Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison

Bob Lyke

Chris L. Peterson
Specialist in Health Care Financing

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Summary

Health Savings Accounts (HSA) are the most recent addition to an array of tax-advantaged accounts that people can use to pay for unreimbursed medical expenses, such as deductibles, copayments, and services not covered by insurance. First available January 1, 2004, HSAs have largely replaced the similar but more restrictive Archer Medical Savings Accounts (MSAs), which never attracted many participants. In addition, people may have access to two employment-based accounts, Health Reimbursement Accounts (HRAs) and health care Flexible Spending Accounts (FSAs). Collectively, these accounts have some features and objectives in common, but they also differ in important respects. Keeping these accounts straight can be difficult, especially when they are discussed informally using different names.

This report provides brief summaries and background information about the four accounts and then compares them with respect to eligibility, contribution limits, use of funds, and other characteristics for tax year 2009. The report concludes with a brief discussion of equity and several other issues. It will be updated when relevant statutory or regulatory changes occur, when new data become available, and as Congress considers issues associated with health care reform.

Contents

Brief Summaries and Background 1
Some Issues 5
Consumer-Driven Health Care 5
Equity 5
Targeted Savings Accounts 5
Health Care Reform 6

Tables

Table 1. Summary of General Features of FSAs, HRAs, HSAs, and MSAs, 2009 3

Contacts

Author Contact Information 6
Additional Author Information 6

Brief Summaries and Background

Four types of tax-advantaged accounts are permitted under current law for people to pay unreimbursed medical expenses such as deductibles, copayments, and services not covered by insurance: health care Flexible Spending Accounts, Health Reimbursement Accounts, Health Savings Accounts, and Archer Medical Savings Accounts.[1]

Flexible Spending Accounts (FSA). Health care FSA are employer-established arrangements that reimburse employees for medical and dental expenses not covered by insurance or otherwise reimbursable. They usually are funded through salary reduction agreements under which employees receive less pay (e.g., $100 less a month) in exchange for equivalent contributions to their accounts (in this case, $1,200 for the year). Employees choose how much to put into their accounts, which can vary from year to year. They forfeit unused balances at the end of the year unless the employer offers a grace period for additional claims of up to 2½ months after the end of the year (e.g., so medical expenses incurred by March 15, 2010, could be reimbursed from the FSA for 2009). A limited, one-time rollover may be made to a Health Savings Account. The entire annual amount of an FSA must be made available to employees at the beginning of the year. Contributions are not subject to income or employment taxes (i.e., Social Security and Medicare taxes), unlike the pay employees otherwise would have received.

FSAs funded by salary reductions are governed by Section 125 of the Internal Revenue Code, which exempts contributions from taxes despite the fact that employees have the choice to receive taxable wages.[2] Most rules regarding FSAs are not spelled out in the Code; they were initially included in proposed regulations that the Internal Revenue Service (IRS) issued in 1984 and 1989. Final rules regarding permissible mid-year election changes were issued in 2000 and 2001. On August 3, 2007, the IRS issued new proposed rules that were to be generally effective on January 1, 2009, though taxpayers could have adopted them sooner.[3] These rules have not yet been finalized. According to a 2006 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. The offer rate in small firms is much lower. Public sector employees often have access to health care FSAs, too.

Health Reimbursement Accounts (HRA) are also employer-established arrangements to reimburse employees for medical and dental expenses not covered by insurance or otherwise reimbursable. As is the case with FSAs, contributions are not subject to either income or employment taxes. However, contributions cannot be made through salary reduction agreements; only employers may contribute. Employers need not actually fund HRAs until employees draw upon them. Also unlike FSAs, reimbursements can be limited to amounts previously contributed. Unused balances may be carried over indefinitely, though employers may limit the aggregate carryovers. A limited, one-time rollover may be made to a Health Savings Account.

[1] For additional general information, see Internal Revenue Service publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, available at http://www.irs.gov/pub/irs-pdf/p969.pdf.

[2] Section 125 governs cafeteria plans; it provides an express exception to the constructive receipt rule, which requires taxation of what is normally nontaxable income when taxpayers have the choice of receiving taxable income or nontaxable income.

[3] *Federal Register*, vol. 50 no. 50 (August 6, 2007), p. 43938.

