

Report for Congress

Received through the CRS Web

Flexible Spending Accounts and Medical Savings Accounts: A Comparison

Updated September 19, 2002

Bob Lyke and Chris L. Peterson
Domestic Social Policy Division

Flexible Spending Accounts and Medical Savings Accounts: A Comparison

Summary

Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified expenses; they first began in the 1970s. Medical savings accounts (MSAs) are tax-advantaged individual savings accounts that can also be used for unreimbursed expenses; they became available under a demonstration that began in 1997. President Bush's FY2003 budget includes changes to flexible spending accounts (FSAs) and a permanent extension and substantial expansion of medical savings accounts (MSAs). The most recent House-passed patient protection bill (H.R. 2563) contains MSA provisions.

FSAs and MSAs are similar in some respects but dissimilar in others. Both can be used for unreimbursed medical expenses, and contributions to both have tax advantages. However, FSA contributions are forfeited if not used by the end of the year, while MSA contributions may be carried over. More important, MSA contributions can be made only when account owners have high deductible health insurance, while contributions to FSAs can occur with any type of insurance. FSAs can also be used for child and dependent care expenses, provided a separate account is established for this purpose.

In 1999, more than one in five private-sector employees could establish an FSA. FSAs were more common for state and local government employees but less so for workers in small businesses. In establishments with fewer than 50 employees, 8% of workers had access, compared to 57% of workers in establishments with at least 2,500 employees. In July 2003, FSAs are to be available to federal employees in the executive and legislative branches for the first time. Although there is little information on participation in FSAs, such information exists on MSAs. Fewer than 85,000 MSAs were established through June 2001, far lower than the number authorized by statute. Low participation rates are one reason new legislation is being considered. These other points might be noted about health care FSAs and MSAs:

- ! FSAs are limited to employees and former employees, while MSAs are limited to people who either are self-employed or are employees covered by a high deductible insurance plan established by their small employer.
- ! IRS imposes no dollar limit on health care FSA contributions, but employers generally do. MSA contributions, which can be made when the account owner has qualifying high deductible insurance, are limited to a percentage of the deductible.
- ! Contributions to FSAs and MSAs are exempt from taxes, as are withdrawals used for deductible medical expenses.
- ! FSAs can be used only for unreimbursed medical expenses that would be deductible under the Internal Revenue Code, with some exceptions. MSAs may also be used for such expenses (also with some exceptions), though nonqualified withdrawals are also permitted. The latter withdrawals are taxable and generally subject to an additional penalty.

Contents

Introduction	1
Flexible Spending Accounts	2
Basis for Tax Treatment	3
Data on Use	6
Medical Savings Accounts	7
Basis for Tax Treatment	8
Data on Use	9
Direct Comparison of FSAs and MSAs	10
Eligibility	10
Contributions	11
Qualifying Expenses	11
Nonqualified Withdrawals	12
Carryover of Unused Funds	12
Current Legislation	12
Conclusion	14

Flexible Spending Accounts and Medical Savings Accounts: A Comparison

Introduction

Flexible spending accounts (FSAs) are employer-established benefit plans that reimburse employees for specified 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 costs of health care were of growing concern. In contrast to traditional insurance plans, FSAs generally allow employees to vary benefit amounts in accordance with their anticipated health care needs.

Medical savings accounts (MSAs) are tax-advantaged individual savings accounts that can also be used for unreimbursed expenses. They too were proposed as a flexible arrangement for dealing with rising health care costs. A limited number of MSAs became available under a demonstration that began in 1997 and originally was to be closed to new accounts at the end of 2000. However, authority to establish new MSAs was extended through December 31, 2002, by legislation at the end of the 106th Congress (the Community Renewal Tax Relief Act of 2000, P.L. 106-554 (H.R. 5662, incorporated into H.R. 4577)). This legislation also formally renamed MSAs as Archer MSAs. The authority to establish new MSAs was extended once more, through December 31, 2003, by legislation signed into law in March 2002 (the Job Creation and Worker Assistance Act of 2002, P.L. 107-147 (H.R. 3090)).

FSAs and MSAs are similar in some respects but dissimilar in others. Both can be used for unreimbursed medical expenses, and contributions to both have tax advantages. However, FSA contributions are forfeited if not used by the end of the year, while MSA contributions may be carried over. More important, MSA contributions can be made only when account owners have high deductible insurance, while contributions to FSAs can occur with any type of insurance. High deductible insurance may be most attractive to people who are young and healthy, resulting in risk pooling imbalances.

