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Health Care Flexible Spending Accounts

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Summary

Health care Flexible Spending Accounts (FSAs) are benefit plans established by employers to reimburse employees for health care expenses such as deductibles and copayments. FSAs are usually funded by employees through salary reduction agreements, although employers are permitted to contribute as well. The contributions to and withdrawals from FSAs are tax exempt.

FSA contributions are forfeited if not used by the end of the year. Legislation has been introduced in recent years to permit part or all of remaining balances to be rolled over to accounts next year or to qualified retirement accounts, and it is expected that similar bills will be introduced in the 109th Congress.

According to the 2002 Medical Expenditure Panel Survey, 39% of private-sector employees could establish a health care FSA, though actual usage was lower. FSAs were not as common for workers in small businesses. In establishments with fewer than 50 employees, 7% of workers had access, compared to 57% of workers in establishments with at least 50 employees. In July 2003, FSAs became available to federal employees for the first time.

These other points should be noted about health care FSAs:

- FSAs are limited to employees and former employees.
- The Internal Revenue Service (IRS) imposes no dollar limit on health care FSA contributions, but employers generally do.
- FSAs can be used only for unreimbursed medical expenses that would be deductible under the Internal Revenue Code, not including insurance and several other exceptions.
- Employers may impose additional restrictions.

FSAs are different from Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Archer Medical Savings Accounts (MSAs). For a comparison of these four accounts, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*. This report will be updated for new data or as legislative activity occurs.

The President's FY2006 budget does not include any proposals regarding FSAs.

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Health care Flexible Spending Accounts (FSAs) are employer-established benefit plans to reimburse employees for specified health care expenses as they are incurred. They arose in the 1970s as a way to provide employees with a flexible benefit at a time when the cost of health care was a growing concern. In contrast to traditional insurance plans, FSAs generally allow employees to vary benefit amounts in accordance with their anticipated health care needs. FSAs can be used for unreimbursed medical expenses, and contributions to FSAs have tax advantages. However, FSA contributions are forfeited if not used by the end of the year.

This report describes FSAs, the basis for their tax treatment, and data on their use.[1] The report concludes with a brief discussion of recent presidential and legislative proposals affecting FSAs.

Background

FSAs are employer-established benefit plans that reimburse employees for specified expenses as they are incurred. They usually are funded through salary reduction arrangements under which employees receive less take-home pay in exchange for contributions to their accounts. Employees each year choose how much to put in their accounts, which they may use for dependent care or for medical and dental expenses. However, there must be separate accounts for these two purposes, and amounts unused at the end of the year must be forfeited to the employer. If FSAs meet these and other rules, contributions are not subject to either income or employment taxes. The focus of this report is on the FSAs devoted to health care.

To illustrate the tax savings, consider a health care FSA funded for an employee through a salary reduction arrangement. Before the start of the year, the employee elects to reduce his salary by $75 a month in exchange for contributions of that amount to the FSA. Other employees might choose to contribute more or less than $75. Throughout the year, as the employee incurs medical and dental expenses not covered by insurance or other payments, he may use funds in the account to pay them. His total draw, which must be available at the start of the year, is limited to $900 (the sum of his monthly contributions for the year). If all $900 is used the first

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[1] FSAs are different from the three other types of tax-advantaged health care accounts: Health Savings Accounts, Health Reimbursement Accounts, and Archer Medical Savings Accounts. For a comparison of all these accounts, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson. Also see Internal Revenue Service publication number 969, *Health Savings Accounts and Other Tax-Favored Plans*, which is available through the IRS website, [http://www.irs.gov].

nine months, for example, he generally cannot replenish the account until the next year. Any amount that remains unspent after 12 months is forfeited to the employer. If the FSA was funded by the employer, as sometimes is the case, the employee's draw must similarly be available at the start of the year. It is possible for FSAs to be funded both by salary reductions and employer contributions.

If the employee were in the 25% tax bracket, the federal income tax savings from the $900 salary reduction used to fund the account generally would be $225 (i.e., $900 x .25); in addition, the employee could save $69 in Social Security and Medicare taxes (i.e., $900 x .0765).[2] There could be state income tax savings as well. If the employee were in the 15% tax bracket, the federal income tax savings would be $135, three-fifths as large, while if he were in the top 35% bracket they would be commensurately greater, $315).[3]

The employer would also save $69 in employment taxes from the $900 salary reduction. Employers often use these savings to help pay the expenses of administering an FSA.

