REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - I-03
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Subject: Health Reimbursement Arrangements

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Referred to: Reference Committee K
(Ruth M. Covell, MD, Chair)

At the 2002 Interim Meeting, the House of Delegates adopted Resolution 807, which called for the AMA to study the possibilities afforded by Health Reimbursement Arrangements (HRAs) to accomplish the objectives of Medical Savings Accounts (MSAs). The Board of Trustees assigned the requested study to the Council on Medical Service for a report back to the House at the 2003 Interim Meeting.

This report summarizes the June 2002 Internal Revenue Service (IRS) revenue ruling on HRAs; compares and contrasts HRAs with MSAs and Flexible Spending Accounts (FSAs); summarizes relevant AMA policy; describes pending legislation that would establish new types of health accounts (i.e., Health Savings Accounts and Health Savings Security Accounts); and presents several recommendations.

IRS REVENUE RULING ON HRAs

In June 2002, the IRS issued a revenue ruling on HRAs (Revenue Ruling 2002-41 and Notice 2002-45). According to the IRS, an HRA is an arrangement that:

- is paid for solely by the employer and is not provided pursuant to salary reduction election;
- reimburses the employee for qualified medical expenses (as defined by § 213(d) of the Internal Revenue Code) incurred by the employee or the employee's spouse and dependents;
- provides reimbursements up to a maximum dollar amount for a coverage period; and
- permits, but does not require, any unused portion of the maximum dollar amount at the end of a coverage period to be carried forward to increase the maximum reimbursement amount in subsequent coverage periods.

COMPARISON OF HRAs, MSAs, and FSAs

HRAs have been characterized by many as another mechanism in the growing migration to consumer-directed health care, in which patients are empowered to have greater control over health care decision-making, as well as experience the financial consequences of those decisions. The appendix to this report compares and contrasts the features of HRAs, with those of MSAs and FSAs.

Governed by Section 220 of the Internal Revenue Code (IRC), MSAs combine personal savings accounts with high-deductible health insurance plans. MSAs can be established by the self-employed or by employees in companies with 50 or fewer workers. Contributions made by employers are exempt from income and employment taxes, while contributions by individual employees (allowed only if the employer does not contribute) are tax-deductible. MSA earnings and withdrawals for qualified medical expenses are tax-exempt. Withdrawals for non-medical expenses are subject to income tax and a 15% penalty (although there is no penalty after age 65). Unused MSA balances can roll over from year to year. In addition, since the MSA is owned by the employee it is completely portable.

Governed by Section 125 of the IRC, FSAs are employer-established arrangements that reimburse employees for qualified medical expenses. In contrast to MSAs, the self-employed cannot establish FSAs. FSAs are typically funded through salary reduction agreements in which employees choose to receive less pay (e.g., $125 per month) in exchange for an equal contribution to their account (e.g., $1,500 annually). Employees can choose the amount to put into their accounts up to a limit determined by the employer, and the amount can vary from year to year. The contributions are exempt from both income and payroll taxes. However, account balances cannot be carried over to the following year. Rather, unused balances are forfeited to the employer.

As previously noted, HRAs are also employer-established arrangements that reimburse employees for qualified medical expenses. Contributions by employers and reimbursements to employees are not subject to income or employment taxes. However, only the employer can contribute to HRAs. Employers may permit unused balances to be carried over, but they also can limit the aggregate rollover amount. Similarly, the employer may or may not allow retirees or departing employees access to unspent balances after they have left the company. HRAs are governed by Sections 105 and 106 of the IRC.

In summary, there are a number of key similarities and differences between HRAs, MSAs, and FSAs. Although HRAs may accompany any type of health plan, they most often involve, like MSAs, a high-deductible health insurance plan coupled with an individual spending account. Because HRAs are less hamstrung by regulations than MSAs, they are available to employers of all sizes and typically afford greater opportunity for experimentation and innovation in benefit design. On the other hand, HRAs, in contrast to MSAs, belong to the employer rather than the employee and may not be portable upon an employee's departure from the company. A major difference between HRAs and FSAs is that unspent FSA balances cannot be rolled over at the end of the year, whereas employers may permit HRA balances to be carried over.

RELEVANT AMA POLICY

Current AMA policy is silent on HRAs. However, extensive, longstanding AMA policy supports the promotion and expansion of MSAs (Policies H-165.869, H-165.879, H-165.920[7], and H-180.957, AMA Policy Database). Policy H-165.869[3] specifically details a number of current restrictions on MSAs that need to be repealed. Along with other efforts to liberalize MSA rules, Policy H-165.863 advocates for eliminating the 50-employee limit, and allowing employees to rollover any unexpended funds from a FSA into a MSA. Policy H-165.920[16] also supports federal legislation to rescind IRS regulations requiring annual forfeiture of unspent funds in employer provided FSAs.

PROPOSED NEW ACCOUNTS

The version of the Medicare Prescription Drug and Modernization Act of 2003 that was passed by the House of Representatives in June 2003 (H.R. 1) contained provisions from a previously passed bill (H.R. 2596) that would create Health Savings Accounts (HSAs) and Health Savings Security Accounts (HSSAs). HSAs would basically expand and replace MSAs, and would implement a number of changes that are consistent with AMA policy. For example, the current MSA eligibility limits on employer size and total enrollment would be removed; the current allowable deductible for individuals and families would be lowered; both employers and employees would be allowed to make contributions to HSAs; and up to $500 of unspent FSA balances could be deposited in the HSA annually.

