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Statement for the
Working Group on Health Care Security
of the Advisory Committee on Employee Welfare and Pension Benefit Plans

Employee Benefits Security Administration, U.S. Department of Labor

on
Defined Contribution Health Care Plans

by
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Chairman Szczur and members of the working group, I am pleased to appear before you today to discuss defined contribution health care plans. My name is Paul Fronstin. I am a senior research associate and director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues.

Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Overview

The term “defined contribution” has been used interchangeably with the term “consumer-driven” health benefits to describe a wide range of possible approaches to give employees more incentive to control the cost of either their health benefits or health care and to reduce the size and volatility of employer spending. Options for increasing “consumerism” in health benefits and health care include the traditional large-employer health plan choice model, the out-of-pocket choice model, tiered provider networks, health spending accounts, and vouchers.

The most common model currently emerging combines a high-deductible health benefit with a health reimbursement arrangement (HRA).¹ As an example, an employer may provide a comprehensive health benefit that has a high deductible for employee-only coverage of, say, \$2,000 a year. In order to help employees pay for expenses incurred before the deductible is reached, the employer would also give employees access to an HRA with, say, \$1,000 a year. The employee would use the \$1,000 in the HRA to pay for the first \$1,000 of health care services. While the actual deductible is \$2,000, in this example, because the employer provides an HRA with \$1,000, employees are subject only to a \$1,000 “deductible gap” or “corridor” that is sandwiched between the HRA on the front end and comprehensive coverage on the back end.

Generally, employers have a tremendous amount of flexibility in designing health benefits that incorporate an HRA. The amount of money credited to the HRA, the level of the deductible, the comprehensiveness of the insurance, the health care services that count toward the deductible, and the health care services that can be reimbursed by the HRA are all subject to how the employer designs the plan. Employers can offer comprehensive insurance that covers 100 percent of health care costs after the deductible has been met, or they may offer coverage with 80 percent coinsurance, or some other portion of costs. If employers choose to pay less than 100 percent of health care expenses after the deductible has been met, they then have the option of designing the plan with or without a maximum out-of-pocket limit.

Employers can vary employee cost sharing based on whether health care services are provided by in-network or out-of-network health care providers. Employers may choose to pay 100 percent of the health care consumed after the deductible has been met

for employees who use network providers, but pay only 70 percent or 80 percent if employees use an out-of-network provider. Employers may also design the health benefit such that any charge above the usual, customary and reasonable (UCR) rate does not count toward the deductible when out-of-network providers are used. To the degree that employers allow employees to use the HRA for health care services that do not count towards the deductible, and to the degree that employees use those health care services, the gap between the HRA and the deductible will increase.

HRAs can be set up as funded accounts or notional arrangements. With notional arrangements, the accounts only exist on paper. Employers would pay claims out of pocket as they are incurred and adjust the so-called fund balance in the employee's account accordingly. Under an HRA, employees are allowed to rollover unused funds into the following year. While there are no legal limits as to how much employees can accumulate in an HRA, employers can place restrictions on the amount that can be carried over, and can put a ceiling on the value of the HRA. Funds in the HRA can accumulate tax-free as long as they remain employer-provided funds paid out only for qualified medical expenses. HRAs can also earn interest tax-free as long as the interest is used for qualified medical expenses.

Employers can allow employees to use the funds in the HRA even after the employee has changed jobs, retired, or become unemployed. As long as the HRA is used for qualified medical expenses, distributions from the HRA are not counted as part of the employees' taxable income, even if distributions are from a former employer.

Health plans that use HRAs typically use preferred provider organization (PPO) managed-care arrangements where fees are already negotiated between providers and the plan sponsor. As a result, employees benefit from these discounted fees.

Benefits and Drawbacks From the Standpoint of the Employer

HRAs are attracting attention as a potential way to address the rising cost of providing health benefits to employees. The idea behind the HRA plan design is to give employees greater responsibility for how they spend their health care dollars, providing a greater incentive to seek cost-effective, quality providers and a greater incentive to minimize the use of discretionary health care services. In the long run, this should reduce overall health spending.

However, there is concern over incentives that are being built into health plans with HRAs. One drawback from the standpoint of the employer is that employees may not view the HRA as their own money. Employees that view the HRA as their employer's money may be more likely to spend it unnecessarily, especially healthy employees (the 50 percent of the population that accounts for only 5 percent of spending) who would expect to roll over a significant portion of the account each year. For example, a healthy employee may not hesitate to spend \$200 on an office visit when that employee also expects to rollover the remaining \$800 into year two. That employee may actually view the office visit as a "free" visit, since a co-payment from the employee's own pocket would not be required.

