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Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison, 2013

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Summary

Four types of tax-advantaged accounts can be used to pay for unreimbursed qualifying medical expenses: health care flexible spending accounts (FSAs), health reimbursement accounts (HRAs), health savings accounts (HSAs), and medical savings accounts (MSAs). Qualifying unreimbursed medical expenses are defined in the Internal Revenue Code (IRC) and typically include deductibles, copayments, and goods and/or services not covered by insurance. The goods and/or services can include medical services rendered by physicians, surgeons, dentists, and other medical practitioners. The costs of equipment, supplies, diagnostic devices, and prescription drugs are also qualifying medical expenses.

Although these four tax-advantaged health accounts share some common features, they also differ in important respects. This report provides brief summaries of the tax-exempt accounts and compares them with respect to eligibility, contribution limits, use of funds, and other characteristics for tax year 2013. A basic discussion of the four accounts is followed by a side-by-side comparison of their key features. The accounts can be summarized as follows, where all accounts reimburse qualifying medical and dental expenses not covered by insurance.

- FSAs are *employer-established* accounts that reimburse employees for qualifying expenses. They are usually funded through salary reduction agreements under which employees receive lower monetary wages in exchange for equivalent contributions to their FSAs.
- HRAs are *employer-established* arrangements that reimburse employees for qualifying expenses. Contributions cannot be made through the employees' salary reduction agreements; only employers may contribute. Health reimbursement *accounts* and health reimbursement *arrangements* are synonyms.
- HSAs are savings accounts that the account holders use to pay for qualifying expenses. They are established by *individuals* who must hold high-deductible health plans (HDHPs) in order to establish or contribute to the HSA. Contributions to the accounts can be made by any individual or firm.
- MSAs are accounts that the account holders use to pay for qualifying expenses. They were established by *individuals* who held high-deductible health plans (HDHPs) in order to establish or contribute to the MSA. Individuals generally cannot open MSAs after December 31, 2007, but those who had accounts by this date may maintain them. MSA eligibility was limited to people who were self-employed or employed by an employer with fewer than 50 employees. Contributions may be made by the employer or account holder, but not both in the same year.

The report concludes with a brief discussion of the usage in these four accounts. Comparing usage is difficult because no single data source contains comparable information on all four accounts and the years of data availability differ across data source. In broad terms, 40% of all civilian workers in 2012 had access to a health care flexible spending account. Of those private firms offering health benefits in 2012, 26% offered an HSA-qualified HDHP.

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Introduction

Four types of tax-advantaged accounts can be used to pay for qualifying unreimbursed medical expenses: Health Care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Medical Savings Accounts (MSAs).[1] Qualifying medical expenses typically include deductibles, copayments, and goods and/or services not covered by insurance. (More details are given below.) This report describes current law surrounding these accounts and provides a side-by-side comparison of their key features. The report also provides an indication of the relative prevalence of the accounts.

There are two broad categories of tax provisions that can lower an individual's tax liability because of qualifying medical expenses. First, qualifying medical expenses can be a tax deduction. Tax filers can itemize medical expenses incurred by him- or herself, spouse, and dependents if these expenses are over the legislative minimum.[2]

Second, tax filers can use one (or occasionally more) of the tax-advantaged accounts discussed in this report. Although the accounts differ in many ways, each account contains contributed income that the account holder uses to pay for qualifying medical expenses. Each account provides tax savings to the account holder because the money contributed to the account is not considered a part of the individual's adjusted gross income.[3] Therefore, no taxes are paid on this income, and for those arrangements where the income is placed in an account, no taxes are paid on interest earned on the income in the account. Moreover, the tax filer does not need to itemize deductions to receive tax savings from the account.

Itemized deductions cannot be funded through a tax-advantaged account, and expenses funded through an account cannot be declared as itemized deductions. In other words, "double counting" is prohibited.

