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A Comparison of Tax-Advantaged Accounts for Health Care Expenses

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A Comparison of Tax-Advantaged Accounts for Health Care Expenses

Individuals can use three common categories of tax-advantaged accounts to pay for certain unreimbursed medical expenses:

- **Health flexible spending arrangements (FSAs)**, an employer-established benefit primarily funded by employees through salary-reduction agreements
- **Health reimbursement arrangements (HRAs)**, an employer-established benefit funded by employers
- **Health savings accounts (HSAs)**, which are paired with certain high-deductible health plans (HDHPs) and can be funded by individuals, employers, or both.

Eligibility for FSAs and HRAs is tied to whether an individual's employer offers the account as a benefit. These accounts are generally part of a range of employee benefits that employers may offer. In contrast, HSAs are not necessarily provided through employers (although employers can incorporate HSAs as part of a benefits package). In other words, eligible individuals may establish and contribute to HSAs outside of the employment setting or irrespective of being employed.

The three categories of accounts generally share two tax advantages: (1) employer contributions (and, where applicable, certain employee contributions) toward the aforementioned tax-advantaged accounts can be excluded from an employee's gross income and from payroll taxes and (2) withdrawals from such accounts may be tax-free if such amounts are used to pay for *qualified medical expenses*. (HSAs have additional tax advantages.)

Each type of account has a different set of medical expenses that would be considered *qualified medical expenses*, but all three account types generally consider, at minimum, the following to be qualified medical expenses: the costs of diagnosis, cure, mitigation, treatment, or prevention of disease and the costs for treatments affecting any part of the body; the amounts paid for transportation to receive medical care; and qualified long-term-care services. For example, costs for ambulances, body scans, and chiropractors would fall within the definition of *medical care*, whereas personal-use expenses (e.g., toothpaste) and general health expenses (e.g., weight-loss programs) generally would not. Qualified medical expenses include only *unreimbursed* amounts (i.e., they do not include amounts paid by insurance companies for medical care).

Outside of these general similarities, the three categories of tax-advantaged accounts have many different features. Features specific to each account category include eligibility, the qualifying health insurance associated with the account (if any), contribution limits, the types of medical care considered *qualifying medical expenses*, the ability to carry over funds from one year to the next, the ability to invest account balances, and the extent to which funds are available to an individual upon termination of employment.

For context, the 2017 Bureau of Labor Statistics National Compensation Survey estimated that, in 2017, approximately 53% of privately employed individuals with health insurance had an FSA, approximately 10% of privately employed individuals with health insurance had a plan with an HRA, and approximately 21% of privately employed individuals with health insurance had a plan with an HSA. This is the most recent year for which these data are available.

This report provides a brief summary of each tax-advantaged account for health care expenses, highlighting key aspects regarding eligibility, contributions, withdrawals, and the treatment of unused balances for that particular account, as well as data on availability and use. It also provides a side-by-side comparison of these accounts along related topics.

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Introduction

There are three common categories of tax-advantaged accounts that individuals can use to offset their health care costs:¹

- Health flexible spending arrangements (FSAs)²
- Health reimbursement arrangements (HRAs)³
- Health savings accounts (HSAs)⁴

Developmentally, these accounts are somewhat distinct from one another. FSAs developed out of provisions included in the Revenue Act of 1978 (P.L. 95-600) that codified the tax treatment of employee benefits provided through salary-reduction agreements, a mechanism employers can use to offer a variety of tax-advantaged benefits to their employees.⁵ HRAs were defined formally through a notice released by the Internal Revenue Service (IRS) in 2002.⁶ Since then, both Congress and the IRS have established different categories of HRAs, with the goal of incentivizing employers and expanding employers' ability to offer HRAs to their employees.⁷ HSAs were first authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) as a way to help people save and pay for unreimbursed medical expenses, such as health insurance cost sharing (e.g., deductibles, co-payments, and coinsurance)

¹ To facilitate easy reading, this report often uses the term *account* to refer collectively to both certain tax-advantaged *accounts* and certain tax-advantaged *arrangements*.

² Flexible spending arrangements (FSAs) also may be offered for dependent-care expenses. This report covers only health FSAs and often refers to such arrangements simply as *FSAs*.

³ Multiple types of health reimbursement arrangements (HRAs) exist. This report covers group health plan HRAs, qualified small employer HRAs (QSEHRAs), individual coverage HRAs (ICHRAs), excepted benefit HRAs, and retiree-only HRAs.

⁴ In addition to these three account categories, there are Archer medical savings accounts (MSAs). In general, Archer MSAs can be thought of as an older, more restrictive version of HSAs that are similarly paired with certain high-deductible health plans (HDHPs). Since December 31, 2007, individuals generally have not been able to open new Archer MSAs, except for limited instances. As a result, few Americans currently and actively contribute to this type of account; in 2018, 4,495 tax forms reported an Archer MSA that received employer contributions and 13,221 tax forms reported an Archer MSA that received individual contributions. From a budgetary standpoint, the Joint Committee of Taxation estimated Archer MSAs would reduce federal revenues by less than \$50 million from 2020 through 2024. Due to their limited use, Archer MSAs have been excluded from this report. 26 U.S.C. §220; Internal Revenue Service (IRS), *Statistics of Income—2018 Individual Income Tax Returns Line Item Estimates*, Publication 4801 (Rev. 09-2020), p. 192, at <https://www.irs.gov/pub/irs-pdf/p4801.pdf>; and U.S. Congress, Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2020-2024*, committee print, prepared by Joint Committee on Taxation, 116th Cong., 2nd sess., November 5, 2020, JCX-23-20, p. 20.

⁵ The Revenue Act of 1978 did not define the specific benefits that could be made available under a salary-reduction agreement. The IRS first formally acknowledged FSAs and discussed the rules around such benefit in the context of salary-reduction agreements in IRS, "Internal Revenue Service News Release IR-84-22," Announcement 84-24, I.R.B. 1984-10, 39, January 1, 1984; and IRS, "Tax Treatment of Cafeteria Plans," 49 *Federal Register* 19321, May 7, 1984.

⁶ IRS, "Part III: Administrative, Procedural, and Miscellaneous—Health Reimbursement Arrangements," Notice 2002-45, at <https://www.irs.gov/pub/irs-drop/n-02-45.pdf>. Hereinafter, IRS, Notice 2002-45.

⁷ QSEHRAs were established by Congress in the 21st Century Cures Act (P.L. 114-255), which became law in 2016, and ICHRAs and excepted benefit HRAs were established by the IRS through regulations issued in 2019. IRS, Department of the Treasury, Employee Benefits Security Administration, Department of Labor; Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 84 *Federal Register* 28934, July 20, 2019 (hereinafter, IRS, "Health Reimbursement Arrangements"). See report on H.R. 5447, which included language similar to the 21st Century Cures Act QSEHRA language, U.S. Congress, House Committee on Ways and Means, *Small Business Health Care Relief Act of 2016*, 114th Cong., 2nd sess., June 21, 2016, H.Rept. 114-634 (Washington: GPO, 2016).

and services not covered by insurance. When combined with high-deductible health plans (HDHPs), HSAs are seen as one of the primary types of consumer-driven health care, where more of the initial costs for utilized medical care are placed on the consumer to promote more cost-conscious behaviors.

Notwithstanding these distinct histories, the three accounts often are considered together due to their similar (though not identical) abilities to pay for unreimbursed medical expenses, their tax-advantaged status, and their structures.

Individuals generally are eligible to participate in FSAs or HRAs only through their employers. These accounts typically are part of a range of employee benefits that employers may offer. In general, employers offer FSAs and HRAs in addition to employer-sponsored health insurance coverage or as a method to facilitate the purchase of health insurance coverage.

