Health Care Consumerism: Lessons My 401(k) Plan Taught Me

Changes to the U.S. health care system are here. As we think about how individuals will pay for health care—while actively employed and while retired—our experiences with 401(k) plans provide some valuable lessons. In order to support employees in this new health care world—a challenge arguably more daunting than the 401(k) challenge we faced 20 years ago—some very different types of support are needed. Employers should consider providing their employees with the resources to manage health care changes.

by **Allen T. Steinberg** | *Law Offices of Allen T. Steinberg*

The past few years have seen an intense focus on changes to the U.S. health care system, the Affordable Care Act (ACA) and employer responsibilities in providing health coverage to employees. Much of the focus has been on shorter term, more immediate concerns—such as the cost of health care, the cost of complying with the employer mandate under ACA, administrative burdens associated with categorizing employees and tracking employees' hours and the myriad reporting and disclosure requirements established under ACA.

However, there is a longer term need that employers—and the benefits community as a whole—have not yet addressed. Although this need may not have the same urgency as the ACA mandates, it is a matter of great importance: the need for resources to help employees make optimal health care coverage and financing decisions and to improve health literacy and numeracy. This article will discuss some of the lessons we have learned from 401(k) plans over the past 30 years—as employees took control of their retirement benefits—and the applicability of those lessons to health care.

Background on the Rise of the 401(k) Plan and Financial Education

The 401(k) plan was born in 1978[1] and has since "grown up" to become the dominant employer-sponsored retirement vehicle in the United States.[2] Employers have learned many lessons about how to play the role of plan sponsor. They have encouraged employees to contribute through the use of tools such as matching contributions and automatic enrollment and have offered investment options better suited to meeting employee needs, such as through a reduced emphasis on employer stock, use of balanced funds and offering "qualified" default investments. Employers also have helped employees through complex investment decisions with offerings such as target-date funds, managed accounts, online tools, outside investment advisors and automatic rebalancing.

A Few Words About Behavioral Economics

Behavioral economics uses psychological insights to help understand economic decisions.

Behavioral economists recognize that individuals apply *heuristics* (mental shortcuts) to help make decisions—even if the decisions generate suboptimal results. In the 401(k) area, some of the key behavioral issues faced by plan sponsors are complexity aversion and hyperbolic discounting.

- *Complexity aversion* means that individuals seek to avoid making decisions when faced with choices that they consider too complex. They avoid these decisions by procrastinating or accepting the "default" option. This is why automatic enrollment and default investments are so powerful.
- *Hyperbolic discounting* means that individuals overvalue current costs and benefits—and excessively discount future events. This is why it is difficult to get individuals to reduce current consumption for long-term, deferred needs.

These—and other behavioral challenges—are well-researched and well-documented.[5]

Throughout this period, employers have labored mightily to teach employees key principles of saving and investing. This has been a Sisyphean job—a seemingly futile task that must be repeated endlessly.[3] After 30-plus years of effort, challenges continue to face employers that seek to provide employees with the tools to make these important financial decisions. However, overall, it is reasonable to conclude that things have gotten better—Automatic enrollment has helped increase participation rates, and target-date funds are capturing an increasing share of new 401(k) contributions.[4] But they have gotten better only because employers and the benefits community continuously invest in developing new resources and responding to changes in markets and demographics. And they have gotten better because, with help from behavioral economics, the benefits community has learned how to provide resources that overcome emotional barriers as well as gaps in employee knowledge. (See the sidebar, "A Few Words About Behavioral Economics.")

A variety of reasons are behind these employer actions, including fiduciary requirements under the Employee Retirement Income Security Act and negative consequences to highly paid employees from failure to meet the actual deferral percentage/actual contribution percentage tests under the Internal Revenue Code. Employers also recognize that insufficient retirement savings will (ultimately) have an adverse impact on retirement patterns and (in some cases) believe providing financial education to employees is just the right thing to do. At the core of the employer commitment is a recognition that under 401(k) plans, employees are responsible for accumulating and managing their retirement savings, and employers (as plan sponsors and fiduciaries) feel the burden of providing employees with the resources necessary to exercise that responsibility.

