

A Check-up on School Employee Health Care: A Proposal to Reduce Costs Without Reducing Quality

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About Ohio Smart Schools

www.OhioSmartSchools.org

The report is part of the Ohio Smart Schools initiative, which was established by KnowledgeWorks and its subsidiary Ohio Education Matters in 2010 to find ways to give the state's 1.8 million students a world-class education that will allow them and the state to thrive in an increasingly competitive global economy – at the very time that Ohio faces a projected \$8 billion budget shortfall in fiscal years 2012 and 2013.

This collaborative, nonpartisan initiative set out to seek ideas and approaches that would allow the state to achieve innovative education reform against a grim budgetary picture. Working with a number of partners, collaborators and stakeholders, Ohio Smart Schools has begun issuing recommendations across a broad array of spending issues to help state leadership in Ohio determine how best to continue the state's investment in education.

Ohio Smart Schools continues to search out effective practices, the most promising research and ideas from the public in three areas:

- **Improving student achievement** without raising costs
- **Reducing spending** without hurting student achievement
- **Tapping community strengths** to help support student achievement

Other reports and resources – covering topics ranging from 21st-learning approaches to more effective forms of regional governance or best practices in non-instructional spending – are being made available at OhioSmartSchools.org as research is complete.

About This Report: A Check-up on School Employee Health Care:

Ohio Education Matters in August 2010 contracted with the University of Cincinnati's Economics Center (UCEC) to examine potential strategies to generate savings and provide current context by updating an 2006 health care report completed by the management consultants Mercer Group. The Economics Center for Education & Research was founded in 1977 and is a leading source of economic information and resources for educators, students, businesses and the community. In addition to UCEC, contributors to this report include Greg Harris and Andrew Benson.

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Employee benefits represent one-fifth of Ohio's primary and secondary public education spending, with the cost of health care benefits alone in Ohio's 613 public school districts reaching more than \$1.9 billion a year.¹

Economic pressures and higher costs have increased spending on health care benefits even as the number of employees in Ohio's public schools has decreased over the past five years.²

Addressing these increases in costs is complicated. Health care is negotiated between districts and employee unions in local collective bargaining agreements, and benefits are considered part of the total compensation package for employees. Public sector employees typically have health care plans that require small or no employee contributions, in contrast to health plans in the private sector.

Rising health care costs and the sluggish economy have put pressure on school districts to find ways to reduce costs. The fact that employee benefits is the second-largest spending area in school districts' budgets compels state and local leaders to find ways to slow the growth of spending and perhaps reduce costs without significantly reducing the level of benefits to educators.

This report evaluates savings options for the state to consider in the area of school employee health care benefits, and makes recommendations on the most promising options.

By restructuring how school districts purchase health insurance, the state and local districts could save as much as \$138 million a year in health care spending in primary and secondary education, or about 7% of total annual costs.

In addition, the state and districts could save even more – perhaps as much as 37% on a typical health care plan – if they pursued lower-cost insurance plan offerings that have resulted in savings for businesses and other organizations.³

Context for Ohio

Ohio has 191,077 enrollees in its school employee health care plans at an annual cost of approximately \$1.9 billion.⁴ But Ohio does not have a unified health care system; instead it has several hundred agreements brokered across 613 school districts and other educational units. The plans vary in what they offer employees, what they require from employees in contributions and what the cost is to each district.

About 88% of Ohio school employees are enrolled in Preferred Provider Option (PPO) health care plans, which typically provide a network of health care providers who are approved by the insurer for the patient to use at his or her discretion. The insurer pays a portion of the bill as approved by the plans and the patient pays the difference between what is covered and what is billed. They are typically cheaper than traditional health insurance; however, recent estimates show that PPOs increased in costs for school employees in Ohio and are now less competitive in relation to traditional health insurance.⁵

¹ "Analysis of School Employee Health Benefits: An Update to the Mercer Study," University of Cincinnati Economics Center, Nov. 2010. The report was commissioned by Ohio Education Matters, a subsidiary of KnowledgeWorks. The report is available at www.ohioeducationmatters.org See also, Ohio Facts 2010, Ohio Legislative Service Commission. <http://www.lsc.state.oh.us/fiscal/ohiofacts/sep2010/2010ohiofacts.pdf>

² The cost of health care increased an estimated 7.8% from FY06 to FY10 even as the number of employees enrolled in health plans decreased 12%. See University of Cincinnati Economics Center, Nov. 2010.

