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

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Summary

Four types of tax-advantaged accounts can be used to pay for unreimbursed medical expenses: health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs). Unreimbursed medical expenses typically include deductibles, copayments, and goods and/or services not covered by insurance. Although these accounts share some common features, they also differ in important respects.

This report provides brief summaries of the four accounts and compares them with respect to eligibility, contribution limits, use of funds, and other characteristics for tax year 2010. The report then discusses changes to the accounts resulting from the enactment of the Patient Protection and Affordable Care Act (P.L. 111-148 as amended). The final section of the report covers participation levels in these accounts. The report will be updated when relevant statutory or regulatory changes occur, when new data become available, and as Congress considers issues associated with these accounts.

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Introduction

Four types of tax-advantaged accounts can be used to pay for unreimbursed medical expenses: health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs).[1] Unreimbursed medical expenses typically include deductibles, copayments, and goods and/or services not covered by insurance.[2] The first part of this report describes the current law surrounding these accounts and provides a side-by-side comparison of their key features. The second section details changes to the accounts effective over the next two years that were enacted by the Patient Protection and Affordable Care Act (P.L. 111-148 as amended). The third section investigates the participation rates in each account type. The report will be updated when relevant statutory or regulatory changes occur, when new data become available, and as Congress considers issues associated with these accounts.

Current Law

The text in this section provides summaries of each account as of June 2010. Although the accounts differ in many ways, they each provide tax savings to the account holders. **Table 1** provides a more detailed side-by-side comparison of the laws and regulations governing each account.

Flexible Spending Accounts

FSAs are *employer-established* arrangements that reimburse employees for medical and dental expenses not covered by insurance or otherwise reimbursable.[3] They are usually funded through salary reduction agreements under which employees receive lower monetary wages in exchange for equivalent contributions to their flexible spending accounts. For example, employees may forgo $100 a month in their 2010 paychecks in exchange for a $1,200 annual contribution to their FSA. Employees choose how much to put into their accounts, and this amount can vary from year to year. Employees 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, 2011, could be reimbursed from the FSA for 2010). The entire annual amount of an FSA must be made available to employees at the beginning of the year.

While compensation received as wages is subject to income taxes, as well as Social Security and Medicare taxes, compensation received as FSA contributions is not subject to these taxes. (Social Security and Medicare together are known as employment taxes.) For this reason, employees who anticipate having health expenses not covered by insurance may prefer FSAs over monetary wages.

[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] These accounts may not be used to pay for health insurance premiums.

[3] For additional information on FSAs, see CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

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.[4] Most rules regarding FSAs are not spelled out in the Code; they were initially included in proposed regulations issued by the Internal Revenue Service (IRS) in 1984 and 1989, and have been subsequently modified.[5]

Health Reimbursement Accounts

HRAs are *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 subject to neither income nor employment taxes. However, contributions cannot be made through the employees' salary reduction agreements; only employers may contribute. In addition, funds must be used for qualified medical expenses as defined by the IRC. Employers may restrict the types of medical and health services that are eligible for reimbursement. For example, an employer may choose not to reimburse expenses associated with acupuncture treatments. Unlike FSAs, 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.

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.[6]

Health Savings Accounts

HSAs are tax-exempt accounts that are used to pay for medical and dental expenses not covered by insurance or otherwise reimbursable. Unlike the FSAs and MSAs (discussed below), they are established by *individuals* with an insurance plan meeting certain criteria. An individual may purchase an HSA-qualified insurance plan through the individual insurance market. For those individuals with *employer-sponsored* insurance, the *employer* must offer a HSA-qualified plan in the small group or large group insurance market.

To be HSA-qualified, the insurance plan must be a high-deductible health plan (HDHP). The required level of deductible varies over time with the cost of living. In 2010, a HDHP is defined as one with a deductible of at least $1,200 for self-only coverage and $2,400 for family coverage. There are other criteria, including that the plan holder have no other health insurance policy, with some exceptions.

[4] 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.

