

**PRESENT LAW AND BACKGROUND RELATING TO THE
TAX TREATMENT OF THE COST OF OVER-THE-COUNTER
MEDICINE AS A MEDICAL CARE EXPENSE**

Scheduled for a Public Hearing
Before the
SUBCOMMITTEE ON OVERSIGHT
of the
HOUSE COMMITTEE ON WAYS AND MEANS
on April 25, 2012

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION



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INTRODUCTION AND SUMMARY

The Subcommittee on Oversight of the Committee on Ways and Means has scheduled a public hearing on April 25, 2012, on the impact of limitations on the use of tax-advantaged accounts for the purchase of over-the-counter medicine. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a summary of historical and present law rules applicable to the tax treatment of reimbursements for costs of over-the-counter medicine by an employer under an accident or health plan and use of funds from a health savings account for the purchase of over-the-counter medicine. Specifically the summary discusses the law before and after the enactment of section 9003 of the Patient Protection and Affordable Care Act (referred to as the “Affordable Care Act”)² which provides that any exclusion from income for such reimbursement or use of HSA funds only applies to the cost of over-the-counter medicine if the medicine is prescribed by a physician. This document also discusses issues related to the tax treatment of the cost of over-the-counter medicine as a cost of medical care and provides selected data on over-the-counter medicine.

¹ This document may be cited as follows: Joint Committee on Taxation, *Present Law and Background Relating to the Tax Treatment of the Cost of Over-the-Counter Medicine as a Medical Care Expense* (JCX-37-12), April 23, 2012. This document can be found on our website at www.jct.gov.

² Pub. L. No 111-148. Various provisions of the Affordable Care Act are amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

I. PRESENT LAW

A. Tax Treatment of Employer-Provided Medical Care

Exclusion from income for employer-provided health coverage

The Code³ generally provides that the value of employer-provided health coverage under an accident or health plan is excludible from gross income.⁴ In addition, any reimbursements under an employer-provided accident or health plan for medical care expenses for employees, their spouses, their dependents, and adult children under age 27 generally are excluded from gross income.⁵ The exclusion applies both to health coverage in the case in which an employer directly pays the cost of employees' medical expenses not covered by insurance (*i.e.*, a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There generally is no limit on the amount of employer-provided health coverage that is excludible. A similar rule excludes employer-provided health insurance coverage from the employees' wages for payroll tax purposes.⁶

Employers may also provide health coverage in the form of an agreement to reimburse medical expenses of their employees (and their spouses and dependents), not reimbursed by a health insurance plan, through arrangements which allow reimbursement for medical care not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Health coverage provided in the form of one of these arrangements is also excludible from gross income as employer-provided health coverage under an accident or health plan.⁷ However, the amounts available for reimbursement must be exclusively for reimbursement for medical care because the exclusion does not apply to amounts which the employee would be entitled to irrespective of whether he or she incurs expenses for medical care.⁸ Further, the expense must be substantiated before reimbursement in order for the reimbursement to be excludible.

³ All references to the Code and all section references in this document are to the Internal Revenue Code of 1986 unless otherwise specified.

⁴ Sec. 106. Health coverage provided to active members of the uniformed services, military retirees, and their dependents is excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

⁵ Sec. 105(b).

⁶ Secs. 3121(a)(2) and 3306(a)(2). See also section 3231(e)(1) for a similar rule with respect to compensation for purposes of Railroad Retirement Tax.

⁷ Sec. 106.

⁸ Treas. Reg. sec. 1.105-2.

Cafeteria plan

Definition of a cafeteria plan

A cafeteria plan is a separate written plan of an employer under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit (as defined below). If an employee receives a qualified benefit based on his or her election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.⁹ However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits generally results in gross income to the employee, regardless of what benefit is elected and when the election is made.¹⁰ A cafeteria plan generally may not provide for deferral of compensation.

Qualified benefits

Qualified benefits under a cafeteria plan are generally employer-provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer-provided health coverage, group-term life insurance coverage, and benefits under a dependent care assistance program. In order to be excludable, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusion. However, some employer-provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits.¹¹ A plan offering any nonqualified benefit is not a cafeteria plan.¹²

Health flexible spending arrangement under a cafeteria plan

A flexible spending arrangement for medical expenses under a cafeteria plan (commonly called a “Health FSA”) is health coverage in the form of an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount of the salary reduction contributions made available for use in reimbursing the employee for his or her medical expenses.¹³ For years before 2013, there is no statutory limit on the dollar amount of salary reduction that an employer may permit to be contributed to a Health FSA under

⁹ Sec. 125(a).

