

**GOVERNMENTAL RELEASES ON THE HEALTH SAVINGS ACCOUNT
(HSA) IN CHRONOLOGICAL ORDER OF RELEASE.
(Compiled by FBG)**

Section	Pages	Date issued	Purpose
I.	2 - 6	12/08/03	The HSA Law (SECTION 223)
II.	7	12/08/03	Section 106 (AMENDED)
III.	8 – 16	12/22/03	Notice 2004-2: Guidance on Health Savings Accounts
IV.	17	3/30/04	Rev. Proc. 2004—22: Permitting RX benefits until 1/1/06.
V.	18 – 19	3/30/04	Notice 2004-23: Preventive care safe harbor
VI.	20	3/30/04	Notice 2004-25: Safe harbor on delay of establishing a custodial account
VII.	21 – 22	4/12/04	Rev. Rul. 2004-38: Permitting RX benefits until 1/1/06.
VIII.	23 – 25	6/1/04	Rev. Rul. 2004-45: Coordinating the HSA and the FSA.
IX.	26	7/6/04	Notice 2004-43: Permitting HDHP plans that do not meet the requirements until 1/1/06 if due to state law restrictions.
X.	27 – 57	7/23/04	Notice 2004-50: 88 Q&A covering all aspects of the HSA.
XI.	FAQs		From IRS website on 2/18/05

Internal Revenue Code § 223

§ 223. Health savings accounts

(a) Deduction allowed

In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

(b) Limitations

(1) In general

The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

(2) Monthly limitation

The monthly limitation for any month is 1.12 of—

(A) in the case of an eligible individual who has self-only coverage under a high deductible health plan as of the first day of such month, the lesser of—

(i) the annual deductible under such coverage, or

(ii) \$2,250, or

(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, the lesser of—

(i) the annual deductible under such coverage, or

(ii) \$4,500.

(3) Additional contributions for individuals 55 or older

(A) In general

In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

(B) Additional contribution amount

For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

<u>For taxable years beginning in:</u>	<u>The additional contribution amount is:</u>
2004	\$500
2005	\$600
2006	\$700
2007	\$800
2008	\$900
2009 and thereafter	\$1,000

(4) Coordination with other contributions

The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual, and

(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) (and such amount shall not be allowed as a deduction under subsection (a)).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

(5) Special rule for married individuals

In the case of individuals who are married to each other, if either spouse has family coverage—

(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

(6) Denial of deduction to dependents

No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(7) Medicare eligible individuals

The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

(c) Definitions and special rules

For purposes of this section—

(1) Eligible individual

(A) In general

The term “eligible individual” means, with respect to any month, any individual if—

(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and (ii) such individual is not, while covered under a high deductible health plan, covered under any health plan— (I) which is not a high deductible health plan, and (II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) Certain coverage disregarded

Subparagraph (A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance, and
(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) High deductible health plan

(A) In general

The term “**high deductible health plan**” means a health plan—

(i) which has an annual deductible which is not less than—
(I) \$1,000 for self-only coverage, and
(II) twice the dollar amount in subclause (I) for family coverage, and
(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) \$5,000 for self-only coverage, and
(II) twice the dollar amount in subclause (I) for family coverage.

(B) Exclusion of certain plans

Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) Safe harbor for absence of preventive care deductible

A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).

(D) Special rules for network plans

In the case of a plan using a network of providers—

(i) Annual out-of-pocket limitation

Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) Annual deductible

Such plan’s annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(3) Permitted insurance

The term “**permitted insurance**” means—

(A) insurance if substantially all of the coverage provided under such insurance relates to—
(i) liabilities incurred under workers’ compensation laws,
(ii) tort liabilities,
(iii) liabilities relating to ownership or use of property, or
(iv) such other similar liabilities as the Secretary may specify by regulations,
(B) insurance for a specified disease or illness, and
(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) Family coverage

The term “**family coverage**” means any coverage other than self-only coverage.

(5) Archer MSA

The term “**Archer MSA**” has the meaning given such term in section 220(d).

(d) Health savings account

For purposes of this section—

(1) In general

The term “**health savings account**” means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—
(i) unless it is in cash, or
(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—
(I) the dollar amount in effect under subsection (b)(2)(B)(ii), and
(II) the dollar amount in effect under subsection (b)(3)(B).
(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.
(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) Qualified medical expenses

(A) In general

The term “**qualified medical expenses**” means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

(B) Health insurance may not be purchased from account

Subparagraph (A) shall not apply to any payment for insurance.

(C) Exceptions

Subparagraph (B) shall not apply to any expense for coverage under—

- (i) a health plan during any period of continuation coverage required under any Federal law,
- (ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),
- (iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or
- (iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a Medicare supplemental policy (as defined in section 1882 of the Social Security Act).

(3) Account beneficiary

The term “**account beneficiary**” means the individual on whose behalf the health savings account was established.

(4) Certain rules to apply

Rules similar to the following rules shall apply for purposes of this section:

- (A) Section 219(d)(2) (relating to no deduction for rollovers).
- (B) Section 219(f)(3) (relating to time when contributions deemed made).
- (C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).
- (D) Section 408(g) (relating to community property laws).
- (E) Section 408(h) (relating to custodial accounts).

(e) Tax treatment of accounts

(1) In general

A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) Account terminations

Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) Tax treatment of distributions

(1) Amounts used for qualified medical expenses

Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

(2) Inclusion of amounts not used for qualified medical expenses

Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

(3) Excess contributions returned before due date of return

(A) In general

If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

- (i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual’s return for such taxable year, and
- (ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) Excess contribution

For purposes of subparagraph (A), the term “**excess contribution**” means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5)) which is neither excludable from gross income under section 106(d) nor deductible under this section.

(4) Additional tax on distributions not used for qualified medical expenses

(A) In general

The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

(B) Exception for disability or death

Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(C) Exception for distributions after Medicare eligibility

Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

(5) Rollover contribution

An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) In general

Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

(B) Limitation

This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

(6) Coordination with medical expense deduction

For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) Transfer of account incident to divorce

The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be

treated as a health savings account with respect to which such spouse is the account beneficiary.

(8) Treatment after death of account beneficiary

(A) Treatment if designated beneficiary is spouse

If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings account shall be treated as if the spouse were the account beneficiary.

(B) Other cases

(i) In general

If, by reason of the death of the account beneficiary, any person acquires the account beneficiary's interest in a health savings account in a case to which subparagraph (A) does not apply—

(I) such account shall cease to be a health savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such beneficiary's gross income for the last taxable year of such beneficiary.

(ii) Special rules

(I) Reduction of inclusion for predeath expenses

The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) Deduction for estate taxes

An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) Cost-of-living adjustment

(1) In general

Each dollar amount in subsections (b)(2) and (c)(2)(A) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins determined by substituting for "calendar year 1992" in subparagraph (B) thereof—

(i) except as provided in clause (ii), "calendar year 1997", and

(ii) in the case of each dollar amount in subsection (c)(2)(A), "calendar year 2003".

(2) Rounding

If any increase under paragraph (1) is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

(h) Reports

The Secretary may require—

(1) the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

Internal Revenue Code § 106

§ 106. Contributions by employer to accident and health plans

(a) General rule

Except as otherwise provided in this section, gross income of an employee does not include employer provided coverage under an accident or health plan.

(b) Contributions to Archer MSAs

(1) In general

In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) No constructive receipt

No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) Special rule for deduction of employer contributions

Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) Employer Archer MSA contributions required to be shown on return

Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) Archer MSA contributions not part of COBRA coverage

Paragraph (1) shall not apply for purposes of section 4980B.

(6) Definitions

For purposes of this subsection, the terms “ **eligible individual** ” and “ **Archer MSA** ” have the respective meanings given to such terms by section 220.

(7) Cross reference

For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) Inclusion of long-term care benefits provided through flexible spending arrangements

(1) In general

Effective on and after January 1, 1997, gross income of an employee shall include employer provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) Flexible spending arrangement

For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A)

specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

Code § 106(d) was added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 (Dec. 8, 2003), effective for taxable years beginning after December 31, 2003.

(d) Contributions to health savings accounts

(1) In general

In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) Special rules

Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) Cross reference

For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

Notice 2004-2

PURPOSE

This notice provides guidance on Health Savings Accounts.

BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003. HSAs are established to receive tax-favored contributions by or on behalf of eligible individuals and amounts in an HSA may be accumulated over the years or distributed on a tax-free basis to pay or reimburse qualified medical expenses.

A number of the rules that apply to HSAs are similar to rules that apply to Individual Retirement Accounts (IRAs) under sections 219, 408 and 408A, and to Archer Medical Savings Accounts (Archer MSAs) under section 220. For example, like an Archer MSA, an HSA is established for the benefit of an individual, is owned by that individual, and is portable. Thus, if the individual is an employee who later changes employers or leaves the work force, the HSA does not stay behind with the former employer, but stays with the individual.

This notice provides certain basic information about HSAs in question and answer format, without attempting to enumerate all of the specific rules that apply under section 223.

The notice is divided into five parts. Part I of the notice explains what HSAs are and who can have them. Part II describes how HSAs can be established. Parts III and IV cover contributions to HSAs and distributions from HSAs. Part V discusses other matters relating to HSAs.

QUESTIONS AND ANSWERS

Set forth below are questions and answers concerning HSAs.

I. What Are HSAs and Who Can Have Them?

Q-1. What is an HSA?

A-1. An HSA is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

Q-2. Who is eligible to establish an HSA?

A-2. An "eligible individual" can establish an HSA. An "eligible individual" means, with respect to any month, any individual who: (1) is covered under a high-deductible health plan (HDHP) on the first day of such month; (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage); (3) is not entitled to benefits under Medicare (generally, has not yet reached age 65); and (4) may not be claimed as a dependent on another person's tax return.

Q-3. What is a "high-deductible health plan" (HDHP)?

A-3. Generally, an HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. Specifically, for self-only coverage, an HDHP has an annual deductible of at least \$1,000 and annual out-of-pocket expenses required to be paid

(deductibles, co-payments and other amounts, but not premiums) not exceeding \$5,000. For family coverage, an HDHP has an annual deductible of at least \$2,000 and annual out-of-pocket expenses required to be paid not exceeding \$10,000. In the case of family coverage, a plan is an HDHP only if, under the terms of the plan and without regard to which family member or members incur expenses, no amounts are payable from the HDHP until the family has incurred annual covered medical expenses in excess of the minimum annual deductible. Amounts are indexed for inflation. A plan does not fail to qualify as an HDHP merely because it does not have a deductible (or has a small deductible) for preventive care (e.g., first dollar coverage for preventive care). However, except for preventive care, a plan may not provide benefits for any year until the deductible for that year is met. See A-4 and A-6 for special rules regarding network plans and plans providing certain types of coverage.

