply, the individual making the qualified HSA funding distribution must remain an “eligible individual” for the HSA for what the notice terms a “testing period.” This period begins with the month in which the qualified HSA funding distribution is contributed to the HSA, and ends on

the last day of the 12th month following that month. If the individual ceases to be an eligible individual at any time during this period, regular taxes and the 10% penalty apply.

Notice 2008-51 specifies that employers are not responsible for reporting whether an employee remains an eligible individual during the testing period. Furthermore, IRA trustees and custodians can rely on reasonable representations by the IRA account holder in determining whether a requested distribution satisfies the requirements for a qualified HSA funding distribution.

To explain how qualified HSA funding distributions work in practice, the notice includes 10 examples.

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rates as primary cost decelerators. To further keep costs in check, employers will look more to wellness and disease management programs than to employee cost-shifting, the firm predicts. Potential cost accelerators include the capital needs of the health care industry in an era of constructing new facilities and increased cost-shifting to private payers from the uninsured, Medicare and Medicaid.

Information in reports such as these can be useful to employers as they begin to plan for benefits renewal. However, as the PWC report notes, while medical costs and premiums tend to move in the same direction, cost is not a foolproof predictor of premium rates, since plan design features—such as a plan’s benefits structure and cost-sharing formulas—as well as overall health care costs, influence premium rates.



## Health Plan Costs Will Continue to Rise, But At a More Moderate Pace

Recent surveys of insurers, employers and health plans indicate that employment-based health plan costs will increase around 10% in the next year, representing a slight decline in the rate of increases seen in recent years.

A survey from Aon Consulting of 70 U.S. health insurers, representing more than 100 million covered individuals, projects health care costs will rise 10.6% for health maintenance organizations (HMOs), 10.5% for point-of-service (POS) plans, 10.7% for preferred provider organizations (PPOs), 10.5% for consumer-directed health (CDH) plans and 12.4% for indemnity plans. These projections are the lowest reported since the study began in 2001, and are slightly down from last year's trend rate increases (which were 10.9% for HMOs, 10.8% for POS plans, 11.2% for PPOs, 10.7% for CDH plans and 12.7% for indemnity plans).

The firm's consultants attribute the lower-than-usual increases to more employers and employees using wellness, health promotion and consumer-driven programs. The rate of increase, however, remains at more than twice the consumer price index.

General prescription drug costs are expected to rise 9.2%, or slightly less than last year's 9.5% rate. The increase for specialty pharmacy was higher, at 12.2%, but this is below the 15.1% rate seen last year. A reduced number of new drug

approvals by the federal Food and Drug Administration (FDA), along with a slowed rate of drug adoption across the board, explain the lower cost projection, according to Aon.

As to specific types of medical spending, the Aon study projects—

Category	Expected Increase	Previous Increase
Medicare Supplement (w/ Rx)	7.3%	1.2%
Medicare Supplement (w/o Rx)	7.3%	9.0%
Medicare Advantage (w/ Rx)	7.7%	9.2%
Medicare Advantage (w/o Rx)	7.0%	8.0%
Dental DMHO	4.2%	4.5%
Dental PPO	6.3%	6.1%
Dental Indemnity	7.0%	7.1%
Vision	3.1%	3.1%

A second report, this one from PricewaterhouseCoopers (PWC), surveyed 500-plus employers and health plans covering more than 11 million individuals. This report projects growth in 2009 medical cost trends at 9.6%, compared with 9.9% in 2008. This effective leveling off follows five years of cost deceleration.

Looking into 2009, PWC cites improved medical management of high-cost patients and continued generic substitution

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