This report compares FSAs and MSAs. It begins by describing FSAs, the basis for their tax treatment, and data on their use. It then describes the MSA demonstration authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the basis for their tax treatment, and data on their use. The report continues by making comparisons of FSAs and MSAs with respect to these points:

- ! eligibility,
- ! contributions,
- ! qualified withdrawals,
- ! nonqualified withdrawals, and
- ! carryover of unused funds.

The report concludes with a brief discussion of current legislation. In general, it discusses particular bills only when they are considered by committee or on the floor.

Flexible Spending Accounts

FSAAs 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 other than insurance. 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 FSAAs meet these and other rules, contributions are not subject to either income or employment taxes.

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 9 months, he generally cannot replenish the account until the next year; while if \$100 or so remains unspent after 12 months, it is forfeited to the employer. If the FSA were 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 FSAAs to be funded both by salary reductions and employer contributions.

If the employee were in the 30% tax bracket, the federal income tax savings from the \$900 salary reduction used to fund the account would be \$270 (i.e., $\$900 \times .30$); in addition, the employee could save \$69 in social security and Medicare taxes (i.e., $\$900 \times .0765$).¹ 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, half as large, while if he were in the top 38.6% bracket they would be commensurately greater, \$347.40).

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.

¹ If the employee's earnings exceeded the social security wage base (\$80,400 in 2001), the only savings would be \$13 from Medicare taxes (i.e., $\$900 \times .0145$). Reductions in social security taxes due to FSA salary reductions could affect the social security benefits that the worker later receives.

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.²

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.

In September 2002, the Office of Personnel Management (OPM) announced that, for the first time, federal employees in the executive and legislative branches will be able to enroll in health care and child-care FSAs.³ A request for proposal will be published soon in order to find a third-party administrator of the program. OPM expects open season for enrollment to begin in May 2003, with the FSA in effect in July 2003.

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.⁴ 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 (typically reimbursements for health care or dependent 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

² The breakeven point for an employee in the 30% bracket who contributes \$900 would generally be \$561 (i.e., \$900 minus income tax savings of \$270 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.

³ In the same news release, OPM also publicized new options in the Federal Employees Health Benefits Program. One of those is a “consumer-driven” health plan offered by the American Postal Workers Union. Such plans are also called Health Reimbursement Arrangements or Medical *Spending* Accounts — not to be confused with the Medical Savings Accounts discussed here, which are presently available only to the self-employed or those employed by a small businesses with qualifying high-deductible insurance.

⁴ For an overview of other flexible arrangements, see CRS Report 94-586, *Flexible Benefit Plans*, by James R. Storey (out of print).

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

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 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:

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 Irish, Leon E. Cafeteria Plans in Transition. *Tax Notes*, Dec. 17, 1984. p. 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 (FR) 19321 (May 7, 1984), 49 FR 50733 (Dec. 31, 1984), and 54 FR 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. One general requirement for FSAs is that the maximum annual reimbursement must be limited to less than 500% of any premium for the participant's coverage (including both employer-paid and employee-paid portions of the premium); this would distinguish FSAs from health insurance generally.

⁹ 65 *Federal Register* 15548 (March 23, 2000) and 66 *Federal Register* 1837 (January 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.

- ! 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-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 Similarly, employers may exclude certain elective expenses from their plans, or they might require employees who terminate employment to continue to participate until the end of the plan year.

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.

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 FR 9460, Q and A 7. Some of the seven requirements listed in the text had been issued in 1984.

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

Data on Use

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

FSAs are more common in larger firms. The 1999 Medical Expenditure Panel Survey found that FSAs were offered in 37% of large-firm establishments (50 or more workers) but in only 3% of small-firm establishments.¹³

Nearly 22% of private-sector workers (23 million) had access to an FSA — that is, their employer offered an FSA and the worker was eligible to enroll — according to the 1999 Department of Labor National Compensation Survey. As expected, as establishment size increases, so does the likelihood that these workers have access to an FSA. In small establishments, 8% of workers had access, compared to 57% of workers in establishments with at least 2,500 employees. Among full-time workers, 26% had access to an FSA, compared to 11% of part-time workers.¹⁴

Workers in state and local governments are more likely to have access to an FSA than their private-sector counterparts. A 1998 Department of Labor survey of full-time employees in state and local governments found that 47% (6.7 million) had access to an FSA, more than twice the rate of private-sector workers. Access to an FSA also varied between the state and local levels. In local governments, less than a third of full-time workers had access to an FSA, while at the state level 70% of full-time workers had access.¹⁵

According to one 2001 survey, there is not substantial enrollment in FSAs offered by private-sector firms. For example, in nearly four out of five medium and large employers that offered a health care FSA, 30% or fewer employees enrolled in it. In nearly two out of three medium and large employers that offered a dependent

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.