Example (1): A Plan provides coverage for A and his family. The Plan provides for the payment of covered medical expenses of any member of A's family if the member has incurred covered medical expenses during the year in excess of \$1,000 even if the family has not incurred covered medical expenses in excess of \$2,000. If A incurred covered medical expenses of \$1,500 in a year, the Plan would pay \$500. Thus, benefits are potentially available under the Plan even if the family's covered medical expenses do not exceed \$2,000. Because the Plan provides family coverage with an annual deductible of less than \$2,000, the Plan is not an HDHP.

Example (2): Same facts as in example (1), except that the Plan has a \$5,000 family deductible and provides payment for covered medical expenses if any member of A's family has incurred covered medical expenses during the year in excess of \$2,000. The Plan satisfies the requirements for an HDHP with respect to the deductibles. See A-12 for HSA contribution limits.

Q-4. What are the special rules for determining whether a health plan that is a network plan meets the requirements of an HDHP?

A-4. A network plan is a plan that generally provides more favorable benefits for services provided by its network of providers than for services provided outside of the network. In the case of a plan using a network of providers, the plan does not fail to be an HDHP (if it would otherwise meet the requirements of an HDHP) solely because the out-of-pocket expense limits for services provided outside of the network exceeds the maximum annual out-of-pocket expense limits allowed for an HDHP. In addition, the plan's annual deductible for out-of-network services is not taken into account in determining the annual contribution limit. Rather, the annual contribution limit is determined by reference to the deductible for services within the network.

Q-5. What kind of other health coverage makes an individual ineligible for an HSA?

A-5. Generally, an individual is ineligible for an HSA if the individual, while covered under an HDHP, is also covered under a health plan (whether as an individual, spouse, or dependent) that is not an HDHP. See also A-6.

Q-6. What other kinds of health coverage may an individual maintain without losing eligibility for an HSA?

A-6. An individual does not fail to be eligible for an HSA merely because, in addition to an HDHP, the individual has coverage for any benefit provided by "permitted insurance." Permitted insurance is insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. In addition to permitted insurance, an individual does not fail to be eligible for an HSA merely

because, in addition to an HDHP, the individual has coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or longterm care. If a plan that is intended to be an HDHP is one in which substantially all of the coverage of the plan is through permitted insurance or other coverage as described in this answer, it is not an HDHP.

Q-7. Can a self-insured medical reimbursement plan sponsored by an employer be an HDHP?

A-7. Yes.

II. How Can An HSA Be Established?

Q-8. How does an eligible individual establish an HSA?

A-8. Beginning January 1, 2004, any eligible individual (as described in A-2) can establish an HSA with a qualified HSA trustee or custodian, in much the same way that individuals establish IRAs or Archer MSAs with qualified IRA or Archer MSA trustees or custodians. No permission or authorization from the Internal Revenue Service (IRS) is necessary to establish an HSA. An eligible individual who is an employee may establish an HSA with or without involvement of the employer.

Q-9. Who is a qualified HSA trustee or custodian?

A-9. Any insurance company or any bank (including a similar financial institution as defined in section 408(n)) can be an HSA trustee or custodian. In addition, any other person already approved by the IRS to be a trustee or custodian of IRAs or Archer MSAs is automatically approved to be an HSA trustee or custodian. Other persons may request approval to be a trustee or custodian in accordance with the procedures set forth in Treas. Reg. § 1.408-2(e) (relating to IRA nonbank trustees). For additional information concerning nonbank trustees and custodians, see Announcement 2003-54, 2003-40 I.R.B. 761.

Q-10. Does the HSA have to be opened at the same institution that provides the HDHP?

A-10. No. The HSA can be established through a qualified trustee or custodian who is different from the HDHP provider. Where a trustee or custodian does not sponsor the HDHP, the trustee or custodian may require proof or certification that the account beneficiary is an eligible individual, including that the individual is covered by a health plan that meets all of the requirements of an HDHP.

III. Contributions to HSAs.

Q-11. Who may contribute to an HSA?

A-11. Any eligible individual may contribute to an HSA. For an HSA established by an employee, the employee, the employee's employer or both may contribute to the HSA of the employee in a given year. For an HSA established by a self-employed (or unemployed) individual, the individual may contribute to the HSA. Family members may also make contributions to an HSA on behalf of another family member as long as that other family member is an eligible individual.

Q-12. How much may be contributed to an HSA in calendar year 2004?

A-12. The maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility and health plan coverage as of the first day of the month. For calendar year 2004, the maximum monthly contribution for eligible individuals with self-only coverage under an HDHP is 1/12 of the lesser of 100% of the annual deductible under the HDHP (minimum of \$1,000) but not more than \$2,600. For eligible individuals with family coverage under an HDHP, the maximum monthly contribution is 1/12 of the lesser of 100% of the annual deductible under the HDHP (minimum of \$2,000) but not more than \$5,150. In addition to the maximum contribution amount, catch-up contributions, as described in A-14, may be made by or on behalf of individuals age 55 or older and younger than 65. All HSA

contributions made by or on behalf of an eligible individual to an HSA are aggregated for purposes of applying the limit. The annual limit is decreased by the aggregate contributions to an Archer MSA. The same annual contribution limit applies whether the contributions are made by an employee, an employer, a self-employed person, or a family member. Unlike Archer MSAs, contributions may be made by or on behalf of eligible individuals even if the individuals have no compensation or if the contributions exceed their compensation. If an individual has more than one HSA, the aggregate annual contributions to all the HSAs are subject to the limit.

Q-13. How is the contribution limit computed for an individual who begins self-only coverage under an HDHP on June 1, 2004 and continues to be covered under the HDHP for the rest of the year?

A-13. The contribution limit is computed each month. If the annual deductible is \$5,000 for the HDHP, then the lesser of the annual deductible and \$2,600 is \$2,600. The monthly contribution limit is \$216.67 ($\$2,600 / 12$). The annual contribution limit is \$1,516.69 ($7 \times \216.67).

Q-14. What are the “catch-up contributions” for individuals age 55 or older?

A-14. For individuals (and their spouses covered under the HDHP) between ages 55 and 65, the HSA contribution limit is increased by \$500 in calendar year 2004. This catch-up amount will increase in \$100 increments annually, until it reaches \$1,000 in calendar year 2009. As with the annual contribution limit, the catch-up contribution is also computed on a monthly basis. After an individual has attained age 65 (the Medicare eligibility age), contributions, including catch-up contributions, cannot be made to an individual’s HSA. Example: An individual attains age 65 and becomes eligible for Medicare benefits in July, 2004 and had been participating in self-only coverage under an HDHP with an annual deductible of \$1,000. The individual is no longer eligible to make HSA contributions (including catch-up contributions) after June, 2004. The monthly contribution limit is \$125 ($\$1,000 / 12 + \$500 / 12$ for the catch-up contribution). The individual may make contributions for January through June totaling \$750 ($6 \times \125), but may not make any contributions for July through December, 2004.

Q-15. If one or both spouses have family coverage, how is the contribution limit computed?

A-15. In the case of individuals who are married to each other, if either spouse has family coverage, both are treated as having family coverage. If each spouse has family coverage under a separate health plan, both spouses are treated as covered under the plan with the lowest deductible. The contribution limit for the spouses is the lowest deductible amount, divided equally between the spouses unless they agree on a different division. The family coverage limit is reduced further by any contribution to an Archer MSA. However, both spouses may make the catch-up contributions for individuals age 55 or over without exceeding the family coverage limit.

Example (1): H and W are married. H is 58 and W is 53. H and W both have family coverage under separate HDHPs. H has a \$3,000 deductible under his HDHP and W has a \$2,000 deductible under her HDHP. H and W are treated as covered under the plan with the \$2,000 deductible. H can contribute \$1,500 to an HSA ($1/2$ the deductible of \$2,000 + \$500 catch up contribution) and W can contribute \$1,000 to an HSA (unless they agree to a different division).

Example (2): H and W are married. H is 35 and W is 33. H and W each have a selfonly HDHP. H has a \$1,000 deductible under his HDHP and W has a \$1,500 deductible under her HDHP. H can contribute \$1,000 to an HSA and W can contribute \$1,500 to an HSA.

Q-16. In what form must contributions be made to an HSA?

A-16. Contributions to an HSA must be made in cash. For example, contributions may not be made in the form of stock or other property. Payments for the HDHP and contributions to the HSA can be made through a cafeteria plan. See A-33.

Q-17. What is the tax treatment of an eligible individual's HSA contributions?

A-17. Contributions made by an eligible individual to an HSA (which are subject to the limits described in A-12) are deductible by the eligible individual in determining adjusted gross income (i.e., "above-the-line"). The contributions are deductible whether or not the eligible individual itemizes deductions. However, the individual cannot also deduct the contributions as medical expense deductions under section 213.

Q-18. What is the tax treatment of contributions made by a family member on behalf of an eligible individual?

A-18. Contributions made by a family member on behalf of an eligible individual to an HSA (which are subject to the limits described in A-12) are deductible by the eligible individual in computing adjusted gross income. The contributions are deductible whether or not the eligible individual itemizes deductions. An individual who may be claimed as a dependent on another person's tax return is not an eligible individual and may not deduct contributions to an HSA.

Q-19. What is the tax treatment of employer contributions to an employee's HSA?

A-19. In the case of an employee who is an eligible individual, employer contributions (provided they are within the limits described in A-12) to the employee's HSA are treated as employer-provided coverage for medical expenses under an accident or health plan and are excludable from the employee's gross income. The employer contributions are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act. Contributions to an employee's HSA through a cafeteria plan are treated as employer contributions. The employee cannot deduct employer contributions on his or her federal income tax return as HSA contributions or as medical expense deductions under section 213.

Q-20. What is the tax treatment of an HSA?

A-20. An HSA is generally exempt from tax (like an IRA or Archer MSA), unless it has ceased to be an HSA. Earnings on amounts in an HSA are not includable in gross income while held in the HSA (i.e., inside buildup is not taxable). See A-25 regarding the taxation of distributions to the account beneficiary.

Q-21. When may HSA contributions be made? Is there a deadline for contributions to an HSA for a taxable year?

A-21. Contributions for the taxable year can be made in one or more payments, at the convenience of the individual or the employer, at any time prior to the time prescribed by law (without extensions) for filing the eligible individual's federal income tax return for that year, but not before the beginning of that year. For calendar year taxpayers, the deadline for contributions to an HSA is generally April 15 following the year for which the contributions are made.

Although the annual contribution is determined monthly, the maximum contribution may be made on the first day of the year. See A-22 regarding correcting excess contributions.

Example: B has self-only coverage under an HDHP with a deductible of \$1,500 and also has an HSA. B's employer contributes \$200 to B's HSA at the end of every quarter in 2004 and at the end of the first quarter in 2005 (March 31, 2005). B can exclude from income in 2004 all of the employer contributions (i.e., \$1,000) because B's exclusion for all contributions does not exceed the maximum annual HSA contributions. See A-12.