¹⁰ Prop. Treas. Reg. sec. 1.125-1(b).

¹¹ Examples of nonqualified benefits include scholarships (sec. 117), employer-provided meals and lodging (sec. 119), educational assistance (sec. 127), and fringe benefits (sec. 132).

¹² Prop. Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer Medical Savings Accounts, group-term life insurance for an employee’s spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

¹³ Sec. 125 and Prop. Treas. Reg. sec. 1.125-5.

its cafeteria plan. Beginning with 2013, the maximum amount of salary reduction for a year is limited to \$2,500.¹⁴ Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the “use-it-or-lose-it rule”).¹⁵ A Health FSA is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.¹⁶ A Health FSA can also include employer flex-credits which are nonelective employer contributions that the employer makes for every employee eligible to participate in the employer’s cafeteria plan, to be used only for one or more excludible qualified benefits (but not as cash or a taxable benefit).¹⁷

A flexible spending arrangement including a Health FSA (under a cafeteria plan) is generally distinguishable from other employer-provided health coverage by the relationship between the value of the coverage for a year and the maximum amount of reimbursement reasonably available during the same period. A flexible spending arrangement for health coverage generally is defined as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.¹⁸

Health reimbursement arrangement

Rather than offering a Health FSA through a cafeteria plan, an employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called health reimbursement arrangements (“HRAs”). Some of the rules applicable to HRAs and Health FSAs are similar (*e.g.*, the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot include salary reduction contributions and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.¹⁹

¹⁴ Sec. 125(i), added by sec. 9005 of the Affordable Care Act.

¹⁵ Sec. 125(d)(2) and Prop. Treas. Reg. sec. 1.125-5(c).

¹⁶ Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. sec. 1.125-1(e).

¹⁷ Prop. Treas. Reg. sec. 1-125-5(b).

¹⁸ Sec. 106(c)(2) and Prop. Treas. Reg. sec. 1.125-5(a).

¹⁹ Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

B. Health Savings Accounts

Present law provides that individuals with a high deductible health plan (and generally no other health plan)²⁰ may establish and make tax-deductible contributions to a health savings account (“HSA”).²¹ An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Subject to certain limitations, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize their deductions on their tax return (rather than claiming the standard deduction). Income from investments made in HSAs is not taxable and the overall income is not taxable upon disbursement for medical expenses.

For 2012, the maximum aggregate annual contribution that can be made to an HSA is \$3,100 in the case of self-only coverage and \$6,250 in the case of family coverage. The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2012 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,200 for self-only coverage or \$2,400 for family coverage for 2012 and that limits the sum of the annual deductible and other payments that the individual must make with respect to covered

²⁰ An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is “permitted insurance” or “permitted coverage.” Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker’s compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (*e.g.*, auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

²¹ An Archer medical savings account (“Archer MSA”), similar to an HSA, is also a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan. Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for certain individuals covered by high deductible health plans. For example, only self-employed individuals and employees of small employers are eligible to have an Archer MSA. After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer. The same definition of qualified medical expense, and thus the same definition of medical care, applies to Archer MSAs as applies to HSAs.

benefits to no more than \$6,050 in the case of self-only coverage and \$12,100 in the case of family coverage for 2012.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income. Generally, qualified medical expenses are amounts paid by the HSA account holder for medical care of the account holder or for his or her spouse or dependents. An additional 20-percent tax is added for all HSA disbursements not made for qualified medical expenses. The additional 20-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65).

Unlike reimbursements from a Health FSA or HRA, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income. Instead, the individual is the beneficial owner of his or her HSA, and thus the individual is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and Internal Revenue Service enforcement.²²

²² This is similar to the treatment of other individual tax-favored accounts, for example, whether an exception to the 10-percent early withdrawal tax applies to a distribution from an individual retirement arrangement.