Background

In general, qualifying medical expenses are defined in the Internal Revenue Code (IRC) at Section 213(d) and typically include deductibles, copayments, and goods and/or services not covered by insurance.[4] The goods and/or services can include medical services rendered by physicians, surgeons, dentists, and other medical practitioners. The costs of equipment, supplies, devices, and prescription drugs are also qualifying expenses. To qualify, the medical care must be

[1] For additional general information, see Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, IRS publication 969, January 20, 2013, http://www.irs.gov/pub/irs-pdf/p969.pdf.

[2] The phrase "tax filer" is used for simplicity. A more complete phrase is "tax filing unit." The tax filer may be an individual, a couple filing individually, a couple filing jointly, or the head of a household. A couple can be a man and a woman, two men, or two women; for more information, see IRS Revenue Ruling 2013-17.

[3] Adjusted gross income is equal to gross income minus certain exclusions (e.g., public assistance payments, contributions to retirement plans) minus some above-the-line deductions (e.g., trade and business deductions, losses from sale of property, and alimony payments).

[4] Section *213(d)* describes which expenses may be taken into account in determining the itemized deduction for medical expenses. Qualifying medical expenses are further explained in Internal Revenue Service, *Medical and Dental Expenses*, IRS Publication 502, December 10, 2012, pp. 5-17, http://www.irs.gov/pub/irs-pdf/p502.pdf.

primarily used to alleviate or prevent a physical or mental defect or illness. Care used to benefit general health (e.g., exercise equipment, vitamins, and vacations) is not a qualifying medical expense. Some examples of qualifying medical expenses are breast reconstruction surgery, disabled dependent care expenses, fertility enhancement (as specified), hospital services, lifetime care—advance payments, long-term care, psychiatric care, special education, and transplants. Some examples of expenses that are not qualifying medical expenses are cosmetic surgery, funeral expenses, health club dues, and household help. Over-the-counter medications are not qualified medical expenses unless prescribed by a physician. Finally, insulin is always a qualifying medical expense, whether or not it is purchased with a prescription.

Table 1 provides a more detailed side-by-side comparison of the laws and regulations governing each account. In each case, the reimbursement is for qualifying medical and dental expenses not covered by insurance. The beneficiaries for all accounts are the employee, spouse, and dependents.[5]

Flexible Spending Accounts

FSAs are *employer-established* arrangements that reimburse employees for qualifying expenses.[6] FSAs are usually funded through salary reduction agreements in compliance with Section 125(i) of the IRC, under which employees receive lower monetary wages in exchange for equivalent contributions to their flexible spending accounts.[7] For example, employees may forgo $100 a month in their 2013 paychecks, which will result in a $1,200 annual contribution to their FSA. The entire annual amount of an FSA must be made available to employees at the beginning of the year. Suppose the above employee had surgery during February, and incurred over $1,500 in unreimbursed qualifying medical expenses. The employee could use the full $1,200 annual FSA contribution to help pay for these expenses, even though he or she may have contributed only $200 into the account by that point in the year.

Beginning in 2013, contributions are limited to $2,500 per employee. If each member of a married couple is eligible to enroll in an FSA, then each member can contribute up to $2,500. The FSA limits are adjusted for inflation yearly using the Consumer Price Index for All-Urban Consumers (CPI-U).[8] Prior to 2013, the IRS did not set a maximum annual contribution. Plans typically had a dollar or percentage maximum for elective contributions from salary reductions. Within these limits, 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 (i.e., so medical expenses incurred by March 15, 2013, could be reimbursed from the FSA from the 2012 contribution).

[5] Other individuals can be account beneficiaries, especially following the death of the account holder.

[6] For many years, the IRC 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 through these accounts. For additional information on FSAs, see archived CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

[7] Employers are also permitted to fund FSAs through nonelective payments to the employees. In this case, the payments to the employee are tax exempt under Section 105 and Section 106 of the IRC. Moreover, there is no limit on these nonelective employer payments, and they may be in addition to the $2,500 limit imposed on employee Section 125(i) salary reduction agreements.