Q-22. What happens when HSA contributions exceed the maximum amount that may be deducted or excluded from gross income in a taxable year?

A-22. Contributions by individuals to an HSA, or if made on behalf of an individual to an HSA, are not deductible to the extent they exceed the limits described in A-12. Contributions by an employer to an HSA for an employee are included in the gross income of the employee to the extent that they exceed the limits described in A-12 or if they are made on behalf of an employee who is not an eligible individual. In addition, an excise tax of 6% for each taxable year is imposed on the account beneficiary for excess individual and employer contributions. However, if the excess contributions for a taxable year and the net income attributable to such excess contributions are paid to the account beneficiary before the last day prescribed by law (including extensions) for filing the account beneficiary's federal income tax return for the taxable year, then the net income attributable to the excess contributions is included in the account beneficiary's gross income for the taxable year in which the distribution is received but the excise tax is not imposed on the excess contribution and the distribution of the excess contributions is not taxed.

Q-23. Are rollover contributions to HSAs permitted?

A-23. Rollover contributions from Archer MSAs and other HSAs into an HSA are permitted. Rollover contributions need not be in cash. Rollovers are not subject to the annual contribution limits. Rollovers from an IRA, from a health reimbursement arrangement (HRA), or from a health flexible spending arrangement (FSA) to an HSA are not permitted.

IV. Distributions from HSAs.

Q-24. When is an individual permitted to receive distributions from an HSA?

A-24. An individual is permitted to receive distributions from an HSA at any time.

Q-25. How are distributions from an HSA taxed?

A-25. Distributions from an HSA used exclusively to pay for qualified medical expenses of the account beneficiary, his or her spouse, or dependents are excludable from gross income. In general, amounts in an HSA can be used for qualified medical expenses and will be excludable from gross income even if the individual is not currently eligible for contributions to the HSA. However, any amount of the distribution not used exclusively to pay for qualified medical expenses of the account beneficiary, spouse or dependents is includable in gross income of the account beneficiary and is subject to an additional 10% tax on the amount includable, except in the case of distributions made after the account beneficiary's death, disability, or attaining age 65.

Q-26. What are the “qualified medical expenses” that are eligible for tax- free distributions?

A-26. The term “qualified medical expenses” are expenses paid by the account beneficiary, his or her spouse or dependents for medical care as defined in section 213(d) (including nonprescription drugs as described in Rev. Rul. 2003-102, 2003-38 I.R.B. 559), but only to the extent the expenses are not covered by insurance or otherwise. The qualified medical expenses must be incurred only after the HSA has been established. For purposes of determining the itemized deduction for medical expenses, medical expenses paid or reimbursed by distributions from an HSA are not treated as expenses paid for medical care under section 213.

Q-27. Are health insurance premiums qualified medical expenses?

A-27. Generally, health insurance premiums are not qualified medical expenses except for the following: qualified long-term care insurance, COBRA health care continuation coverage, and health care coverage while an individual is receiving unemployment compensation. In addition, for individuals over age 65, premiums for Medicare Part A or B, Medicare HMO, and the

employee share of premiums for employer-sponsored health insurance, including premiums for employer-sponsored retiree health insurance can be paid from an HSA. Premiums for Medigap policies are not qualified medical expenses.

Q-28. How are distributions from an HSA taxed after the account beneficiary is no longer an eligible individual?

A-28. If the account beneficiary is no longer an eligible individual (e.g., the individual is over age 65 and entitled to Medicare benefits, or no longer has an HDHP), distributions used exclusively to pay for qualified medical expenses continue to be excludable from the account beneficiary's gross income.

Q-29. Must HSA trustees or custodians determine whether HSA distributions are used exclusively for qualified medical expenses?

A-29. No. HSA trustees or custodians are not required to determine whether HSA distributions are used for qualified medical expenses. Individuals who establish HSAs make that determination and should maintain records of their medical expenses sufficient to show that the distributions have been made exclusively for qualified medical expenses and are therefore excludable from gross income.

Q-30. Must employers who make contributions to an employee's HSA determine whether HSA distributions are used exclusively for qualified medical expenses?

A-30. No. The same rule that applies to trustees or custodians applies to employers. See A-29.

Q-31. What are the income tax consequences after the HSA account beneficiary's death?

A-31. Upon death, any balance remaining in the account beneficiary's HSA becomes the property of the individual named in the HSA instrument as the beneficiary of the account. If the account beneficiary's surviving spouse is the named beneficiary of the HSA, the HSA becomes the HSA of the surviving spouse. The surviving spouse is subject to income tax only to the extent distributions from the HSA are not used for qualified medical expenses. If, by reason of the death of the account beneficiary, the HSA passes to a person other than the account beneficiary's surviving spouse, the HSA ceases to be an HSA as of the date of the account beneficiary's death, and the person is required to include in gross income the fair market value of the HSA assets as of the date of death. For such a person (except the decedent's estate), the includable amount is reduced by any payments from the HSA made for the decedent's qualified medical expenses, if paid within one year after death.

V. Other Matters.

Q-32. What discrimination rules apply to HSAs?

A-32. If an employer makes HSA contributions, the employer must make available comparable contributions on behalf of all "comparable participating employees" (i.e., eligible employees with comparable coverage) during the same period. Contributions are considered comparable if they are either the same amount or same percentage of the deductible under the HDHP. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). The comparability rule does not apply to amounts rolled over from an employee's HSA or Archer MSA, or to contributions made through a cafeteria plan. If employer contributions do not satisfy the comparability rule during a period, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

Example: Employer X offers its collectively bargained employees three health plans, including an HDHP with self-only coverage and a \$2,000 deductible. For each employee electing the HDHP self-only coverage, X contributes \$1,000 per year on behalf of the employee to an HSA.

X makes no HSA contributions for employees who do not elect the HDHP. X's plans and HSA contributions satisfy the comparability rule.

Q-33. Can an HSA be offered under a cafeteria plan?

A-33. Yes. Both an HSA and an HDHP may be offered as options under a cafeteria plan. Thus, an employee may elect to have amounts contributed as employer contributions to an HSA and an HDHP on a salary-reduction basis.

Q-34. What reporting is required for an HSA?

A-34. Employer contributions to an HSA must be reported on the employee's Form W-2. In addition, information reporting for HSAs will be similar to information reporting for Archer MSAs. The IRS will release forms and instructions, similar to those required for Archer MSAs, on how to report HSA contributions, deductions, and distributions.

Q-35. Are HSAs subject to COBRA continuation coverage under section 4980B?

A-35. No. Like Archer MSAs, HSAs are not subject to COBRA continuation coverage.

Q-36. How do the rules under section 419 affect contributions by an employer to an HSA?

A-36. Contributions by an employer to an HSA are not subject to the rules under section 419. An HSA is a trust that is exempt from tax under section 223. Thus, an HSA is not a "fund" under section 419(e)(3) and, therefore, is not a "welfare benefit fund" under section 419(e)(1).

Q-37. May eligible individuals use debit, credit or stored-value cards to receive distributions from an HSA for qualified medical expenses?

A-37. Yes.

Q-38. Are HSAs subject to other statutory rules and provisions?

A-38. Yes. HSAs are subject to other statutory rules and provisions not addressed in this notice. No inference should be drawn regarding issues not expressly addressed in this notice that may be suggested by a particular question or answer, or by the inclusion or exclusion of certain questions.

COMMENTS REQUESTED

Comments are requested on the questions and answers set forth in this notice. In addition, comments are requested on any other issue not addressed in this notice but which should be addressed in future IRS guidance. In particular, comments are requested as to the following:

1. The appropriate standard for preventive care in section 223(c)(2)(C).
2. The relationship between section 223 and the rules governing health FSAs in cafeteria plans under section 125 and the proposed and final regulations under section 125 (in particular, Prop. Treas. Reg. § 1.125-2 Q&A 7).
3. Whether transition relief should be provided in cases of inappropriate coordination of an HDHP with other coverage.
4. The relationship between HSAs and health FSAs or HRAs.
5. The application of the nondiscrimination rules in section 125 to HSAs offered under a cafeteria plan.
6. The corrective procedures in instances where employer contributions exceed the statutory contribution limits.
7. The relationship between limits on out-of-pocket expenses in section 223(c)(2)(A) and reasonable lifetime maximums on benefits in health insurance plans.

Send comments to: CC:DOM:CORP:R (Notice 2004-2), Room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORT:R (Notice 2004-2), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, D.C. Alternatively,

taxpayers may submit comments electronically at:

Notice.2004.2.Comments@irscounsel.treas.gov (a Service Comments e- mail address).

DRAFTING INFORMATION

The principal authors of this notice are Elizabeth Purcell and Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice contact Ms. Purcell or Ms. Tanner on (202) 622-6080 (not a toll- free call).

Internal Revenue Bulletin: 2004-15
April 12, 2004

Rev. Proc. 2004-22

Section 223.—Health Savings Accounts

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SECTION 1. PURPOSE

This revenue procedure provides transition relief from Revenue Ruling 2004-38 for determining an “eligible individual” under section 223 who may make contributions to a Health Savings Account (HSA). The transition relief covers the months before January 1, 2006, in the case of an individual who is covered by both a high deductible health plan (HDHP) and by a separate plan or rider that provides prescription drug benefits before the minimum annual deductible of the HDHP is satisfied.

SECTION 2. BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish HSAs for taxable years beginning after December 31, 2003. Generally, an “eligible individual” is an individual who is covered by an HDHP and no health plan that is not an HDHP. Revenue Ruling 2004-38, clarifies that an individual who is covered by a health plan that provides prescription drug benefits before the minimum annual deductible of an HDHP has been satisfied, is not an “eligible individual” under section 223(c)(1)(A) and may not make contributions to an HSA. Because of the short period between the enactment of HSAs and the effective date of section 223, many employers and health insurance providers have been unable to modify the benefits provided under their existing health plans to conform to the statutory requirements for an HDHP. Thus, it is appropriate to provide transition relief to allow individuals to contribute to an HSA who would otherwise qualify as eligible individuals but for coverage by a prescription drug benefit provided under a separate plan or rider that is not an HDHP.

SECTION 3. APPLICATION

For months before January 1, 2006, an individual who would otherwise be an “eligible individual” under section 223(c)(1)(A), but is covered by both an HDHP that does not provide benefits for prescription drugs and by a separate health plan or rider that provides prescription drug benefits before the minimum annual deductible of the HDHP is satisfied (*i.e.*, the separate prescription drug plan is not an HDHP), will continue to be an “eligible individual” and may make contributions to an HSA based on the annual deductible of the HDHP.

SECTION 4. EFFECT ON OTHER DOCUMENTS

The holding of Revenue Ruling 2004-38 is suspended in part and replaced by the transition relief provided in this revenue procedure for months before January 1, 2006.

