

CRS Report for Congress

Health Care Flexible Spending Accounts

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Summary

Health care Flexible Spending Accounts (FSAs) are benefit plans established by employers to reimburse employees for health care expenses such as deductibles and copayments. FSAs are usually funded by employees through salary reduction agreements, although employers are permitted to contribute as well. The contributions to and withdrawals from FSAs are tax-exempt.

Historically, health care FSA contributions were forfeited if not used by the end of the year. However, in 2005 the Internal Revenue Service (IRS) formally determined that employers may extend the deadline for using unspent balances up to 2½ months after the end of the plan year (i.e, until March 15 for most plans). The Tax Relief and Health Care Act of 2006 (P.L. 109-432) allows individuals to make limited, one-time rollovers from balances in their health care FSAs to Health Savings Accounts. In the 110th Congress, as in previous Congresses, legislation has been introduced to permit part or all of remaining balances to be rolled over to accounts next year or to qualified retirement accounts.

According to the 2006 Medical Expenditure Panel Survey, 53% of private-sector employees could establish a health care FSA. The accounts were not as common for workers in small businesses. In establishments with fewer than 50 employees, 9% of workers had access, compared with 70% of workers in establishments with at least 50 employees. Access is more common (81%) for state and local government employees. However, only a minority of employees with access to an FSA actually participate. In July 2003, FSAs became available to federal employees for the first time. In September 2008, about 240,000 federal employees had health care FSAs.

These other points might be noted about health care FSAs:

- FSAs are limited to employees and former employees.
- The IRS imposes no dollar limit on health care FSA contributions, but employers generally do.
- FSAs generally can be used only for unreimbursed medical expenses that would be deductible under the Internal Revenue Code, but not for health insurance or long-term care insurance premiums.
- Employers may impose additional restrictions.

Health care FSAs are different from Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Archer Medical Savings Accounts (MSAs). See CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

The President's FY2009 budget proposal would eliminate health care FSAs, or at least the tax preferences for them. The change is part of his proposal to replace the tax exclusion for employer health insurance with a new standard deduction for health insurance.

This report will be updated for new data or as legislative activity occurs.

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Health Care Flexible Spending Accounts

Health care Flexible Spending Accounts (FSAs) are employer-established benefit plans to reimburse employees for specified health care 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 cost of health care was a growing concern. In contrast to traditional insurance plans, FSAs generally allow employees to vary benefit amounts in accordance with their anticipated health care needs. FSAs can be used for unreimbursed medical expenses, and contributions to FSAs have tax advantages. However, FSA contributions are generally forfeited if not used by the end of the year, although employers may extend the deadline for using unspent balances up to 2½ months after the end of the plan year (i.e., March 15 for most plans).

This report¹ describes FSAs, the basis for their tax treatment, and data on their use.² The report concludes with a brief discussion of recent presidential and legislative proposals affecting FSAs.

Background

FSAs 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, adoption assistance, or for medical and dental expenses. However, there must be separate accounts for these three purposes, and amounts unused at the end of the year must be forfeited to the employer. If FSAs meet these and other rules, contributions are not subject to either income or employment taxes. The focus of this report is on the FSAs devoted to health care.

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

¹ Chris L. Peterson, CRS Specialist in Health Care Financing, contributed to portions of this report.

² FSAs are different from the three other types of tax-advantaged health care accounts: Health Savings Accounts, Health Reimbursement Accounts, and Archer Medical Savings Accounts. For a comparison of all these accounts, see another CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson. Also see Internal Revenue Service publication number 969, *Health Savings Accounts and Other Tax-Favored Plans*, which is available through the IRS website, [<http://www.irs.gov>].

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 nine months, for example, he cannot replenish the account until the next year. Any amount that remains unspent at the end of the year (or after the 2 ½ month extension, if available) is forfeited to the employer.³ If the FSA was 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 FSAs to be funded both by salary reductions and employer contributions.

If the employee were in the 25% tax bracket, the federal income tax savings from the \$900 salary reduction used to fund the account generally would be \$225 (i.e., \$900 x .25); in addition, the employee could save \$69 in Social Security and Medicare taxes (i.e., \$900 x .0765).⁴ 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, three-fifths as large, while if he were in the top 35% bracket they would be commensurately greater, \$315.⁵

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.

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.⁶

³ The Tax Relief and Health Care Act of 2006 (P.L. 109-432) provided that individuals may make limited, one-time rollovers from balances in their FSAs to Health Savings Accounts.

⁴ If the employee's earnings exceeded the Social Security wage base (\$102,000 in 2008), the only savings would be \$13 from Medicare taxes (i.e., \$900 x .0145). Reductions in Social Security taxes due to FSA salary reductions could affect the Social Security benefits that the worker later receives, though not by much.