[8] Patient Protection and Affordable Care Act, P.L. 111-148, as amended, Section 9005.

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. For this reason, employees who anticipate having health expenses not covered by insurance may prefer FSAs over monetary wages.

As mentioned above, many FSAs are funded by salary reduction agreements. These FSAs are governed by Section 125 of the IRC, which exempts contributions from taxes even though the employees have the choice to receive taxable wages.[9] 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 provisions of the Code. For example, nonelective employer-funded FSAs for health care are tax-exempt under Sections 105 and 106.

Most rules regarding FSAs are not spelled out in the IRC; they were initially included in proposed regulations issued by the Internal Revenue Service (IRS) in 1984 and 1989, and have been subsequently modified.[10]

Health Reimbursement Accounts

HRAs are *employer-established* accounts used to reimburse employees and in some instances former employees for qualifying medical expenses. Health reimbursement *accounts* are sometimes termed health reimbursement *arrangements*. As is the case with FSAs, contributions are not subject to either income or employment taxes. However, contributions cannot be made through the employees' salary reduction agreements; only employers may contribute.

HRAs differ from FSAs in several important respects. Employers may restrict the types of medical and health services that are eligible for reimbursement from the list of qualified medical expenses. For example, an employer may choose not to reimburse expenses associated with acupuncture treatments even though the IRS considers acupuncture a qualifying medical expense. Employers need not actually fund HRAs until employees draw upon them, and the total reimbursement amount for a coverage period need not be available at all times during the period. In addition, the coverage period for the reimbursement amount may be less than a year, and HRAs reimbursements can be limited to amounts previously contributed.[11]

Unused HRA balances may be carried over indefinitely, although employers may limit the aggregate carryovers and the carryovers must be used for qualified medical expenses. Finally, employees who change jobs or retire may take the funds in their HRA with them, if their employer has set up an account which allows for this. The provisions in this paragraph, however, are optional (not required) for the employer.

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[9] Section 125 governs cafeteria plans; it provides an 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. However, not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans,

[10] See Mulvey, *Op. Cit*., and Internal Revenue Service, "Employee Benefits—Cafeteria Plans," 72 *Federal Register* 43938 - 43989, August 6, 2007. A final version of these rules was never published. FSAs were not specifically authorized by legislation.

[11] Internal Revenue Service, *Notice 2002-45*, Part IV.

HRAs are governed by Section 105 of the IRC, which allows health plan benefits used for medical care to be exempt from taxes, and Section 106 of the IRC, which allows employer contributions to those plans to be tax-exempt. Rules regarding HRAs were spelled out by the IRS in 2002.[12]

Health Savings Accounts

HSAs are tax-exempt accounts that are used to pay for qualifying medical expenses.[13] Unlike FSAs and HRAs, they are established by *individuals* with an insurance plan meeting certain criteria. In particular, the individual must have a high deductible health (insurance) plan (HDHP). For those individuals with *employer-sponsored* insurance, the *employer* must offer an HSA-qualified plan for the *employee* to be eligible for an HSA. An individual may also purchase an HSA-qualified insurance plan through the individual insurance market.

To be HSA-qualified, the HDHP must meet certain requirements. In 2013, an HDHP must have a deductible of at least $1,250 for self-only coverage and $2,500 for family coverage.[14] The deductible is indexed annually for inflation using the CPI-U. There are other criteria including that the plan holder have no other major medical health insurance policy.

In 2013, HSA contributions are limited to $3,250 for self-only coverage and $6,450 for family coverage. These limits are indexed annually by the CPI-U. An additional annual contribution of $1,000 is allowed for people who were age 55 and older at the end of their last tax year and not enrolled in Medicare as of the current month; this contribution is not indexed for inflation. HSA holders cannot contribute to their account in any month they do not have qualifying HDHPs as of the first day of the month. On the other hand, HSA holders can draw funds from their accounts even if they are not permitted to contribute.

