dm-t | news

CRS compares tax-favored options available for paying health care costs

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

There are four types of tax-advantaged accounts that can be used to pay for unreimbursed medical expenses: (1) Health Care Flexible Spending Accounts (FSAs), (2) Health Reimbursement Accounts (HRAs), (3) Health Savings Accounts (HSAs), and (4) Archer Medical Savings Accounts (MSAs). A newly updated Congressional Research Service (CRS) Report compares their respective eligibility rules, contribution limits, use of funds, and other key characteristics for tax year 2013. It also notes how these accounts are affected by the Affordable Care Act (ACA), how accessible they are to taxpayers, and how many people use them.

Comparison of the four types of accounts. As summarized by the CRS Report, the four tax-advantaged accounts have the following salient features.

...*FSAs.* These are employer-established arrangements that are usually funded through salary reduction agreements under Code Sec. 125. The employee's contribution isn't subject to either income or employment taxes. Under the ACA, beginning in 2013, FSA contributions are limited to $2,500 per employee. The FSA limits are adjusted for inflation yearly. Unless the employer offers a grace period for additional claims of up to 2 1/2 months, an employee's unused balance is forfeited at the end of the year.

...*HRAs.* These are employer-established arrangements that are funded *only* through employer contributions. HRA contributions are not subject to either income or employment taxes under Code Sec. 106, and health care benefits used for medical care are tax exempt under Code Sec. 105. HRAs differ from FSAs in several important respects. For example, employers may restrict the types of medical and health services that are eligible for reimbursement.

dm-t
decoria · maichel · teague
P | 509.535.3503
F | 509.535.9391
7307 N. Division, Suite 222
Spokane, WA 99208
www.dm-t.com

HRAs are group health plans that typically consist of a promise by an employer to reimburse medical expenses (as defined in Code Sec. 213(d)) for a year up to a certain amount, with unused amounts available to reimburse medical expenses in future years. That causes a problem under Sec. 2711 of the Public Health Service Act (PHSA), as added by the ACA, which generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits. IRS has ruled that HRAs are permitted when they are integrated with other employer-provided coverage, and are not permitted when they are stand-alone accounts. An integrated HRA is one where an HRA is integrated with other coverage as part of a group health plan, and such other coverage alone would comply with Sec. 2711 of the PHSA. Except for stand-alone HRA that contain retirees only, which can continue on or after Jan. 1, 2014, stand-alone HRAs will not be permitted coverage on or after Jan. 1, 2014. For example, an employer can't provide employees with HRA funding to purchase coverage on the individual market.

...*HSAs.* These are tax-exempt accounts under Code Sec. 223 that can be established (and to which contributions can be made) only when the account owner has a qualifying 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. For example, for 2013 as well as 2014, the plan must have a deductible of at least $1,250 for self-only coverage and $2,500 for family coverage.

For 2013, annual out-of-pocket expenses (deductibles, co-pays, and other amounts, but not premiums) can't exceed $6,250 for self-only coverage or $12,500 for family coverage (for 2014, $6,350 and $12,700 respectively). The plan holder may have no other major medical health insurance policy. Contributions made by employers are exempt from income and employment taxes, and account owners may deduct contributions they make. Withdrawals for medical expenses are not taxed, but those for other purposes are and are subject to an additional 20% penalty, except in cases of disability, death, or attaining age 65. Unused balances may be carried over from year to year without limit. Contributions for 2013 are limited to $3,250 for self-only coverage and $6,450 for family coverage (for 2014, $3,300 and $6,550 respectively). An additional contribution of $1,000 is allowed to people age 55 and older.

dm-t
decoria · maichel · teague
P | 509.535.3503
F | 509.535.9391
7307 N. Division, Suite 222
Spokane, WA 99208
www.dm-t.com

...*MSAs.* These accounts, also known as Archer MSAs, are earlier versions of HSAs and are in limited use under current law. Per Code Sec. 220, MSAs can be established generally only when account owners have qualifying high deductible insurance and no other coverage. Contributions made by employers are exempt from income and employment taxes, and contributions by account owners (which are allowed only if the employer doesn't contribute) are deductible. Withdrawals are not taxed if used for medical expenses, but those used for other purposes generally are and are subject to an additional 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 MSA minimum deductible levels are higher and the contribution limits are lower. With one exception, no MSAs can be created after Dec. 31, 2007, although MSAs existing at that time are grandfathered. The exception is that an employee who begins to work for an employer that already sponsors MSAs may open an MSA.

Effect of ACA-Patient-Centered Outcomes Research Trust Fund fee. The Patient-Centered Outcomes Research Institute (Institute) was established by the ACA to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. Under Code Sec. 9511, the Institute is to be funded in part by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans. Code Sec. 4375 imposes those fees on "specified health insurance policies" (generally, any accident or health insurance policy, including a policy under a group health plan, issued with respect to individuals residing in the U.S.), and Code Sec. 4376 imposes those fees on "applicable self-insured health plans" (generally, any employer or employee organization sponsored plan for providing accident or health coverage other than through an insurance policy). The fee is equal to the "average number of lives covered during the policy year or plan year," multiplied by the applicable dollar amount for the year. For policy and plan years ending after Sept. 30, 2012 and before Oct. 1, 2013, the applicable dollar amount is $1; after Sept. 30, 2013 and before Oct. 1, 2014, $2; and after Oct. 1, 2014 and before Oct. 1, 2019, an inflation-adjusted amount.

dm-t
decoria · maichel · teague
P | 509.535.3503
F | 509.535.9391
7307 N. Division, Suite 222
Spokane, WA 99208
www.dm-t.com

The CRS study says that for FSAs, the Patient-Centered Outcomes Fee will be owed by a small number of plan sponsors (for self-insured insurance plans) or insurers (for other insurance plans). A footnote explains that FSAs where the employer contributes over $500 during the year owe the fee for that year. For HRAs, the fee will be owed by plan sponsors (for self-insured insurance plans) or insurers (for other insurance plans). The CRS report says, without further elaboration, that the fee owed by HRA sponsors may be smaller than the standard fee under certain circumstances.

No fee will be owed by HSAs or MSAs, says the CRS report, although the HDHP associated with the HSA or MSA would owe the fee.

Accessibility and usage of these accounts. According to various surveys and research studies quoted by the CRS report:

> ... 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. In establishments with fewer than 100 employees, 20% of the workers had access to a health care FSA.
>
> ... HSAs are only available to employees who have HDHPs. In 2012, 26% of firms offering health benefits offered an HSA-qualified HDHP (up from 18% in 2011 and 12% in 2010). 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 in recent years; the percentage was 4% in 2010, 7% in 2011, and 5% in 2012.
>
> ... 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. A substantial majority of these individuals are likely to be HSA holders.

The CRS report says that almost no data is available on usage of MSAs, as very few new MSAs are being created, and the number of them always has been limited.

dm-t
decoria · maichel · teague
P | 509.535.3503
F | 509.535.9391
7307 N. Division, Suite 222
Spokane, WA 99208
www.dm-t.com