⁵ In 2008, the 15% bracket for single filers applies to taxable income (that is, after exemptions and deductions are subtracted) of over \$8,025 to \$32,550; for married couples filing jointly, the bracket extends from over \$16,050 to \$65,100. The 25% brackets for these taxpayers are from over \$32,550 to \$78,850 and from over \$65,100 to \$131,450, respectively.

⁶ The breakeven point for an employee in the 25% bracket who contributes \$900 would generally be \$606 (i.e., \$900 minus income tax savings of \$225 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.

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.

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. 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 (in this case, reimbursements for health 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.⁷

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.⁸ 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.

Regardless of how they are funded, rules regarding FSAs are not spelled out in the Internal Revenue Code;⁹ rather, they were included in proposed regulations that

⁷ In addition, cafeteria plans may include some taxable benefits; like cash, these are taxable if the employee selects them.

⁸ For a critical discussion of the Internal Revenue Service’s interpretation of constructive receipt with respect to employee benefit plans and Section 125, see Leon E. Irish, “Cafeteria Plans in Transition,” *Tax Notes*, December 17, 1984, pp. 1135-1136.

⁹ 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 (continued...)

the Internal Revenue Service (IRS) issued for cafeteria plans in 1984 and 1989.¹⁰ Final rules regarding circumstances in which employers may allow employees to change elections during a plan year were issued in March 2000 and January 2001.¹¹ 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,

- 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;¹² and

⁹ (...continued)

106(c)(2) when it disallowed coverage of long-term care services through such accounts.

¹⁰ 49 *Federal Register* 19321, May 7, 1984, 49 *Federal Register* 50733, December 31, 1984 and 54 *Federal Register* 9460, March 7, 1989. The proposed regulations were not finalized, but they remained the position of the IRS. (With the August 2007 proposed rules cited earlier in this CRS report, the IRS formally withdrew these proposed regulations.) The rules cover both FSAs funded by salary reductions and FSAs funded by nonelective employer contributions. Although employers generally do not permit annual reimbursements from FSAs to exceed the amount slated for contribution during the year, the proposed regulations do not require this. The proposed regulations allow a maximum annual reimbursement of up to 500% of the total annual contribution, or “premium” (including both employer-paid and employee-paid portions of the contribution to the FSA). An FSA operating in this way would be more similar to typical health insurance in that the maximum benefit is not limited to the year’s contribution total. However, such an FSA would still differ from typical health insurance in that the maximum benefit is relatively low.

¹¹ 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.

¹² Thus an employer might refund the same dollar amount to every participant, even though some used all their benefits while others forfeited unused amounts.

- health care FSAs must exhibit the risk-shifting and risk-distribution characteristics of insurance.¹³

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.

In August 2007, the IRS issued new proposed rules for cafeteria plans that will generally be effective on January 1, 2009, though taxpayers may adopt them sooner. These rules have not yet been finalized.¹⁴

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.¹⁵ (One reason they might do so is to limit the financial risk that employees might resign having received reimbursements that exceed their contributions.) Similarly, employers may exclude certain elective expenses from their plans.

FSAs can provide tax savings for the first dollars of health care expenditures that people have each year, similar to the tax savings associated with comprehensive insurance plans having negligible deductibles and copayments. However, taxpayers normally are allowed to deduct out-of-pocket 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 might be justified since participants 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.

¹³ 54 *Federal Register* 9460, Q and A 7. Some of the seven requirements listed in the text had been issued in 1984.

¹⁴ 72 *Federal Register* 43938, August 6, 2007.

¹⁵ 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. Although surveys yield similar findings about the availability of FSAs, little is known about the number and characteristics of workers who participate.

The 2006 Medical Expenditure Panel Survey (MEPS) found that 21% of private-sector establishments offered an FSA to their workers. FSAs are more common in larger firms: they were offered in 67% of establishments with 50 or more workers but in only 5% of smaller establishments. Similarly, a greater percentage of employees had access to an FSA if they worked in a large firm instead of a small one. In firms with fewer than 50 employees, 9% of workers had access, compared with 70% of workers in firms with at least 50 employees. Overall, 53% of private-sector employees could establish an FSA, according to this survey.

FSAs are more likely to be offered in large firms than they were two years ago. In 2004, 62% of large-firm establishments offered FSAs, compared with 67% in 2006.

According to the 2006 MEPS, more than half (53%) of private-sector employees have access to an FSA, while 81% of state and local government employees do.