HSAs can 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; in other words, owners do not have to itemize deductions to take advantage of this tax savings. Withdrawals for qualifying medical expenses are not taxed; those used for any non-medical purpose are taxable. In addition, withdrawals for non-medical purposes are subject to a 20% 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 IRC. The Treasury Department provides revenue guidance as well.[15]

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[12] Internal Revenue Service, *Notice 2002-45*. HRAs were not specifically authorized by legislation.

[13] For additional information on health savings accounts, see archived CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2012*, by Janemarie Mulvey.

[14] On May 2, 2013, the IRS published the deductible and contribution limits for 2014. See Internal Revenue Procedure 2013-25, available at http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.

[15] The remainder of the rules is in various sections of the IRC. For additional information, see archived CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2012*, by Janemarie Mulvey.

Medical Savings Accounts

MSAs, also known as Archer MSAs,[16] are a precursor to HSAs.[17] Like HSAs, MSAs can be established and contributions made only when insurance plan holders have an 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 deductions. Withdrawals are not taxed if used for medical expenses; those used for non-medical purposes are taxable and are subject to a 20% penalty except in cases of disability, death, or attaining age 65. 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 MSAs' minimum deductible levels are higher and the contribution limits are lower.[18]

MSAs were first authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA limited the total number of MSAs that could be created by all employers. With one exception, no MSAs could be created after December 31, 2007, although MSAs existing at that time were grandfathered. The exception is that an employee who begins to work for an employer that already sponsors MSAs is permitted to open an MSA. Most statutory rules governing MSAs are in Section 220 of the IRC.[19]

ACA Market Reforms and Tax-Preferred Accounts

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) specified that health insurance plans cannot include a cap on benefits. Because HRAs do cap benefits, some have questioned whether HRAs are permitted after the ACA market reforms take effect on January 1, 2014. The IRS has ruled that HRAs are permitted when they are *integrated* with the other employer-provided coverage, and are not permitted when they are *stand alone* accounts. An integrated HRA is one where the employees are enrolled in the primary group health plan coverage and no one but the employees are permitted to enroll in the primary group health plan coverage.[20]

Most other HRAs are stand-alone HRAs and will not be permitted coverage on or after January 1, 2014.[21] For example, it is not permitted for an employer to provide employees with HRA funding to purchase coverage on the individual market.

[16] Representative Bill Archer sponsored the authorizing legislation.

[17] This discussion excludes Medicare MSAs.

[18] Details are provided in **Table 1**.

[19] Section 6693, Section 4973, and Section 4975 of the IRC also contain provisions governing MSAs.

[20] For more information, see Department of Labor, *FAQs About Affordable Care Act Implementation (Part XI)*, January 24, 2013, http://www.dol.gov/ebsa/pdf/faq-aca11.pdf.

[21] Stand-alone HRAs that are retire-only plans can continue on or after January 1, 2014, because the ACA market reforms do not apply to retiree-only plans.

Table 1. Summary of General Rules for FSAs, HRAs, HSAs, and MSAs, 2013

	Health Care Flexible Spending Accounts (FSAs) IRC Sections 105, 106, and 125	Health Reimbursement Accounts (HRAs) IRC Sections 105 and 106	Health Savings Accounts (HSAs) IRC Section 223	Medical Savings Accounts (Archer MSAs) IRC Section 220
Setting up an Account				
Eligibility	Employees whose employers offer this benefit. Former employees and retirees may be included. The self-employed are not eligible. Any size employer can offer FSAs.	Employees whose employers offer this benefit. Former employees and retirees may be included. The self-employed are not eligible. Any size employer can offer HRAs.	Individuals with a qualifying high-deductible health insurance plan (HDHP) on the first day of the month who are not enrolled in Medicare. Individuals with other major medical policies are not eligible. Individuals with health FSAs or HRAs are usually not eligible.[a] Individuals who can be claimed as another's dependent are not eligible.[b] Married couples cannot have joint HSAs. However, HSAs can be used to pay qualified medical expenses in a family HDHP. Ineligible individuals may keep previously established accounts but cannot make contributions.	Individuals with a qualifying HDHP who are self-employed, employees of a small employer (average of 50 or fewer workers), or a formerly-small employer. Ineligible individuals may keep previously established accounts but cannot make contributions. December 31, 2007, was generally the final day for most individuals to open a new MSA. The exception is that an employee who begins to work for an employer who already sponsors MSAs is permitted to open a MSA.