In contrast, HSAs are not necessarily provided through employers (although employers can include them as part of a benefits package). In other words, eligible individuals may establish and contribute to HSAs outside of the employment setting or irrespective of being employed. HSAs are paired with certain HDHPs.⁸

Although often paired with or offered alongside health insurance coverage, these three categories of tax-advantaged accounts do not function like health insurance coverage, in the traditional sense. Operationally, the accounts are more similar to other tax-advantaged savings accounts (e.g., individual retirement arrangements, 401[k]s) than to traditional health insurance coverage. For example, after an individual (or an individual's employer) establishes the account, contributions are put into the account and withdrawals are taken out of the account (so long as there is a balance). There are rules about who can establish an account, when an individual (or employer) can establish an account, when contributions can be made, how much can be contributed, in what circumstances withdrawals can be made, and what tax advantages exist for an account. Such rules vary by account. As such, the three categories of accounts have different tax implications.

This report provides a brief summary of each tax-advantaged account for health care expenses, highlighting key aspects regarding eligibility, contributions, withdrawals, and the treatment of unused balances for that particular account, as well as data on availability and use. It also provides a side-by-side comparison of these accounts and covers the following topics: setting up an account, contributing to an account, withdrawing funds from an account, and closing an account. The table generally includes the information presented in the body of the report.

Health Flexible Spending Arrangements

Health FSAs are employer-established benefits that reimburse employees for certain medical expenses. FSAs usually are funded by employees through a salary-reduction agreement under a cafeteria plan; a *cafeteria plan* allows employees to choose between cash (typically as part of their paychecks and therefore taxable) or a nontaxable benefit (in this case, contributions to an

⁸ To be paired with a health savings account (HSA), the HDHP must meet certain cost-sharing requirements, including having a high enough deductible. Specifically, the HDHP must (1) have a deductible above a certain threshold (\$1,400 for single coverage and \$2,800 for family coverage in 2021), (2) limit out-of-pocket expenditures for covered benefits to an amount below a certain threshold (\$7,000 for single coverage and \$14,000 for family coverage in 2021), and (3) cover only preventive care services and telehealth services before the deductible is met.

FSA).⁹ FSAs also can be funded by nonelective employer contributions. In this instance, the employee does not have the choice between taxable cash or a nontaxable benefit.

Employee and employer FSA contributions are excluded from an employee's wages and therefore are not subject to federal income or payroll taxes.¹⁰

Eligibility

FSAs generally are available only to current employees of an employer offering this benefit. Self-employed individuals are not eligible to establish and contribute to FSAs.¹¹ In offering this benefit, employers may establish additional eligibility requirements.

Qualifying Insurance

FSAs generally are offered alongside employer-sponsored health insurance, but employees typically are not required by law to enroll in the employer-sponsored group health insurance coverage (or in any specific type of coverage) in order to enroll in the FSA.¹² Employers may choose to limit FSA eligibility to only those employees enrolled in the employer's sponsored plan.¹³

Contributions

FSA contributions can be made by employees (i.e., salary-reduction agreements as part of cafeteria plans), employers (i.e., nonelective employer contributions), or some combination of both.

When FSAs are funded by employees as part of a cafeteria plan, employees elect an annual amount to contribute to their FSAs prior to the start of the year. This amount typically is taken out of the employees' pretax income on a prorated basis throughout the year, such that the sum of these withdrawals equals the total annual elected amount. In general, the contribution amount cannot be changed during the year.¹⁴ The maximum amount an employee can contribute to a health FSA is \$2,750 in 2021, though employers may establish a lower limit.¹⁵

⁹ As an example of a cafeteria plan, instead of receiving a full salary (say, \$40,000), an employee may elect to receive a reduced salary of \$39,100 (subject to federal income and payroll taxes) and to apply \$900 to a benefit (not subject to, or excluded from, federal income and payroll taxes), such as an FSA.

¹⁰ Contributions to FSAs offered through cafeteria plans are tax-exempt under Internal Revenue Code (IRC) §125. Nonelective employer-funded health FSAs are tax-exempt under IRC §§105 and 106.

¹¹ *Self-employed*, as defined in IRC §401(c).

¹² In the event that the FSA is not offered as a *limited excepted benefit*, as often is the case, employees would be required to enroll in an employer-sponsored health insurance plan. An FSA is considered to be a *limited excepted benefit* if the FSA satisfies the following requirements: the FSA (1) must be offered alongside group plan health insurance and (2) must provide a benefit that is at most two times an enrollee's salary-reduction amount. 26 C.F.R. §54.9831-1(c)(3) and Internal Revenue Service (IRS), "Application of Market Reform and Other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain Other Employer Healthcare Arrangements," Notice 2013-54, at <https://www.irs.gov/pub/irs-drop/n-13-54.pdf>.

¹³ Proposed Regulation 26 C.F.R. §1.125-5(g).

¹⁴ As an example, an individual may be allowed to change contribution amounts when there is a change in family status. In light of the Coronavirus Disease 2019 (COVID-19) pandemic and recession, Congress created a temporary rule that may allow employees to make midyear changes in their FSA contribution amounts (for plan years ending in 2021). For more information on this ability, see the "Temporary COVID-19 FSA Rules" text box.

¹⁵ Such amount is indexed for inflation in future years. IRS, "26 CFR 601.602: Tax Forms and Instructions," Revenue Procedure 2020-45, at <https://www.irs.gov/pub/irs-drop/rp-20-45.pdf> (hereinafter, IRS, Revenue Procedure 2020-45).

Employers also may provide additional contributions, subject to certain limitations.¹⁶ In such cases, employers determine the amount of nonelective employer contributions and provide that amount in addition to the employee's contribution (i.e., the employer contribution does not reduce the employee's salary).

The total FSA amount must be made available to employees at the start of the year, regardless of whether the contributions are spread throughout the year. For example, take an employee who elected to contribute \$2,400 to his or her health FSA for a given plan year; if FSA contributions were paid on a monthly basis, the employee would contribute \$200 a month to the FSA. That employee would be able to access all \$2,400 on the first day of the plan year (even though he or she would have contributed only \$200).

Qualifying Medical Expenses

In general, FSA funds can be used only for unreimbursed payments of qualifying medical care expenses incurred by the employee, the employee's spouse, the employee's *dependents*, and the employee's nondependent children younger than 27 years of age at the end of the taxable year.¹⁷ FSA qualified medical expenses include all unreimbursed medical care under Internal Revenue Code (IRC) Section 213(d) (see "Medical Care and Qualified Medical Expenses," below) and menstrual care products. FSA qualified medical expenses do not include amounts for the reimbursement of health insurance premiums, long-term-care coverage or expenses, or anything covered under another health plan.

Employers may restrict certain types of medical care under IRC Section 213(d) from the list of eligible qualified medical expenses.¹⁸ For example, an employer may disallow FSA reimbursements for expenses associated with acupuncture treatments, even though acupuncture is otherwise considered a qualifying medical care expense under IRC Section 213(d).

¹⁶ For the FSA to be considered a limited excepted benefit, employer contributions cannot exceed the amount the employee contributes to the FSA, unless the employee contributes less than \$500 to the FSA, in which case the employer can contribute up to \$500. In addition, FSAs typically are subject to the same contribution nondiscrimination rules applicable to accident or health plans generally. Specifically, FSAs are subject to the nondiscrimination rules under IRC §105(h), which state that if a self-insured plan offers tax-free benefits to employees, the plan cannot discriminate in favor of highly compensated employees. In addition, when offered through a cafeteria plan, FSAs must satisfy cafeteria plan nondiscrimination rules in IRC §125(b), (c), (e), and (g). 26 C.F.R. §54.9831-1(c)(3)(v)(B); Proposed Regulation 26 C.F.R. §1.125-1(j).