¹⁴ U.S. Department of Labor. *Employee Benefits in Private Industry, 1999*, Washington, December 19, 2001, Table 4 [<http://www.bls.gov/ncs/ebs/sp/ebnr0006.pdf>]. This survey provides the number of stand-alone FSAs, which it calls “reimbursement plans.” In addition, the survey estimates the number of cafeteria plans (“flexible benefit plans”), most of which are likely to include FSAs. In this memorandum, the percentage of workers with access to an FSA is estimated as the sum of the percentage of those with access to a reimbursement plan and the percentage of those with access to a flexible benefit plan. As a result, these numbers may slightly overstate the percentage of workers with access to an FSA.

¹⁵ U.S. Department of Labor. *Employee Benefits in State and Local Governments, 1998*. Washington, December 2000, Tables 3 and 130. Also for this survey, CRS calculated the likely percentage of employees who had access to an FSA by combining the estimates for flexible benefit plans and reimbursement plans.

care FSA, 5% or fewer employees enrolled in it.¹⁶ Reasons for low FSA participation may include employer restrictions (enrollment waiting periods for new workers or exclusion of part-time workers, for example), employee perceptions of complexity, concerns about end-of-year forfeitures, and limited employer encouragement. For lower income employees, the tax savings may not be sufficient incentive to participate. Dependent care FSAs would likely be of interest only to workers with young children.

The modest participation levels suggest that 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).¹⁷ 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.¹⁸

Medical Savings Accounts

MSAs are personal savings accounts for unreimbursed medical expenses. They are used to pay for health care not covered by insurance, including deductibles and copayments. Currently, a limited number of MSAs may be established by taxpayers who have qualifying high deductible insurance (and no other health insurance, with some exceptions) and who either are self-employed or are employees covered by the high deductible plan established by their small employer. (For additional details on MSA requirements, see the direct comparisons of FSAs and MSAs in the next section of this report.)¹⁹

Employer contributions to MSAs are not subject to either income or employment taxes, while contributions made by individuals (allowed only if the

¹⁶ *2001 Hay Benefits Report*, v. 1, p. IX-8. Philadelphia, 2001. Survey results may not be representative of all medium and large employers.

¹⁷ 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. p. 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.

¹⁸ For a critical review of the congressionally mandated study see: Schaffer, Daniel C., 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.

¹⁹ Also see CRS Report 96-805, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Guidance on Frequently Asked Questions*, by Beth C. Fuchs, Bob Lyke, Richard Price, and Madeleine Smith, pp. 23-37.

employer does not contribute) are deductible in determining adjusted gross income.²⁰ MSAs are held in trust by insurance companies, banks, and other financial institutions, and whatever earnings they have are exempt from taxes. Withdrawals are not taxed if they are for medical expenses unreimbursed by insurance or otherwise, while other distributions, being non-qualified, are included in gross income and subject with some exceptions to an additional 15% penalty.

If the taxpayer (the account owner) were in the 30% tax bracket, the tax savings from an employer's \$900 MSA contribution would be the same as described earlier for a \$900 FSA contribution: \$270 in income taxes and \$69 in social security and Medicare taxes (with the employer also saving the latter). Income tax savings would be larger for taxpayers in higher tax brackets and smaller for those in the lower 15% bracket. There could be state income tax savings as well. For individuals making their own contributions, tax savings would be limited to income tax reductions.

For MSAs, the tax exemption for account earnings results in additional tax savings. For given earnings, the savings are larger for taxpayers in higher tax brackets and smaller for those in lower brackets.