In July 2003, FSAs became available to federal employees for the first time. In September 2008, there were about 240,000 federal health care FSAs.¹⁶

According to a 2006 survey by Mercer Human Resources Consulting, 81% of employers with 500 or more employees offered a health care FSA, and an average of 20% of eligible employees participated. Among employers with 10 or more employees, 30% offered a health care FSA, and an average of 36% of eligible employees participated. The average amount contributed was \$1,208.

Reasons for low FSA participation include employee perceptions of complexity, concerns about end-of-year forfeitures, and limited employer encouragement. Younger employees, particularly if single, may not have enough health care expenses to make participation worthwhile. For lower income employees, the tax savings may be inconsequential.

The modest participation levels suggest that early 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,

¹⁶ Office of Personnel Management, incremental summary for 2005 benefit period.

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, pp. 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
(continued...)

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

Principal Rules Regarding FSAs

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.¹⁹ Employers may set additional conditions for eligibility.

FSAs 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 in plans with higher deductibles.

Contributions

FSA contributions may be made by employers (through nonelective payments), employees (through salary reduction plans), or both. FSA contributions occur during the plan year, which is usually a calendar year. Since most FSAs are funded through salary reductions, contributions typically occur pro-rata throughout the year.

The IRS imposes no specific dollar limit on health care FSA contributions, though plans typically have a dollar or percentage maximum for elective contributions made through salary reductions.²⁰ Employers set limits to reduce losses from employees who quit or die when their withdrawals (which might total the year's allowable draw) exceed their contributions from salary reductions. For 2008, each federal employee may contribute up to \$5,000 to his or her health care FSA.

¹⁷ (...continued)

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 Daniel C. Schaffer 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 49 *Federal Register* 19321, Q and A 4.

²⁰ Limits are applied to adoption assistance and dependent care FSAs, based upon the statutory provisions for these benefits.

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.²¹ One exception disallows their use for long-term care and for other health insurance coverage, including premiums for any employer plan. A second exception is that FSAs may cover nonprescription drugs. 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). Premium conversion plans are common among businesses that offer health insurance, particularly among large companies. The federal government implemented a premium conversion plan in October 2000.

Nonqualified Withdrawals

FSA funds may be used only for qualifying expenses, as defined above; they generally 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).

One exception to the rule prohibiting nonqualified withdrawals is that military reservists called to active duty for at least 179 days or for an indefinite period may receive some or all of the unused funds in their account. Employers are permitted but not required to allow these withdrawals.

Carryover of Unused Funds

Historically, FSA balances unused at the end of the year were forfeited to the employer; they could not be carried over.²² On August 23, 2004, Senator Grassley, then chairman of the Senate Committee on Finance, requested the Treasury Department to assess whether it had the authority to modify the “use or lose it” rule without a directive from the legislative branch. On December 23, 2004, Treasury Secretary John W. Snow responded by letter that Congress had effectively ratified the rule and that changes would require legislative action.

²¹ Allowable expenses are discussed in IRS publication number 502, *Medical and Dental Expenses*, available through the IRS website at [<http://www.irs.gov>].

²² Since employees control how much is contributed through salary reduction plans, in effect they can “carry over” amounts they do not anticipate using by not putting them into the account in the first place.

Nonetheless, on May 18, 2005, the IRS issued a notice that employers may extend the deadline for using unspent balances up to 2½ months after the end of the plan year (i.e., until March 15 for most plans).²³ FSAs are still subject to the “use it or lose it” rule; however, the notice allows employers to offer access to the FSAs for up to 14½ months instead of 12 months.

The rationale for the new notice is based on other benefits covered under the section of the Internal Revenue Code dealing with cafeteria plans, Section 125. Cafeteria plans may not include a benefit that defers compensation, which is the basis of the “use it or lose it” rule. However, according to the new notice, payment from a plan is not considered deferred compensation even if the payment occurs after the end of the plan year if that payment occurs within “a short, limited period” after the end of the plan year. The notice cites other regulations and rulings stating that benefits are not considered deferred if they “are received by the employee on or before the fifteenth day of the third calendar month after the end of the employer’s taxable year [that is, March 15].... Consistent with these other areas of tax law, Treasury and the IRS believe it is appropriate to modify the current prohibition on deferred compensation in the proposed regulations under § 125 to permit a grace period after the end of the plan year during which unused benefits or contributions may be used.”

The employer has the option to offer this 2½-month grace period but is not required to do so. For implementation, the cafeteria plan document must be amended to include a grace period, and the period must apply to all participants in the plan. The IRS notice does not alter other features of FSAs, so at the end of the applicable grace period, unused balances still must be forfeited to the employer.

Employers’ initial reaction to the rule change has been mixed, with some welcoming the added flexibility but others concerned about additional administrative burdens and exposure to increased financial risk.