¹⁷ In this context, the term *dependent* is as defined for tax purposes. A *dependent* is either (1) a qualifying child or (2) a qualifying relative. There are several tests to determine whether an individual is a taxpayer's qualifying child or relative. For more information, see Appendix A in CRS Report R44993, *Child and Dependent Care Tax Benefits: How They Work and Who Receives Them*. Technically, the individual must be either (1) the taxpayer's dependent or (2) an individual whom the taxpayer could have claimed as a dependent except that (a) the individual has gross income that equals or exceeds the personal exemption amount (\$4,300 in 2021, according to the IRS), (b) the individual files a joint return, or (c) the individual (or his/her spouse, if filing jointly) could be claimed as a dependent on another taxpayer's return. IRS, "Health Savings Accounts and Other Tax-Favored Health Plans," Publication 969, February 11, 2021, p. 17, at <https://www.irs.gov/pub/irs-pdf/p969.pdf> (hereinafter, IRS, Publication 969). Gross income amount for 2021 was published in IRS, Revenue Procedure 2020-45.

¹⁸ Proposed Regulation 26 C.F.R. §1.125-5(k)(2).

Medical Care and Qualified Medical Expenses

All categories of accounts discussed in this report allow tax-advantaged withdrawals for *qualified medical expenses*, and all three refer to the same definition of *medical care* that is used for the medical and dental expenses itemized deduction to determine which withdrawals are considered *qualified medical expenses*. This definition of *medical care* is at Internal Revenue Code (IRC) Section 213(d). Put simply, items that would qualify for the medical and dental expenses itemized deduction generally would be considered *qualifying medical expenses* for the tax-advantaged accounts discussed in this report.

The definition of *medical care* at IRC Section 213(d) does not provide an exhaustive list of all items that are considered medical care; rather, it provides a broad definition of the term *medical care* to include amounts paid for “the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.” It also includes certain transportation and lodging expenditures, amounts paid for health insurance and qualified long-term-care costs, and limited amounts of long-term-care insurance premiums. As this definition is interpreted, costs for ambulances, body scans, and chiropractors would fall within the definition of *medical care*, whereas, in general, personal-use expenses (e.g., toothpaste) and general health expenses (e.g., weight-loss programs) would not. With respect to the Coronavirus Disease 2019 (COVID-19) pandemic, personal protective equipment, such as masks, hand sanitizers, and sanitizing wipes, is considered within the definition of *medical care* if such items are purchased primarily to prevent the spread of COVID-19.

Certain account-specific rules may prevent portions of the IRC Section 213(d) definition from being considered a qualified medical expense for that particular account. For example, for health savings accounts (HSAs), qualified medical expenses include all amounts paid for items under the definition of *medical care* established in IRC Section 213(d) but generally exclude payments for most types of health insurance premiums. Such partial uses of the definition of *medical care* vary between the categories of accounts and are noted throughout the report and in **Table 1**.

The Internal Revenue Service (IRS)-issued Publication 502 provides more detailed information about what generally is and is not considered medical care under the medical and dental expenses itemized deduction. As such, Publication 502 also indicates which items generally are considered a qualifying medical expense for purposes of the tax-advantaged accounts discussed in this report, though it does not incorporate any account-specific rules. Furthermore, even though Publication 502 indicates that over-the-counter medicines are not considered medical care for the medical and dental expenses itemized deduction, such medicines are considered qualifying medical expenses for purposes of the tax-advantaged accounts discussed in this report.

Source: IRC §§213 and 223; IRS, “Amounts Paid for Certain Personal Protective Equipment Treated as Medical Expenses,” Announcement 2021-7, at <https://www.irs.gov/pub/irs-drop/a-21-07.pdf>; and IRS, “Medical and Dental Expenses,” Publication 502, January 8, 2021, at <https://www.irs.gov/pub/irs-pdf/p502.pdf>.

Notes: Although IRS Publication 502 includes a list of items that are considered medical care, the list does not include all possible medical expenses.

Treatment of Unused Balances

Participation in a health FSA is tied to a set period of time (plan year), which generally lasts 12 months and does not need to follow the calendar year. When an employer chooses to offer an FSA as part of a cafeteria plan, the employer generally must select one of three mutually exclusive options for handling any unused balances at the end of the plan year:¹⁹

- Employees forfeit unused balances, which then revert to the employer
- Employees are given a “grace period” of up to 2½ months after the end of the plan year. Employees can be reimbursed for expenses incurred during this additional time. At the end of the grace period, unused amounts are forfeited and revert to the employer. For example, medical expenses incurred by March 15,

¹⁹ Employers are permitted, but not required, to allow military reservists called to active duty to receive some or all of the remaining funds in their accounts.

2021, could be reimbursed from FSA contributions for a January-December 2020 plan year

- Employees may carry over a limited amount of unused health FSA funds into the next FSA plan year (up to \$550 in 2020 contributions)²⁰

In general, employees who leave their jobs forfeit their FSA balances. In some instances, individuals may be able to retain access to their health FSAs through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage.²¹

If an employee leaves his or her job mid-plan year having withdrawn more money than contributed, the employee generally cannot be charged for the negative balance.

Temporary COVID-19 Flexible Spending Arrangement Rules

Congress established temporary rules to address how the COVID-19 pandemic and recession impacted flexible spending arrangements (FSAs). These rules were included in the Consolidated Appropriations Act, 2021 (P.L. 116-260).

Under these rules, employers who offer FSAs to their employees are allowed, but not required, to provide any of the following flexibilities:

- Allow employees to carry over unused FSA balances from FSAs that end in 2020 or 2021
- Extend grace periods from 2½ months to 12 months for FSAs that end in 2020 or 2021
- Allow individuals who stop participating in an FSA (e.g., as a result of termination) in calendar year (CY) 2020 or CY2021 to continue to access unused balances through the end of the applicable FSA plan year
- Allow employees to prospectively modify their contribution amounts in the middle of a plan year that ends in 2021

Source: IRS, “Additional Relief for Coronavirus Disease (COVID-19) Under §125 Cafeteria Plans,” Notice 2021-15, at <https://www.irs.gov/pub/irs-drop/n-21-15.pdf>.

Notes: For an overview of how FSAs could be impacted by the COVID-19 pandemic and recession, see CRS In Focus IF11576, *Potential COVID-19 Impacts on Health Flexible Spending Arrangements (FSAs) and Recent Health FSA Changes*.

Data on Availability and Use

About 16% of nonfederal public and private employers offered FSAs to their employees in 2018.²² Larger employers were more likely to offer FSAs; 12% of firms with 3-24 workers

²⁰ This amount is indexed for inflation. The employer may specify a lower carryover amount. IRS, “Section 125 Cafeteria Plans—Modification of Permissive Carryover Rule for Health Flexible Spending Arrangements and Clarification Regarding Reimbursements of Premiums by Individual Coverage Health Reimbursement Arrangements,” Notice 2020-33, at <https://www.irs.gov/pub/irs-drop/n-20-33.pdf>.

²¹ Generally, a former employee would be able to sign up for Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) FSA coverage if the former employee were eligible for COBRA coverage; the former employer were subject to COBRA coverage requirements; and the following criteria were met: (1) the FSA was offered as a limited excepted benefit; (2) the maximum annual COBRA FSA premium was equal to or exceeded the maximum FSA benefit; and (3) the amount an employee would pay in premiums for the COBRA FSA coverage was less than the balance in the FSA. 26 C.F.R. §54.4980B-2. For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

²² Gary Claxton et al., *Employer Health Benefits*, Kaiser Family Foundation, October 3, 2018, pp. 227-228, at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018> (hereinafter, Claxton et al., *Employer Health Benefits*, 2018).

offered FSAs, whereas about 35% of firms with 25-199 workers and 76% of firms with 200 or more workers offered FSAs.²³

Based on the 2020 Bureau of Labor Statistics National Compensation Survey, approximately 43% of privately employed individuals had access to an FSA in March 2020. Individuals employed at larger firms were more likely than those employed at smaller firms to have access to FSAs, and employees with higher wages were more likely than those with lower wages to have access to FSAs.²⁴

With respect to FSA participation, the 2017 Bureau of Labor Statistics National Compensation Survey found that approximately 53% of privately employed individuals with health insurance had an FSA in 2017.²⁵ Of privately employed individuals enrolled in non-HDHPs, approximately 66% had an FSA. Of privately employed individuals enrolled in HDHPs, approximately 37% had an FSA.