DRAFTING INFORMATION

The principal author of this revenue procedure is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this revenue procedure, contact Ms. Tanner at (202) 622-6080 (not a toll-free call).

Internal Revenue Bulletin: 2004-15
April 12, 2004

Notice 2004-23

Health Savings Accounts—Preventive Care

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PURPOSE

This notice provides a safe harbor for preventive care benefits allowed to be provided by a high deductible health plan (HDHP) without satisfying the minimum deductible under section 223(c)(2) of the Internal Revenue Code.

BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003.

Among the requirements for an individual to qualify as an eligible individual under section 223(c)(1) (and thus to be eligible to make tax-favored contributions to an HSA) is the requirement that the individual be covered under an HDHP. An HDHP is a health plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied. However, section 223(c)(2)(C) provides a safe harbor for the absence of a preventive care deductible. That section states, "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary)." An HDHP may therefore provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible. On the other hand, there is no requirement in section 223 that an HDHP provide benefits for preventive care or provide preventive care with a deductible below the minimum annual deductible.

PREVENTIVE CARE SAFE HARBOR

Preventive care for purposes of section 223(c)(2)(C) includes, but is not limited to, the following:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services (see attached APPENDIX).

However, preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition (See below for request for comments regarding drug treatments.)

INTERACTION WITH STATE LAW HEALTH CARE REQUIREMENTS

Section 220(c)(2)(B)(ii) allows a high deductible health plan for purposes of an Archer Medical Savings Account to provide preventive care without a deductible if required by state law. However, section 220 does not define preventive care for this purpose. Section 223(c)(2)(C), for purposes of an HSA, does not condition the exception for preventive care on state law requirements. State insurance laws often require health plans to provide certain health care without regard to a deductible or on terms no less favorable than other care provided by the health plan. The determination of whether health care that is required by state law to be provided by an HDHP without regard to a deductible is "preventive" for purposes of the exception for preventive care under section 223(c)(2)(C) will be based on the standards set forth in this notice and other guidance issued by the IRS, rather than on how that care is characterized by state law.

COMMENTS REQUESTED

Notice 2004-2, 2004-2 I.R.B. 269, requested comments concerning the appropriate standard for preventive care in section 223(c)(2)(C). We continue to request comments on the appropriate standard for preventive care, and in particular, recommendations concerning any benefit or service that should be added to those set forth in this notice and appendix. In addition, we request comments on the extent to which benefits provided by an employee assistance program, mental health program or wellness program may qualify as preventive care, including comments regarding the scope of treatments provided as benefits through counseling and health assessments. In particular, we request comments on the extent to which drug treatments, either solely by prescription or as part of an overall treatment regimen should be treated as preventive care and the appropriate standards for differentiating between drug treatments that would be considered preventive care and those that would not be considered preventive care.

Send comments to: CC:PA:LPD:PR (Notice 2004-2), Room 5203, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Comments may be hand-delivered between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (Notice 2004-2), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, D.C. Alternatively, taxpayers may submit comments electronically at: *Notice.2004.2.Comments@irs.counsel.treas.gov* (a Service Comments e-mail address).

DRAFTING INFORMATION

The principal author of this notice is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Tanner at (202) 622-6080 (not a toll-free call).

Part III – Administrative, Procedural, and Miscellaneous
Notice 2004-25

PURPOSE

This notice provides transition relief for calendar year 2004 for eligible individuals who establish an HSA or on before April 15, 2005 from the requirement that qualified medical expenses may only be paid or reimbursed by an HSA if incurred after the HSA has been established. This notice modifies prior guidance in Q&A 26 of Notice 2004-2, 2004-2 I.R.B. 269.

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003.

Because of the short period between the enactment of HSAs and the effective date of section 223, many taxpayers who otherwise would be eligible to establish and contribute to HSAs (i.e., generally, individuals covered by a high deductible health plan (HDHP)) have been unable to do so because they cannot locate trustees or custodians who are willing and able to open HSAs at this time.

BACKGROUND

Contributions to an HSA may only be made by or on behalf of eligible individuals as defined in section 223(c)(1)(A). For any month, an eligible individual must, among other requirements, be covered on the first day of the month by a HDHP (as defined by section 223(c)(2)). Although the amount of the contribution to an HSA is based on the number of months an individual is an eligible individual (i.e., is covered by the HDHP), contributions up to the annual maximum limit generally may be made to the HSA as early as the first day of the taxable year and as late as April 15 of the year following the year for which contributions are made. Notice 2004-2, Q&A 21.

On January 12, 2004, Notice 2004-2 was published, providing general guidance concerning HSAs under section 223. The notice provides that distributions from an HSA exclusively to pay or reimburse qualified medical expenses of the account beneficiary, his or her spouse, or dependents, are excluded from gross income. Answer 26 of the notice states that, “The qualified medical expenses must be incurred only after the HSA has been established.” However, after an HSA is established, distributions from the HSA exclusively to pay or reimburse qualified medical expenses continue to be excluded from the account beneficiary’s gross income whether or not the account beneficiary continues to be an eligible individual. Notice 2004-2, Q&A 28.

TRANSITION RELIEF FOR HSAs ESTABLISHED FOR CALENDAR YEAR 2004 For calendar year 2004, an HSA established by an eligible individual on or before April 15, 2005, may pay or reimburse on a tax-free basis an otherwise qualified medical expense if the qualified medical expense was incurred on or after the later of: (1) January 1, 2004, or (2) the first day of the first month that the individual became an eligible individual under section 223.

EFFECT ON OTHER DOCUMENTS

The rule in the second sentence of Notice 2004-2, Q&A 26, which states that, “The qualified medical expenses must be incurred only after the HSA has been established,” is suspended and replaced by the transition relief in this notice. That rule continues to apply to HSAs established for calendar year 2005 and later years.

DRAFTING INFORMATION

The principal author of this notice is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Tanner on (202) 622-6080 (not a toll-free call).

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Health Savings Accounts (HSAs). This ruling provides that if an individual is covered by both a high deductible health plan (HDHP) that does not cover prescription drugs and by a separate prescription drug plan (or rider) that provides benefits before the minimum annual deductible of the HDHP has been satisfied, that individual is not an eligible individual under section 223(c)(1)(A) of the Code and may not make contributions to a Health Savings Account.

ISSUE

May an individual contribute to a Health Savings Account (HSA) under section 223 of the Internal Revenue Code if the individual is covered by both a high deductible health plan (HDHP) that does not cover prescription drug benefits and by a separate prescription drug plan (or rider) that does not qualify as an HDHP because the plan provides benefits before the individual has satisfied the minimum annual deductible required by section 223(c)(2)(A)?

FACTS

Individual A is covered by a health plan that satisfies the requirements for an HDHP under section 223(c)(2), including the minimum annual deductible required by section 223(c)(2)(A). The HDHP does not include coverage for prescription drug benefits. Individual A is also covered by another plan (or rider) which provides prescription drug benefits. The prescription drug coverage is not subject to a deductible, but requires a copayment for each prescription. Individual A has no other health coverage, is not eligible for Medicare and may not be claimed as a dependent on another's return.

LAW AND ANALYSIS

Section 223(a) allows a deduction for contributions to an HSA for an "eligible individual." Section 223(c)(1)(A) provides that an "eligible individual" means, with respect to any month, any individual who, in addition to other requirements, is covered under an HDHP on the first day of such month and is not, while covered under an HDHP, "covered under any health plan which is not a high deductible health plan, and which provides coverage for any benefit which is covered under the high deductible health plan."

Section 223(c)(2)(A) defines an HDHP as a health plan that satisfies certain requirements with respect to minimum annual deductibles and maximum annual out-of-pocket expenses.

Section 223(c)(1)(B) provides that, in addition to coverage under an HDHP, an eligible individual may also have specifically enumerated coverage that is disregarded for purposes of the deductible. Disregarded coverage includes "permitted insurance" and other specified coverage ("permitted coverage"). "Permitted insurance" is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. "Permitted coverage" (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision care or long-term care. Prescription drug benefits are not listed as permitted insurance or as permitted coverage under section 223(c)(1)(B).

The legislative history of section 223 explains these provisions by stating that "eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan." The legislative history also explains that, "[a]n individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage." H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003).

Under section 223, an eligible individual cannot be covered by a health plan that is not an HDHP unless that health plan provides coverage for permitted insurance or permitted coverage. A plan that provides benefits for prescription drugs is a health plan. Prescription drug benefits are not in the list of permitted insurance or permitted coverage. Consequently, an individual who is covered by both an HDHP and by a prescription drug plan is not an eligible individual for the purpose of contributing to an HSA unless the prescription drug coverage is also an HDHP (*i.e.*, the prescription drug plan does not provide benefits unless the required minimum annual deductible under section 223(c)(2)(A) for an HDHP has been satisfied).

HOLDINGS

Individual A is covered by both an HDHP that does not cover prescription drugs and by a separate prescription drug plan (or rider) that provides benefits before the minimum annual deductible of the HDHP has been satisfied. Individual A is not an “eligible individual” under section 223(c)(1)(A) and may not make contributions to an HSA. The result is the same if this prescription drug benefit is provided as a benefit under a health plan (and not separately) or as a benefit for Individual A under a spouse’s plan.

However, if a separate prescription drug plan (or rider) does not provide benefits until the minimum annual deductible of the HDHP has been satisfied, or the prescription drug plan is part of an HDHP and subject to the minimum annual deductible, Individual A is an eligible individual under section 223(c)(1)(A).

See Rev. Proc. 2004-22, published elsewhere in this Internal Revenue Bulletin for information concerning transition relief.

DRAFTING INFORMATION

The principal author of this Rev. Rul. is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this Rev. Rul., contact Ms. Tanner at (202) 622-6080 (not a toll-free call).

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Health Savings Account (HSA) - interaction with other health arrangements. This ruling addresses the interaction between Health Savings Accounts (HSAs), health flexible spending arrangements (health FSAs), and health reimbursement arrangements (HRAs).

ISSUE

In the situations described below, may an individual make contributions to a Health Savings Account (HSA) under section 223 of the Internal Revenue Code if the individual is covered by a high deductible health plan (HDHP) and also covered by a health flexible spending arrangement (health FSA) or a health reimbursement arrangement (HRA)?

FACTS

Situation 1. An individual is covered by an HDHP (as defined under section 223(c)(2)(A)). The HDHP has an 80/20 percent coinsurance feature above the deductible. The individual is also covered by a health FSA under a section 125 cafeteria plan and an HRA that meets the requirements of Notice 2002-45, 2002-2 C.B. 93. The health FSA and HRA pay or reimburse all section 213(d) medical expenses that are not covered by the HDHP (such as co-payments, coinsurance, expenses not covered due to the deductible and other medical expenses not covered by the HDHP). The health FSA and HRA coordinate the payment of benefits under the ordering rules of Notice 2002-45. The individual is not entitled to benefits under Medicare and may not be claimed as a dependent on another person's tax return.