³ That savings represents a fully insured group of about 400 employees moving from a typical Preferred Provider Option to a High Deductible Health Plan, as outlined below in this report in Table 1.

⁴ See University of Cincinnati Economics Center, Nov. 2010.

⁵ Ibid.

About 72% of school districts purchase their health insurance through consortia with other districts, but most involve 10 or fewer districts. These consortia do achieve discounts, although the economies of scale pale in comparison to states that have statewide health insurance pooling for school employees only or combine school employees with other state employees when purchasing insurance.⁶

More than five years ago, Ohio seriously examined its educator health care system and passed legislation advocating a statewide pool for school district health insurance plans in its 2005-06 biennial budget. To this end, House Bill 66 established a nine-member School Employees Health Care Board (SEHCB) and an 18-member Advisory Committee. The SEHCB was charged with creating a plan by the close of 2006 to implement a statewide health insurance pool for public education employees. The SEHCB contracted with the management consultants Mercer Group to develop a state pooling plan in compliance with legislative mandate.⁷

The 2006 Mercer study presented four scenarios for health care savings:

- **Scenario One: Voluntary health insurance purchasing system.** The voluntary system would provide information on best practice plans that districts would be free to join. If 30% of districts participated, overall annual savings were estimated at \$30 million to \$45 million. If a health management plan were added, annual savings were forecast at an additional \$15 million.
- **Scenario Two: Mandated disclosure.** If the state mandated that districts provide a fully transparent public comparison of their health care benefits practices compared to best-in-class results, a savings of \$60 million to \$85 million was estimated.
- **Scenario Three: Mandated five regional pools.** If all districts were to participate in one of five regional purchasing pools (based on current Medicaid regions), the estimated savings were \$120 million to \$170 million.
- **Scenario Four: Mandated single pool.** A single statewide plan would yield savings estimated at \$140 million to \$190 million.

Mercer ultimately recommended five regional health insurance pools (scenario three) where health insurance benefits would be made available to all school districts and educational service centers. The five regions would be based on current Medicaid regions. One health insurance pool would be selected by the board to administer plans in each region, with each pool offering two preferred provider organization (PPO) plans, one high deductible health plan/health savings account (HDHP/HSA) and, where available, a health maintenance organization (HMO).⁸

To support the pools, Mercer recommended the establishment of statewide standards for health insurance procurement, administration and evaluation. For example, standards would be set in regards to funding and reserve requirements, networks, eligibility, claim processing, quality improvement, reporting requirements and plan design.

Despite the state's interest in pursuing the regional health care pools outlined by Mercer, an alliance that included teacher unions and insurers (which profit from locally negotiated contracts) persuaded the legislature to veer away from a purchasing pools mandate and to instead focus on adopting best practices at the district level.⁹ The labor community in particular believed pooling

⁶ Ibid.

⁷ The Atlanta-based Mercer Group provides management consulting services to federal, state and local governments, health care providers, transit authorities, utilities, and private-sector clients. www.mercergroupinc.org

⁸ See Appendix A for an explanation of health plan offerings.

⁹ The Hands off Our Health Care Coalition formed to oppose health care pooling for public school employees. Members of the Hands Off Our Health Care Coalition included the Ohio Federation of Teachers, the Ohio Association of Public School Employees, AFSCME Ohio Council 8, Service Employees International Union District 1199, the Columbus Education Association, the Akron Education Association, and the Ohio Conference of the American Association of University Professors. See, for instance, http://aaupuc.org/CoalitionQuestionsHealthBoardLegality_19Jan06.pdf

undermined its ability to collectively bargain agreements at the local level, with much precedent of having surrendered pay increases in return for better health plans.

In its January 2007 report, the SEHCB offered a revised plan that was estimated to save \$60 million to \$120 million annually without creating the regional pools envisioned by the original legislation and Mercer. Changed were ultimately passed by the legislature.