Health Reimbursement Arrangements

HRAs are employer-established accounts that can be used to pay or reimburse employees and/or former employees for qualified medical expenses, including (in some instances) health insurance premiums. HRAs, unlike FSAs and HSAs, are funded solely by employers; employees cannot contribute to HRAs.²⁶

There are five types of HRAs:²⁷

- **Group health plan HRAs**, which are paired with a group health plan (e.g., employer-sponsored insurance)²⁸
- **Individual coverage HRAs (ICHRAs)**, which are paired with individual coverage²⁹
- **Qualified small employer HRAs (QSEHRAs)**, which can be offered by small employers and are paired with minimum essential coverage³⁰

²³ Claxton et al., *Employer Health Benefits*, 2018.

²⁴ Bureau of Labor Statistics (BLS), “Table 40. Financial Benefits: Access, Private Industry Workers, March 2020,” in *National Compensation Survey: Employee Benefits in the United States, March 2020*, Bulletin 2793, September 2020, at <https://www.bls.gov/ncs/ebs/benefits/2020/employee-benefits-in-the-united-states-march-2020.pdf#page=335> (hereinafter, BLS, “Financial Benefits”).

²⁵ 2017 is the most recent year with available data. BLS, *National Compensation Survey-Benefits*, Series IDs NBU215000000000020422, NBU215000000000020423, NBU215000000000020432, NBU215000000000020433, October 4, 2018, at <https://www.bls.gov/ncs/ebs/data.htm>.

²⁶ HRA contributions are tax-exempt under IRC §§105 and 106.

²⁷ These HRA types may be further structured in an HSA-compatible way (e.g., limited-purpose HRA). As such, employers could offer a limited-purpose, individual coverage HRA (ICHRA). For more information on the HSA-compatible variants of HRAs, see the text box titled “HSA Interactions with Other Tax-Advantaged Arrangements” under “Health Savings Accounts.”

²⁸ *Group health plan* refers to plans offered through a plan sponsor, such as an employer or a union.

²⁹ *Individual coverage* refers to plans that individuals and families buy on their own (i.e., not through a plan sponsor). For more information on the plans that can be paired with these types of HRAs, see “Qualifying Insurance.”

³⁰ *Minimum essential coverage*, as the term is defined at 26 U.S.C. §5000A(f); 26 U.S.C. §106(g). Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance and individual insurance).

- **Excepted benefit HRAs**, which are more limited than other HRAs and must be offered alongside employer-sponsored coverage
- **Retiree-only HRAs**, which are available only to retirees.

These different types of HRAs generally share various features. However, some distinctions are associated with each HRA type. These distinctions are described below and further specified in **Table 1**.

Eligibility

Except for QSEHRAs and retiree-only HRAs, HRAs generally are available to current and former employees whose employers offer that benefit. QSEHRAs are available only to current employees of small businesses offering that benefit. Retiree-only HRAs are available only to former employees of employers offering that benefit. Self-employed individuals are not eligible to establish and contribute to HRAs.³¹

Qualifying Insurance

Generally, HRAs must either (1) require that covered individuals be simultaneously enrolled in a certain type of health insurance coverage (group health plan HRAs, QSEHRAs, and ICHRAs) or (2) be provided in a more limited manner and offered alongside employee-sponsored insurance (excepted benefit HRAs). Retiree-only HRAs do not need to satisfy either of these criteria.

For those HRAs in the first category, the health insurance coverage in which covered individuals can be enrolled does not need to satisfy arrangement-specific cost-sharing requirements (e.g., have a high enough deductible); instead, it needs to be a specified type of coverage (e.g., group health plan, individual coverage, Medicare), and the type varies depending on the HRA. Generally, individuals with group health plan HRAs must be enrolled in a group health plan (e.g., employer-sponsored coverage) and individuals with ICHRAs must be enrolled in individual coverage. Individuals with QSEHRAs must be enrolled in *minimum essential coverage*, which generally includes most types of comprehensive coverage (e.g., group coverage, individual coverage, Medicare, Medicaid).³²

Excepted benefit HRAs must be offered alongside employer-sponsored health insurance. Similar to FSAs, employees are not required by law to enroll in the employer-sponsored group health insurance coverage (or in any specific type of coverage) in order to enroll in the excepted benefit HRA.³³

Contributions

Only employers can make HRA contributions. For all HRAs except QSEHRAs and excepted benefit HRAs, there are no statutory contribution limits to the accounts;³⁴ however, employers set

³¹ *Self-employed*, as defined in IRC §401(c).

³² For information on the types of plans in which an individual with a QSEHRA can enroll, see IRS, “Appendix A: Types of Minimum Essential Coverage,” in Notice 2017-67 at <https://www.irs.gov/pub/irs-drop/n-17-67.pdf> (hereinafter, IRS, Notice 2017-67).

³³ IRS, “Health Reimbursement Arrangements”.

³⁴ HRAs generally are subject to the same contribution nondiscrimination rules applicable to accident or health plans more broadly. Specifically, self-funded HRAs are subject to the nondiscrimination rules under IRC §105(h). IRS, Notice 2002-45.

a maximum contribution amount when designing the plan (i.e., the HRA is not an open-ended benefit).³⁵

Contributions to QSEHRAs are capped at \$5,300 for self-only coverage and \$10,700 for family coverage for 2021, though employers may establish lower limits.³⁶ QSEHRA limits must be prorated for part-year-eligible individuals.³⁷ Contributions to excepted benefit HRAs are capped at \$1,800 for 2021, though employers may establish a lower limit.³⁸

Employers have discretion in when HRA contributions are made (e.g., monthly, annually). If contributions are not made annually, reimbursements can be limited to the balance of the account. In other words, and unlike FSAs, the total arrangement contribution amount is not required to be made available on the first day of the arrangement.³⁹ Finally, HRAs generally are notional accounts; employers need not actually fund HRAs until employees draw on them.⁴⁰

Qualifying Medical Expenses

In general, HRA funds can be used only for unreimbursed payments of qualifying medical care incurred by the employee (current and former), the employee's spouse (including spouses of deceased employees), the employee's *dependents* (including dependents of deceased employees), and the employee's nondependent children younger than 27 years of age at the end of the taxable year.⁴¹ HRA-qualified medical expenses include all items within the definition of medical care under IRC Section 213(d) and menstrual care products.⁴² Although health insurance premiums generally are included in the definition of medical care at IRC Section 213(d), some HRA categories are not allowed to reimburse for certain types of premiums (see **Table 1**). As with FSAs, employers may restrict the types of medical and health services that are eligible for reimbursement by HRA funds.

For those HRAs that require covered individuals to be simultaneously enrolled in a certain type of health insurance coverage, individuals must be enrolled in such coverage in order to make withdrawals from their HRAs.

Treatment of Unused Balances

Unused balances from all types of HRAs may be carried forward, though employers may limit the aggregate carryovers.⁴³ Carried-over QSEHRA amounts count toward the subsequent year's

³⁵ IRS, Notice 2002-45.

³⁶ Such amount is indexed to inflation for future years. 26 U.S.C. §9831(d)(2)(B)(iii) and IRS, Revenue Procedure 2020-45.

³⁷ 26 U.S.C. §9831(d)(2)(D)(i).

³⁸ Such amount is indexed to inflation for future years. 26 C.F.R. §54.9831-1(c)(3)(viii)(B) and IRS, "Part III: Administrative, Procedural, and Miscellaneous—26 C.F.R. 54.9831-1, Special Rules Relating to Group Health Plans," Revenue Procedure 2020-43, at <https://www.irs.gov/pub/irs-drop/rp-20-43.pdf>.

³⁹ IRS, Notice 2002-45.

⁴⁰ U.S. Government Accountability Office (GAO), *Consumer Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements*, GAO-10-616, July 2010, p. 7, at <https://www.gao.gov/assets/gao-10-616.pdf>.

⁴¹ In this context, the term *dependent* is as defined for tax purposes. See footnote 17.

⁴² See "Medical Care and Qualified Medical Expenses."

