



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

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## *HSAs, FSAs, HRAs*

### *Which Consumer-Driven Health Care Option Should You Choose?*

With the alarming increases in health care costs, employers are looking to consumer driven health plans to help rein in expenditures. Consumer driven health plans (CDHPs), which include Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), Flexible Spending Accounts (FSAs), and defined-contribution plans, give individuals more choices and more control over the money being used to purchase health care. These plans encourage consumers to be value-conscious shoppers in the health care marketplace.

**Survey Shows CDHP Participants Display Cost-Conscious Behavior.** Individuals in consumer driven health plans are more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors, to be more engaged in wellness programs, and to be more inclined to think that financial incentives matter in holding down costs, according to the results of the 2009 Consumer Engagement in Health Care Survey conducted by the Employee Benefit Research Institute (EBRI). Regarding cost-conscious behavior, individuals enrolled in employer-based CDHPs in 2009 were more likely than those with traditional coverage to say that they had:

- Checked whether the plan would cover care (61 percent CDHP vs. 50 percent traditional);
- Asked for a generic drug instead of a brand name (56 percent CDHP vs. 46 percent traditional);
- Talked to their doctor about prescription drug options and costs (44 percent CDHP vs. 35 percent traditional);
- Talked to their doctor about other treatment options and costs (40 percent CDHP vs. 33 percent traditional);
- Asked their doctor to recommend a less-costly prescription drug (39 percent CDHP vs. 34 percent traditional);

- Developed a budget to manage health care expenses (32 percent CDHP vs. 15 percent traditional);
- Checked the price of service before getting care (35 percent CDHP vs. 25 percent traditional); and
- CDHP enrollees were more likely than traditional-plan enrollees to take advantage of a wellness program, either a health-risk assessment or a health-promotion program. Slightly more than 70 percent of CDHP enrollees participated in a health-risk assessment, compared with 56 percent of traditional-plan enrollees. Similarly, 53 percent of CDHP enrollees participated in a health-promotion program, compared with 42 percent among traditional-plan enrollees.

Overall, the survey of employers found that in 2009, 4 percent of the population — 5 million adults ages 21-64 — was enrolled in a CDHP, up from 3 percent in 2008. Enrollment in high deductible health plans (HDHPs) increased from 11 percent in 2008 to 13 percent — 16.2 million people — in 2009. (NOTE: EBRI defines “CDHP” as a high deductible plan with an HSA or HRA. EBRI calls high deductible plans without an HSA or HRA an HDHP.)

As the satisfaction of consumer driven health plans has increased over the years, the interest has grown significantly. Unfortunately, many consumers and employers are confused about the differences between the various consumer driven plans and which option would be best for them. The Council for Affordable Health Insurance (CAHI) first prepared this analysis in 2002 and has updated it annually in an effort to help people make informed choices about consumer driven health plans.

**Health Savings Accounts.** A Health Savings Account is a special, tax-free account that must be coupled with an HSA-qualified high deductible health insurance

policy. The HSA has set annual contribution limits (including “catch-up” contributions for people over age 55), and both the employer and individual may contribute to the HSA. The HSA-qualified insurance protects the insured from the cost of a catastrophic illness, prolonged hospitalization or a particularly unhealthy year. The savings account is controlled by the insured and is intended to pay small and routine health care expenses.

We know that people want access to HSA-qualified plans, and the uninsured choose them when buying insurance. For example, a recent survey from America’s Health Insurance Plans shows that HSA plans have grown from 438,000 people covered in 2004 to more than 8 million people in 2009.