Tax savings can exceed losses due to forfeiture of a remaining balance at the end of the year; thus, not all of an account must be used for employees to come out ahead financially. Since tax savings are greater in the higher tax brackets, higher income employees may be less concerned about forfeitures (assuming they recognize they could still be better off) than lower income employees.[4]

The tax savings associated with a health care FSA are not unlike those for traditional comprehensive health insurance, which also allows employer payments to be excluded from the income and employment taxes of the employees as well as from the employment taxes of the employer.

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[2] If the employee's earnings exceeded the Social Security wage base ($90,000 in 2005), the only savings would be $13 from Medicare taxes (i.e., $900 x .0145). Reductions in Social Security taxes due to FSA salary reductions could affect the Social Security benefits that the worker later receives, though not by much.

[3] In 2005, the 15% bracket for single filers applies to taxable income (that is, after exemptions and deductions are subtracted) of $7,301 to $29,700; for married couples filing jointly, the bracket extends from $14,601 to $59,400. The 25% brackets for these taxpayers are from $29,701 to $71,950 and from $59,401 and $119,950, respectively.

[4] The breakeven point for an employee in the 25% bracket who contributes $900 would generally be $606 (i.e., $900 minus income tax savings of $225 and employment tax savings of $69). The employee comes out ahead if unreimbursed expenses exceed that amount, assuming they would have been incurred in the absence of the FSA. If expenses would not have been incurred except for the FSA, then the breakeven point generally would be higher since the employee presumably values the obtained services at less than the market price.

Basis for Tax Treatment

FSAs are one way that employment benefits can be varied to meet the needs of individual employees without loss of favorable tax treatment. Flexible benefit arrangements generally qualify for tax advantages as "cafeteria plans," under which employees choose between cash (typically take-home pay) and certain nontaxable benefits (in this case, reimbursements for health care expenses) without paying taxes if they select the benefits. The general rule is that when taxpayers have an option of receiving cash or nontaxable benefits they are taxed even if they select the benefits; they are deemed to be in constructive receipt of the cash since it is made available to them. Section 125 of the Internal Revenue Code provides an express exception to this rule when certain nontaxable benefits are chosen under a cafeteria plan.[5]

FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. FSAs are considered part of a cafeteria plan when they are *funded through voluntary salary reductions*; this exempts the employee's choice between cash (the salary subject to reduction) and normally nontaxable benefits (such as health care) from the constructive receipt rule and permits the latter to be received free of tax.[6] Thus, instead of receiving a full salary (for example, $30,000), the employee can receive a reduced salary of $29,100 with a $900 FSA contribution and will need to treat only $29,100 as taxable income.

However, if FSAs are funded by *nonelective employer contributions* then their tax treatment is not governed by the cafeteria plan provisions in Section 125; in this situation, the employee does not have a choice between receiving cash and a normally nontaxable benefit. Instead, the benefits are nontaxable since they are directly excludable under some other provision of the Code. For example, nonelective employer-funded FSAs for dependent care are tax-exempt under Section 129, while nonelective employer-funded FSAs for health care are tax-exempt under Sections 105 and 106.

Particular rules governing the tax treatment of FSAs are not spelled out in the Internal Revenue Code;[7] rather, they were included in proposed regulations that the Internal Revenue Service (IRS) issued for cafeteria plans in 1984 and 1989.[8] Final

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[5] In addition, cafeteria plans may include some taxable benefits; like cash, these are taxable if the employee selects them.

[6] For a critical discussion of the Internal Revenue Service's interpretation of constructive receipt with respect to employee benefit plans and Section 125, see Leon E. Irish, Cafeteria Plans in Transition, *Tax Notes*, Dec. 17, 1984, pp. 1135-1136.

[7] For many years, the Code had no explicit reference to FSAs. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) added a definition in subsection 106(c)(2) when it disallowed coverage of long-term care services through such accounts.