⁴³ IRS, Notice 2002-45, and IRS, "Health Reimbursement Arrangements," p. 28888.

annual contribution limit.⁴⁴ Carried-over excepted benefit HRA amounts do not count toward the subsequent year's annual contribution limit.⁴⁵

Except for QSEHRAs, if an employee leaves his or her job, the employee may forfeit his or her HRA balance, unless the employer has structured the HRAs so that former employees may access such funds. In some instances, individuals may be able to retain access to their HRAs through COBRA continuation coverage.⁴⁶ For QSEHRAs, employees forfeit their QSEHRA balance once they leave their jobs.

Data on Availability and Use

Group health plan HRAs are often, though not exclusively, offered alongside HDHPs.⁴⁷ According to the 2020 Kaiser Family Foundation employer health benefits survey, about 8% of the nonfederal public and private employers that offered health benefits to their employees in 2020 offered an HDHP paired with an HRA.⁴⁸ Larger employers (i.e., firms with 200 or more workers) and small employers (i.e., firms with 3-199 workers) were equally likely to offer HRAs alongside an HDHP.⁴⁹

Based on the 2017 Bureau of Labor Statistics National Compensation Survey, approximately 10% of privately employed individuals participating in medical care plans had an HRA in 2017.⁵⁰ In that year, approximately 6% of privately employed individuals enrolled in non-HDHPs had an HRA and approximately 15% of privately employed individuals enrolled in HDHPs had an HRA.

Data on QSEHRAs, ICHRAs, and excepted benefit HRAs are limited due to the recency of those HRA types.⁵¹

Health Savings Accounts

HSAs, another type of tax-advantaged account, are paired with HDHPs and provide individuals with ways to save and pay for unreimbursed medical expenses.⁵² Unlike for the other accounts discussed in this report, eligibility for HSAs is not contingent on an employer offering health

⁴⁴ IRS, Notice 2017-67.

⁴⁵ 26 C.F.R. §54.9831-1(c)(3)(viii)(B)(2).

⁴⁶ Not all employers are subject to federal COBRA coverage requirements. For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

⁴⁷ Unlike HSA-eligible HDHPs, HRA-paired HDHPs do not have to satisfy any requirements (e.g., have a high enough deductible). In other words, HRAs can be paired with plans that are not HDHPs, as such term is used for HSA purposes.

⁴⁸ The source did not discuss HRAs offered with a non-HDHP plan. Gary Claxton et al., *Employer Health Benefits*, Kaiser Family Foundation, October 8, 2020, p. 133, at <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf> (hereinafter, Claxton et al., *Employer Health Benefits*, 2020).

⁴⁹ Claxton et al., *Employer Health Benefits*, 2020, p. 134.

⁵⁰ 2017 is the most recent year with available data. BLS, *National Compensation Survey-Benefits*, Series IDs NBU215000000000020422, NBU215000000000020424, NBU215000000000020432, NBU215000000000020434, October 4, 2018, at <https://www.bls.gov/ncs/ebs/data.htm>.

⁵¹ QSEHRAs were established by the 21st Century Cures Act (P.L. 114-255), which became law in December 2016. ICHRAs and excepted benefit HRAs were established in a final rule issued on June 20, 2019, by the Departments of Health and Human Services, Labor, and the Treasury. The final rule generally applies to plan years beginning on or after January 1, 2020.

⁵² For more information regarding HSAs, see CRS Report R45277, *Health Savings Accounts (HSAs)*.

insurance or establishing the account as an employee benefit, although employers may choose to provide employer contributions and may allow pretax employee contributions as a benefit to eligible employees. Relatedly, an HSA is owned by an individual and established with an insurer, bank, or other IRS-approved trustee. As such, account holders retain access to their HSAs even if the account holders change jobs or their employers no longer offer HSA benefits to their employees.⁵³

HSAs have two tax advantages that differentiate them from FSAs and HRAs. First, individuals may make contributions to their HSAs outside of the employment setting on a post-tax basis; such contributions are tax-deductible as an above-the-line deduction. Second, unused balances in an HSA may be invested and account earnings are tax exempt. HSAs have additional tax-advantages; if an HSA plan is offered by an employer, employer contributions and employee cafeteria plan contributions are excluded from income and payroll taxes.

Eligibility

Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-eligible HDHP, do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return.⁵⁴

Qualifying Insurance

As implied by the name, HSA-eligible HDHPs must meet certain cost-sharing-related requirements.⁵⁵ For an HDHP to be HSA-qualified, the plan must

- have a deductible above a certain threshold (\$1,400 for single coverage and \$2,800 for family coverage in 2021),⁵⁶
- limit out-of-pocket expenditures for covered benefits to an amount below a certain threshold (\$7,000 for single coverage and \$14,000 for family coverage in 2021),⁵⁷ and
- cover only preventive care and telehealth services before the deductible is met.

Temporary COVID-19 Health Savings Account Rules

Congress established two temporary rules that sought to address how the COVID-19 pandemic and corresponding recession impacted HSAs and the high-deductible health plans (HDHPs) that HSAs are paired with. Both rules were included in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). The first rule specified that HSA-qualified HDHPs that begin on or before December 31, 2021, are allowed to cover telehealth services before the deductible has been met. This requirement applies to telehealth and other

⁵³ An individual's ability to continue contributing to an HSA remains contingent upon the individual maintaining HSA eligibility.

⁵⁴ *Disqualifying coverage* generally is considered any health plan that is not an HDHP and that provides coverage for any benefit covered under the HDHP.

⁵⁵ *Cost sharing* refers to the amounts an insured individual pays for health care services included under his or her health plan. A plan's cost sharing may include deductibles, co-payments, and coinsurance. Cost-sharing requirements include out-of-pocket limits, which cap the total amount an individual would have to pay (through deductibles, co-payments, and coinsurance) for covered services. Cost sharing does not include premiums or amounts paid for services not covered by the plan.

⁵⁶ These amounts are indexed for inflation and adjusted annually. IRS, "26 CFR 601.602: Tax Forms and Instructions," Revenue Procedure 2020-32, at <https://www.irs.gov/pub/irs-drop/rp-20-32.pdf> (hereinafter, IRS, Revenue Procedure 2020-32).

⁵⁷ *Ibid.* These amounts are indexed for inflation and adjusted annually.

remote-care services provided on or after January 1, 2020. This provision was intended to increase health care access for HSA-qualified HDHP enrollees who may have COVID-19 and to protect other patients from potential exposure. As such, if an HSA-qualified HDHP plan administrator initially responded to the COVID-19 pandemic by providing telehealth services without a deductible, enrollees of that plan would not lose their HSA eligibility as a result of that decision.

The second rule specified that for plan years beginning on or before December 31, 2021, telehealth and other remote care would not be considered disqualifying health coverage that would prevent an otherwise eligible individual from being considered HSA-eligible. As such, and under this rule, individuals could be enrolled in an HSA-eligible HDHP and in a separate telehealth policy and still would be eligible to contribute to their HSAs.

Source: IRC §223(c)(2); IRS, “COVID-19 Guidance Under §125 Cafeteria Plans and Related to High-Deductible Health Plans,” Notice 2020-29, at <https://www.irs.gov/pub/irs-drop/n-20-29.pdf>; and U.S. Congress, Senate Committee on Finance, Coronavirus Aid, Relief, and Economic Security Act Subtitle D—Finance Committee Section-by-Section, committee print, 116th Cong., 2nd Sess., at <https://www.finance.senate.gov/imo/media/doc/CARES%20Act%20Section-by-Section%20%28Finance%20Health%29.pdf>.

Not all HDHPs are HSA-qualified HDHPs. For example, a plan may meet the deductible and out-of-pocket limit requirements but may cover more than preventive care services and telehealth services before the deductible is met; this plan would not be considered an HSA-qualified HDHP, even though it is a plan with a high deductible.

An HSA-eligible HDHP may be an employer-sponsored plan or may be purchased directly by the individual (i.e., in the individual market).