HRAs are governed by Section 105 of the Internal Revenue Code, which allows health plan benefits used for medical care to be exempt from taxes, and Section 106 of the Code, which allows employer contributions to those plans to be tax-exempt. Rules regarding HRAs are spelled out in IRS revenue rulings and notices issued in 2002.[4]

Health Savings Accounts (HSA) are tax-exempt accounts for paying medical and dental expenses not covered by insurance or otherwise reimbursable. They can be established and contributions made only when the owner has qualifying high deductible insurance (a deductible of at least $1,150 for self-only coverage and $2,300 for family coverage, plus other criteria) and no other coverage including Medicare, with some exceptions. Contributions are limited to $3,000 for self-only coverage and $5,950 for family coverage. An additional contribution of $1,000 is allowed people age 55 and older. (The dollar amounts in the last several sentences are for 2009.) HSAs carry tax advantages that can be significant for some people. Contributions made by employers are exempt from income and employment taxes; account owners may deduct contributions they make. Withdrawals for medical expenses are not taxed; those used for other purposes are taxable and subject to a 10% penalty except in cases of disability, death, or attaining age 65. Unused balances may be carried over from year to year without limit. As of January 2008, about 6.1 million people were covered by HSA-high deductible health plans. The number includes policy-holders (not all of whom may have had HSAs) as well as their family members.[5]

HSAs were first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Most statutory rules are in Section 223 of the Internal Revenue Code, though there is Department of the Treasury and IRS revenue guidance as well.[6]

Archer Medical Savings Accounts (MSA) might be viewed as a restricted precursor to HSAs. Like them, MSAs can be established and contributions made only when account owners have qualifying high deductible insurance and no other coverage, with some exceptions. Contributions made by employers are exempt from income and employment taxes, while contributions made by account owners (allowed only if the employer does not contribute) are deductible. Withdrawals are not taxed if used for medical expenses; those used for other purposes are taxable and generally subject to an additional 15% penalty. Unused balances may be carried over from year to year without limit. The principal difference is that eligibility is limited to people who are self-employed or who are employees covered by a high deductible plan established by their small employer (50 or fewer employees, on average). In addition, the minimum deductible levels are higher and the contribution limits are lower. For details, see the comparison table that follows.

MSAs were first authorized by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). The legislation generally limited the total number to 750,000 (not counting accounts of owners who were previously uninsured, among others), though for tax year 2003 (probably the high point), the IRS estimated there were fewer than 80,000 accounts in total. Most MSA owners can now have HSAs, and their MSA balances can be rolled over into the new accounts. Most statutory rules governing MSAs are in Section 220 of the Internal Revenue Code.

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[4] IRS Revenue Ruling 2002-41 and Notice 2002-45.

[5] The number is based on a survey by America's Health Insurance Plans. For more information, see http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf.

[6] For additional information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Bob Lyke.

Table 1. Summary of General Features of FSAs, HRAs, HSAs, and MSAs, 2009

	Health Care Flexible Spending Accounts (FSA)	Health Reimbursement Accounts (HRA)	Health Savings Accounts (HSA)	Medical Savings Accounts (Archer MSA)
Eligibility	Employees whose employers offer this benefit. Former employees may be included. Employers not restricted by size.	Employees whose employers offer this benefit. Former employees may be included. Employers not restricted by size.	Individuals with qualifying health insurance. Ineligible individuals may keep previously established accounts but cannot make contributions.	Individuals with qualifying health insurance who are employees of a small employer (50 or fewer workers) with a high deductible plan or self-employed. Ineligible individuals may keep previously established accounts but cannot make contributions.
Definition of qualifying health insurance	No health insurance requirements.	No health insurance requirements, although HRAs are usually combined with high deductible health insurance.	**Self-only deductible** must be at least $1,150; the **family deductible** must be at least $2,300.. Annual out-of-pocket expenses for covered benefits cannot exceed $5,800 for **self-only coverage** and $11,600 for **family coverage**. Deductible need not apply to preventive care.	**Self-only deductible** must be at least $2,000 but not over $3,000; the **family deductible** must be at least $4,000 but not over $6,050. Annual out-of-pocket expenses for covered benefits cannot exceed $4,000 and $7,350 respectively. Deductible need not apply to preventive care if absence of deductible is required by state law.
Contributions	By employer, employee, or both. Usually funded by employee through salary reduction agreement.	Only by employer.	By any person on behalf of an eligible individual.	By employer or account owner, but not both.
Annual contribution limits	None required, though employers usually impose a limit.	None required. Employers usually set their contributions below the annual deductible of the accompanying health insurance.	$3,000 for **self-only coverage** and $5,950 for **family coverage**. Account owners 55 years old or older and not in Medicare can contribute an additional $1,000 in 2009.	65% of the deductible for **self-only coverage** and 75% of the deductible for **family coverage.**
Qualifying expenses	Most unreimbursed medical expenses, though employers may impose additional limitations. May not be used for long-term care or health insurance premiums.	Most unreimbursed medical expenses, though employers may impose additional limitations. May be used for long-term care and health insurance premiums, if the employer allows.	Most unreimbursed medical expenses. May be used for premiums for long-term care insurance, COBRA, health insurance for those receiving unemployment compensation under federal or state law, and health insurance (other than Medigap policies) for individuals who are 65 years of age and older.	Most unreimbursed medical expenses. May be used for premiums for long-term care insurance, COBRA, and health insurance for those receiving unemployment compensation under federal or state law.