Situation 2. Same facts as Situation 1, except that the health FSA and HRA are limited-purpose arrangements that pay or reimburse, pursuant to the written plan document, only vision and dental expenses (whether or not the minimum annual deductible of the HDHP has been satisfied). In addition, the health FSA and HRA pay or reimburse preventive care benefits as described in Notice 2004-23, 2004-15 I.R.B. 725.

Situation 3. Same facts as Situation 1, except that the individual is not covered by a health FSA. Under the employer's HRA, the individual elects, before the beginning of the HRA coverage period, to forgo the payment or reimbursement of medical expenses incurred during that coverage period. The decision to forgo the payment or reimbursement of medical expenses does not apply to permitted insurance, permitted coverage and preventive care ("excepted medical expenses"). See section 223(c)(1)(B) and Notice 2004-23. Medical expenses incurred during the suspended HRA coverage period (other than the excepted medical expenses if otherwise allowed to be paid or reimbursed by an HRA), cannot be paid or reimbursed by the HRA currently or later (*i.e.*, after the HRA suspension ends). However, the employer decides to continue to make employer contributions to the HRA during the suspension period and thus the maximum available amount under the HRA is not affected by the suspension but is available for the payment or reimbursement of the excepted medical expenses incurred during the suspension period as well as medical expenses incurred in later HRA coverage periods.

Situation 4. Same facts as Situation 1, except that the health FSA and HRA are post-deductible arrangements that only pay or reimburse medical expenses (including the individual's 20 percent coinsurance responsibility for expenses above the deductible) after the minimum annual deductible of the HDHP has been satisfied.

Situation 5. Same facts as Situation 1, except that the individual is not covered by a health FSA. The employer's HRA is a retirement HRA that only reimburses those medical expenses incurred after the individual retires.

LAW AND ANALYSIS

Section 223(a) allows a deduction for contributions to an HSA for an "eligible individual" for any month during the taxable year. Section 223(c)(1)(A) provides that an "eligible individual" means, with respect to any month, any individual who is covered under an HDHP on the first day of such month and is not, while covered under an HDHP, "covered under any health plan which is not a high deductible health plan, and which provides coverage for any benefit which is covered under the high deductible health plan."

Section 223(b) provides a limit on amounts that can be contributed to an HSA. The maximum annual contribution limit for an eligible individual with self-only coverage is the amount required by section 223(b)(2)(A). The maximum annual contribution limit for an eligible individual with family coverage is the amount required by section 223(b)(2)(B).

Section 223(c)(2)(A) defines an HDHP as a health plan that satisfies certain requirements with respect to minimum annual deductibles and maximum annual out-of-pocket expenses. Generally, if substantially all of the coverage in a health plan that is intended to be an HDHP is provided through a health FSA or HRA, the health plan is not an HDHP.

In addition to coverage under an HDHP, section 223(c)(1)(B) provides that an eligible individual may have specifically enumerated coverage that is disregarded for purposes of the deductible. Coverage that may be disregarded includes "permitted insurance" and other specified coverage ("permitted coverage"). "Permitted insurance" is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. "Permitted coverage" (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision care or long-term care. Section 223(c)(2)(C) also provides a safe harbor for the absence of a preventive care deductible. See Notice 2004-23.

The legislative history of section 223 explains these provisions by stating that "eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan." The legislative history also explains that, "[a]n individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage." H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003).

Section 125(a) states that no amount will be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan. Section 125(d) defines a cafeteria plan as a written plan under which participants may choose among two or more benefits consisting of cash and qualified benefits.

Section 125(f) defines qualified benefits as any benefit not included in the gross income of the employee by reason of an express provision in the Code. Qualified benefits include employer-provided accident and health coverage under section 106, including health FSAs.

Notice 2002-45, 2002-2 C.B. 93, describes the tax treatment of HRAs. The notice explains that an HRA that receives tax-favored treatment is an arrangement that is paid for solely by the employer and not pursuant to a salary reduction election under section 125, reimburses the employee for medical care expenses incurred by the employee and by the employee's spouse and dependents, and provides reimbursement up to a maximum dollar amount with any unused portion of that amount at the end of the coverage period carried forward to subsequent coverage periods.

Notice 2002-45, Part IV, states that if an employer provides an HRA in conjunction with another accident or health plan and that other plan is provided pursuant to a salary reduction election under a cafeteria plan, then all the facts and circumstances are considered in determining whether the salary reduction is attributable to the HRA. An accident or health plan funded pursuant to salary reduction is not an HRA and is subject to the rules under section 125.

Under section 223, an eligible individual cannot be covered by a health plan that is not an HDHP unless that health plan provides permitted insurance, permitted coverage or preventive care. A health FSA and an HRA are health plans and constitute other coverage under section 223(c)(1)(A)(ii). Consequently, an individual who is covered by an HDHP and a health FSA or HRA that pays or reimburses section 213(d) medical expenses is generally not an eligible individual for the purpose of making contributions to an HSA. See Rev. Rul. 2004-38, 2004-15 I.R.B. 717, which holds that an individual who is covered by an HDHP that does not provide prescription drug coverage and a separate prescription drug plan or rider that provides benefits before the minimum annual deductible of the HDHP has been satisfied is not an eligible individual for HSA purposes.

However, an individual is an eligible individual for the purpose of making contributions to an HSA for periods the individual is covered under the following arrangements:

Limited-Purpose Health FSA or HRA. A limited-purpose health FSA that pays or reimburses benefits for "permitted coverage" (but not through insurance or for long-term care services) and a limited-purpose HRA that pays or reimburses benefits for "permitted insurance" (for a specific disease or illness or that provides a fixed amount per day (or other period) of hospitalization) or "permitted coverage" (but not for long-term care services). In addition, the limited-purpose health FSA or HRA may pay or reimburse preventive care benefits. The individual is an eligible individual for the purpose of making contributions to an HSA because these benefits may be provided whether or not the HDHP deductible has been satisfied.

Suspended HRA. A suspended HRA, pursuant to an election made before the beginning of the HRA coverage period, that does not pay or reimburse, at any time, any medical expense incurred during the suspension period except preventive care, permitted insurance and permitted coverage (if otherwise allowed to be paid or reimbursed by the HRA). The individual is an eligible individual for the purpose of making contributions to an HSA. When the suspension period ends, the individual is no longer an eligible individual because the individual is again entitled to receive payment or reimbursement of section 213(d) medical expenses from the HRA. An individual who does not forgo the payment or reimbursement of medical expenses incurred during an HRA coverage period, is not an eligible individual for HSA purposes during that HRA coverage period.

If an HSA is funded through salary reduction under a cafeteria plan during the suspension period, the terms of the salary reduction election must indicate that the salary reduction is used only to pay for the HSA offered in conjunction with the HRA and not to pay for the HRA itself. Thus, the mere fact that an individual participates in an HSA funded pursuant to a salary reduction election does not necessarily result in attributing the salary reduction to the HRA.

Post-Deductible Health FSA or HRA. A post-deductible health FSA or HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. The individual is an eligible individual for the purpose of making contributions to the HSA. The deductible for the HRA or health FSA ("other coverage") need not be the same as the deductible for the HDHP, but in no event may the HDHP or other coverage provide benefits before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. Where the HDHP and the

other coverage do not have identical deductibles, contributions to the HSA are limited to the lower of the deductibles. In addition, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied.

Retirement HRA. A retirement HRA that pays or reimburses only those medical expenses incurred after retirement (and no expenses incurred before retirement). In this case, the individual is an eligible individual for the purpose of making contributions to the HSA before retirement but loses eligibility for coverage periods when the retirement HRA may pay or reimburse section 213(d) medical expenses. Thus, after retirement, the individual is no longer an eligible individual for the purpose of the HSA.

In the arrangements described, the individual does not fail to be an eligible individual under section 223 and may contribute to an HSA. In addition, combinations of these arrangements which are consistent with these requirements would not disqualify an individual from being an eligible individual. For example, if an employer offers a combined post-deductible health FSA and a limited-purpose health FSA, this would not disqualify an otherwise eligible individual from contributing to an HSA.

An individual may not be reimbursed for the same medical expense by more than one plan or arrangement. However, if the individual has available an HSA, a health FSA and an HRA that pay or reimburse the same medical expense, the health FSA or the HRA may pay or reimburse the medical expense, subject to the ordering rules in Notice 2002-45, Part V, so long as the individual certifies to the employer that the expense has not been reimbursed and that the individual will not seek reimbursement under any other plan or arrangement covering that expense (including the HSA).

HOLDINGS

In Situation 1, the individual is covered by an HDHP and by a health FSA and HRA that pay or reimburse medical expenses incurred before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied. The health FSA and HRA pay or reimburse medical expenses that are not limited to the exceptions for permitted insurance, permitted coverage or preventive care. As a result, the individual is not an eligible individual for the purpose of making contributions to an HSA. This result is the same if the individual is covered by a health FSA or HRA sponsored by the employer of the individual's spouse. See, Rev. Rul. 2004-38.

In Situation 2, the individual is covered by an HDHP and by a health FSA and HRA that pay or reimburse medical expenses incurred before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied. However, the medical expenses paid or reimbursed by the health FSA and HRA include only vision and dental benefits (which are permitted coverage) and preventive care. All of these benefits may be covered as a separate health plan, as a separate or optional rider, or as part of the HDHP and whether or not the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied. The individual is an eligible individual for the purpose of making contributions to an HSA.

In Situation 3, the individual elects to forgo the payment or reimbursement of medical expenses incurred during an HRA coverage period. The suspension of payments and reimbursements by the HRA does not apply to permitted insurance, permitted coverage and preventive care (if otherwise allowed to be paid or reimbursed by the HRA). The individual is an eligible individual for the purpose of making contributions to an HSA until the suspension period ends and the individual is again entitled to receive, from the HRA, payments or reimbursements of section 213(d) medical expenses incurred after the suspension period.

In Situation 4, the health FSA and HRA pay or reimburse medical expenses (including the 20 percent coinsurance not otherwise covered by the HDHP) only after the HDHP's minimum annual deductible has been satisfied. The individual is an eligible individual for the purpose of making contributions to an HSA.

In Situation 5, the HRA is a retirement HRA that only pays or reimburses medical expenses incurred after the individual retires. The individual is an eligible individual for the purpose of making contributions to an HSA before retirement because the HRA will pay or reimburse only medical expenses incurred after retirement.

Drafting Information

The principal author of this notice is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Tanner at (202) 622-6080 (not a toll-free call).