HSA Interactions with Other Tax-Advantaged Arrangements

Individuals cannot retain the ability to contribute to an HSA if they are enrolled in both an HSA-eligible HDHP and disqualifying coverage. *Disqualifying coverage* generally is considered any health plan that is not an HDHP and that provides coverage for any benefit covered under the HDHP. Health FSAs and health reimbursement arrangements (HRAs) that reimburse any medical expenses (including cost sharing) generally would fall within the definition of *disqualifying coverage*. As such, an individual would not be considered HSA-eligible if he or she were enrolled in both an HSA-eligible HDHP and a health FSA.

However, FSAs and HRAs can be offered in HSA-compatible ways, which would not preclude HSA eligibility. The following FSAs and HRAs are considered HSA-compatible:

- **Limited-Purpose FSA or HRA.** These arrangements can pay or reimburse only preventive care expenses and benefits for coverage or insurance under which substantially all coverage relates to liabilities incurred under workers’ compensation laws, tort liabilities, or liabilities related to ownership or use of property (such as automobile insurance); coverage or insurance for a specified disease or illness; coverage or insurance that pays a fixed amount per day or other period of hospitalization; and coverage or insurance for accidents, disability, dental care, vision care, and telehealth and other remote care (for plan years beginning before 2022).
- **Suspended HRA.** This arrangement does not pay or reimburse for any medical expenses during a suspension period, except for those services that can be paid or reimbursed by a limited-purpose HRA. An individual may suspend an HRA prior to the start of the HRA coverage period; as a result, the individual would be HSA-eligible during the suspension period.
- **Post-deductible FSA or HRA.** These arrangements reimburse medical expenses only after the annual HDHP deductible has been met.
- **Retirement HRA.** This arrangement pays or reimburses only those medical expenses incurred after retirement. After retirement, an individual would no longer be eligible to contribute to an HSA.
- **Premium-Only HRA.** This arrangement reimburses only premiums for health insurance coverage.
- **Combinations of These HSA-Compatible Arrangements.** For example, a limited-purpose/post-deductible FSA.

HSA-eligible individuals who also enroll in any of these HSA-compatible tax-advantaged arrangements would retain their HSA eligibility.

Source: IRS, “Section 223: Health Savings Accounts—Interaction with Other Health Arrangements,” Revenue Ruling 2004-45, at <https://www.irs.gov/pub/irs-drop/rr-04-45.pdf>; IRS, Part III - Administrative, Procedural and Miscellaneous—Qualified Small Employer Health Reimbursement Arrangements Notice 2017-67 at <https://www.irs.gov/pub/irs-drop/n-17-67.pdf>; and IRS, Department of the Treasury, Employee Benefits Security Administration, Department of Labor; Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), “Health Reimbursement Arrangements and Other Account-Based Group Health Plans,” 84 Federal Register 28934, July 20, 2019.

Contributions

Individuals, employers, or both may contribute to HSAs, but the aggregate amount of contributions is subject to an annual limit.⁵⁸ In 2021, the annual contribution limits are \$3,600 for those enrolled in self-only coverage and \$7,200 for those enrolled in family coverage.⁵⁹ Individuals aged 55 and older who are not eligible for Medicare are allowed to contribute up to \$1,000 over the HSA contribution limit each year. These amounts may be prorated for part-year-eligible individuals.⁶⁰ Whereas the annual contribution limits are indexed to inflation and adjusted annually, the additional contributions for those aged 55 and older are not.

Qualifying Medical Expenses

Withdrawals from HSAs are exempt from federal income taxes if used for unreimbursed qualifying medical care expenses for the account holder, the account holder’s spouse, and the account holder’s *dependents*.⁶¹ For HSA purposes, *qualifying medical care expenses* are defined through reference to the definition of medical care at IRC Section 213(d) and also include menstrual care products.⁶² Of the medical expenses mentioned in IRC Section 213(d), health insurance premiums generally are not considered qualified medical expenses for HSA purposes. Only the following specified insurance premiums are considered to be qualified HSA expenses:

- Long-term-care insurance
- Health insurance premiums during periods of continuation coverage required by federal law (e.g., COBRA)
- Health insurance premiums during periods the individual is receiving unemployment compensation
- For individuals aged 65 and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy⁶³

⁵⁸ Employers contributing to an employee’s HSA are subject to comparability rules, where employers are required to make comparable contributions to the accounts of similar categories of HSA-eligible employees. Failure to do so results in an excise tax on the employer contribution amount. Comparability rules do not apply to contributions made through a cafeteria plan. 26 U.S.C. §4980G and 26 C.F.R. §54.4980G-5.

⁵⁹ IRS, Revenue Procedure 2020-32.

⁶⁰ Individuals who are eligible during the last month of the year are treated as if they had been eligible for that entire year and thus are allowed to contribute up to the annual limit, so long as the contribution is before the tax filing date of the following year and the individual maintains eligibility for the duration of the subsequent tax year. For more information on this exception, see “Contribution Limits” in CRS Report R45277, *Health Savings Accounts (HSAs)*.

⁶¹ In this context, the term *dependent* is as defined for tax purposes. See footnote 17.

⁶² See “Medical Care and Qualified Medical Expenses.” 26 U.S.C. §223(d)(2).

⁶³ As defined in §1882 of the Social Security Act.

Individuals may withdraw HSA funds to use for other purposes (i.e., not for qualifying medical care expenses), but these withdrawals are included in the individuals' gross income and are subject to a 20% penalty. The penalty is waived in cases of disability or death and for individuals aged 65 and older.

Withdrawals from an HSA can be made at any time. Unlike some HRAs, an individual need not be covered by qualifying health insurance in order to withdraw money from an HSA.⁶⁴

Treatment of Unused Balances

Unused balances in an HSA may be invested and may accumulate without limit. Account earnings are tax-exempt.

As mentioned above, HSAs are established and owned by the individual. Unlike FSAs and HRAs, account holders retain access to their HSA even if the account holders change jobs or their employers no longer offer employee HSA benefits.⁶⁵

Data on Availability and Use

Data on the total number of HSAs and the number of individuals who have an HSA are not readily available. However, Devenir Research estimated there were more than 30 million HSA accounts in December 2019.⁶⁶

Data on the number of HSAs that receive contributions from employers and employees provide another measure of the accounts' use. For 2018, the IRS estimated that 10.2 million tax forms reported an HSA that received employer contributions and 2.0 million tax forms reported an HSA that received contributions from individuals.⁶⁷ According to IRS data, higher-income earners are more likely than lower-income earners to indicate individual and employer contributions on their tax returns.⁶⁸

With respect to employee access to HSAs and based on the 2020 Bureau of Labor Statistics National Compensation Survey, approximately 32% of privately employed individuals had access to an HSA in March 2020, which is less than the percentage of employees who had access to FSAs in the same year. According to the survey, employees at larger firms were more likely than those at smaller firms to have access to HSAs and employees with higher wages were more likely than those with lower wages to have access to HSAs.⁶⁹

⁶⁴ IRS, "Part III: Administrative, Procedural, and Miscellaneous," Notice 2004-2, at <https://www.irs.gov/pub/irs-drop/n-04-2.pdf>.

⁶⁵ An individual's ability to continue contributing to an HSA remains contingent on the individual maintaining HSA eligibility.

⁶⁶ Individuals may have more than one account, and account holders may not have been eligible to contribute to the HSA at the time of the survey. Devenir Research, *2020 Year-End HSA Market Statistics & Trends Executive Summary*, March 3, 2021, at <https://www.devenir.com/wp-content/uploads/2020-Year-End-Devenir-HSA-Research-Report-Executive-Summary.pdf>. Devenir conducts HSA research and provides investment advisory services to the HSA industry.

⁶⁷ These numbers are not mutually exclusive, nor do they represent the total number of HSAs. For more HSA data information, see "HDHP Enrollment and HSA Utilization" in CRS Report R45277, *Health Savings Accounts (HSAs)*; and IRS, *Statistics of Income—2018 Individual Income Tax Returns Line Item Estimates*, Publication 4801 (Rev. 09-2020), p. 202, at <https://www.irs.gov/pub/irs-pdf/p4801.pdf>.