	Health Care Flexible Spending Accounts (FSA)	Health Reimbursement Accounts (HRA)	Health Savings Accounts (HSA)	Medical Savings Accounts (Archer MSA)
Allowable non-medical withdrawals	None	None	Permitted, subject to income tax and 10% penalty except in cases of disability, death, or attaining age 65.	Permitted, subject to income tax and 15% penalty except in cases of disability, death, or attaining age 65.
Carryover of unused funds	Balances remaining at year's end (or up to 2½ months after year's end, if employer permits) are forfeited to employer. A limited, one-time rollover to an HSA is allowed.	Permitted, although some employers limit amount that can be carried over. A limited, one-time rollover to an HSA is allowed.	Full amount may be carried over indefinitely.	Full amount may be carried over indefinitely.
Portability	Balances generally forfeited at termination, although COBRA extensions sometimes apply.	At discretion of employer, though subject to COBRA provisions.	Portable.	Portable.

Note: Rules are expressed in general terms. Not all details are shown.

Some Issues

Consumer-Driven Health Care

When the accounts discussed in this report are paired with high deductible insurance, they become part of what some call "consumer driven health plans" (CDHP).[7] One objective of CDHPs is to allow owners to choose health care providers and services themselves, not constrained by managed care restrictions. Another is to give owners a financial incentive to save for future health care expenses in exchange for accepting the greater risk of a higher insurance deductible. In theory, CDHPs will slow health care spending and encourage cost-effective care. The extent to which these objectives will be borne out is not clear, largely because the two accounts most likely to be effective in these respects, HRAs and HSAs, are still too new to permit adequate assessment, notwithstanding some early data. Much depends on how high the insurance deductibles are, how much money is put into the accounts and by whom, whether accounts are used to pay for expenditures other than health care (when allowed), and whether people with accounts can make informed choices. Additional key questions are how much competition there is among health care providers and whether prices for health care are or can be transparent.

Equity

The tax savings associated with tax-advantaged health care accounts depend on the taxpayers' marginal tax rates; for federal income taxes alone, these vary from 10% for married couples filing joint returns who have taxable incomes not exceeding $16,700 up to 35% for married couples filing joint returns who have taxable incomes over $372,950. (These figures are for the 2009 tax year; other figures apply to taxpayers with different filing status.) As a consequence, the accounts discussed in this report are more attractive for higher-income taxpayers; indeed, some consider HSAs more a vehicle for building retirement income than paying for health care. Critics of these accounts argue that it is unfair for public health care subsidies (the forgone tax revenue) to flow disproportionately to higher income taxpayers, particularly since they generally have more resources to spend on health care in the first place. However, if the accounts are paired with high deductible insurance, it might be argued that the tax savings are appropriate for taking on more greater financial risk and using less health care (to the extent this actually occurs). The latter arguments do not apply to FSAs when taxpayers do not have high deductible insurance; these accounts subsidize first-dollar payments for health care and may increase health care spending. As FSAs are available only through employer plans, they likely appear inequitable to taxpayers who cannot have them.

Targeted Savings Accounts

Current law provides multiple tax-advantaged savings accounts for education and retirement as well as health care. It may be simpler and more effective to have fewer accounts that would be

[7] HSA and MSA plans require high deductible insurance when contributions are made, though owners can retain accounts after switching to plans with lower deductibles. There is no legal requirement for HRAs to be associated with high deductible coverage, though they usually are. FSAs do not require high deductible insurance.

available for a variety of expenses, as a number of policy makers and analysts have proposed. In 2005, for example, the President's Advisory Panel on Federal Tax Reform recommended that MSAs, HSAs, and FSAs be replaced by new Save for Family accounts that could be used for health care and education expenses; these would have $10,000 annual contribution limits. On the other hand, accounts used for a variety of expenses could be difficult to integrate with the objectives of separate policy areas. For example, the higher contribution limits for general purpose accounts could conflict with attempts to limit tax-advantaged, first-dollar spending in health care.

Health Care Reform

The 111th Congress is considering whether to address health care reform. At the present time, it is difficult to foresee what consideration most reform proposals will give to the accounts discussed in this report. However, it is possible that a new comprehensive health care system would terminate some or all of the accounts since they might no longer be necessary. On the other hand, the accounts remain popular with some taxpayers, and some policy makers might consider them useful for helping individuals and families control their health care expenditures.

Author Contact Information

Bob Lyke

Chris L. Peterson
Specialist in Health Care Financing
cpeterson@crs.loc.gov, 7-4681

Additional Author Information

This report is co-authored by Bob Lyke, who currently is working as a contractor for CRS. He can be reached at rlyke@crs.loc.gov, 7-7355.