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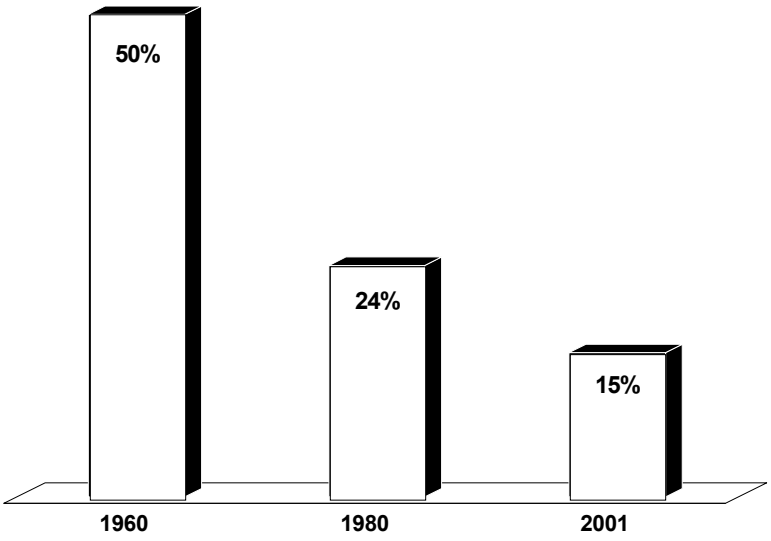
# Health Reimbursement Arrangements: Making a Good Deal Better

**by Devon Herrick**

The proportion of health care paid directly by consumers has been falling for decades. In 1960, individuals paid directly for 50 percent of their health care. Today they pay for only 15 percent. The other 85 percent is paid by third parties, generally employers, insurance companies or the government. [See the Figure.] As their share of health expenses declined, so also did consumers' interest in controlling health care costs. For example, if patients pay only 15 cents out of each dollar they spend on health care, they have an incentive to consume care until its worth to them is only 15 cents at the margin.




Source: Katherine R. Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, January/February 2003.

The widespread adoption of managed care over the past few years was an attempt to blunt these incentives by limiting the ability of patients and doctors to spend third-party insurance money. However, as the patients' share of the bill decreased, so did their power to make decisions about their own health care.

Consumer-driven health care has begun to restore patient power by allowing consumers to control a greater portion of their health care spending and directly experience the financial consequences of the decisions they make.

**Patient Power: MSAs, FSAs and HRAs.** Two well-known mechanisms for consumer-directed spending are Flexible Spending Accounts (FSAs) and Medical Savings Accounts (MSAs). Employees with FSAs usually fund these accounts through pretax deductions from their paychecks. Employers usually fund MSAs. In both cases, the funds are intended for the payment of health care expenses third-party insurers do not pay. However, the popularity of these accounts is limited by restrictions on their funding and use. For example, FSAs have a use-it-or-lose-it provision. The law requires employees to forfeit any unused funds at the end of the year, even though they had to decide at the beginning of the year how much to deposit each month. Failure to predict their health care spending accurately means sacrificing the end-of-year balance or engaging in last-minute spending on items of marginal value. This is one reason why, of the estimated 29 million employees with access to such accounts, only about six million use FSAs to pay medical bills. Far more use the accounts solely to pay their portion of health insurance premiums.

MSAs also face burdens that limit their appeal. For example, they are limited to the self-employed and to small employers who are the least likely to offer health insurance to their employees. The sizes of deductibles and of MSA deposits are also restricted.

Health Reimbursement Arrangements (HRAs) are another type of personal account from which employees can pay directly for their medical care. A June 2002 Internal Revenue Service (IRS) revenue ruling clarified that HRA funds can roll over each year and grow tax free. The ruling puts HRA spending on an even playing field with third-party payments.

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**HRAs Are Flexible**. Firms of any size can establish an HRA program. Like qualified MSAs or FSAs, the accounts are not a taxable employee benefit and employers' contributions are tax deductible. Employers have great flexibility in designing plans to meet their employees' needs. For example, an HRA may accompany any type of health insurance plan or none at all. An employer could place a uniform amount into every employee's HRA, which the employees could use to pay medical expenses or insurance premiums.

Indeed, employers might even tailor benefits to suit different types of employees' medical needs. For instance, employers are allowed to adjust HRA contributions based on such factors as age, medical risk or seniority. Employers might even alter copayments and deductibles to encourage employees to buy medications for chronic conditions. To encourage employees to seek preventive care, employers might stipulate a portion of the HRA is forfeited if not used within the year.

If an employer's HRA plan allows it, after leaving a company employees could use accumulated HRA funds to pay medical bills, COBRA premiums for continuing coverage under the employer's health plan or premiums for a new health insurance plan.

**HRAs for Retirees.** One of the most promising applications of HRAs is for retiree benefits. Employers are currently hard pressed to meet these obligations, particularly with health care costs rising at alarming rates. An HRA may serve as a "defined contribution" retirement benefit plan, giving employers more control over their future obligations.

- Employees can build up funds during their working years to be supplemented with additional postretirement employer contributions.
- As with pension benefits, the employer can institute a vesting requirement so that employees have access to the full value of the funds only after they have been with the company for a number of years.
- After retirement or Medicare eligibility, seniors can use the accumulated funds to pay Medicare Part B premiums, pay medigap premiums or pay for prescription drugs and other medical expenses not covered by insurance.

Researchers from the National Bureau of Economic Research (NBER) have found that, on average, 10 percent of employees account for 80 percent of medical expenses in any given year. Yet many of the individuals with high expenses in one year have low or no medical expenses in other years. If allowed to accumulate over their entire work lives, at the end of 35 years more than 95 percent of retiring individuals would have unused HRA balances.

**Making HRAs Better.** Currently HRA funds must be spent only on qualified medical services. This means employees can never withdraw their HRA funds as cash for nonmedical uses. This also means that employees are barred from choosing between health care and other uses of the money. Yet nothing encourages prudent shopping like the prospect of a cash reward. Without clear-cut incentives, employees will not modify their behavior and become wise consumers of health care. With this in mind, employers should design benefit plans to allow year-end rollovers of unused balances each year and continued access for ex-employees. Employees need to have a clear property right in their HRA balances and to be able to withdraw unused balances in cash — after paying income and payroll taxes on them. These accounts also need to be portable, traveling with employees as they move from job to job.

Finally, the contribution restrictions need to be relaxed. Currently, only the employer can fund an HRA program, and no such program can be tied to salary reduction or deferred compensation. In other words, the employee may not contribute directly or indirectly to the HRA. These restrictions serve no useful purpose.

**Conclusion**. Reformed HRAs would allow employers to control their contributions, while providing employees with incentives to consume medical care wisely. They would also give employees greater control of the health care dollars spent on their behalf. Thus HRAs could fulfill their promise, offering employees more choice and control over the health care they consume and helping employers hold the line on costs.

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