C. Definition of Medical Care

Individual deduction for medical expenses

Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 percent (generally 10 percent for years after 2012) of adjusted gross income (“AGI”).²³ Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.²⁴ Medical care does not include toiletries or similar preparations (such as toothpaste, shaving lotion, shaving cream, etc.) nor does it include cosmetics (such as face creams, deodorants, hand lotions, etc., or any similar preparations used for ordinary cosmetic purposes).²⁵

Under an explicit limitation in the Code, any amount paid during a taxable year for medicine or drugs is deductible as a medical expense only if the medicine or drug is a prescribed drug or insulin.²⁶ The term prescribed drug means a drug or biological which requires a prescription of a physician for its use by an individual.²⁷ Thus, any amount paid for medicine available without a prescription (“over-the-counter medicine”) is not deductible as a medical expense, including any medicine prescribed or recommended by a physician.²⁸

Medical care for excludible reimbursements

For purposes of the exclusion for reimbursements under employer accident and health plans and for distributions from HSAs used for qualified medical expenses, the definition of medical care is generally the same as the definition that applies for the itemized deduction for the cost of medical care. However, prior to the enactment of the Affordable Care Act, the limitation (applicable to the itemized deduction) that only prescription medicines or drugs and insulin are taken into account did not apply. Thus, for example, amounts paid from a Health FSA or HRA, or funds distributed from an HSA to reimburse a taxpayer for nonprescription drugs, such as nonprescription aspirin, allergy medicine, antacids, or pain relievers, were excludable from income even though, if the taxpayer paid for such amounts directly (without such

²³ Sec. 213(a). The 7.5 percent of AGI threshold increases to 10 percent for taxable years beginning after December 31, 2012 under section 9013 of the Affordable Care Act. However, this increase in the percentage does not apply until taxable years beginning after December 31, 2016 with respect to any taxpayer if the taxpayer or the taxpayer’s spouse has attained age 65 before the close of the taxable year.

²⁴ Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

²⁵ Treas. Reg. sec. 1.213-1(g)(2) provides that medicine and drugs do not include these items and that amounts expended for these items are not amounts expended for medical care.

²⁶ Sec. 213(b).

²⁷ Sec. 213(d)(3).

²⁸ Rev. Rul. 2003-58, 2003-1 CB 959.

reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.²⁹ For years beginning after December 31, 2010, the Affordable Care Act changed the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans and for distributions from HSAs used for qualified medical expenses to require that over-the-counter medicine (other than insulin) be prescribed by a physician in order for the medicine to be medical care for these purposes.³⁰ Thus, under present law, a Health FSA or an HRA is only permitted to reimburse an employee for the cost of over-the-counter medicine if the medicine is prescribed by a physician and distributions from an HSA used to purchase over-the-counter medicine is not a qualified medical expense unless the medicine is prescribed by a physician.

²⁹ Rev. Rul. 2003-102, 2993-2 C.B. 559, now obsoleted by Rev. Rul. 2010-23, 2010-39 I.R.B. 388, September 3, 2010.

³⁰ Sec. 9003 of the Affordable Care Act. Notice 2010-59, 2010-39 I.R.B. 388, provides guidance on this change to the definition of medical care for these purposes.

II. ISSUES RELATED TO TAX TREATMENT OF THE COST OF OVER-THE-COUNTER MEDICINE AS MEDICAL CARE EXPENSES

The exclusion for employer-provided health benefits is generally justified on the ground that it encourages employees to prefer health benefits over taxable wages, thereby increasing the number of individuals with health insurance coverage. A generally stated purpose for HSAs combined with high deductible plans is to provide an incentive for individuals to be more cognizant of health care expenses. The policy rationale behind the itemized deduction for medical expenses is that such expenses generally are not discretionary and that high levels of such expenses adversely impact the individual's ability to pay taxes.

Personal expenses are generally not deductible for Federal income tax purposes and employer reimbursement for personal expenses is not generally excludible from gross income. The special tax treatment for the cost of medical care (*e.g.*, the itemized deduction and the exclusion for employer provided reimbursements) is an exception to these general rules. A tax subsidy for over-the-counter medicines not prescribed by a physician may be likened to providing a deduction for personal expenses.³¹ Such medicines (*e.g.*, aspirin and cough syrup) are often routine purchases made by many taxpayers. Further, a subsidy for nonprescription over-the-counter medicines may complicate taxpayers' effort to comply with the law. The task of distinguishing products that are medical from those that are not may prove difficult for many over-the-counter products, such as toiletries and products that promote general health. Thus, continuing to subsidize such expenses may lead more taxpayers to claim tax benefits for such general health products.³² Consequently, some argue that providing a tax subsidy for the purchase of nonprescription over-the-counter medicine is not integral to the policy objectives of the present-law provisions for health expenses, and may be counter to such policies.³³