The Tax Relief and Health Care Act of 2006 (P.L. 109-432) provided that individuals may make limited, one-time rollovers from balances in their FSAs to Health Savings Accounts. IRS guidance issued in February 2007 provides details about the conditions under which these transfers can occur. Among other things, employees must elect to make “qualified HSA distributions” by the last day of the plan year, no reimbursements can be made to employees after that last day, and the HSA distribution cannot exceed the lesser of the balance in the FSA on (1) September 21, 2006, or (2) the date of the distribution.²⁴

²³ IRS Notice 2005-42, available through the IRS website at [<http://www.irs.gov>].

²⁴ IRS Notice 2007-22.

Interaction with Other Health Accounts

It is possible for individuals to have a health care FSA along with other tax-advantaged health accounts — Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).²⁵ However, employers must coordinate how multiple accounts are used so that the eligibility requirements are not violated.

Health care FSAs cannot be used to pay the deductible of an HSA's qualifying high deductible health insurance. As a result, the FSA for those with an HSA must be either a "limited purpose FSA" or a "post-deductible FSA." A limited purpose FSA is one that pays only for preventive care and for medical care not covered by the HSA's qualifying health insurance (for example, vision and dental care). A post-deductible FSA is one that does not pay or reimburse any medical expense until the deductible of the HSA's qualifying health insurance has been met.

For those enrolled in an HRA and FSA at the same time, the accounts cannot pay for the same expenditures. 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 federal requirement that the FSA be limited in purpose or post-deductible. However, the employer has the authority to implement such policies, as well as to require that the FSA be exhausted if the HRA must also be exhausted before the arrangement's health insurance begins.

HSAs and HRAs are offered to federal employees and annuitants through the Federal Employees Health Benefit Program (FEHBP). A federal health care FSA is also available to federal employees, though not to annuitants. For 2005, the U.S. Office of Personnel Management (OPM) prohibited enrollees in FEHBP's HSA or HRA options from enrolling in a health care FSA. Starting in 2006, however, a health care FSA limited to vision and dental care became available for enrollees with the HSA option. Starting in 2007, federal enrollees can purchase separate vision and dental insurance as well.

Health care FSAs can conflict with the objectives of HSAs and HRAs. People with FSAs receive tax advantages for the first dollars of health care expenditures without assuming the additional risk associated with the high deductible insurance that is required of HSAs and that usually accompanies HRAs. While they cannot carry over FSA balances for use in later years, this might not make much difference to those who would not be building up HSA or HRA balances anyway. As a consequence, those who believe that enrollment in high deductible health insurance should be encouraged might oppose further incentives for FSAs.

²⁵ Archer Medical Savings Accounts (MSAs) could also be added to this list, but since they have largely been replaced by HSAs, they were not included in this discussion. More detailed descriptions of these accounts appear in CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

Current Legislation

In the 110th Congress, as in previous Congresses, bills have been introduced to allow unused health care FSA balances to be carried over to the next plan year, including H.R. 298 (McCarthy), H.R. 3306 (Royce), H.R. 3343 (Paul), H.R. 3947 (Larson), and S. 555 (Snowe). Both S. 555 and H.R. 46 (Velazquez) seemingly would allow self-employed individuals to have accounts through cafeteria plans. CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Bob Lyke and Julie M. Whittaker may have more recent information about these and other relevant bills.

The Heroes Earning Assistance and Relief Tax Act (H.R. 6081, P.L. 110-245), signed by the President on June 17, 2008, permitted employers to allow military reservists called to active duty to receive some or all of the remaining funds in their account. (See “Nonqualified Withdrawals,” above).

Several bills would allow long-term care premiums to be paid from flexible spending accounts; these include H.R. 3363 (Pomeroy), H.R. 5559 (Putnam), S. 2337 (Grassley), and S. 3327 (Kerry).

The President’s FY2009 budget proposal would eliminate health care FSAs, or at least the tax preferences for them. Health care FSAs could continue without the tax exclusion (i.e., employees could divert part of their taxable wages into an account to be used for health care expenses), but it is not obvious who would want to have them. It is not clear what would become of current restrictions on health care FSAs under the President’s proposal.

The elimination of health care FSAs is part of the President’s broader proposal to replace the tax exclusion for employer paid health insurance with a new standard deduction for health insurance. Whether the elimination is desirable public policy should be evaluated in the context of that larger proposal. Similarly, identifying who would be aided or penalized by the elimination of health care FSAs should be seen in the context of the larger proposal.

The next Congress may consider legislation to expand health insurance coverage to people who are uninsured. Possibly comprehensive health care reforms will also be considered. What role FSAs might play in these initiatives is likely to be of interest to employers and employees alike.