	Health Care Flexible Spending Accounts (FSAs) IRC Sections 105, 106, and 125	Health Reimbursement Accounts (HRAs) IRC Sections 105 and 106	Health Savings Accounts (HSAs) IRC Section 223	Medical Savings Accounts (Archer MSAs) IRC Section 220
Definition of qualifying health insurance	Any major medical group health plan made available for the year to employees by the employer, but only if the maximum benefit payable to any participant does not exceed two times the participant's salary reduction election for the year (or, if greater, does not exceed $500 plus the amount of the participant's salary reduction election).	Any integrated major medical group health plan.	Must have an HDHP. Self-only deductible must be at least $1,250; the family deductible must be at least $2,500. Annual out-of-pocket expenses for covered benefits cannot exceed $6,250 for self-only coverage and $12,500 for family coverage. Deductible need not apply to preventive care.[c] Out-of-pocket limits do not include premiums.[d]	Must have an HDHP. Self-only deductible must be at least $2,150 but not over $3,200; family deductible must be at least $4,300 but not over $6,450. Annual out-of-pocket expenses for covered benefits cannot exceed $4,300 and $7,850 for self-only and family coverage, respectively. Out-of-pocket limits do not include premiums.[d]
Cost-of-living adjustments for insurance deductibles, copayments, and other monetary provisions	Not applicable (not associated with a particular insurance policy).	Not applicable (not associated with a particular insurance policy).	Yes; adjustments based on the Consumer Price Index for All-Urban Consumers (CPI-U).	Yes; adjustments based on the Consumer Price Index for All-Urban Consumers (CPI-U).
Role of a financial institution or trustee for the account holder	None.[e]	None.[e]	Individual must work with a trustee[f] to set up an account.	Individual must work with a bank or insurance company to set up an account.
Contributing to an Account				
Source of contributions	By employee (through salary reduction plan), by employer (through nonelective payments to employees), or both.	Only by employer.	By any person (including the employer) on behalf of an eligible individual.	By employer or account owner, but not both in the same year.
Fee to the Patient-Centered Outcomes Research Institute[g]	Owed by a small number of plan sponsors (for self-insured insurance plans) or insurers (for other insurance plans).[h]	Owed by plan sponsors (for self-insured insurance plans) or insurers (for other insurance plans).[i]	None owed, although the HDHP associated with the HSA would owe the fee.	None owed, although the HDHP associated with the MSA would owe the fee.

	Health Care Flexible Spending Accounts (FSAs) IRC Sections 105, 106, and 125	Health Reimbursement Accounts (HRAs) IRC Sections 105 and 106	Health Savings Accounts (HSAs) IRC Section 223	Medical Savings Accounts (Archer MSAs) IRC Section 220
Tax status of contributions	Contributions not included in income.	Contributions not included in income.	Individual contributions deductible on individual's tax returns even if individual does not itemize deductions. Employer contributions are not included in individual's income even if made through a Section 125 cafeteria plan.	Individual contributions deductible on individual's tax returns even if individual does not itemize deductions. Employer contributions are not included in individual's income even if made through a Section 125 cafeteria plan.
Annual contribution limits	Each individual has a limit of $2,500 per account for account years beginning after December 31, 2012. If each member of a married couple is eligible to enroll in an FSA, then each person can contribute up to $2,500 under their respective employer's health FSA. Employers may impose a lower limit. Individuals with more than one job may also have more than one FSA account (e.g., an individual with two jobs could have two FSAs with $2,500 in each one).	None.	$3,250 for self-only coverage and $6,450 for family coverage. Account owners at least age 55 and not enrolled in Medicare can contribute an additional $1,000.	65% of the deductible for self-only coverage and 75% of the deductible for family coverage.
Cost-of-living adjustment for annual contribution limits	Yes; adjustments based on the Consumer Price Index for All-Urban Consumers (CPI-U).	Not applicable (no contribution limits).	Generally yes; adjustments based on the Consumer Price Index for All-Urban Consumers (CPI-U). The $1,000 contribution available to account owners at least age 55 and not enrolled in Medicare is not adjusted.	Yes; adjustments based on the Consumer Price Index for All-Urban Consumers (CPI-U).