Others respond that certain over-the-counter medicines are, like prescription drugs, expensive and not routine for most taxpayers. Also, some over-the-counter medicine, such as certain allergy medicines and smoking cessation products, were until recently available by prescription only. Present law addresses this concern by including over-the-counter medicine

³¹ Joint Committee on Taxation, *Options to Improve Tax Compliance and Reform Tax Expenditures* (JCS-02-05), January 2005, Part IV.A, pp. 105-108, includes a description and discussion of a proposal to conform the definition of medical expenses for purposes of the tax treatment of reimbursements from employer-sponsored accident and health plans and HSAs to the definition of medical expenses that may be taken into account for purposes of the itemized deduction for medical expenses. Thus, for example, under that proposal, in contrast to present law, over-the-counter medicine could not be reimbursed through a Health FSA even if the medicine was prescribed by a physician.

³² In response to compliance concerns relating to distinguishing over-the counter drugs from toiletries and products that promote general health, some point out that systems have been developed to distinguish these products from over-the-counter medicine.

³³ The requirement for a prescription for over-the-counter items for medical care only applies to medicines or drugs. Thus, supplies, such as bandages and contact lens solution, continue to be medical care for purposes of the exclusion for employer provided reimbursement from an employer-provided health plan and a distribution from an HSA for qualified medical expenses. These expenses could also be characterized as personal rather than medical expenses for the same reasons as such characterization of over-the counter medicine not prescribed by a physician.

prescribed by a physician in the definition of medical care for employer-provided medical care and health savings arrangements. Thus, these rules include over-the-counter medicine in the definition of medical care for medicine that is part of a medical treatment specifically prescribed by a physician.

Critics of the present law treatment of prescribed over-the-counter medicine as a medical expense argue that the requirement for a prescription from a physician may deter taxpayers from taking advantage of the cost savings made possible by the use of over-the-counter medicine. Alternatively, an individual may be encouraged to visit a doctor in order to obtain a prescription for a medical condition that the individual is able to self-identify and treat after consulting with a pharmacist or other source of medical information. Critics argue that the societal costs of requiring individuals to obtain a prescription from a physician may result in unnecessary visits to a physician and thereby increase national health care costs. They posit that this may offset any increase in revenue caused by disallowing a tax subsidy for the cost of over-the counter medicine without a prescription.³⁴

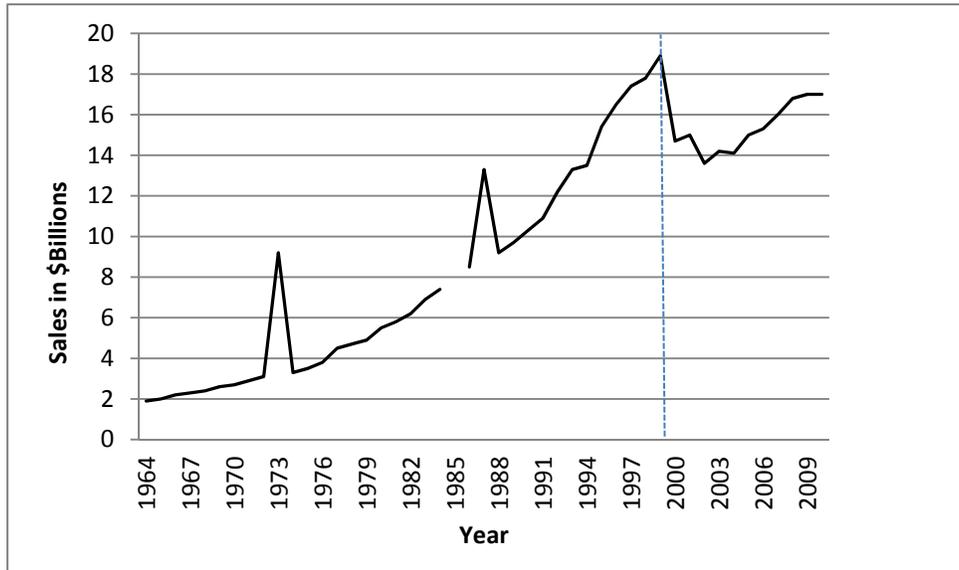
Others argue that requiring a prescription nevertheless provides a bright line standard for distinguishing between a routine expense and the cost of medicine that constitutes current necessary medical treatment.