⁶⁸ CRS Report R45277, *Health Savings Accounts (HSAs)*.

⁶⁹ BLS, "Financial Benefits."

Based on the 2017 Bureau of Labor Statistics National Compensation Survey, approximately 21% of privately employed individuals with health insurance had a plan with an HSA in 2017.⁷⁰ Of those enrolled in HDHPs, approximately 50% of privately employed individuals had an HSA.

Data from the Joint Committee on Taxation estimate that HSAs will reduce federal revenues by \$66.1 billion between FY2020 and FY2024.⁷¹

⁷⁰ 2017 is the most recent year with available data. BLS, *National Compensation Survey-Benefits*, Series IDs NBU2150000000000020422, NBU2150000000000020432, NBU2150000000000020435, October 4, 2018, at <https://www.bls.gov/ncs/ebs/data.htm>.

⁷¹ U.S. Congress, Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2020-2024*, committee print, prepared by Joint Committee on Taxation, 116th Cong., 2nd sess., November 5, 2020, JCX-23-20, p. 33.

Table I. Summary of General Rules for Health Care-Related Tax-Advantaged Accounts
(as applicable for tax year 2021)

	Health Flexible Spending Arrangements (FSAs)	Health Reimbursement Arrangements (HRAs)	Health Savings Accounts (HSAs)
Setting Up an Account			
Eligibility	Employees of an employer that offers this benefit. Self-employed individuals are not eligible.	<p>Group Health Plan HRAs, ICHRAs, and Excepted Benefit HRAs: Employees of an employer that offers this benefit. Former employees of an employer that offers this benefit to former employees. Self-employed individuals are not eligible.</p> <p>QSEHRAs: Generally, employees of a small employer (typically fewer than 50 full-time or full-time-equivalent workers in the prior year) that offers this benefit.^a Self-employed individuals are not eligible.</p> <p>Retiree-Only HRAs: Former employees of an employer that offers this benefit to former employees. Self-employed individuals are not eligible.</p>	Individuals must have an HSA-eligible HDHP, must not have disqualifying health coverage, ^b and cannot be claimed as a dependent on someone else's tax return.
Qualifying Health Insurance	None.	<p>Group Health Plan HRAs: Any non-HRA group health insurance plan that satisfies annual limit and preventive service requirements.^c</p> <p>ICHRAs: Any individual market coverage that satisfies annual limit and preventive service requirements.^d</p> <p>QSEHRAs: Any health insurance plan that is considered minimum essential coverage.^e</p> <p>Excepted Benefit HRAs and Retiree-Only HRAs: None.</p>	An HSA-eligible HDHP. Specifically, any HDHP that (1) has a deductible of at least \$1,400 for self-only coverage and \$2,800 for family coverage, (2) has an annual out-of-pocket maximum of \$7,000 for self-only coverage and \$14,000 for family coverage, and (3) provides only preventative care and telehealth services without a deductible or with a reduced deductible. ^f Out-of-pocket limits do not include premiums.
Annual Cost-of-Living Adjustments for Qualifying Health Insurance Deductibles,	Not applicable.	Group Health Plan HRAs, ICHRAs, and QSEHRAs: Not applicable (not	Yes; adjustments based on the C-CPI-U.

	Health Flexible Spending Arrangements (FSAs)	Health Reimbursement Arrangements (HRAs)	Health Savings Accounts (HSAs)
Co-payments, and Other Monetary Provisions		associated with an insurance policy with particular cost-sharing requirements). Excepted Benefit HRAs and Retiree-Only HRAs: Not applicable.	
Individual Choice of Financial Institution or Trustee Administering Accounts	None.	All HRAs: None.	Individuals can establish an account with a qualified trustee (bank, insurance company, or IRS-approved IRA or Archer MSA trustee). ^g
Contributing to an Account			
Source of Contributions	Generally, by employee (through a salary-reduction agreement). Employers also may contribute.	All HRAs: Only by employer.	Eligible individuals, and employers, family members, and other individuals may make contributions to an individual's HSA on his or her behalf. If offered, eligible employees may make contributions through their employer via a salary-reduction agreement.
Tax Status of Contributions	Employee contributions are made on a pretax basis through an employer; contributions are not included as income and do not have employment or federal income taxes withheld. Employer contributions are not included as income.	All HRAs: Employer contributions are not included as income.	Individual contributions made outside of an employment setting are deductible on account holder's tax returns, even if account holder does not itemize deductions. Employee contributions made on a pretax basis through an employer are not included as income and do not have employment or federal income taxes withheld. Pretax employee contributions are not deductible on account holder's tax return. Employer contributions are not counted as income and are not deductible on account holder's tax return.
Annual Contribution Limits	As typically offered as a limited excepted benefit, individual limit of \$2,750 a year per employer. Employers may set lower limits.	Group Health Plan HRAs, ICHRAs, and Retiree-Only HRAs: No statutory limit for employer contributions.	\$3,600 for self-only coverage and \$7,200 for family coverage. ⁱ

	Health Flexible Spending Arrangements (FSAs)	Health Reimbursement Arrangements (HRAs)	Health Savings Accounts (HSAs)
	Employer contributions cannot exceed the amount of the employee contribution to the FSA, unless the employee contributes less than \$500 to the FSA, in which case the employer can contribute up to \$500.	QSEHRAs: \$5,300 for self-only coverage and \$10,700 for family coverage. ^h Employers may set lower limits. Excepted Benefit HRAs: Individual limit of \$1,800 a year per employer. Employers may set lower limits.	Account holders who are at least 55 years of age and are not enrolled in Medicare may contribute an additional “catch-up” contribution of \$1,000. ^j
Annual Cost-of-Living Adjustments for Contribution Limits	Yes; adjustments based on the C-CPI-U.	Group Health Plan HRAs, ICHRAs, and Retiree-Only HRAs: Not applicable. QSEHRAs and Excepted Benefit HRAs: Yes; adjustments based on the C-CPI-U.	Generally, yes; adjustments based on the C-CPI-U. The “catch-up” contribution is not annually adjusted.
Tax Status of Interest Earned on Account Assets	Not applicable (account balances may not be invested).	All HRAs: Not applicable (account balances may not be invested).	Not taxed.
Allowable Rollovers from Other Tax-Advantaged Accounts	None.	All HRAs: None.	One rollover from an Archer MSA or another HSA in a one-year period, which does not count toward contribution limit. One rollover from a traditional or Roth IRA in a lifetime, which counts toward contribution limit. ^g
Withdrawing Funds from an Account			
When Funds Are Available	All funds are available on the first day of the plan year.	All HRAs: Funds are available as they are deposited.	Funds are available as they are deposited.
Qualifying Health Insurance Enrollment Necessary for Withdrawal	Not applicable.	Group Health Plan HRAs, ICHRAs, and QSEHRAs: Employee and others covered by the HRA must be enrolled in qualifying health insurance. <i>Excepted benefit HRAs and retiree-only HRAs:</i> Not applicable.	No.
Qualifying Medical Expenses	Most unreimbursed medical expenses included in IRC §213(d) and menstrual care products.	Group Health Plan HRAs: Most unreimbursed medical expenses included in IRC §213(d), including health insurance premiums, and amounts paid for long-term-care coverage. ^k Menstrual care products	Most unreimbursed medical expenses included in IRC §213(d), including amounts paid for long-term-care coverage, ^k health care continuation coverage required under federal law (e.g., COBRA), ^m health

