Vermont Legislative Joint Fiscal Office

One Baldwin Street • Montpelier, VT 05633-5701 • (802) 828-2295 • Fax: (802) 828-2483

ISSUE BRIEF

Date: June 28, 2017

Prepared by: Joyce Manchester

How Does Health Care Utilization Vary with the Choice of HSAs vs. HRAs?

Many health insurance plans in Vermont are consumer-driven health plans that consist of high-deductible health plans paired with a medical savings account that can be used to pay for certain out-of-pocket expenses. Two types of medical savings accounts are used frequently: Health Savings Accounts and Health Reimbursement Arrangements. The two types of accounts differ in terms of ownership and their effect on how people make choices about using health care.

What is a Consumer Driven Health Plan (CDHP)?

- A CDHP is a health insurance plan that has two parts:
  - a high-deductible health plan plus
  - a medical savings account in the form of an HSA, HRA, or sometimes a flexible savings account.

What is a Health Savings Account (HSA)?

- A Health Savings Account is a tax-free savings account **belonging to the employee** that can be used to pay for out-of-pocket expenses only with a high-deductible health plan. It may be funded by the employee and/or employer, allows the annual rollover of unused funds, and is portable. If funded by the employer, the amount funded must be 100 percent of the employer's liability for out-of-pocket expenses.

What is a Health Reimbursement Arrangement (HRA)?

- A Health Reimbursement Arrangement consists of tax-free funds **funded and owned by the employer** to pay for out-of-pocket expenses for any type of health insurance plan. Employers may choose to allow annual rollover of unused funds, and the HRA may be portable at the employer's discretion. Employers generally fund about 60 percent of their liability for out-of-pocket expenses.[1]

How does an HSA or HRA affect health care utilization?

- A CDHP requires an individual to pay for the cost of certain types of care, up to a limit, through deductibles. HSAs and HRAs can be used to make those payments. Evidence

[1] The funding ratio is sometimes stated as 50 percent of the out-of-pocket liability associated with a plan. In a health plan in which the out-of-pocket amount is $2500 but employees cover the first $400, that funding ratio is equivalent to 60 percent of the employer's liability. For example, see https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_006131.pdf

suggests that individuals pay more attention to the quantity and type of health care provided when they are aware of the cost of that care.[2]

- Seeing how much health care costs means that consumers ask questions about the need for specific procedures or the choice between a brand-name drug and a generic drug.
- A 2010 study by Aetna[3] of 5.5 million Aetna customers found that compared with enrollees in traditional Preferred Provider Organization (PPO) plans, HSA enrollees had:
    - 9% lower overall medical costs;
    - 15% lower primary care physician utilization for nonroutine visits, such as for a cold or sore throat;
    - more than 20% fewer visits to the Non-urgent Emergency Room; and
    - 11% lower utilization of specialists.

Does the choice of HSAs and HRAs matter? According to the 2010 study by Aetna,

- In general, individuals view HSAs as "their money."
- In general, individuals view HRAs as their employer's money to be used for health care expenses.
- As a result, consumers are likely to use more health care if they have a health plan combined with an HRA than if they have a health plan combined with an HSA.
    - HSAs yielded more dramatic cost savings than HRAs.
- HSA members continued to save beyond the first year.
    - In 2009, 75% of HSA members used some of their HSA funds; 25% used none.
    - In 2009, 56% of HRA members used all of their HRA funds, 31% used some, and 13% used none.
- More recently, Aetna reported in 2014[4] that employers that replace their health benefit plans with Aetna HealthFund CDHPs had lower spending by about $208 per member per year, based on more than a decade of claims data.

[2] For an overview of HRAs and HSAs, see Joanne Sammer and Stephen Miller, "Consumer-Driven Decision: Weighing HSAs vs. HRAs," May 6, 2011 and updated May 16, 2017; available at https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/hsasvshras.aspx

[3] "Aetna HealthFund consistently delivers meaningful savings and engaged members," December 2010; available at http://www.aetna.com/aetna-press/document-library/Aetna_HealthFund_2009_Study_Results_NA_Sell_Sheet.pdf

[4] Aetna news release: "Aetna HealthFund Study Results Highlight More Than a Decade of Helping Employers Save Millions," February 4, 2014; available at https://news.aetna.com/news-releases/aetna-healthfund-study-results-highlight-more-than-a-decade-of-helping-employers-save-millions/

- Members with CDHPs consistently spent less on most types of health care services, including specialist doctor visits, emergency room visits, and total pharmacy costs.

- Members with CDHPs received routine preventive care from their primary care doctors 9% more than members with PPO plans, higher rates of screenings for cervical cancer (nearly 5% higher), colorectal cancer (8%), and prostate cancer (10%) as well as mammograms (3%) and immunizations (3%).

- Plan design has an important impact on utilization; evidence suggests that the more generous the HRA plan, the less likely it is that savings will accrue.

    - If an employer funds an HRA at an amount equivalent to the full deductible, or if they provide a 100 percent co-insurance plan once the deductible is met, employees have less incentive to get engaged in understanding the cost of care. In that situation, it becomes less likely that health care utilization will decline.

    - If utilization turns out to be greater than expected, premiums will rise in the future.