	Health Care Flexible Spending Accounts (FSAs) IRC Sections 105, 106, and 125	Health Reimbursement Accounts (HRAs) IRC Sections 105 and 106	Health Savings Accounts (HSAs) IRC Section 223	Medical Savings Accounts (Archer MSAs) IRC Section 220
Tax status of interest earned on account assets	Not applicable (no account assets).	Not applicable (no account assets).	Not taxed.	Not taxed.
Withdrawing Funds From an Account				
Exceptions to qualifying expenses[j]	None.[k]	Employers may impose limitations in addition to those in the IRC.[k]	None.	None.
Additions to qualifying expenses[j]	May be used for health insurance premiums if the employer has set up a premium conversion plan and a separate FSA for premiums only.[l]	May be used for premiums for health insurance, long-term care insurance,[m] COBRA,[n] and amounts that are not covered under another health plan.	May be used for premiums for long-term care insurance,[m] COBRA,[n] health insurance for those receiving unemployment compensation under federal or state law, and Medicare and other health care coverage (excluding Medigap and other private Medicare supplemental insurance) if the account holder is 65 and over.	May be used for premiums for long-term care insurance,[m] COBRA,[n] and health insurance for those receiving unemployment compensation under federal or state law.
Tax status of non-medical withdrawals	Non-medical withdrawals are not permitted.	Non-medical withdrawals are not permitted.	Non-medical withdrawals are permitted, subject to income tax. A 20% penalty except in cases of disability, death, or attaining age 65.	Non-medical withdrawals are permitted, subject to income tax. A 20% penalty except in cases of disability, death, or attaining age 65.
Availability of dedicated debit card to pay for qualifying expenses at point of sale	Yes, if the employer offers one.	Yes, if the employer offers one.	Yes, if the financial institution offers one.	Yes, if the financial institution offers one.
Reporting requirements for distributions on federal income tax return	No.	No.	Yes.	Yes.

	Health Care Flexible Spending Accounts (FSAs) IRC Sections 105, 106, and 125	Health Reimbursement Accounts (HRAs) IRC Sections 105 and 106	Health Savings Accounts (HSAs) IRC Section 223	Medical Savings Accounts (Archer MSAs) IRC Section 220
Carryover of unused funds	Balances remaining at year's end (or up to 2½ months after year's end, if the employer permits) are forfeited to the employer.[o]	Permitted, although some employers limit the amount that can be carried over.	Full amount may be carried over indefinitely. A qualified funding distribution may be made from a traditional IRA or Roth IRA into an HSA, subject to eligibility.[p]	Full amount may be carried over indefinitely. One rollover into an HSA is allowed per year. The rollover must be made within 60 days of the date of receipt of the funds that are being rolled over.
Closing an Account				
Ownership and portability of account	The employer owns the account. Balances are generally forfeited at termination, although extensions for those covered by COBRA sometimes apply.[n,o]	Ownership is at discretion of employer, although subject to COBRA provisions.[n]	The individual owns the account. The account funds remain with the individual when he or she separates from the employer.	The individual owns the account. The account funds remain with the individual when he or she separates from the employer.
Death of account holder	Benefits not covered after the day of death.	If benefits are paid to individuals other than the employee's spouse or dependents, benefits become taxable.	If spouse is designated beneficiary, becomes spouse's HSA. Otherwise the account becomes taxable.	If spouse is designated beneficiary, it becomes spouse's MSA. Otherwise the account becomes taxable.