Today, the current state law requires all school district and educational service center employee health plans to contain best practices as articulated by the SEHCB. In 2009, the board adopted the first four best practices:

- All health care plans shall include a wellness or healthy lifestyle program.
- All shall include a disease management program.
- All shall include access to institutions and providers offering demonstrated clinically superior health care for complex medical conditions.
- All shall undertake periodic dependent eligibility audits.

Case studies suggest that these best practices should achieve significant savings. Dependency audits, for example, often find 5% to 10% of dependents on a plan are ineligible. A recent eligibility audit of the Cleveland Municipal School District, with 8,000 employees, reduced its fully insured premium costs by more than \$2 million per year. The Columbus Public Schools identified more than 1,200 ineligible dependents during its audit – admittedly a potential upset for some families but a major return on investment for an audit that cost about \$90,000.

Re-examining Health Care Savings Options

With that context in mind, in November 2010, UCEC completed its report, *Analysis of School Employee Health Benefits: Update to the 2006 Mercer study*.¹⁰ Ohio Education Matters shared the report and the recommendations stemming from it with education stakeholders and the School Employees Health Care Board in December 2010 and discussed various promising options to pursue for more health care savings.

UC Economics Center Analysis of School Employee Health Benefits

The report indicated that rate of growth in spending on health care and private insurance, which has risen over the past 20 years at an annual average rate of about 7%, has slowed during the economic downturn. “That slower rate of spending growth is likely to lead to slower rates of growth in health-care costs in the near term,” the authors observe. “The current slower growth rates in healthcare spending and costs may provide some temporary relief for state budgets but this reprieve is likely to end once spending returns to its former trend of about 7 percent annual average growth, which is projected to occur after 2014 when the new national healthcare reform law is implemented fully.”¹¹

Even so, UCEC noted that the changes made in 2007 as a result of the Mercer report likely contributed to a savings of \$154 million across the state in employee health care costs between 2006 and 2010. “This lower spending suggests that school districts are already capturing some savings through changes implemented since 2006,” the authors wrote.

¹⁰ The report is available at www.ohioeducationmatters.org.

¹¹ University of Cincinnati Economics Center, Nov. 2010.

But even with the estimated savings, the total spending on health care benefits for school employees increased an estimated 7.8% from 2006 to 2010, rising from \$1.88 billion to an estimated \$1.98 billion. This occurred even though the number of school employees (and presumably the number of enrollees in health care plans) decreased by 12% from 2006 to 2010. “This the rising costs of medical care have put increasing pressure on health insurance costs,” the authors observed.

Other states have made significant changes in how they purchase health care insurance for school employees. According to the Michigan Legislative Services Bureau, more than 20 states have implemented reforms that combined school employee health insurance either into one statewide pool or in some manner with other public employees. In at least 15 states, K-12 employees are permitted to participate in the state health care plans.¹²

Michigan is one of a few states that reported its savings creating insurance pools. A 2009 Michigan Legislative Services Bureau analysis of Michigan’s teacher health care system calculated that statewide pooling would achieve upwards of \$300 million in savings, with \$65 million to \$75 million saved annually in administration, and an additional \$100 million to \$200 million saved annually from driving lower purchase costs.¹³

UCEC evaluated the savings estimates that Mercer provided in 2006 and offered its own estimates on the potential for those savings if the changes were made in Ohio today.

The center found the following potential savings:

- The state could implement several statewide pooling options (though the process might take up to a year to put into place):
 - The state could save nearly \$7 million in 2010 if it could encourage the voluntary participation of an additional 20% of enrollees into a joint purchasing arrangement (compared to an estimate of \$5.5 million in 2006.)
 - The state could save nearly \$35 million in 2010 if made the joint purchasing agreements mandatory for all school employee health care plans.
 - If the state were to create five regional pools to purchase health care insurance, and have 100% participation, it would save \$132 million (compared to an estimate of \$145 million in 2006.)
 - If the state were to create a single state pool to purchase school employee health care, and have 100% participation, the state would save \$138 million in 2010 (compared to an estimate of \$152 million in 2006.)
- The state could save about \$20 million (compared to \$27.5 million in 2006) if it were to convert all fully-insured plans to self-funding plans by eliminating the commissions of brokers.
- The state would have a loss of \$4.5 million in 2010 (compared to savings of \$20 million in 2006) if it were to move the school employees who are enrolled in traditional health plans into PPO plans. That’s because the cost of PPOs has increased since the original 2006 Mercer report.