[8] 49 *Federal Register* 19321, May 7, 1984, 49 *Federal Register* 50733, Dec. 31, 1984 and 54 *Federal Register* 9460, Mar. 7, 1989. The proposed regulations have not been finalized, but they remain the position of the IRS. The rules cover both FSAs funded by salary reductions and FSAs funded by nonelective employer contributions. Although employers (continued...)

rules regarding circumstances in which employers may allow employees to change elections during a plan year were issued in March 2000 and January 2001.[9] To be exempt from the constructive receipt rule, participants must not have cash or taxable benefits become "currently available"; they must elect specific benefits before the start of the plan year and be unable to change these elections except under specified circumstances. With respect to health care FSAs:

- the maximum amount of reimbursement (reduced by any benefits paid for covered expenses) must be available throughout the coverage period;
- coverage periods generally must be 12 months (to prevent employees from contributing just when they anticipate having expenses);
- reimbursements must be only for medical expenses allowable as deductions under Section 213 of the Code;
- claims must be substantiated by an independent third party;
- expenses must be incurred during the period of coverage;
- after year-end forfeitures, any "experience gains" (the excess of total plan contributions and earnings over total reimbursements and other costs) may at the employer's discretion be returned to participants or used to reduce future contributions, provided individual refunds are not based on participants' claims;[10] and
- health care FSAs must exhibit the risk-shifting and risk-distribution characteristics of insurance.[11]

The effect of the IRS rules is to allow only *forfeitable FSAs* under which employees lose whatever they do not spend each year. The rules disallow three other types of FSAs that had started to spread before 1984: *benefit banks*, which refunded unused balances as taxable compensation at the end of each year; *ZEBRAs*, or zero-

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[8] (...continued)
generally do not permit annual reimbursements from FSAs to exceed the amount slated for contribution during the year, the proposed regulations do not require this. The proposed regulations allow a maximum annual reimbursement of up to 500% of the total annual contribution, or "premium" (including both employer-paid and employee-paid portions of the contribution to the FSA). An FSA operating in this way would be more similar to typical health insurance in that the maximum benefit is not limited to the year's contribution total. However, such an FSA would still differ from typical health insurance in that the maximum benefit is relatively low.

[9] 65 *Federal Register* 15548, Mar. 23, 2000 and 66 *Federal Register* 1837, Jan. 10, 2001. The rules apply to cafeteria plans generally, not just FSAs. The rules allow mid-year election changes for changes in status (marital status, number of dependents, employment status, place of residence) and significant changes in cost or coverage; however, mid-year election changes for health care FSAs are not allowed for cost or coverage changes since the plans must exhibit the risk-shifting and risk-distributions characteristics of insurance. These rules only permit employers to allow mid-year changes, they do not require them.

[10] Thus an employer might refund the same dollar amount to every participant, even though some used all their benefits while others forfeited unused amounts.

[11] 54 *Federal Register* 9460, Q and A 7. Some of the seven requirements listed in the text had been issued in 1984.

based reimbursement accounts, under which reimbursements were subtracted from salaries each month (thus reducing taxable compensation at the time it was paid); and *ultimate ZEBRAs*, under which salaries already paid were recharacterized at the end of the year into reimbursements and taxable compensation. Neither ZEBRAs nor ultimate ZEBRAs had accounts that were funded, and they were criticized as abusive arrangements.

The IRS rules lay out what is permissible with respect to FSA plans, but employers may add their own requirements. For example, the IRS does not limit the amount that an employee can be reimbursed through a health care FSA, but employers may establish their own ceiling.[12] (One reason they might do so is to limit the financial risk that employees might resign having received reimbursements that exceed their contributions.) Similarly, employers may exclude certain elective expenses from their plans.

One justification for the tax advantages of FSAs is that they might be equivalent to the tax savings associated with comprehensive insurance plans having negligible deductibles and copayments; from this perspective, they seem equitable. On the other hand, similar tax savings are not available to individuals who can only claim an itemized deduction for unreimbursed expenses that exceed 7½% of their adjusted gross income.

Data on Use

Few surveys ask about FSAs, and those that do obtain only limited information. Although surveys yield similar findings about the availability of FSAs, little is known about the number and characteristics of workers who participate.