To help frame the comparison to health care, look at how much money is in the 401(k) system. Overall, based on data compiled by the Department of Labor from Forms 5500, annual contributions to 401(k) and similar plans are approximately $280 billion—$180 billion in participant contributions (or almost $2,900 per participant) and another $100 billion in employer contributions (almost $1,600 per participant).[6] With median income from wages of $46,000,[7] this translates into close to 10% of compensation per year. Of course, these amounts grow from a variety of sources (such as with earnings and rollovers from defined benefit plans) and, at the end of 2012, 401(k) assets totaled more than $3.5 trillion. The amount of money in the 401(k) system reaffirms the importance of providing participants with resources to manage this vast pool of money. To quote Voltaire, "With great power comes great responsibility."

Comparison: 401(k) Plans and Health Care

Changes underway in the U.S. health care system bear a remarkable parallel to our experiences with 401(k) plans. With the growth of insurance exchanges (both public and private), high-deductible ("consumer-driven") plans, health savings accounts, "narrow" carrier networks and declining employer support for retiree medical plans, individuals increasingly are responsible for making decisions about how to purchase and pay for health care while working—and for saving for health care costs in retirement. And poor decisions can have catastrophic health and financial consequences.

The challenges facing a successful transition to more employee-centered health care decision making are similar to the challenges faced by employees in the 401(k) space: choosing from an array of poorly understood options, making de-

cisions based on predictions of future circumstances, requiring decisions that include unfamiliar terms with some confusing math thrown into the mix, and a need to choose between current consumption and deferred needs. And yet, individuals are poorly equipped to make these decisions—How many individuals can explain the difference between a copay and a deductible, how much a visit to an out-of-network doctor will cost them or what Medicare covers?

As employers push more responsibility to individual employees, it is safe to say that the lessons from our 401(k) experience—the importance of providing employees with an array of resources, the complex nature of employee decision making (reflecting both financial and behavioral/psychological components) and the never-ending nature of the task—should be extended to health care.

Moreover, the health care challenge is, in this author's estimation, more daunting than the 401(k) challenge we faced 20 years ago. In order to support employees in this new health care world, some very different types of support are needed.

The Basics: Buying Coverage

The basic employee decision regarding which coverages to purchase is complicated, as employees need to assess different types of plans, from traditional preferred provider organizations (PPOs) and health management organizations (HMOs) to newer designs, such as PPOs with "narrow" networks. Plans have an array of deductible structures, such as combined versus separate deductibles for prescription drugs and different deductibles for individuals versus family members and for in-network versus out-of-network care. Employers also offer an alphabet soup of account-based programs to help pay for health care: health savings accounts (HSAs), flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)—each with different rules.

Traditional Health Literacy

Health literacy has been defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[8] In effect, health literacy focuses on issues such as individuals' interactions with health care providers and the ability to understand instructions (such as labels on prescription drugs). This need is substantial and well-documented.[9] Even if employers provide robust resources to help with the basics of selecting an employer-sponsored plan, it is safe to say that health literacy is overlooked.

Retirement-Related Needs

The transition from active employment to retirement adds a new layer of complexity to this mix. As employers have reduced their support for retiree medical coverage, employees are now solely responsible for financing their retiree health care costs. The typical individual will need between $100,000 and $150,000 to pay for health care costs in retirement starting at the age of 65[10]—or about $5,000 per year for things like Medicare premiums, prescription drug insurance, Medicare supplement insurance and out-of-pocket costs. Those numbers double for a married couple. And if an individual retires a few years before the age of 65 (and before Medicare eligibility), the health care needs can increase by 50%. Planning for these costs should start years before retirement, and employees need help in understanding these needs and taking action to accumulate the resources required to finance these costs.