The 15% penalty on non-qualified withdrawals reduces the incentive to use MSAs simply as a tax-advantaged accounts for deferring consumption. However, the economic value of tax benefits can soon exceed the cost of the penalty, particularly for individuals in higher tax brackets.²¹

Basis for Tax Treatment

Health care usually is considered a personal expense for which deductions are disallowed under the Internal Revenue Code, barring express exceptions.²² One long-standing exception permits an itemized deduction for health insurance and unreimbursed medical expenses to the extent they exceed what is considered a catastrophic level (under current law, now 7½% of adjusted gross income). Other established exceptions provide an exclusion for employer contributions toward employer-provided accident and health insurance (which provides the basis for FSAs) and for benefits received under a health plan.

On the basis of these provisions, MSAs would not qualify for tax advantages.²³ However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996

²⁰ This deduction is not limited to taxpayers who itemize their deductions.

²¹ In cases of non-qualified distributions, the economic value of the tax savings comes largely from the deferral of income taxes on the contribution. For taxpayers in the 30% bracket, the tax savings exceed the value of the future tax liability and the 15% penalty in about 7 years, assuming a discount rate of 6%. Taking into consideration the exemption for account earnings and the exclusion for employment taxes would shorten the time period.

²² Section 262(a) reads as follows: "General Rule—Except as otherwise expressly provided in this chapter, no deduction shall be allowed for personal, living, or family expenses."

²³ Prior to the enactment of HIPAA, some employers established MSAs without tax advantages; neither employer contributions nor account earnings were exempt from taxes.

(P.L. 104-191) established a limited demonstration program for MSAs that has the tax advantages outlined above.²⁴ One justification for the MSA tax advantages is that account owners, in electing high deductible insurance, are assuming financial risk that otherwise would have been borne by the insurance company; from this perspective, it would seem equitable to allow the owners similar tax savings with respect to their contributions.²⁵ Another justification may be that health care costs might grow less rapidly if insurance and its associated tax benefits were restricted to high deductible plans. On the other hand, some families might not seek medical care when it would be helpful if their MSA balance were low. The principal controversy is whether the high deductible insurance associated with MSAs makes them most attractive to people who are young and healthy. To the extent this is the case, MSAs may result in risk pool imbalances with the young and healthy paying lower premiums for high deductible plans and older, less-healthy people paying higher rates for traditional low deductible plans.²⁶

Due to these issues, the HIPAA demonstration that Congress enacted in 1996 limited MSAs in a number of ways. In addition to eligibility restrictions, there was a statutory limit on the number of participants (eventually, 750,000 taxpayers with some exceptions) and when new MSAs can be established (generally not after December 31, 2000). Once eligibility was restricted under these tests, MSAs generally would be available only to individuals who either were active participants (had contributions to their accounts) prior to the cut-off date or became active participants through a participating employer. HIPAA also included limits on the allowable insurance deductible, maximum out-of-pocket payment for covered benefits, and account contributions, as described below. The Community Renewal Tax Relief Act of 2000 (included in P.L. 106-554) extended the December 31, 2000, deadline by 2 years, to December 31, 2002. The authority to establish new MSAs was extended once more, through December 31, 2003, by legislation signed into law in March 2002 (the Job Creation and Worker Assistance Act of 2002, P.L. 107-147).

Data on Use

The IRS has estimated that 62,232 MSAs received contributions in tax year 2000 and that an additional 22,640 were established prior to July 1, 2001. MSAs are not counted towards the cut-off threshold if the owners were previously uninsured; thus, not all of these can be compared to the 750,000 statutory ceiling.²⁷

²⁴ The Balanced Budget Act of 1997 (P.L. 105-33) authorized a limited number of Medicare MSAs (called Medicare+Choice MSAs) under a demonstration beginning in 1999. So far, no health plan has offered a Medicare MSA. The authority for these MSAs expires after Dec. 31, 2003. The MSA provisions in this report do not apply to Medicare MSAs.

²⁵ While the tax savings are greater for taxpayers in higher tax brackets, this is also the case for comprehensive insurance with low deductibles.

²⁶ For an earlier discussion of some of these issues, see CRS Report 96-409, *Medical Savings Accounts: Background Issues*, by Bob Lyke

²⁷ IRS Announcement 2001-99, October 2001. In determining whether the statutory ceiling has been reached, all accounts established by an individual are added together and married (continued...)

The slow growth of MSAs can be attributed to many factors, including consumer unfamiliarity and risk aversion, the reluctance of insurance agents to sell lower-price policies, and statutory requirements that limit product flexibility and innovation. The scheduled termination of the demonstration may have discouraged insurers from developing and marketing MSA plans.