[5] See Mulvey, *Op. Cit.*, and Internal Revenue Service, "Employee Benefits—Cafeteria Plans," 72 *Federal Register* 43938 - 43989, August 6, 2007.

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

In 2010, HSA contributions are limited to $3,050 for self-only coverage and $6,150 for family coverage. An additional contribution of $1,000 is allowed people aged 55 and older. HSA holders cannot contribute to their account in any year where they do not have qualifying HDHPs. On the other hand, HSA holders can draw funds for their accounts even if they are not permitted to contribute.

HSAs carry significant tax advantages. Contributions made by employers are exempt from income and employment taxes. Account owners may deduct contributions they make from adjusted gross income.[7] Owners do not have to itemize deductions to take advantage of this tax credit. Withdrawals for medical expenses are not taxed; those used for any non-medical purpose 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.

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. The Treasury Department provides revenue guidance as well.[8]

Medical Savings Accounts

MSAs, also known as Archer MSAs,[9] are a precursor to HSAs.[10] Like HSAs, MSAs can be established and contributions made only when insurance plan holders have a HDHP and no other coverage, with some exceptions. Contributions made by *employers* are exempt from income and employment taxes. Contributions made by *account owners* (allowed only if the employer does not contribute) are deductible for income-tax purposes even if the account owner does not itemize medical deductions. Withdrawals are not taxed if used for medical expenses; those used for non-medical 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 between HSAs and MSAs is that MSA eligibility is limited to people who are self-employed or employed by a small employer (50 or fewer employees, on average). In addition, the minimum deductible levels are higher and the contribution limits are lower.

MSAs were first authorized by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). The legislation limited the total number of accounts to 750,000, with a few MSAs excluded from that total. Most statutory rules governing MSAs are in Section 220 of the Internal Revenue Code.

[7] Adjusted gross income is total income less income that is not subject to tax less certain business deductions. Contributions to HSAs are considered income that is not subject to tax.

[8] For additional information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2010*, by Janemarie Mulvey.

[9] Representative Bill Archer sponsored the authorizing legislation.

[10] This discussion excludes Medicare MSAs.

Table 1. Summary of the Rules for FSAs, HRAs, HSAs, and MSAs, 2010

	Health Care Flexible Spending Accounts (FSAs)	Health Reimbursement Accounts (HRAs)	Health Savings Accounts (HSAs)	Medical Savings Accounts (Archer MSAs)
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. The self-employed are not eligible. Employers not restricted by size.	Individuals with qualifying high-deductible health insurance. Ineligible individuals may keep previously established accounts but cannot make contributions.	Individuals with qualifying high-deductible health insurance who are employees of a small employer (average of 50 or fewer workers). 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 plans.	Self-only deductible must be at least $1,200; the family deductible must be at least $2,400. Annual out-of-pocket expenses for covered benefits cannot exceed $5,950 for self-only coverage and $11,900 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 $4,050 but not over $6,050. Annual out-of-pocket expenses for covered benefits cannot exceed $4,000 and $7,400 respectively.
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 in the same year.
Annual contribution limits	None required, although employers usually impose a limit.	None required. Employers usually set their contributions below the annual deductible of the accompanying health insurance.	$3,050 for self-only coverage and $6,150 for family coverage. Account owners 55 years old or older and not in Medicare can contribute an additional $1,000 in 2010.	65% of the deductible for self-only coverage and 75% of the deductible for family coverage.
Qualifying expenses	Most unreimbursed medical expenses, although employers may impose additional limitations. May not be used for long-term care or health insurance premiums.	Most unreimbursed medical expenses, although 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 (FSAs)	Health Reimbursement Accounts (HRAs)	Health Savings Accounts (HSAs)	Medical Savings Accounts (Archer MSAs)
Allowable non-medical withdrawals	None.	None.	Permitted, subject to income tax. A 10% penalty except in cases of disability, death, or attaining age 65.[a]	Permitted, subject to income tax. A 15% penalty except in cases of disability, death, or attaining age 65.[a]
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 a HSA is allowed.	Permitted, although some employers limit amount that can be carried over. A limited, one-time rollover to a HSA is allowed.	Full amount may be carried over indefinitely.	Full amount may be carried over indefinitely. A limited, one-time rollover to a HSA is allowed.
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. The employer may have no incentive to provide HRA benefits to terminated employees.

a. PPACA will increase this penalty in 2011.