³⁴ If, however, doctors' consultation fees are not covered by the individual's health plan, these may exceed the individual's tax savings from tax-free reimbursement for the cost of the over-the-counter medicine.

III. SELECTED DATA ON OVER-THE-COUNTER MEDICINE

Total over-the-counter (“OTC”) retail drug sales in the United States have consistently increased over previous decades, rising from \$1.9 billion dollars annually in 1964 to \$18.9 billion dollars annually in 1999. Figure 1 shows that retail drug sales over the period 1964 to 2010 have risen and furthermore, have risen at an increasing rate. The data presented in the figure exclude Walmart sales beginning in 2000 (marked by a dotted line), likely accounting for the observed fall in reported sales in the years immediately following 2000. However, since 2002, this data once again shows a continued upward trend in retail sales.

**Figure 1.—Annual Over-the-Counter Retail Drug Sales, 1964 to 2010
(Billions of Dollars)**



Source: Consumer Healthcare Products Association.

Notes: All figures are in nominal dollars. 2000-2010 data excludes Walmart; The 1995 sales figure represents a change in the way Nielsen defined an OTC drug and thus shows a greater increase than for other years. The number is more representative of the true OTC drug market as defined by the Food and Drug Administration. The statistic does not include vitamins/minerals/nutritional supplements.

In 1987, the only available data was provided by Kline & Co. for 1988 FDA/CHPA symposium. It showed \$13.3 billion but included vitamins and nutritional supplements.

In 1986, the CHPA compiled data using only OTC product categories represented by the industry - *e.g.*, not all categories of oral health care and topicals, no vitamins and nutritional supplements. Data for 1985 is not available.

Table 1 decomposes total OTC retail sales of drugs and certain other products from Figure 1 above into sales by category for a subset of years, 2007 to 2010. In all four years, cough and cold remedies, pain products, heartburn medicines, and toothpaste comprise the largest portion of overall sales. In 2010, cough and cold remedies comprised 24 percent of total OTC retail drug sales; internal analgesics (used to relieve pain) comprised 14 percent; heartburn medicines comprised eight percent; and toothpaste (which is generally categorized by the Internal Revenue Service as a toiletry rather than as a drug) comprised eight percent.

**Table 1.—Over-the-Counter Retail Drug Sales, by Category
(Millions of Dollars)**

OTC Category	2007	2008	2009	2010
Acne Remedies	\$332	\$338	\$339	\$350
Analgesics, External	\$315	\$318	\$305	\$313
Analgesics, Internal (includes other pain products)	\$2,424	\$2,451	\$2,492	\$2,341
Antidiarrheals	\$176	\$169	\$166	\$163
Anti-Smoking Products	\$507	\$493	\$494	\$485
Cough/Cold and Related	\$3,662	\$4,083	\$4,207	\$4,054
Eye Care	\$441	\$459	\$472	\$500
First Aid	\$624	\$645	\$650	\$675
Foot Care	\$357	\$349	\$336	\$336
Heartburn (includes anti-gas)	\$1,268	\$1,242	\$1,270	\$1,386
Laxatives	\$758	\$807	\$822	\$832
Lip Remedies	\$403	\$417	\$407	\$419
Oral Antiseptics and Rinses	\$728	\$744	\$731	\$722
Sunscreens and Blocks	\$414	\$477	\$499	\$550
Toothpaste	\$1,246	\$1,251	\$1,268	\$1,288
All Others	\$2,394	\$2,515	\$2,525	\$2,557

Source: The Nielsen Company (total U.S. - food, drug, and mass, excluding Wal-Mart).

Sales figures are approximate for 52 weeks ending the Saturday prior to January 1 of a given year.

Sales are in millions of nominal U.S. dollars. A few categories include a combination of OTC medicines as well as health-related products which are not classified as medicines by the Food and Drug Administration.

Table 2 shows the percentage of firms offering Health FSAs in 2003 by size of firm. Firms with the greatest number of employees are the most likely to offer Health FSAs while smaller firms are less likely to do so.

Table 2.—Percent of Firms Offering Flexible Spending Accounts in 2003

Type of Firm	Percent
Small firms (3-199 workers)	14%
Midsize firms (200-999 workers)	57%
Large firms (1000-4999 workers)	76%
Very large firms (5000+ workers)	83%

Source: Kaiser Family Foundation and Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits 2000, 2003.