Source: Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969, January 2013, http://www.irs.gov/publications/p969/index.html.

a. Individuals with an HDHP and one or more of the following accounts can contribute to an HSA: (1) A "limited purpose FSA" or "limited purpose HRA." These arrangements pay only for preventive care and for medical care not covered by the HSA's qualifying health insurance (e.g., vision and dental care); (2) A "suspended HRA," which does not pay or reimburse the medical expenses incurred during the suspension period except preventive care and medical care not covered by the HSA's qualifying health insurance; (3) A "post-deductible FSA" or "post-deductible HRA." These arrangements do not pay for or reimburse any medical expense until the deductible of the HSA's qualifying health insurance has been met; or (4) A retirement HRA which pays for or reimburses only those medical expenses incurred after retirement. These limited types of accounts are not discussed in this report.

b. The IRS defines a dependent as a qualifying child or a qualifying relative who satisfies certain rules concerning whether the tax-filer is claimed as a dependent, whether the child or relative files a joint return, and the citizenship and residency status of the child or relative. The IRS definition of a qualifying child is based on the relationship with the tax-filer, age, residence, source of the child's support, and whether the child files a joint return. The IRS definition of a qualifying relative is based on qualifying-child status, member of household or relationship, gross income of the relative, and source of the relative's support. There is no age requirement for qualifying relatives. For more information, see Internal Revenue Service, *Exemptions, Standard Deduction, and Filing Information, 2012*, Publication 501,

January 2013, pp. 11-22, http://www, http://www.irs.gov/pub/irs-pdf/p501.pdf. Note that the IRS definition of dependent is different from the definition used by many health insurance plans,

c. Preventive care includes some evidence-based items or services evaluated by the United States Preventive Services Task Force (USPSTF); immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); evidence-informed preventive care and screenings (for infants, children, and adolescents) provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional preventive care and screenings for women not described by the USPSTF, as provided in comprehensive guidelines supported by HRSA.

d. In addition, insurers or employers may require that out-of-pocket limits not include out-of-network services if the plan uses a network of providers.

e. A bank has a role if participants receive a debit card associated with the account.

f. Qualifying trustees include banks, insurance companies, and anyone already approved by the IRS to be a trustee of individual retirement accounts or Archer MSAs.

g. The Patient Protection and Affordable Care Act (ACA, P.L. 112-148) created the Patient Centered Outcomes Research Institute to study comparative effectiveness, among other topics. This institute is furnished by mandatory fees paid by insurers (for conventionally-insured plans) or sponsors (for self-insured plans). The plan sponsor is usually the employer.

h. FSAs where the employer contributes over $500 during the year owe the fee for that year.

i. The fee owned by HRS sponsors may be smaller than the standard fee under certain circumstances.

j. Qualifying medical expenses are defined in Section 213(d) of the IRC. The limitations and additions to qualifying medical expenses are found in IRC regulations and notes.

k. For those enrolled in an HRA and FSA at the same time, the accounts cannot pay for the same expenses. Amounts in the HRA must be exhausted before reimbursements may be made from the FSA, except for qualifying expenses not covered by the HRA. When a person is enrolled in an HRA and an FSA, there is no requirement that the FSA be limited in purpose or post-deductible (see note a). However, the employer has the authority to implement such policies.

l. For more information, see archived CRS Report R40729, *Premium Conversion of Health Insurance*, by Janemarie Mulvey.

m. Long-term care insurance is private insurance designed to protect against the risk associated with the potential cost of financing expensive long-term care services and supports. Long-term care insurance premiums are a qualified medical expense. Deductions for long-term care insurance premiums increase with the age of the beneficiary and are adjusted for inflation annually. For more information, see CRS Report R40601, *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*, by Janemarie Mulvey.