Patient Protection and Affordable Care Act (PPACA) Changes to Tax-Advantaged Accounts

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), imposes various restrictions on the accounts.[11] One set of changes makes three of the savings accounts more compatible with the existing Internal Revenue Code (IRC) requirements covering what can be itemized for those who do take deductions for medical expenses.[12] Under current law, over-the-counter (OTC) medications (except insulin) cannot be included in itemized deductions unless they are prescribed by a physician. However, under current law, OTC medications can by funded through FSA, HSA, or MSA accounts. Starting in 2011, PPACA will prohibit using funds from FSA, HSA, and MSA accounts for OTC medications (except insulin) unless they are prescribed by a physician.[13]

The second change concerns limits on the FSA contribution. No statutory limits on the amount an employee can contribute to a FSA existed prior to PPACA. Instead, individual employers often imposed their own limits. Beginning in 2013, PPACA will limit the annual amount an employee can contribute to $2,500.

The final change is that PPACA, effective in 2011, increases the penalties imposed for account withdrawals for nonmedical purposes for those under age 65 in two accounts The penalty for nonmedical withdrawals from HSAs will increase to 20% from 10%. The penalty for nonmedical withdrawals from MSAs will increase to 20% from 15%.

Participation in the Tax-Advantaged Accounts

Measuring total participation in the four tax-advantaged accounts is difficult because of a lack of reliable and timely data. The Department of Labor (Bureau of Labor Statistics) and the Treasury Department (IRS), a few research organizations, and several human resources private-sector consulting firms measure various concepts of account participation. To use HSAs as an example, measures of total HSA participation include

- the number of individuals (adults and children) whose medical expenses can be funded through an HSA because they are covered by a HSA-eligible HDHP;
- the number of employees who chose a HSA-eligible, employer-provided insurance plan and go on to actually open an HAS;
- the number of tax-filing household units who take the HSA deduction; and

[11] For more information on this issue, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)* , by Janemarie Mulvey.

[12] This is the deduction currently taken when qualified medical expenses exceed 7.5% of adjusted gross income.

[13] In the past, the IRS has defined a drug as prescribed if its purchase requires a prescription. For example, aspirin would not be eligible for reimbursement even when recommended by a physician because its purchase does not require a prescription. For more information, see Internal Revenue Service, *Medical and Dental Expenses*, November 10, 2009.