Considering lower-cost insurance plans for employees

As noted above, Mercer had originally recommended that the plan offerings in the new health care pools would no longer include traditional plans and Point of Service (POS) plans, which are more costly. At the time, most school employees (80%) were enrolled in PPO plans, which offered flexibility in coverage without some of the more restrictive requirements regarding specialist care under

¹² States that created a state plan for school employees include Arkansas, Florida, Kentucky, Louisiana, Mississippi, and North Carolina. States that combined school and municipal employees in one state plan include California (which is the largest pooled program in the country), Georgia, Hawaii, Missouri, Nevada, New Jersey, New York, South Carolina, Tennessee, Utah, Washington and West Virginia. Not all of the pooled programs are mandatory for school employees. The authors note that none of the states permit collective bargaining on the type and level of benefits offered through the health plans. See University of Cincinnati Economics Center, Nov. 2010.

¹³ Michigan Legislative Services Bureau. (2009). An In Depth Look at the Michigan Health Benefits Program: (The Dillon Prescription for Public Sector Health Care Reform).

traditional plans. Additional cost savings were expected by eliminating the traditional and POS plans, which would drive the roughly 7% of employees into the less costly PPOs. (Only 8.5% were in Health Maintenance Organizations and 3.8% were in Health Reimbursement Arrangements or Health Savings Account plans in 2006. See Appendix A for explanation of plan offerings.)

However, the University of Cincinnati Economics Center estimated that in 2010 more than 88% of school employees were in PPOs, and only 5% were in traditional or POS plans (with 6.4% in HMOs and less than 1% in HRA/HSA plans.)

UCEC estimates that the costs of coverage in PPOs increased the most among the health plans between 2008 and 2010, a 9.72% increase, making it the most expensive health care plan.

“Thus, currently PPO plans are now, on average, the most expensive per employee for school districts,” the UCEC authors write. “This change in relative plan costs has implications for the ability of school districts to realize any savings from eliminating the traditional and POS plans and moving enrollees to the now more expensive PPO plan.”

As noted, the report indicates that with the increase in costs of the PPO plans, the expected \$20 million annual savings in the Mercer report could be an estimated \$4.5 million increase in employer costs with the elimination of traditional and POS plans.

The plan with the largest decrease in employer costs per employee, 5.21% from 2008 to 2010, was the Health Reimbursement Arrangements and Health Savings Accounts, which are accompanied by a High Deductible Health Plan (HDHP).

While only a fraction of school districts – an estimated 7.1% in 2010 – offered these plans and less than 1% of school employees were enrolled in them – they are among the fastest growing health plan offerings in the country.

“Enrollment in high-deductible health insurance plans linked to health savings accounts continues to surge, with the biggest growth in plans offered by larger employers,” reports the Investment News.¹⁴ As of January 2010, 10 million people were enrolled in HSA-linked health insurance plans, a 25% increase in one year.

Health Reimbursement Arrangements (HRA) were first implemented in 1955 and became popular about 10 years ago, while Health Savings Accounts (HSA)¹⁵ were authorized under 2003 federal law. Enrollment in HSAs has risen steadily since then. Estimates are that 4.8% of the privately insured U.S. population younger than 65 was enrolled in those plans.

They offer an approach that costs the employee less¹⁶, provides a tax advantage and provides flexibility, putting the management of health care cost more firmly in the employees’ hands, as they encounter the full cost of health services and products until reaching a high deductible, which by federal law is now a minimum of \$1,200 for an individual or \$2,400 for a family.¹⁷

Proponents contend it will help reduce health care costs and increase efficiency as the decisions are consumer driven and informed by the real costs of health care products and services. Premiums are

¹⁴ “Health savings account enrollment on rise,” Investment News, May 30, 2010. Accessed January 2011. <http://www.investmentnews.com/article/20100530/REG/305309979>

¹⁵ The primary difference between HRAs and HSAs is that employers own the former and employees own the latter, which are portable and offer a tax-deferred contributions. Employers typically make a contribution to the employee HRA and HSA. For a fuller discussion, see for instance, http://en.wikipedia.org/wiki/Health_savings_account or <http://www.healthinsurance.info/plans/HRA.HTM>

¹⁶ Among large employers surveyed, the savings in premiums for family coverage between a traditional health care plan and an HSA linked to HDHP was 27%. *Investment News*, May 2010.