Individuals are faced with a dizzying array of voices and a totally new set of health insurance options when they become eligible for Medicare—Coverages under Medicare Parts A and B, Medicare Advantage and Medicare supplement plans are unlike the coverages familiar to active employees. Employers—those no longer involved in retiree health care—are unlikely to provide meaningful support. And available resources (typically, insurance brokers) may have financial incentives that do not align with individual needs. So individuals need—but are currently unlikely to receive—help in understanding their choices and selecting the optimal coverage.

Supporting Health Care Decision Making

To date, there has been limited focus on developing resources to help employees undertake their growing responsibilities. Yes, employers and health exchange operators may offer tools to help employees model their annual costs under different health care options. And employers may also provide financial incentives (such as varying subsidies for different plan options and employer contributions to an HSA) to steer employees toward high-deductible health plans. These efforts seem analogous to where 401(k) plans were 20 years ago, when employees were offered financial incentives (matching contributions) and basic modeling resources (calculators showing how 401(k) accounts accumulate over time).

If we think about the changes in the 401(k) arena over the past 20 years—from automatic enrollment and automatic rebalancing to target-date funds and managed accounts—we can begin to appreciate how much further we need to come in the effort to support health care decision making.

As previously noted, the average 401(k) plan total annual contribution is approximately $4,500 per year. By way of comparison, the average annual cost of health care is almost $5,000 per year per person.[11] For an employee starting (at the age of 40) to save for health care in retirement, the annual amount of savings needed is $7,000 per person (assuming retirement at the age of 65).[12] So, in total, the average employee is responsible for trying to manage an annual health care "budget" of more than $12,000 (for current and future expenses)—$24,000 for a couple.

In effect, the average employee has to navigate the complexities of managing an annual health care budget that is far larger than the employee's retirement budget—with far fewer resources.

Conclusion

The ability to understand health insurance and health care choices, make choices that are right for the individual and finance these choices affects individuals' health—and wealth. As we think about how individuals will pay for health care—while actively employed and while retired—our experiences with 401(k) plans provide some valuable lessons about health care. Those lessons must be understood—and applied.

Changes to the U.S. health care system are here. Employers should consider providing employees with the resources to manage those changes now. BQ

Endnotes

1. Section 401(k) was added to the Internal Revenue Code as a part of the Revenue Act of 1978; see www.ebri.org/pdf/publications/facts/0205fact.a.pdf.
2. This article focuses on 401(k) plans and does not reference 403(b), 457 or other defined contribution plans. This reflects the author's perspective that 401(k) plan sponsors have taken the lead in providing education and resources to employees and provide the best "model" for approaching health care literacy and numeracy.
3. The myth of King Sisyphus is that, as punishment for his misdeeds, he was compelled to push a boulder up a hill, only to watch it roll back down and to repeat this action forever.
4. See www.ebri.org/pdf/briefspdf/EBRI_IB_408_Dec14.401(k)-update.pdf.
5. See, for example, www.sibson.com/publications/perspectives/volume_20_issue_3/using-behavioral-economics.html, www.nber.org/papers/w7682.pdf and http://scholar.harvard.edu/files/laibson/files/life-cycle_consumption_and_hyperbolic_discount_functions.pdf.
6. Author's calculations, based upon *Private Pension Plan Bulletin,* Abstract of 2012 Form 5500 Annual Reports, U.S. Department of Labor, Employee Benefits Security, Tables D-3 and D-8, www.dol.gov/ebsa/pdf/2012pension plan bulletin.pdf.
7. See www.bls.gov/oes/current/oes_nat.htm, 17-0000.
8. See www.health.gov/communication/literacy/quickguide/factsbasic.htm.
9. See http://nnlm.gov/outreach/consumer/hlthlit.html.
10. See www.ebri.org/pdf/notespdf/EBRI_Notes_10_Oct-14_Svgs-IRAs.pdf.
11. Author's calculations, based on Health Cost Institute report, www.healthcostinstitute.org/files/2013 HCCUR 12-17-14.pdf.
12. Author's calculation, based on Retiree Health Choices, Inc. CaLiPER retiree medical cost calculator, using 6% annual return on retiree medical savings, www.retireehealthchoices.com/index.php/products-and-services/lifetime-costs-calculator.

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