The 2002 Medical Expenditure Panel Survey (MEPS) found that 11% of private-sector establishments offered an FSA to their workers. FSAs are more common in larger firms; FSAs were offered in 47% of large-firm establishments (50 or more workers) but in only 3% of small-firm establishments.[13] Similarly, a greater percentage of employees had access to an FSA if they worked in a large-firm establishment instead of a small one. In establishments with fewer than 50 employees, 7% of workers had access, compared to 57% of workers in establishments with at least 50 employees. Overall, 39% of private-sector employees could establish an FSA, according to MEPS.

According to a 2004 survey by Mercer Human Resources Consulting, 81% of employers with 500 or more employees offered a health care FSA, and an average of 20% of eligible employees participated. Among employers with 10 or more

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[12] A $5,000 limit applies to dependent care FSAs. The latter are governed by Section 129, which includes that limit.

[13] CRS calculations were made from a MEPS-Insurance Component table provided by statisticians at the Agency for Healthcare Research and Quality. The percentages pertain to establishments that provided information regarding the fringe benefits they offer.

employees, 25% offered a health care FSA, and an average of 36% of eligible employees participated. The average amount contributed was $1,295.[14]

Reasons for low FSA participation include employee perceptions of complexity, concerns about end-of-year forfeitures, and limited employer encouragement. Younger employees, particularly if single, may not have enough health care expenses to make participation worthwhile. For lower income employees, the tax savings may be inconsequential.

The modest participation levels suggest that early concerns about the extent to which FSAs would reduce tax revenue may have been exaggerated. In 1985, a congressionally mandated study concluded that forfeitable FSAs would increase health expenditures by approximately 4% and 6%, depending on an employee's health plan, and that revenue loss would be $7 billion (in 1983 dollars).[15] However, the study assumed that all employees with employment-based health insurance would eventually have FSAs. Moreover, the revenue estimate did not reflect any reduction in health care use from additional cost-sharing requirements that employers sometimes impose when implementing FSAs. These reductions would partially offset increases in health care use due to funding FSAs with pre-tax dollars.[16]

Federal government employees in nearly all agencies can enroll in an FSA. Federal FSAs were introduced with an initial effective date of July 1, 2003, and nearly 32,000 employees participated in the health care FSA that year. Approximately one in eight forfeited some amount at the end of the year, with an average forfeiture per participant of $220. Following the open season for 2004 enrollment, the number of federal health care FSA enrollees increased to 133,000. Following the 2005 open season, the number of federal health care FSA enrollees further increased to 157,000.

Principle Rules Regarding FSAs

Eligibility

Eligibility for FSAs is limited to employees whose employers offer plans; people who are self-employed or unemployed generally cannot participate. However,

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[14] Tom Herman, A Setback for a Popular Health Benefit; Treasury Rejects Effort to Ease "Use-It-or-Lose-It" Provision of Flexible Spending Accounts. *Wall Street Journal*. Jan. 5, 2005. p. D1.

[15] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. A Study of Cafeteria and Flexible Spending Accounts, July 1985, pp. 18 and 20. The study was mandated by Section 531(b)(6) of the Deficit Reduction Act of 1984 (P.L. 98-369). The three prototype health plans on which the study was based had deductibles of $0/$0, $150/$300 and $150/$300 for individuals and families, respectively; 15% coinsurance; and cost-sharing maximums of $150/$300, $500/$1,000, and no limit.

[16] For a critical review of the congressionally mandated study, see Daniel C. Schaffer and Daniel M. Fox, Tax Law as Health Policy: A History of Cafeteria Plans 1978-1985, *The American Journal of Tax Policy*, v. 8, spring 1989, p. 47.

former employees can be eligible provided the plan is not established predominantly for their benefit.[17] Employers may set additional conditions for eligibility.

FSAs allow coverage of a spouse and dependents. FSAs do not have to be linked with any particular type of insurance, though it is said some employers establish FSAs in order to win employee acceptance of greater cost-sharing.

Contributions

FSA contributions may be made by employers (through nonelective payments), employees (through salary reduction plans), or both. FSA contributions occur during the plan year, which is usually a calendar year. Since most FSAs are funded through salary reductions, contributions typically occur pro-rata throughout the year.