Over time, as some employees build an account balance, employee cost sharing responsibility will be reduced to zero, which will effectively mean that employees once

again have “first-dollar” (no deductible) coverage. At the point where an employee has an HRA that is valued as high as their deductible, additional contributions to the HRA may be viewed by the employee as “free” to use without dipping into the part of the HRA that can be used to meet the deductible. The ability to access real dollars upon job termination will temper the induced demand effect.

Benefits and Drawbacks From the Standpoint of the Employee

Most employees are healthy. On average, 50 percent of the population with employment-based health benefits accounts for only 5 percent of the spending. As a result, in any given year most employees will not use a substantial amount of health care services. These employees are likely to benefit the most from HRAs and they will likely be able to rollover unused funds in the HRA nearly each year. They will also be likely to switch to even higher deductible health plans, assuming they are available, as their HRA increases in value, thereby reducing their monthly premium. When they do suffer a catastrophic event, they will presumably have enough money in their HRA to cover most if not all of their out-of-pocket expenses.

Less healthy employees may or may not benefit from the HRA. Twenty percent of the population accounts for 80 percent of all health-care spending. Many of the people in the top 20 percent would likely use their entire HRA each year. Out-of-pocket costs for this group may be substantially higher than they would otherwise be if they were on a first-dollar comprehensive plan. Higher-income employees may welcome the new plan structure because affordability of out-of-pocket expenses may not be an issue, and the HRA may give them the flexibility and control over spending and treatment choices that

they desire. Lower-income employees with health conditions may be at the biggest disadvantage under a plan with an HRA, as many simply cannot afford higher out-of-pocket expenses.

Retiree Health Benefits and Accounts

Defined contribution health accounts are being used for retiree health benefits. Some employers have established retiree medical accounts (RMAs) for retirees to use to purchase health benefits during retirement. RMAs are typically notional accounts. In an RMA, participants typically are credited a fixed-dollar amount for each year of plan participation. Credits can also vary based on a combination of age and service. Credits in the account may accumulate interest and the value of the credits could grow over time or could vary with age or years of service, but it is possible that the value of the account would not grow as fast as the anticipated cost of providing retiree health benefits. Essentially, in this type of model the risk of unpredictable health benefit cost increases is borne by employees.

When a worker retires, he or she could then use the money in the account to purchase health insurance, although the money in the account may or may not be enough to pay for health insurance in retirement. A recent study found that 2 percent of large employers adopted RMAs for current retirees, while 7 percent adopted them for future retirees and 13 percent adopted them for new hires (McDevitt, et al., 2002).

HRAs can also be used for retiree health benefits. They can be used to pay for premiums, health care services, or both. There is one key difference between an HRA that can be used for retiree health benefits and an RMA: An RMA is dedicated to retiree

health benefits. In contrast, while employees can use an HRA to pay for premiums or health care services in retirement, employees are also using the account for current consumption of health care services while they are working. As a result, money may not be available in the HRA upon retirement for retiree health benefits, especially for historically unhealthy employees.

The main advantage of using an RMA or HRA for retiree health benefits is that the expenses are predictable for the employer. The employer is responsible only for pre-funding a specific dollar amount. Employees/retirees bear the burden if the amount accumulated in the RMA or HRA is not large enough to fully cover expenses for health insurance or health care services in retirement.

Conclusion

There is strong interest among employers in redesigning health benefit programs in response to rising costs. A few employers have turned to, and many others are considering, high-deductible health benefits coupled with HRAs. A movement to these plans has implications for health benefit costs, utilization of health care services, quality of health care, the health status of the population, risk selection, and efforts to expand health insurance coverage. Ultimately, the success or failure of these plans will be measured by their effect on the cost of providing health benefits and its effect on the number of people with and without health benefits.

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ⁱ In Revenue Ruling 2002-41 and Notice 2002-45 (published in Internal Revenue Bulletin 2002-28, dated July 15, 2002) the Internal Revenue Service (IRS) provided guidance clarifying the general tax treatment of HRAs, the benefits offered under an HRA, the interaction between HRAs and cafeteria plans, FSAs, COBRA, and other matters.