Internal Revenue Bulletin: 2004-27
July 6, 2004

Notice 2004-43

Health Savings Accounts—Transition Relief for State Mandates

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PURPOSE

This notice provides transition relief for individuals in states where high deductible health plans (HDHPs) as described in section 223(c)(2) are not available because state laws require health plans to provide certain benefits without regard to a deductible or below the minimum annual deductible of section 223(c)(2)(A)(i). The transition relief covers months before January 1, 2006, for state requirements in effect on January 1, 2004.

BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish health savings accounts (HSAs) for taxable years beginning after December 31, 2003. An "eligible individual" under section 223(c)(1) must be covered by a "high deductible health plan" (HDHP). An HDHP under section 223(c)(2) must satisfy certain requirements with respect to minimum annual deductibles and maximum out-of-pocket expenses. However, section 223(c)(2)(C) permits a safe harbor for the absence of a preventive care deductible. An eligible individual may also have certain permitted insurance and permitted coverage under section 223(c)(1)(B).

Notice 2004-23, 2004-15 I.R.B. 725, describes a safe harbor for preventive care benefits that may be provided by an HDHP without a deductible or with a deductible below the minimum annual deductible for an HDHP. In addition, the notice indicates that whether health care required by state law without regard to a deductible is "preventive" will be based on the standards set forth in Notice 2004-23 and other guidance issued by the IRS, rather than on how the benefits are characterized by state law.

Several states currently require that health plans provide certain benefits without regard to a deductible or with a deductible below the minimum annual deductible requirements of section 223(c)(2) (e.g., first-dollar coverage or coverage with a low deductible). These health plans are not HDHPs under section 223(c)(2) and individuals covered under these health plans are not eligible to contribute to HSAs. Because of the short period between the enactment of HSAs and the effective date of section 223, these states have had insufficient time to modify their laws to conform to the standards of section 223. Thus, it is appropriate to provide transition relief that treats HDHPs as qualifying under section 223(c)(2) when the sole reason the plans are not HDHPs is because of state-mandated benefits. During the transition period, otherwise eligible individuals covered under these plans will be treated as eligible individuals for purposes of section 223(c)(1) and may contribute to an HSA.

APPLICATION

For months before January 1, 2006, a health plan which would otherwise qualify as an HDHP under section 223(c)(2), except that it complies with state law requirements that certain benefits be provided without a deductible or below the minimum annual deductible of section 223(c)(2)(A)(i), will be treated as an HDHP for purposes of section 223(c)(2), if the disqualifying benefits are required by state law in effect on January 1, 2004.

DRAFTING INFORMATION

The principal author of this notice is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Tanner at (202) 622-6080 (not a toll-free call).

PURPOSE This notice provides guidance on Health Savings Accounts.

BACKGROUND

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003. Notice 2004-2, 2004-2 I.R.B. 269, provides certain basic information on HSAs in question and answer format. This notice addresses additional questions relating to HSAs.

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QUESTIONS AND ANSWERS

I. Eligible individuals

Q-1. If an employer offers an employee a choice between a low-deductible health plan and a high-deductible health plan (HDHP), and the employee selects coverage only under the HDHP, is the employee an eligible individual under section 223(c)(1)?

A-1. Yes, if the employee is otherwise an eligible individual. To determine if an individual is an eligible individual, the actual health coverage selected by the individual is controlling. Thus, it does not matter that the individual could have chosen, but did not choose, a low-deductible health plan or other coverage that would have disqualified the individual from contributing to an HSA.

Q-2. May an otherwise eligible individual who is eligible for Medicare, but not enrolled in Medicare Part A or Part B, contribute to an HSA?

A-2. Yes. Section 223(b)(7) states that an individual ceases to be an eligible individual starting with the month he or she is entitled to benefits under Medicare. Under this provision, mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, the term “entitled to benefits under” Medicare means both eligibility and enrollment in Medicare. Thus, an otherwise eligible individual under section 223(c)(1) who is not actually enrolled in Medicare Part A or Part B may contribute to an HSA until the month that individual is enrolled in Medicare.

Example (1). Y, age 66, is covered under her employer's HDHP. Although Y is eligible for Medicare, Y is not actually entitled to Medicare because she did not apply for benefits under Medicare (i.e., enroll in Medicare Part A or Part B). If Y is otherwise an eligible individual under section 223(c)(1), she may contribute to an HSA.

Example (2). In August 2004, X attains age 65 and applies for and begins receiving Social Security benefits. X is automatically enrolled in Medicare. As of August 1, 2004, X is no longer an eligible individual and may not contribute to an HSA.

Q-3. May an otherwise eligible individual under section 223(c)(1) who is age 65 or older and thus eligible for Medicare, but is not enrolled in Medicare Part A or Part B, make the additional catch-up contribution under section 223(b)(3) for persons age 55 or older?

A-3. Yes. See Notice 2004-2, Q&A 14, on catch-up contributions.

Q-4. Is a government retiree who is enrolled in Medicare Part B (but not Part A) an eligible individual under section 223(c)(1)?

A-4. No. Under section 223(b)(7), an individual who is enrolled in Medicare may not contribute to an HSA.

Q-5. If an otherwise eligible individual under section 223(c)(1) is eligible for medical benefits through the Department of Veterans Affairs (VA), may he or she contribute to an HSA?

A-5. An otherwise eligible individual who is eligible to receive VA medical benefits, but who has not actually received such benefits during the preceding three months, is an eligible individual under section 223(c)(1). An individual is not eligible to make HSA contributions for any month, however, if the individual has received medical benefits from the VA at any time during the previous three months.

Q-6. May an otherwise eligible individual who is covered by an HDHP and also receives health benefits under TRICARE (the health care program for active duty and retired members of the uniformed services, their families and survivors) contribute to an HSA?

A-6. No. Coverage options under TRICARE do not meet the minimum annual deductible requirements for an HDHP under section 223(c)(2). Thus, an individual covered under TRICARE is not an eligible individual and may not contribute to an HSA.

Q-7. May an otherwise eligible individual who is covered by both an HDHP and also by insurance contracts for one or more specific diseases or illnesses, such as cancer, diabetes, asthma or congestive heart failure, contribute to an HSA if the insurance provides benefits before the deductible of the HDHP is satisfied?

A-7. Yes. Section 223(c)(1)(B)(i) provides that an eligible individual covered under an HDHP may also be covered “for any benefit provided by permitted insurance.” Section 223(c)(3)(B) provides that the term “permitted insurance” includes “insurance for a specified disease or illness.” Therefore, an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP.

Q-8. Must coverage for “permitted insurance” described in section 223(c)(3) (liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization), be provided under insurance contracts?

A-8. Yes. Benefits for “permitted insurance” under section 223(c)(3) must generally be provided through insurance contracts and not on a self-insured basis. However, where benefits (such as workers' compensation benefits) are provided in satisfaction of a statutory requirement and any resulting benefits for medical care are secondary or incidental to other benefits, the benefits will qualify as “permitted insurance” even if self-insured.

Q-9. May an individual who is covered by an HDHP and also has a discount card that enables the user to obtain discounts for health care services or products, contribute to an HSA?

A-9. Yes. Discount cards that entitle holders to obtain discounts for health care services or products at managed care market rates will not disqualify an individual from being an eligible individual for HSA purposes if the individual is required to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied.

Example. An employer provides its employees with a pharmacy discount card. For a fixed annual fee (paid by the employer), each employee receives a card that entitles the holder to choose any participating pharmacy. During the one-year life of the card, the card holder receives discounts of 15 percent to 50 percent off the usual and customary fees charged by the providers, with no dollar cap on the amount of discounts received during the year. The cardholder is responsible for paying the costs of any drugs (taking into account the discount) until the deductible of any other health plan covering the individual is satisfied. An employee who is otherwise eligible for an HSA will not become ineligible solely as a result of having this benefit.

Q-10. Does coverage under an Employee Assistance Program (EAP), disease management program, or wellness program make an individual ineligible to contribute to an HSA?

A-10. An individual will not fail to be an eligible individual under section 223(c)(1)(A) solely because the individual is covered under an EAP, disease management program or wellness program if the program does not provide significant benefits in the nature of medical care or treatment, and therefore, is not considered a “health plan” for purposes of section 223(c)(1). To determine whether a program provides significant benefits in the nature of medical care or treatment, screening and other preventive care services as described in Notice 2004-23 will be disregarded. See also Q&A 48 on incentives for employees who participate in these programs.

Example (1). An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee’s problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs. This EAP is not a “health plan” under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Example (2). An employer maintains a disease management program that identifies employees and their family members who have, or are at risk for, certain chronic conditions. The disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan. Typical interventions include monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks. This

disease management program is not a “health plan” under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Example (3). An employer offers a wellness program for all employees regardless of participation in a health plan. The wellness program provides a wide-range of education and fitness services designed to improve the overall health of the employees and prevent illness. Typical services include education, fitness, sports, and recreation activities, stress management and health screenings. Any cost charged to the individual for participating in the services are separate from the individual’s coverage under the health plan. This wellness program is not a “health plan” under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Q-11. If an employee begins HDHP coverage mid-month, when does the employee become an eligible individual? (For example, coverage under the HDHP begins on the first day of a biweekly payroll period.)

A-11. Under section 223(b)(2), an eligible individual must have HDHP coverage as of the first day of the month. An individual with employer-provided HDHP coverage on a payroll-by-payroll basis becomes an eligible individual on the first day of the month on or following the first day of the pay period when HDHP coverage begins.

Example. An employee begins HDHP coverage on the first day of a pay period, which is August 16, 2004, and continues to be covered by the HDHP throughout 2004. For purposes of contributing to an HSA, the employee becomes an eligible individual on September 1, 2004.

II. High Deductible Health Plans (HDHPs)

Q-12. What is family HDHP coverage under section 223?

A-12. Under section 223(c)(4), the term “family coverage” means any coverage other than self only coverage. Self-only coverage is a health plan covering only one individual; self-only HDHP coverage is an HDHP covering only one individual if that individual is an eligible individual. Family HDHP coverage is a health plan covering one eligible individual and at least one other individual (whether or not the other individual is an eligible individual).

Example. An individual, who is an eligible individual, and his dependent child are covered under an “employee plus one” HDHP offered by the individual’s employer. The coverage is family HDHP coverage under section 223(c)(4).

Q-13. Can a state high-risk health insurance plan (high-risk pool) qualify as an HDHP?

A-13. Yes. If the state’s high-risk pool does not pay benefits below the minimum annual deductible of an HDHP as set forth in section 223(c)(2)(A), the plan can qualify as an HDHP.

Q-14. May an HDHP impose a lifetime limit on benefits?

A-14. Yes. An HDHP may impose a reasonable lifetime limit on benefits provided under the plan. In such cases, amounts paid by the covered individual above the lifetime limit will not be treated as out-of-pocket expenses in determining the annual out-of-pocket maximum. However, a lifetime limit on benefits designed to circumvent the maximum annual out-of-pocket amount in section 223(c)(2)(A) is not reasonable.