The IRS imposes no specific dollar limit on health care FSA contributions, though plans typically have a dollar or percentage maximum for elective contributions made through salary reductions. Employers set limits to reduce losses from employees who quit or die when their withdrawals (which might total the year's allowable draw) exceed their contributions from salary reductions. For 2005, federal employees may contribute up to $4,000 to their health care FSA.

Qualifying Expenses

Under IRS guidelines, health care FSAs can be used for any unreimbursed (and unreimbursable) medical expense that is deductible under Section 213 of the Internal Revenue Code, with several important exceptions.[18] One exception disallows their use for long-term care and for other health insurance coverage, including premiums for any employer plan. Employers may add their own limitations.

The restriction against paying health insurance premiums can be circumvented if the employer offers a separate premium conversion plan. This arrangement allows employees to pay their premiums through what are deemed to be pre-tax salary reductions. For example, if employees pay $600 a year for health insurance (with their employer paying the balance), their payment can be considered to be made directly by their employer (and so exempt from income and employment taxes) instead of included in their wages (and so taxable). Premium conversion plans are common among businesses that offer health insurance, particularly among large companies. The federal government implemented a premium conversion plan in October 2000.

Nonqualified Withdrawals

FSA funds may be used only for qualifying expenses, as defined above; they cannot be withdrawn for other purposes. To ensure compliance, reimbursement

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[17] 49 *Federal Register* 19321, Q and A 4.

[18] Allowable expenses are discussed in IRS publication number 502, *Medical and Dental Expenses*, which is available through its website, [http://wwwirs.gov].

claims must be accompanied by a written statement from an independent third party (e.g., a receipt from a health care provider).

Carryover of Unused Funds

FSA balances unused at the end of the year are forfeited to the employer; they cannot be carried over. However, since employees can control how much is contributed through salary reduction plans, in effect they can "carry over" amounts they do not anticipate using by not putting them into the account in the first place.

Current Legislation

Prior to his FY2005 budget proposal, President Bush's annual budget submissions sought to allow up to $500 in unused balances in health care FSAs to be carried over to the following year without being taxed, to be distributed to participants (in which case they would be taxed), or to be rolled over into certain qualified deferred compensation plans (Section 401(k), 403(b), and 457(b) plans). However, neither the President's FY2005 budget nor his FY2006 budget included a carryover provision.

In the 108th Congress, the House passed one bill (an amended version of H.R. 4279), which would have allowed up to $500 in unused health care FSA balances to be rolled over to the following year or into a Health Savings Account.[19] This was the only legislative proposal to be voted on in 2004 that would have directly affected health care FSAs.

On August 23, 2004, Senator Grassley, chairman of the Senate Committee on Finance, requested the Treasury Department to assess whether it has the authority to modify the "use or lose it" rule without a directive from the legislative branch. On December 23, 2004, Treasury Secretary John W. Snow responded that Congress had effectively ratified the rule and that changes would require legislative action.

It is anticipated that bills will be introduced in the 109th Congress to allow a rollover of some health care FSA funds.

Conclusion

FSAs can provide tax savings for the first dollars of health care expenditures that people have each year. In contrast, taxpayers normally are allowed to deduct medical expenses only to the extent they exceed 7½% of adjusted gross income, and then only if the taxpayer itemizes deductions. The more favorable treatment for FSAs might be justified since participants generally assume additional financial risk for their health care. Some might question, however, whether the savings are

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[19] For more information about Health Savings Accounts, see CRS Report RL32467, *Health Savings Accounts*, by Bob Lyke, Chris Peterson, and Neela Ranade.

proportional to the risk and whether they are equitable among people of similar incomes. This issue might be considered as Congress continues to review the tax treatment of health insurance and health care expenses.

FSAs might be seen as conflicting with health savings accounts. By design, FSAs provide tax subsidies for the first dollar of healthcare expenditures, while health savings accounts are coupled with high deductible insurance. Although it is technically possible for an individual to make contributions to both accounts in the same year, the accounts cannot cover the same expenditures. People who have a healthcare FSA may not see much need to have a health savings account