¹⁷ A survey found that actual deductibles last year were far higher than the federal minimums, at \$2,203 for a single coverage in a large employer group and \$3,907 for family coverage. *Investment News*, May 2010.

typically lower, and if employers pass some of that cost savings along to employees, the plans can be attractive to employees, especially those who are healthier and are not frequent users of the health care system. Contributions to the HSAs can be rolled over indefinitely.

But the plans have their detractors, who contend that employees, especially those who are more frequent users of the health plan, could face a significant shift in cost sharing. That might cause some employees to forego choosing that plan, if it is an option. Others question the fairness that some health plans, like HSAs, offer tax breaks, while others do not.

Table 1 shows the potential cost savings for a school district that would shift from a typical PPO plan to high deductible health plans that include more cost-sharing by employees but also produce savings overall. This table uses historical data from a fully insured group of about 400 employees.¹⁸

As Table 1 shows, the district currently provides a typical PPO health care plan, with some co-pays for the employees using providers in the PPO network that are subject to an annual cap. No deductible has to be met before insurance benefits accrue.

Table 1: Example of Potential Savings from Health Care Plan Options

	Current	Option 1	Option 2	Option 3	Option 4	Option 5
Decrease*	0%	-3.95%	-9.08%	-15.00%	-27.55%	-37.44%
Benefits	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	\$500/\$1,000	\$1,000/\$2,000	\$2,500/\$5,000	\$5k/\$10k
Out-of-Pocket Max	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000	\$2,000/\$2,000	\$2,500/\$5,000	\$5k/\$10k
Office Visit	\$15 copay	\$15 copay	\$15 copay	\$20/\$40 copay	Ded, 100/0	Ded, 100/0
Inpatient Hospital	Covered in full	Covered in full	Ded, 80/20	Ded, 80/20	Ded, 100/0	Ded, 100/0
Outpatient	Covered in full	Covered in full	Covered in full	Covered in full	Ded, 100/0	Ded, 100/0
Diagnostic Lab	Covered in full	Covered in full	Covered in full	Covered in full	Ded, 100/0	Ded, 100/0
Emergency Room	\$75 copay	\$100 copay	\$75 copay	\$75 copay	Ded, 100/0	Ded, 100/0
Retail RX	\$10/\$20	\$10/\$20/\$30	\$10/\$20/\$30	\$10/\$20/\$30	Ded, 100/0	Ded, 100/0
Mail Order RX	\$20/\$40	\$20/\$40/\$60	\$20/\$40/\$60	\$20/\$40/\$60	Ded, 100/0	Ded, 100/0

*Decreases estimated on historical carrier data. Actuals determined by underwriting specific to group.
Source: HORAN, 2010

In Option 1, with just a slight change in the co-pays for employees, the cost savings over the original plan is 3.95%. Option 2, by adding a deductible of \$500 for individual and \$1,000 for family and thus additional employee cost sharing, reduces employer costs by 9.08%.

Option 3 adds a much higher deductible and continues the co-pays subject to a higher cap, and the savings jump to 15%.

Options 4 and 5, however, reveal significant savings with high-deductible health plans, with the \$2,500/\$5,000 deductibles yielding savings of 27.55% and the \$5,000/\$10,000 deductible yielding a savings of 37.44%.

The scenarios do not assume that the savings are held by the employer only and some of those savings could be redistributed to employees through contributions to Health Savings Accounts or

¹⁸ Ohio Education Matters asked HORAN, an Ohio-based insurance and financial services firm that represents more than 500 companies, including several school districts, to prepare this data of potential savings. Actual savings would be based on underwriting by the insurance carrier to a specific group or employer.

lower employee premiums. Contributions by the employer to the Health Savings Accounts are not factored into the options, for instance, which would reduce the employee potential costs.

While higher deductibles and co-payments may not be desirable to employees who may have very few out-of-pocket costs now for health care, most American workers have come to accept that maintaining quality health care benefits requires them to shoulder a larger share of costs. Also, the impact on employees varies depending on health care use, as noted.