Example. A health plan has an annual deductible that satisfies the minimum annual deductible under section 223(c)(2)(A)(i) for self-only coverage and for family coverage. After satisfying the deductible, the plan pays 100 percent of covered expenses, up to a lifetime limit of \$1 million. The lifetime limit of \$1 million is reasonable and the health plan is not disqualified from being an HDHP because of the lifetime limit on benefits.

Q-15. If a plan imposes an annual or lifetime limit on specific benefits, are amounts paid by covered individuals after satisfying the deductible treated as out-of-pocket expenses under section 223?

A-15. The out-of-pocket maximum in section 223(c)(2)(A) applies only to covered benefits. Plans may be designed with reasonable benefit restrictions limiting the plan's covered benefits. A restriction or exclusion on benefits is reasonable only if significant other benefits remain available under the plan in addition to the benefits subject to the restriction or exclusion.

Example (1). In 2004, a self-only health plan with a \$1,000 deductible includes a \$1 million lifetime limit on covered benefits. The plan provides no benefits for experimental treatments, mental health, or chiropractic care visits. Although the plan provides benefits for substance abuse treatment, it limits payments to 26 treatments per year, after the deductible is satisfied. Although the plan provides benefits for fertility treatments, it limits lifetime reimbursements to \$10,000, after the deductible is satisfied. Other than these limits on covered benefits, the plan pays 80 percent of major medical expenses incurred after satisfying the deductible. When the 20 percent coinsurance paid by the covered individuals reaches \$4,000, the plan pays 100 percent. Under these facts, the plan is an HDHP and no expenses incurred by a covered individual other than the deductible and the 20 percent coinsurance are treated as out of-pocket expenses under section 223(c)(2)(A).

Example (2). In 2004, a self-only health plan with a \$1,000 deductible imposes a lifetime limit on reimbursements for covered benefits of \$1 million. While the plan pays 100 percent of expenses incurred for covered benefits after satisfying the deductible, the plan imposes a \$10,000 annual limit on benefits for any single condition. The \$10,000 annual limit under these facts is not reasonable because significant other benefits do not remain available under the plan. Under these facts, any expenses incurred by a covered individual after satisfying the deductible are treated as out-of-pocket expenses under section 223(c)(2)(A).

Q-16. If a plan limits benefits to usual, customary and reasonable (UCR) amounts, are amounts paid by covered individuals in excess of UCR included in determining the maximum out-of-pocket expenses paid?

A-16. Restricting benefits to UCR is a reasonable restriction on benefits. Thus, amounts paid by covered individuals in excess of UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.

Q-17. Can a plan with no express limit on out-of-pocket expenses qualify as an HDHP?

A-17. A health plan without an express limit on out-of-pocket expenses is generally not an HDHP unless such limit is not necessary to prevent exceeding the out-of-pocket maximum.

Example (1). A plan provides self-only coverage with a \$2,000 deductible and pays 100 percent of covered benefits above the deductible. Because the plan pays 100 percent of covered benefits after the deductible is satisfied, the maximum out-of-pocket expenses paid by a covered individual would never exceed the deductible. Thus, the plan does not require a specific limit on out-of-pocket expenses to insure that the covered individual will not be subject to out-of-pocket expenses in excess of the maximum set forth in section 223(c)(2)(A).

Example (2). A plan provides self-only coverage with a \$2,000 deductible. The plan imposes a lifetime limit on reimbursements for covered benefits of \$1 million. For expenses for covered benefits incurred above the deductible, the plan reimburses 80 percent of the UCR costs. The plan includes no express limit on out-of-pocket expenses. This plan does not qualify as a HDHP because it does not have a limit on out-of-pocket expenses.

Example (3). The same facts as Example 2, except that after the 20 percent coinsurance paid by the covered individual reaches \$3,000, the plan pays 100 percent of the UCR costs until the \$1 million limit is reached. For the purpose of determining the individual's out-of-pocket expenses, the plan only takes into account the 20 percent of UCR paid by the individual. This plan satisfies the out-of-pocket limit.

Q-18. A health plan which otherwise qualifies as an HDHP imposes a flat dollar penalty on a participant who fails to obtain pre-certification for a specific provider or for certain medical procedures. Is the penalty paid by the covered individual included in determining the maximum out-of-pocket expenses paid?

A-18. No. The penalty is not an out-of-pocket expense and, therefore, does not count toward the expense limits in section 223(c)(2)(A).

Q-19. A health plan which otherwise qualifies as an HDHP generally requires a 10 percent coinsurance payment after a covered individual satisfies the deductible. However, if an individual fails to get pre-certification for a specific provider, the plan requires a 20 percent coinsurance payment. Is the increased coinsurance amount included in determining the maximum out-of-pocket expenses paid?

A-19. No. Under the facts set forth, only the generally applicable 10 percent coinsurance payment is included in computing the maximum out-of-pocket expenses paid. The result is the same if the plan imposes a higher coinsurance amount for an out-of-network provider. See also Notice 2004-2, Q&A 4.

Q-20. Are cumulative embedded deductibles under family coverage subject to the out-of-pocket maximum?

A-20. Yes. An HDHP generally must limit the out-of-pocket expenses paid by the covered individuals, either by design or by its express terms.

Example (1). In 2004, a plan which otherwise qualifies as an HDHP provides family coverage with a \$2,000 deductible for each family member. The plan pays 100 percent of covered benefits for each family member after that family member satisfies the \$2,000 deductible. The plan contains no express limit on out-of-pocket expenses. Section 223(c)(2)(A)(ii)(II) limits the maximum out-of-pocket expenses to \$10,000 for family coverage. The plan is an HDHP for any family with two to five covered individuals ($\$2,000 \times 5 = \$10,000$). However, the plan is not an HDHP for a family with six or more covered individuals.

Example (2). The same facts as Example 1, except that the plan includes an umbrella deductible of \$10,000. The plan reimburses 100 percent of covered benefits if the family satisfies the \$10,000 in the aggregate, even if no single family member satisfies the \$2,000 embedded deductible. This plan qualifies as an HDHP for the family, regardless of the number of covered individuals.

Q-21. Are amounts incurred by an individual for medical care before a health plan's deductible is satisfied included in computing the plan's out-of-pocket expenses under section 223(c)(2)(A)?

A-21. A health plan's out-of-pocket limit includes the deductible, co-payments, and other amounts, but not premiums. Notice 2004-2 Q&A 3. Amounts incurred for noncovered benefits (including amounts in excess of UCR and financial penalties) also are not counted toward the deductible or the out-of-pocket limit. If a plan does not take copayments into account in determining if the deductible is satisfied, the copayments must still be taken into account in determining if the out-of-pocket maximum is exceeded.

Example. In 2004, a health plan has a \$1,000 deductible for self-only coverage. After the deductible is satisfied, the plan pays 100 percent of UCR for covered benefits. In addition, the plan pays 100 percent for preventive care, minus a \$20 copayment per screening. The plan does not take into account copayments in determining if the \$1,000 deductible has been satisfied. The copayments must be included in determining if the plan meets the out-of-pocket maximum. Unless the plan includes an express limit on out-of-pocket expenses taking into account the copayments, or limits the copayments to \$4,000, the plan is not an HDHP.

Q-22. If an employer changes health plans mid-year, does the new health plan fail to satisfy section 223(c)(2)(A) merely because it provides a credit towards the deductible for expenses incurred during the previous health plan's short plan year and not reimbursed?

A-22. No. If the period during which expenses are incurred for purposes of satisfying the deductible is 12 months or less and the plan satisfies the requirements for an HDHP, the new plan's taking into account expenses incurred during the prior plan's short plan year (whether or

not the prior plan is an HDHP) and not reimbursed, does not violate the requirements of section 223(c)(2)(A).

Example. An employer with a calendar year health plan switches from a non-HDHP plan to a new plan with the first day of coverage under the new plan of July 1. The annual deductible under the new plan satisfies the minimum annual deductible for an HDHP under section 223(c)(2)(A)(i) and counts expenses incurred under the prior plan during the first six months of the year in determining if the new plan's annual deductible is satisfied. The new plan satisfies the HDHP deductible limit under section 223(c)(2)(A).

Q-23. If an eligible individual changes coverage during the plan year from self-only HDHP coverage to family HDHP coverage, does the individual (or any other person covered under the family coverage) fail to be covered by an HDHP merely because the family HDHP coverage takes into account expenses incurred while the individual had self-only coverage?

A-23. No.

Example. An eligible individual has self-only coverage from January 1 through March 31, marries in March and from April 1 through December 31, has family coverage under a plan otherwise qualifying as an HDHP. The family coverage plan applies expenses incurred by the individual from January through March toward satisfying the family deductible. The individual does not fail to be covered by an HDHP. The family coverage satisfies the deductible limit in section 223(c)(2)(A)(i)(II). The individual's contribution to an HSA is based on three months of the self-only coverage (i.e., 3/12 of the deductible for the self-only coverage) and nine months of family coverage (9/12 of the deductible for family coverage).

Q-24. How are the minimum deductible in section 223(c)(2)(A) for an HDHP and the maximum contribution to an HSA in section 223(b) calculated when the period for satisfying a health plan's deductible is longer than 12 months?

A-24. The deductible limits in section 223(c)(2)(A) are based on 12 months. If a plan's deductible may be satisfied over a period longer than 12 months, the minimum annual deductible under section 223(c)(2)(A) must be increased to take into account the longer period in determining if the plan satisfies the HDHP deductible requirements. The adjustment will be done as follows: (1) Multiply the minimum annual deductible in section 223(c)(2)(A)(i) (as adjusted under section 223(g)) by the number of months allowed to satisfy the deductible. (2) Divide the amount in (1) above by 12. This is the adjusted deductible for the longer period that is used to test for compliance with section 223(c)(2)(A). (3) Compare the amount in (2) to the plan's deductible. If the plan's deductible equals or exceeds the amount in (2), the plan satisfies the requirements for the minimum deductible in section 223(c)(2)(A). (Note that the deductible for an HDHP may not exceed the out-of-pocket maximum under section 223(c)(2)(A)(ii).) If the plan qualifies as an HDHP, an eligible individual's maximum annual HSA contribution will be the lesser of the amounts in (1) or (2) below: (1) Divide the plan's deductible by the number of months allowed to satisfy the deductible, and multiply this amount by 12; (2) The statutory amount in section 223(b)(2)(A)(ii) for self-only coverage (\$2,600 in 2004) or section 223(b)(2)(B)(ii) for family coverage (\$5,150 in 2004), as applicable.