**Flexible Spending Accounts.** Congress authorized FSAs under the Revenue Act of 1978. FSAs allow employees to contribute some of their own salary on a pretax basis to an account to pay for health care expenses or their share of health insurance premiums. Like HSAs, contributions to an FSA are exempt from both income and payroll taxes. However, under the tax code, only employers can set up this program for their employees, thus excluding the self-employed and millions of employees who are prohibited from creating their own accounts. But the biggest downside of FSAs is the use-it-or-lose-it provision. Although employees contribute the money, employers get to keep any unspent balance at year’s end. Because it is difficult for a family to predict its annual medical expenses, employees often overfund their accounts and by December find themselves spending their funds on unnecessary or frivolous health care so they will not have to forfeit the remaining money.

**Health Reimbursement Arrangements.** In June 2002, the IRS authorized HRAs and published guidance regarding their tax treatment. HRAs offer employers few restrictions and, as a result, attracted a lot of interest from employers looking at consumer driven options. (HSAs were not yet available.) Notice that it is not called a Health Reimbursement “Account” (a common mistake) but “Arrangement.” HRAs allow the employee to use the employer’s money solely for medical expenses. The funds are owned by the employer, not by the employee, and they may not be withdrawn for nonmedical expenditures. If withdrawals are permitted for nonmedical expenses, the plan will be disqualified for all em-

ployees, and they will owe taxes on all amounts paid out of the HRA, including all prior medical reimbursements. Unspent HRA balances may accumulate from year to year, and employers may or may not allow departing employees access to the balances after they have left the company. With some exceptions, the large majority of employers are not making the funds available.

**It’s All about Incentives.** One of the main differences between the FSA, HRA and the HSA is the financial incentive to be a value-conscious health care consumer. FSA funds do not accrue to the employee and therefore offer the employee little incentive to control spending — at least at the end of the year. Indeed, the only way to gain value from the money is to spend it. If HRAs are treated like FSAs, they could increase health care spending rather than reduce it, as any consumer driven plan should. These problems could be fixed, however. Congress did authorize a one-time rollover of unused FSA funds to an HSA (same for HRA funds). Congress should go further than a one-time allowance and change the FSA’s use-it-or-lose-it rule to a use-it-or-save-it provision. Congress also could give employees an ownership right to their HRA funds. However, as more and more individuals and employers move to the HSA option — which they surely will do since the advantages to having an HSA greatly outweigh those of FSAs and HRAs for most people — the political pressure and need to amend FSAs and HRAs may diminish. Those who want a consumer driven option will simply choose an HSA.

For a side-by-side comparison of HRAs, FSAs and HSAs, please see the table below. For a complete analysis of the HSA law, please see CAHI’s *Issues and Answers: Answering Your Questions about Health Savings Accounts*.