School districts would need to work with labor organizations to negotiate such shifts, and some collective bargaining agreements in recent years have successfully navigated these changes. These trends indicate that health care plans with higher out-of-pocket costs for employees are a possible strategy in some districts to avoid more drastic cuts in staffing or course offerings and supports for students.

Options for Ohio

As a result of the work of the Ohio School Employee Healthcare Board, the state has introduced best practice mandates into education health care plans that should yield healthier employees and healthy savings. If Ohio did nothing more, it would still be on track towards a more efficient system – one that has already reined in costs.

But the state could take additional actions to ensure greater savings in employee health care:

- The state should give the SEHCB an extra lever by ensuring that all districts comply with best practices within one year, as opposed to timing best practice implementation with the expiration of collective bargaining agreements (about one-third of district agreements expire each year).
- The state should revisit health care pools. We join the call of others who maintain that the state must use its leverage and buying power to drive down costs.¹⁹ Moving to five regional buying pools would deliver savings of \$132 million and may be preferable to a statewide pool, in that the regional approach may allow for some variation in delivery to meet market preferences that may occur. The pools should be in place by July 2012.
- The state should consider steps to encourage school districts and employees to shift to lower-cost health care plans that incentivizes healthier practices and behaviors by employees. The state might want to consider adjusting state aid to school districts to reflect the potential savings that districts could get if they shift to lower-cost and more efficient health care plans. While savings to districts could be as high as 37% as outlined, the state could, for instance, assume that savings of up to 15% are possible for those who have not already shifted to the high-deductible health plans. That reduction could begin as early as FY13.

In short, the evidence is clear that the state could reduce the \$1.9 billion spent today on school employee health care plans without compromising the quality of health care, and those savings will go a long way to shifting dollars towards spending that directly support student achievement.

¹⁹ The authors of *Redesigning Ohio* make that recommendation among others that are designed to make the state's health care system, both for employees and Medicaid recipients, more responsive in getting better outcomes at a reduced costs. See *Redesigning Ohio*, December 2010. The report was commissioned by the Ohio Chamber of Commerce and the eight regional chambers of commerce in Ohio's major metropolitan areas. See <http://www.ohiochamber.com/mx/hm.asp?id=RedesigningOhio>

Appendix A: Descriptions of Health Care Plans

Below are brief descriptions of the types of employee health care plans described in the report.

Traditional health insurance plans, also known as indemnity or fee-for-service health insurance, typically offer the most choice of doctors and hospitals, no specialist referrals or pre-certification, and no utilization reviews. The insurer is billed for a portion of the service and pays a percentage up until a deductible amount is reached, and then it typically pays 100% subject to annual caps. However, it is more costly to the employer and employee than managed care plans.

The Preferred Provider Option (PPO) network provides a network of care providers that are approved by the insurer for the patient can use at his or her discretion. The insurer pays the bill and the patient pays the difference between what is covered and what is billed. They are typically cheaper than traditional health insurance.

Health Maintenance Organizations (HMO) are designed to provide efficient and effective patient service at costs which are lower than traditional and PPO health insurance. Patients must see a primary care physician within the HMO and that physician manages the health care. Patients pay a portion of some services. **Point of Service (POS)** health care plans are a type of managed care, but they offer certain flexibilities over HMOs, such as a wider network of physicians from which to choose. Patients can choose out of network physicians, but they will have a higher out-of-pocket cost to do so.

Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA) offer an approach that is lower cost to the employer, provides a tax advantage, and provides flexibility to the employee but puts the management of health care more firmly in their hands, as they encounter the full cost of health services and products until reaching a deductible of a minimum now of \$1,200 for an individual or \$2,400 for a family. That plan is called a **High Deductible Health Plan (HDHP)** and proponents contend it will help reduce health-care costs and increase efficiency as the decisions are consumer driven. Opponents question the equity of the tax-deductions for those who do or don't have an HSA, and they question whether employees will prefer this option and whether it will benefit all users.

The primary difference between HRAs and HSAs is that employers own the former and employees own the latter, which are portable and offer tax-deferred contributions. Employers typically make a contribution to the employee HRA and HSA.