Uninsured individuals or those with qualifying health insurance (i.e., individual deductible of at least $500, family deductible of at least $1,000) would be eligible to establish an HSSA, provided their adjusted gross income did not exceed a designated threshold. Individuals could contribute $2,000 annually if they have individual coverage, and $4,000 if they have family coverage, or are uninsured. Additional "catch-up" contributions could be made for those age 55 and over. In addition to covering unreimbursed qualified medical expenses, regular health insurance premiums could be paid from a HSSA if the deductible requirements are met.

At the time that this report was written, it was unclear if either of these provisions would be included in the conference agreement on the Medicare Prescription Drug and Modernization Act of 2003. It should be noted, however, that the Joint Committee on Taxation estimated that for fiscal years 2004-2013, the cost of these provisions, due to revenue loss, would be $163.4 billion for HSSAs, $5.7 billions for HSAs, and $8.6 billion for the FSA rollover.

DISCUSSION

The Council on Medical Service believes that the June 2002 IRS revenue ruling, and the emerging growth of HRAs, are positive developments for patients. Like MSAs and FSAs, HRAs are not a taxable employee benefit and contributions made by employers are tax deductible. HRAs are extremely flexible and can accompany any type of health plan. There also is no limit on the size of the contributions that employers may make to a HRA. As a result, the Council believes that the AMA should support HRAs as another mechanism for empowering patients to have greater control over their health care decision-making and, further, that employers should be strongly encouraged to consider offering HRAs to their employees.

At the same time, the Council believes there are several improvements that could be made to further enhance the benefits of HRAs. First, the Council believes that HRAs should be made into "real" accounts (i.e., belonging to the individual employee), rather than the current "notional" arrangements (i.e., employers reimburse employees for qualified medical expenses up to a predetermined amount, but do not make actual deposits into individual accounts). Such a change would provide employees with greater incentives to consume medical services wisely.

Second, as the sponsor of Resolution 807 (I-02), the Kansas Medical Society (KMS), accurately pointed out in correspondence to the Council, the IRS ruling allows, but does not require, employers to roll over unspent balances remaining at the end of the year. Some employers impose caps or vesting requirements to restrict the amount that may be rolled over. The Council agrees

with KMS that HRAs would be enhanced by requiring employers to rollover all unspent balances on an annual basis.

Third, employers are allowed, but not required, to provide retiring and departing employees access to HRAs, and in practice very few employers are allowing this to occur. The Council favors enhanced portability of HRAs, and believes that employers should be required to make unspent HRAs balances available to employees upon their retirement or departure from the company. Such a requirement would allow retirees to use HRAs as a "defined contribution" plan and potentially build up funds during their working years which could later be used to pay for medical expenses and insurance premiums.

In summary, although there has not yet been enough experience with HRAs to determine the extent to which they have expanded individual choice and raised cost-consciousness, the Council is encouraged by the recent IRS revenue ruling and strongly supports employer efforts to establish HRAs. The Council will continue to monitor the ongoing implementation of HRAs and will report further to the House of Delegates as needed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That the American Medical Association (AMA) support Health Reimbursement Arrangements as another mechanism for empowering patients to have greater control over their health care decision-making. (New HOD Policy)

2. That it is the policy of the AMA that: (a) Health Reimbursement Arrangements (HRAs) be made into real (rather than notional) accounts with ownership by the individual employee; (b) employers be required to rollover all unspent HRA balances annually; and (c) employers be required to make unspent HRA balances available to employees upon their retirement or departure from the company. (New HOD Policy)

3. That the AMA strongly encourage employers to consider offering Health Reimbursement Arrangements to their employees. (Directive to Take Action)

4. That the AMA report to the House on the implementation of Health Savings Accounts. (Directive to Take Action)

Fiscal Note: Develop communication to and/or meet with employers regarding HRAs at estimated total cost of $2,257.

APPENDIX

Comparison of Health Reimbursement Arrangements (HRAs), Medical Savings Accounts (MSAs), and Flexible Savings Accounts (FSAs)

	HRAs	MSAs	FSAs
Eligibility	Employees whose employers offer the benefit.	Employees of small employers (50 or fewer workers) or self-employed.	Employees whose employers offer the benefit.
Ownership	Employer	Individual/Employee	Individual/Employee
Funding Source	Employer only.	Employee or employer, but not both, or self-employed.	Employee, employer or both (typically the employee).
Funding Method	Employer reimburses employee when presented with receipt.	Money is deposited directly into the account.	Pretax wages designated by the employee are deposited into the account.
Type of Corresponding Health Plan	Any type of health plan.	High deductible plans only.	None required.
Qualifying Medical Expenses	Expenses defined under § 213(d) of the IRC, although employer may impose additional limitations. Employer may allow use for long-term care and health insurance premiums.	Expenses defined under § 213(d) of the IRC. May be used for premiums for long-term care insurance, COBRA, and health insurance for those receiving unemployment compensation.	Expenses defined under § 213(d) of the IRC. May not be used for long-term care or health insurance premiums.
Annual Contribution Limit	None, although employers often set their contributions below the annual health plan deductible.	65% of deductible for self-only plan; 75% for family plan.	None, although employers usually impose a limit.
Tax Treatment	Reimbursements to employees are tax free if used on qualified medical expenses.	Tax free if used on qualified medical expenses. Subject to income tax and 15% penalty if used on non-medical expenses (no penalty after age 65).	Contributions are tax free and reduce annual taxable income.
Carryover of Unused Funds	Permitted, although employer may limit the carryover amount.	May be carried over indefinitely.	Not permitted. Balances unspent at end of year are forfeited to employer.
Portability	Yes, but at the discretion of the employer, and subject to COBRA provisions.	Yes.	Balances usually forfeited at termination, although COBRA extensions may apply.

Sources: Congressional Research Service, Council for Affordable Health Insurance, Galen Institute, National Center for Policy Analysis.