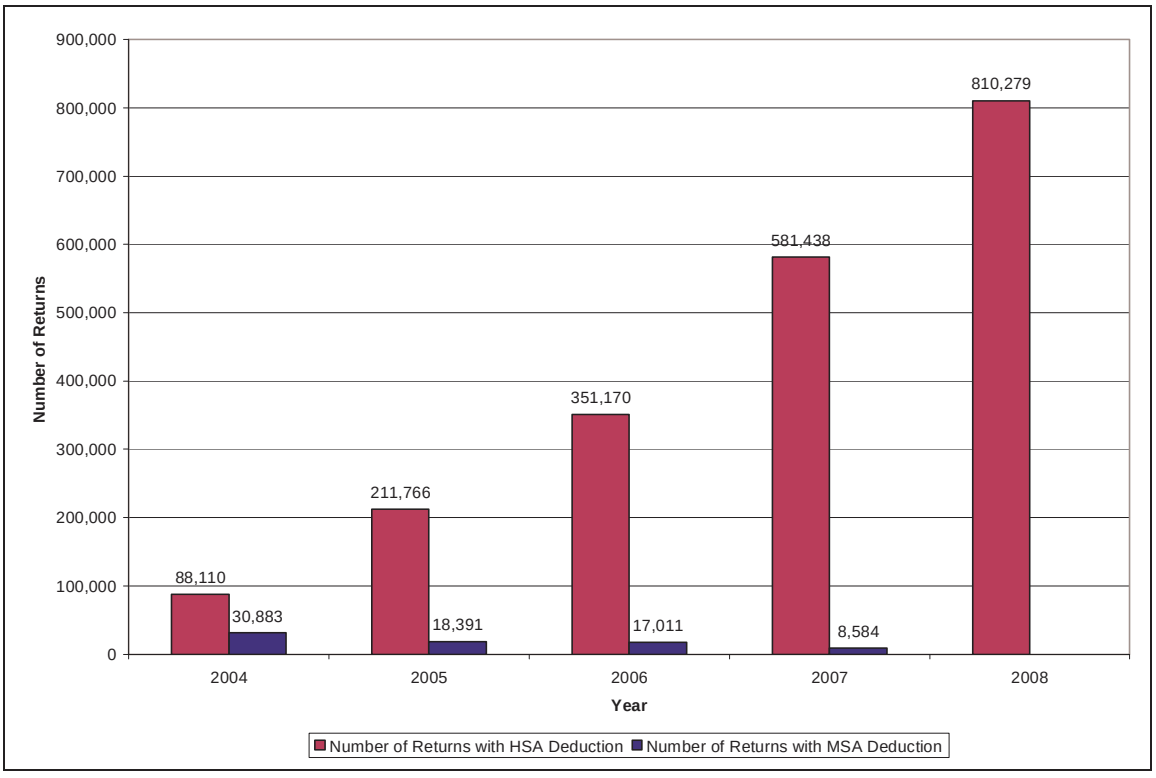
- the number of individuals or households in a sample who report having an HSA when asked by an interviewer, with those numbers statistically adjusted to represent the number in the population as a whole.

These concepts are neither the "correct" nor "incorrect" measures of HSA participation. Rather, they are simply measures of different ideas. The various concepts have different strengths and weaknesses as measures. Nevertheless, a primary criteria for reporting data on the four savings accounts is to use ideas that are comparable across all accounts.

Unfortunately, there does not appear to be a participation measure available for all four accounts. Instead, CRS reports one accurate measure for two accounts. Because all individuals with a HSA or a MSA can claim deductions on their tax returns, the IRS maintains data on the number of tax returns with these deductions. **Figure 1** presents the number of returns that filed for a HSA deduction and that filed for a MSA deduction.

Using tax returns as the unit of HSA and MSA measurement has at least three disadvantages. First, each return could represent an individual, a married couple, or a family. Second, the number of adults and children eligible to use funds in each HSA is unknown. Third, the most recent available data cover 2008, while other data sources have 2009 data available. Nevertheless, there is no other source with which CRS is familiar that allows for a comparison of these two accounts.

Figure 1. Number of IRS Returns Claiming the HSA Deduction and the MSA Deduction, 2004-2008



Source: Internal Revenue Service, *Individual Income Tax Returns, Preliminary Data, various years*, http://www.irs.gov/taxstats/indtaxstats/article/0,,id=133414,00.html#_prelim.

Notes: Almost no return should claim both deductions. Data for the number of returns with a MSA in 2008 were not reported by the IRS.

In every year since 2004, the number of returns with an HSA deduction far exceeded the number of returns with an MSA deduction. Moreover, the number of HSA returns increase rapidly since their inception in 2004, while the number of MSA returns declined rapidly.

Similar IRS participation data do not exist for FSAs and HRAs, which are available only through employer-sponsored health insurance coverage and are not enumerated on an individual's income tax return. One survey of employers found that between 2% and 3% of the workers covered by health insurance enrolled in an HRA between 2006 and 2009.[14] CRS has not found a comparable percentage of workers covered by health insurance who were enrolled in a FSA.

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[14] The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2009 Annual Survey*, 2009, p. 130.