	Health Flexible Spending Arrangements (FSAs)	Health Reimbursement Arrangements (HRAs)	Health Savings Accounts (HSAs)
	May not be used for health insurance premiums, long-term-care coverage or expenses, ^k or amounts covered under another health plan.	also are considered a qualifying medical expense. May not be used to purchase individual market coverage. ICHRAs, QSEHRAs, and Retiree-Only HRAs: Most unreimbursed medical expenses listed in IRC §213(d), including health insurance premiums, ^l and amounts paid for long-term-care coverage. ^k Menstrual care products also are considered a qualifying medical expense. Excepted Benefit HRAs: Most unreimbursed medical expenses qualified by IRC §213(d), including amounts paid for health care continuation coverage (e.g., COBRA), ^m and, generally, short-term, limited-duration insurance. ⁿ Menstrual care products also are considered a qualifying medical expense. May not be used for Medicare premiums or, generally, individual health insurance coverage premiums or group health plan premiums.	insurance for those receiving unemployment compensation under federal or state law, and if the account holder is 65 years of age or older, Medicare and other health care coverage (excluding Medigap and other private Medicare supplemental insurance). Menstrual care products also are considered a qualifying medical expense. May not be used for health insurance premiums not mentioned above.
Ability of Employer to Further Restrict Qualifying Medical Expenses	Employers may impose additional limitations on what is considered a qualifying medical expense.	All HRAs: Employers may impose additional limitations on what is considered a qualifying medical expense.	Not possible.
Qualifying Medical Expenses Incurred by Which Individuals	Employee, employee's spouse and dependents, and employee's children under the age of 27. ^o	Group Health Plan HRAs, IRCHRAs, and Excepted Benefit HRAs: Employee (current and former), employee's spouse and dependents (including those of deceased employees), and employee's children under the age of 27. ^o QSEHRAs: Current employee, spouse and dependents of the employee (including	Account holder and account holder's spouse and dependents. ^o

	Health Flexible Spending Arrangements (FSAs)	Health Reimbursement Arrangements (HRAs)	Health Savings Accounts (HSAs)
		those of deceased employees), and the employee's children under the age of 27. ^o Retiree-Only HRAs: Former employee, former employee's spouse and dependents (including those of deceased employees), and former employee's children under the age of 27. ^o	
Tax Status of Nonmedical Withdrawals	Nonmedical withdrawals generally are not permitted.	All HRAs: Nonmedical withdrawals generally are not permitted.	Nonmedical withdrawals are permitted but must be counted as income and generally are subject to a 20% penalty tax. ^p
Closing an Account			
Length of Time Funds Are Available	Generally, one year.	All HRAs: Employers have discretion and may specify a period of less than one year.	Indefinitely.
Carryover of Unused Funds	In general, limited amounts may be carried over, at employer's discretion. ^q In light of the COVID-19 pandemic and recession, all unused balances may be carried over, at employer's discretion, from FSAs that end in 2020 and 2021. ^r	All HRAs: Unused amounts generally may be carried over indefinitely, although employers may limit the amount that can be carried over. QSEHRAs: Carried-over amounts count toward the annual contribution limit. Excepted Benefit HRAs: Carried-over amounts do not count toward the annual contribution limit.	Full amount may be carried over indefinitely.
Portability of Account	In general, any amounts in the account are forfeited when an employee separates from the employer, although extensions for those covered by COBRA sometimes apply. ^m In light of the COVID-19 pandemic and recession, individuals who stop participating in an FSA (e.g., as a result of termination) in 2020 and 2021 may continue to access unused balances through the FSA plan year, at employer's discretion. ^r	Group Health Plan HRAs, ICHRAs, Excepted Benefit HRAs, and Retiree-Only HRAs: Unless the employer has determined otherwise, amounts in the account are forfeited when an employee separates from the employer, although extensions for those covered by COBRA sometimes apply. ^m QSEHRAs: Any amounts in the account are forfeited when an employee separates from the employer.	The account and account funds remain with the individual if the individual changes employers or leaves the workforce.

Source: Congressional Research Service (CRS) analysis of IRC §§105, 106, 125, 223, and 9831(d) and other IRS sources (available upon request to congressional clients).

Notes: To facilitate easy reading, the term *account* is often used in this table to refer collectively to both certain tax-advantaged *accounts* and certain tax-advantaged *accounts arrangements*. COVID-19 = Coronavirus Disease 2019; C-CPI-U = Chained Consumer Price Index for All Urban Consumers; COBRA = Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) continuation coverage; HDHP = high-deductible health plan; ICHRA = individual coverage health reimbursement arrangement; IRA = individual retirement arrangement; IRC = Internal Revenue Code; IRS = Internal Revenue Service; MSA = medical savings account; and QSEHRA = qualified small employer health reimbursement arrangement.

- a. Employers may exclude employees who have not completed 90 days of service with the employer; are younger than 25 years of age prior to the plan year; are part-time or seasonal employees; are covered by a collective bargaining agreement, if health benefits were the subject of good-faith bargaining; and are nonresident aliens with no earned income from sources within the United States.
- b. *Disqualifying coverage* generally is considered any health plan that is not an HDHP and that provides coverage for any benefit that is covered under the HDHP.
- c. Group health plan HRAs also can be integrated with Medicare and TRICARE plans, if certain conditions are met.
- d. ICHRAs also can be integrated with Medicare, if certain conditions are met.
- e. *Minimum essential coverage*, as the term is defined at 26 U.S.C. §5000A(f). 26 U.S.C. §106(g). Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance, individual insurance).
- f. The ability to cover telehealth services before the deductible is a temporary flexibility that was incorporated in response to the COVID-19 pandemic and corresponding recession. It applies to HDHPs with plan years that begin on or before December 31, 2021.
- g. In general, Archer MSAs can be thought of as an older, more-restrictive version of HSAs that are similarly paired with certain HDHPs. Since December 31, 2007, individuals generally have not been able to open new Archer MSAs, except for limited instances. As a result, few Americans currently and actively contribute to these types of accounts.
- h. These amounts are prorated for part-year-eligible individuals.
- i. These amounts may be prorated for part-year-eligible individuals. Where applicable, these annual limits must be reduced by the amount of any contributions individuals make to their Archer MSAs during the same year or by the amount of any direct contributions to an individual's HSA from a traditional or Roth IRA.
- j. The contribution is zero for individuals entitled to Medicare benefits.
- k. 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.
- l. For QSEHRAs, reimbursements for pretax premiums for group health plan coverage sponsored by an eligible employee's spouse's employer must be counted as income.
- m. 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 the employee's 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. For more information on COBRA continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

- n. Short-term, limited-duration insurance (STLDI) is coverage generally sold in the individual market that must have a specified expiration date that is less than 12 months after the original effective date of the contract and that cannot last longer than 36 months, taking into account renewals or extensions. For more information on STLDI, see STLDI section in CRS In Focus IFI 1359, *Applicability of Federal Requirements to Selected Health Coverage Arrangements: An Overview*.
- o. In this context, the term *dependent* is as defined for tax purposes. A *dependent* is either (1) a qualifying child or (2) a qualifying relative. There are several tests to determine whether an individual is a taxpayer's qualifying child or relative. For more information, see Appendix A in CRS Report R44993, *Child and Dependent Care Tax Benefits: How They Work and Who Receives Them*. Technically, the individual must either be (1) the taxpayer's dependent or (2) an individual whom the taxpayer could have claimed as a dependent, except that (a) the individual has gross income that equals or exceeds the personal exemption amount (\$4,300 in 2021, according to the IRS); (b) the individual files a joint return; or (c) the individual (or his or her spouse, if filing jointly) could be claimed as a dependent on another taxpayer's return.
- p. The penalty tax does not apply in cases of disability, death, or after an account holder attains the age of 65.
- q. Balances remaining at current year's end may be (1) forfeited to the employer; (2) carried over for 2½ months after current year's end to reimburse qualifying expenses for the current year; or (3) carried over to reimburse qualifying medical expenses for the following year, subject to a \$550 limit in 2020 plan year funds. The employer must choose one option that will apply to all employees.
- r. This temporary flexibility was provided in the Consolidated Appropriations Act, 2021 (P.L. 116-260). For more information on all flexibilities provided by this act, see IRS, "Additional Relief for Coronavirus Disease (COVID-19) Under §125 Cafeteria Plans," Notice 2021-15, at <https://www.irs.gov/pub/irs-drop/n-21-15.pdf>.

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