n. In 1985, Congress enacted legislation to provide some former employees temporary access to their former employers' health insurance. Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), an employer with 20 or more employees must provide the option of continuing an individual's health coverage under the employer's group health insurance plan if the individual experiences a qualifying event. Qualifying events include, for the employee, termination or reduction in hours of employment (for reasons other than gross misconduct). Qualifying events include, for spouses and dependent children, the death of the covered employee, divorce or legal separation from the employee, the employee's becoming eligible for Medicare, and the end of a child's dependency under a parent's health insurance policy.

o. Military reservists ordered or called to active duty are permitted to remove funds from their FSAs without facing penalties.

p. Rules for eligibility are found in IRS Bulletin 2008-35.

Account Usage

Data limitations make it difficult to compare measures of account usage across the four accounts. Nevertheless, this section provides a brief overview of the available information, distinguishing between the accessibility of the account and the enrollment in the account.[22] It is easier for each individual employer to report whether it offers one of these accounts than to report the number of employees actually enrolled. For this and perhaps other reasons, published data are more readily available on access than on enrollment. Because very few new MSAs are being created, and because the number of MSAs has always been limited, there are almost no data available on their number. The report also presents measures of the enrollment in each of the four account types. It should be emphasized that the data are not comparable across the accounts.

Accessibility

The National Compensation Survey, a survey of employers conducted by the Bureau of Labor Statistics (BLS), reports the percent of workers who have access to health care FSAs. According to the BLS survey, 40% of all civilian workers in 2012 had access to a health care FSA. When viewed by firm size, 53% of civilian workers in firms with 100 or more workers had access to an FSA. The accounts were not as common for civilian workers in small businesses. In establishments with fewer than 100 employees, 20% of the workers had access to a health care FSA.[23]

The definition of accessibility is not as straightforward for HSAs and HRAs. Unlike with FSAs, those who hold HSAs must have HDHPs. One measure of HSA accessibility is therefore possession of an HDHP that qualifies for an HSA. According to a survey of private employers conducted by the Kaiser Family Foundation and the Health Research & Educational Trust (KFF/HRET) in 2012, 26% of firms offering health benefits offered an HSA-qualified HDHP.[24] This percent was 12% in 2010 and 18% in 2011.[25] Workers in larger firms were more likely to have access to an HDHP than those in smaller firms. Although employers are not required to restrict HRA benefits to employees with HDHPs, most employers chose to do so. Of employers offering health benefits, there was no discernible upward or downward trend in the percent who offered an HDHP and an HRA; the percentage was 4% in 2010, 7% in 2011, and 5% in 2012.

Enrollment

The Employee Benefit Research Institute conducts annual internet surveys of adults ages 21 to 64, inclusive. The survey measures the number of adults with either an HSA or an HRA. The

[22] For more information about the data sources, see archived CRS Report RS22877, *Health Savings Accounts and High-Deductible Health Plans: A Data Primer*, by Carol Rapaport.

[23] Bureau of Labor Statistics, National Compensation Survey, *Employee Benefits in the United States*, Table 41, http://www.bls.gov/ncs/ebs/benefits/2012/ownership/private/table25a.pdf.

[24] The Henry J. Kaiser Family Foundation and the Health Research & Educational Trust, *Employer Health Benefits 2012 Annual Survey*, 2012, pp. 132-136, http://ehbs.kff.org/pdf/2012/8345.pdf.

[25] The percent estimates are not significantly different from the estimates for the previous year at a 95% level of confidence.

results are then extrapolated. The research concluded that the combined number of adults with either an HSA or an HRA was 4.8 million in 2009, 5.4 million in 2010, 8.5 million in 2011, and 11.6 million in 2012.[26] A substantial majority of these individuals are likely to be HSA holders.

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[26] Different people were surveyed in each year. Paul Fronstin, *Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006-2012*, Employee Benefit Research Institute, Issue Brief Number 382, January 2013, p. 7, http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=5153.