Direct Comparison of FSAs and MSAs

This section compares health care FSAs and MSAs with respect to a number of points. Its focus is general similarities and differences; not all rules are mentioned.

Eligibility

Eligibility for FSAs is limited to employees whose employers offer plans; people who are self-employed or unemployed generally cannot participate. However, former employees can be eligible provided the plan is not established predominantly for their benefit.²⁸ Employers may set additional conditions for eligibility.

In contrast, eligibility to establish MSAs is limited to people who have qualifying high deductible insurance (and no other health insurance, with some exceptions) and who either are self-employed or are employees covered by the high deductible plan established by their small employer. (A small employer is defined as having on average 50 or fewer employees during either of the two preceding calendar years.²⁹)

People may keep MSAs once they no longer have qualifying high deductible insurance, though they cannot make further contributions. For 2002, qualifying high deductible insurance must have a deductible for self-only coverage that is not less than \$1,650 nor more than \$2,500 and a ceiling on annual out-of-pocket expenses for covered benefits that does not exceed \$3,300. For family coverage, the deductible must not be less than \$3,300 nor more than \$4,950, and the ceiling on out-of-pocket expenses must not exceed \$6,050. Medicare is considered another form of insurance; thus, when people turn 65 they no longer can start or contribute to an MSA.³⁰

²⁷ (...continued)

individuals opening separate accounts are treated as having one account.

²⁸ 49 FR 19321, Q and A 4.

²⁹ Once having met this test and made contributions, it can continue to be treated as a small employer provided it does not employ on average more than 200 persons a year.

³⁰ Other insurance that is allowed includes coverage for accidents, disability, dental care, vision care, long-term care, workers' compensation, and insurance for specific diseases or illnesses or that pays a fixed amount per day or per hospitalization. The Balanced Budget Act of 1997 (P.L. 105-33) authorized a limited number of Medicare MSAs (called Medicare+Choice MSAs) under a demonstration beginning in 1999. So far, no health plan has offered a Medicare MSA. The MSA provisions in this report do not apply to Medicare MSAs.

Both FSAs and MSAs 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. MSA contributions may be made by employers or by employees, but not by both. MSA contributions may not be made through a cafeteria plan. MSA contributions may be made only when the account owner has qualifying high deductible insurance (as defined above) and no other health insurance.

FSA contributions occur during the plan year (which is usually a calendar year), while MSA contributions may be made until the due date (without regard to extensions) for the taxpayer's return. Since most FSAs are funded through salary reductions, contributions typically occur pro-rata throughout the year. The pattern for MSA contributions is not known.

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

Annual MSA contributions are limited to 65% of the insurance deductible in the case of a self-only policy and 75% of the insurance deductible in the case of a family policy. For employees, contributions cannot exceed compensation from the employer; for the self-employed, they cannot exceed net earnings from the trade or business with respect to which the high deductible health plan is established. Contributions that exceed any of these limits are subject to an excise tax.

Employers must make comparable MSA contributions for all participating employees who have comparable coverage. Either the same amount must be contributed for each employee or the same percentage of the deductible must be. Separate calculations are allowed for part-time employees.

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.³¹ One exception disallows their use for long-term care; another disallows their use for other health insurance

³¹ Allowable expenses are discussed in an IRS publication number 502, *Medical and Dental Expenses*, which is available at [http://www.irs.ustreas.gov/forms_pubs/pubs.html].

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). The federal government implemented a premium conversion plan in October 2000.

MSAs can also be used for unreimbursed medical expenses that are deductible under Section 213, but generally not health insurance. The latter restriction does not apply to qualified long-term care insurance, continuation coverage required under federal law (such as COBRA), and health insurance when the individual receives unemployment compensation.

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

MSA funds may be withdrawn for nonqualified uses, subject to two restrictions. First, the sum must be included in the taxpayer's gross income; second, a 15% penalty would be added except in cases of disability, death, or attaining age 59½.

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 to FSAs through salary reduction plans, in effect they can "carry over" amounts they do not anticipate using by not putting them in the account in the first place.

MSA funds may be carried over indefinitely. Upon death, an MSA may be passed on to a surviving spouse without federal tax liability; otherwise, it is included in the gross income of the beneficiary or of the decedent on the latter's final return. MSA balances are taken into account for determining whether there is any estate tax liability.