	HSA	FSA	HRA
<b>Eligibility</b>	<p>To receive a tax deduction for contributions to the account, an individual must be covered under a HSA-qualified high deductible health plan (HDHP). The person must also not be enrolled in Medicare, or any other health plan that is not a high deductible health plan. (Exception: Individuals may maintain coverage for accidents, disability, dental care, vision care and long-term care and certain other types of “permitted insurance.”)</p> <p>Employees can have a limited-purpose health Flexible Savings Account (FSA) or Health Reimbursement Arrangement (HRA), a suspended HRA, a post-deductible health FSA or HRA, or a retirement HRA (see IRS Publication 969).</p>	Individual must work for an employer who offers one.	Individual must work for an employer who offers one.
<b>Who “owns” it?</b>	Individual/employee.	Individual/employee.	Employer.
<b>Who funds it?</b>	Typically individual and/or employer. Both may make contributions in the same year. Employer allowed to make additional contribution to help lower-paid workers.	Employee only via payroll deduction (self-employed precluded).	Employer only (self-employed precluded).
<b>How is it funded?</b>	<p>For both 2010 and 2011, the maximum allowable contribution to an HSA is \$3,050 for individual coverage and \$6,150 for family.</p> <p>Taxpayers are allowed full-year contributions for part-year coverage. However, they must maintain a qualified HDHP for a full year beginning in the month the HSA begins or pay a tax on the contribution plus 10% penalty. Contributions to the HSA may be made through §125 Cafeteria Plans. An employee is allowed a one-time rollover of unused funds from an HRA or FSA as long as it is before 01/01/2012. Also allowed is a one-time transfer from an IRA to an HSA. IRA rollovers cannot exceed the HSA contribution limit or excess-contributions rules (i.e., penalty and tax) apply.</p>	A set amount of pretax wages designated by the employee is deposited directly into an account via payroll deduction.	Employer funding only. Account is “notional” not cash deposits. Employer reimburses employee when presented with a valid receipt.
<b>What type of corresponding health plan is required?</b>	<p>HSA-qualified high deductible health plans in 2010 and 2011 must have a minimum deductible of \$1,200 for individuals and \$2,400 for family coverage. Total out-of-pocket costs, including deductibles, coinsurance and copayments (but not premiums), for covered benefits under the plan cannot exceed \$5,950 for an individual and \$11,900 for a family. Since the law does not specifically detail a maximum deductible, the out-of-pocket spending cap in effect becomes the maximum deductible. Thus, a plan that pays 100% of all costs above the deductible could have a 2010 deductible as high as \$5,950 for an individual or \$11,900 for a family. All amounts are indexed for inflation.</p> <p>HDHPs are allowed to offer first-dollar coverage for preventive care and still qualify. Penalties for going out of the PPO network do not count toward the total costs to the insured. Employees can have a limited-purpose health FSA or HRA, a suspended HRA, a post-deductible health FSA or HRA, or a retirement HRA (IRS Publication 969).</p>	Any type of health plan arrangement.	Any type of health plan arrangement.

	HSA	FSA	HRA
<b>Does interest accrue?</b>	Interest can be accrued tax free in qualified HSAs.	Interest not accrued, because it cannot be saved.	Interest not accrued or addressed in IRS regulations.
<b>How are expenses substantiated?</b>	It is self-substantiation of expenses.	The employer must approve expenses and can disallow for reimbursement even though the expense may be a qualified §213(d) expense.	The employer must approve expenses and can disallow for reimbursement even though the expense may be a qualified §213(d) expense.
<b>Is it portable?</b>	Completely portable. The individual owns the HSA and takes it with him or her when leaving employment.	Not portable. Unused funds must be spent by year's end (or by termination of employment before year's end), otherwise individual loses money.	Not portable. HRAs cannot be rolled over to a new employer. An employer is under no obligation to continue the arrangement after employee departure, however an employer may chose to continue reimbursing a former employee's expenses from the HRA.
<b>Can funds be used for non-medical expenses?</b>	Funds used for non-medical expenses are taxed as income and incur a 10% penalty. After age of Medicare eligibility there is no penalty.	No, health portion of FSA only used for expenses defined under §213(d) of IRC.	No, only expenses defined under §213 (d) of IRC.
<b>What is the tax treatment?</b>	Qualified expenses reimbursed from the HSA are tax free.	Contributions to the FSA are tax free and so reduce annual taxable income. No limit by law, but the plan sets either a maximum dollar or percentage contribution amount.	Reimbursements to employee are tax free as long as they are used on qualified health care purchases.
<b>Is there a "catch up" contribution provision for older workers?</b>	Catch-up contributions for individuals who are 55 or older are \$1,000 per year.  Married couples may both contribute a catch-up contribution to an HSA if both are eligible, but they must both open an HSA in their own name.	Not available.	Not available.
<b>How are unused balances treated with other benefit?</b>	Unused funds roll over automatically every year.	Money is forfeited back to employer at year's end if there are any remaining FSA funds, unless the employer offers a grace period. However, in coordination with an HSA, employees are allowed a onetime rollover from an FSA as long as it is before 01/01/2012.	Unused funds may be rolled over to successive years if allowed by the employer. In coordination with an HSA, employees are allowed a onetime roll-over from an HRA as long as it is before 01/01/2012.

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