Current Legislation

Under current law, amounts in FSAs that are unused at the end of the year must be forfeited to the employer. However, President Bush's FY2003 budget would 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).

President Bush's FY2003 budget also includes a permanent extension and expansion of MSAs. The Administration's proposal would:

- ! repeal limits on the number of accounts;
- ! make active accounts generally available to anyone with qualifying high deductible insurance (thus repealing restrictions limiting them to employees of small employers and self-employed individuals);
- ! allow contributions up to the amount of the insurance deductible (thus deleting the 65% and 75% ceilings);
- ! allow contributions to be made both by employers and account owners;
- ! lower minimum insurance deductibles from \$1,650 to \$1,000 for single coverage and \$3,300 to \$2,000 for family coverage;
- ! allow plans to be offered through cafeteria plans; and
- ! allow plans to provide up to \$100 of allowable preventive services per individual each year without counting against the deductible.

These proposals regarding FSAs and MSAs are nearly identical to those contained in President Bush's FY2002 budget, with some exceptions. The FY2003 budget proposal for MSAs added a provision that allows plans to provide up to \$100 of allowable preventive services per individual each year without the person first having to meet the deductible and without that amount counting toward the deductible. Also, in the FY2002 proposals for FSAs, the changes would take effect after December 31, 2001; in the FY2003 budget, the changes would take effect after December 31, 2003.

A number of bills were introduced in the first session of the 107th Congress to bring about the changes proposed in the President's FY2002 budget.³² The House-passed patient protection bill (H.R. 2563, Representative Ganske, passed August 2, 2001) would also allow qualifying high deductible insurance plans not to have a deductible for preventive care, even if this is not required by state law. In addition, the limits on deductibles and out-of-pocket expenses would not apply to out-of-network care. Comparable provisions are contained in H.R. 1524 (introduced by Representative Thomas, Chairman of the House Committee on Ways and Means) and S. 1067 (Senator Grassley, Ranking Member of the Senate Committee on Finance).

On July 25, 2002, the House passed H.R. 4946 (Representative J.D. Hayworth), the Improving Access to Long-Term Care Act of 2002, which includes a provision

³² In general, this report will discuss particular bills only when they are considered by committee or on the floor. Congressional offices can prepare lists of all FSA and MSA bills that have been introduced by using the Legislative Information System (LIS) available through the CRS home page. Under Links to Other Sites, click on the LIS and then "Advanced Search" under Bill Text. In the Word/Phrase box, then type the term "flexible spending arrangement" or "medical savings account."

regarding MSAs. The legislation would allow individuals who are enrolled in a Medicare+Choice MSA plan (presently there are none) to contribute to an Archer MSA. A similar provision had been included in the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954, introduced by Representative Nancy Johnson, Chairwoman of the committee's Health Subcommittee) as passed by the House Ways and Means Committee. However, the provision was dropped from the version of the bill that passed the House on June 28.

Conclusion

FSA and MSA are alike in some respects and different in others. Some people might consider them essentially substitutes for one another, notwithstanding differences in eligibility, contributions, and use, while others would emphasize their dissimilarity.

One key difference is the requirement that MSA contributions occur only when account owners have high deductible insurance. Since high deductible insurance may be most attractive to people who are young and healthy (that is, people who do not anticipate needing much health care), this insurance might become relatively inexpensive while the cost of other insurance, held primarily by people who are older or less healthy, would be pushed upward. MSA opponents argue that this risk pool imbalance will inevitably occur and that the cost differences are likely to be significant. In contrast, MSA proponents argue that MSAs can be attractive to many people, including people with health problems who want free choice of doctors, and that whatever cost differences occur will be minor.

A second key difference is that MSA balances can be rolled over indefinitely in tax-advantaged savings accounts. Opponents argue this feature gives people with the means to save an unwarranted tax shelter, while proponents argue that it encourages people to set aside funds for future medical and long-term care expenses.

The MSA demonstration established by the Health Insurance Portability and Accountability Act of 1996 is unlikely to resolve these issues, even with the recent two-year extension. The MSAs it allows are so restricted, and the number of people who likely will have them is so small, that it will be difficult to generalize from whatever information becomes available.

Both FSAs and MSAs 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 and MSAs might be justified since participants in both cases generally assume additional financial risk for their health care. Some might question, however, whether the savings are 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.