Example. For 2004, a health plan takes into account medical expenses incurred in the last three months of 2003 to satisfy its deductible for calendar year 2004. The plan's deductible for self only coverage is \$1,500 and covers 15 months (the last three months of 2003 and 12 months of 2004). To determine if the plan's deductible satisfies section 223(c)(2)(A) the following calculations are performed: (1) multiply \$1,000, the minimum annual deductible in section 223(c)(2)(A)(i), by 15, the number of months in which expenses incurred are taken into account to satisfy the deductible, = \$15,000; (2) divide \$15,000 by 12 = \$1,250; (3) The HDHP minimum deductible for self-only coverage for 15 months must be at least \$1,250. Because the plan's deductible, \$1,500, exceeds \$1,250, the plan's self-only coverage satisfies the deductible rule in section 223(c)(2)(A). The maximum annual HSA contribution in 2004 for an eligible individual with self-only coverage under these facts is \$1,200, the lesser of (1) $(\$1,500/15) \times 12 = \$1,200$; or (2) \$2,600.

Q-25. A health plan which otherwise meets the definition of an HDHP negotiates discounted prices for health care services from providers. Covered individuals receive benefits at the discounted prices, regardless of whether they have satisfied the plan's deductible. Do the discounted prices prevent the health plan from being an HDHP as defined in section 223(c)(2)?

A-25. No.

III. Preventive care

Q-26. Does a preventive care service or screening that also includes the treatment of a related condition during that procedure come within the safe harbor for preventive care in Notice 2004-23?

A-26. Yes. Although Notice 2004-23 states that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition, in situations where it would be unreasonable or impracticable to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a preventive care service or screening as described in Notice 2004-23 also falls within the safe-harbor for preventive care. For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the deductible in an HDHP has been satisfied.

Q-27. To what extent do drugs or medications come within the safe-harbor for preventive care services under section 223(c)(2)(C)?

A-27. Notice 2004-23 sets out a preventive care deductible safe harbor for HDHPs under section 223(c)(2)(C). Solely for this purpose, drugs or medications are preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of high cholesterol with cholesterol lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute preventive care. In addition, drugs or medications used as part of

procedures providing preventive care services specified in Notice 2004-23, including obesity weight-loss and tobacco cessation programs, are also preventive care. However, the preventive care safe harbor under section 223(c)(2)(C) does not include any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications used to treat an existing illness, injury or condition.

IV. Contributions

Q-28. Who may make contributions on behalf of an eligible individual?

A-28. Although Q&A 11 of Notice 2004-2 only refers to contributions by employers or family members, any person (an employer, a family member or any other person) may make contributions to an HSA on behalf of an eligible individual.

Q-29. May a state government make an HSA contribution on behalf of eligible individuals insured under the state's comprehensive health insurance programs for high-risk individuals (state high-risk pool)?

A-29. Yes. See also Q&A 13.

Q-30. How is the maximum annual HSA contribution limit in section 223(b)(2) determined for an eligible individual with family coverage under an HDHP that includes embedded individual deductibles and an umbrella deductible?

A-30. Generally, under section 223(b)(2)(B), the maximum annual HSA contribution limit for an eligible individual with family coverage under an HDHP (without regard to catch-up contributions) is the lesser of: (1) the annual deductible under the HDHP, or (2) the statutory limit on family coverage contributions as indexed by section 223(g). An HDHP often has a stated maximum amount of expenses the family could incur before receiving benefits (i.e., the umbrella deductible), but also provides payments for covered medical expenses if any individual member of the family incurs medical expenses in excess of the minimum annual deductible in section 223(c)(2)(A)(i)(II) (the embedded individual deductible). The maximum annual HSA contribution limit for an eligible individual who has family coverage under an HDHP with embedded individual deductibles and an umbrella deductible as described above, is the least of the following amounts: (1) the maximum annual contribution limit for family coverage specified in section 223(b)(2)(B)(ii) (\$5,150 for calendar year 2004); the umbrella deductible; or the embedded individual deductible multiplied by the number of family members (2) (3) covered by the plan. See Notice 2004-2, Q&A 3, which requires that the embedded individual deductible satisfy the minimum annual deductible for an HDHP.

Example (1). In 2004, H and W, a married couple, have HDHP coverage for themselves and their two dependent children. The HDHP will pay benefits for any family member whose covered expenses exceed \$2,000 (the embedded individual deductible), and will pay benefits for all family members after their covered expenses exceed \$5,000 (the umbrella deductible). The maximum annual contribution limit under section 223(b)(2)(B)(ii) is \$5,150. The embedded deductible multiplied by the number of family members covered is \$8,000 (4 X \$2,000). The

maximum annual contribution which H and W can make to their HSAs is \$5,000 (the least of \$5,000, \$5,150 or \$8,000). The \$5,000 limit is divided equally between H and W, unless they agree to a different division. See Q&A 32 and Notice 2004-2, Q&A 15.

Example (2). The same facts as Example 1, except the HDHP provides coverage only for H and W. The maximum annual contribution limit under section 223(b)(2)(B)(ii) is \$5,150. The umbrella deductible is \$5,000. The embedded individual deductible multiplied by the number of family members covered is \$4,000 (2 X \$2,000). The maximum annual contribution which H and W can make to their HSAs for 2004 is \$4,000 (the least of \$5,000, \$5,150 or \$4,000).

Q-31. How do the maximum annual HSA contribution limits apply to family HDHP coverage that may include an ineligible individual?

A-31. The maximum annual HSA contribution for a married couple with family HDHP coverage is the lesser of: (1) the lowest HDHP family deductible applicable to the family (minimum \$2,000) or (2) the section 223(b)(2)(B) statutory maximum (\$5,150 in 2004). Although the special rule for married individuals in section 223(b)(5) generally allows a married couple to divide the maximum HSA contribution between spouses, if only one spouse is an eligible individual, only that spouse may contribute to an HSA (notwithstanding the treatment under section 223(b)(5)(A) of both spouses as having only family coverage). For an HDHP with embedded individual deductibles see Q&A 30.

Example (1). In 2004, H and W are a married couple and neither qualifies for catch-up contributions under section 223(b)(3). H and W have family HDHP coverage with a \$5,000 deductible. H is an eligible individual and has no other coverage. W also has self-only coverage with a \$200 deductible. W, who has coverage under a low-deductible plan, is not an eligible individual. H may contribute \$5,000 (the lesser of \$5,000 or \$5,150) to an HSA while W may not contribute to an HSA.

Example (2). The same facts as Example 1, except that, in addition to the family HDHP with a \$5,000 deductible, W has self-only HDHP coverage with a \$2,000 deductible rather than self-only coverage with a \$200 deductible. Both H and W are eligible individuals. H and W are treated as having only family coverage under section 223(b)(5). The maximum combined HSA contribution by H and W is \$5,000, to be divided between them by agreement.

Example (3). The same facts as Example 1, except that, in addition to the family HDHP with a \$5,000 deductible, W has family HDHP coverage with a \$3,000 deductible rather than self-only coverage with a \$200 deductible. Both H and W are eligible individuals. H and W are treated as having family HDHP coverage with the lowest annual deductible under section 223(b)(5)(A). The maximum combined HSA contribution by H and W is \$3,000, to be divided between them by agreement.

Example (4). The same facts as Example 1, except that, in addition to family coverage under the HDHP with a \$5,000 deductible, W has family coverage with a \$500 deductible rather than self-only coverage with a \$200 deductible. H and W are treated as having family coverage with the

lowest annual deductible under section 223(b)(5)(A). Neither H nor W is an eligible individual and neither may contribute to an HSA.

Example (5). The same facts as Example 1, except that, in addition to the family HDHP with a \$5,000 deductible, W is enrolled in Medicare rather than having self-only coverage with a \$200 deductible. W is not an eligible individual. H may contribute \$5,000 to an HSA while W may not contribute to an HSA.

Example (6). Individual X is a single individual who does not qualify for catch-up contributions. X is an eligible individual and has a dependent. X and his dependent have family HDHP coverage with a \$5,000 deductible. The dependent also has self-only coverage with a \$200 deductible. X may contribute \$5,000 to an HSA while the dependent may not contribute to an HSA.

Q-32. How may spouses agree to divide the annual HSA contribution limit between themselves?

A-32. Section 223(b)(5) provides special rules for married individuals and states that HSA contributions (without regard to the catch-up contribution) “shall be divided equally between them unless they agree on a different division.” Thus, spouses can divide the annual HSA contribution in any way they want, including allocating nothing to one spouse. See also Notice 2004-2, Q&A 15.

Example. In 2004, X, an eligible individual, has self-only HDHP coverage with a \$1,200 deductible from January 1 through March 31. In March, X and Y marry. Neither X nor Y qualifies for the catch-up contribution. From April 1 through December 31, 2004 X and Y have HDHP family coverage with a \$2,400 deductible. Y is an eligible individual from April 1 through December 31, 2004. X and Y’s contribution limit for the nine months of family coverage is \$1,800 (nine months of the deductible for family coverage. $9/12 \times \$2,400$). X and Y divide the \$1,800 between them. X’s contribution limit to his HSA for the three months of single coverage is \$300 (three months of the deductible for self-only coverage. $3/12 \times \$1,200$). The \$300 limit is not divided between X and Y. See also Q&A 23.

Q-33. What is the contribution limit for an eligible individual covered by an HDHP and also by a post-deductible health reimbursement arrangement (HRA)?

A-33. Rev. Rul. 2004-45, Situation 4, describes a post-deductible HRA that does not pay or reimburse any medical expense incurred before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. The ruling states that the deductible for the HRA need not be the same as the deductible for the HDHP, but in no event may the HDHP or other coverage provide benefits before the minimum annual deductible under section 223(c)(2)(A)(i) is satisfied. Where the HDHP and the other coverage do not have identical deductibles, contributions to the HSA are limited to the lower of the deductibles. In addition, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid by the HDHP or the other coverage before the minimum annual deductible under section 223(c)(2)(A)(i) has been satisfied.

Example. In 2004, an individual has self-only coverage under an HDHP with a deductible of \$2,500. The individual is also covered under a post-deductible HRA (as described in Rev. Rul. 2004-45) which pays or reimburses qualified medical expenses only after \$2,000 of the HDHP's deductible has been satisfied (i.e., if the individual incurs covered medical expenses of \$2,250, the HRA will pay \$250). Because the HRA's deductible of \$2,000 is less than the HDHP's deductible of \$2,500, the individual's HSA contribution limit is \$2,000.

Q-34. An account beneficiary wants to withdraw an excess contribution from an HSA before the due date of his or her federal income tax return (including extensions), to avoid the 6 percent excise tax under section 4973(a)(5). How is the net income attributable to the excess contribution computed?

A-34. Section 223(f)(3)(A)(ii) provides that any distribution of excess contribution to an HSA must be "accompanied by the amount of net income attributable to such excess contribution." Any net income is included in the individual's gross income. The rules for computing attributable net income for excess IRA contributions apply to HSAs. See Treas. Reg. § 1.408-11 and Notice 2004-2, Q&A 22.

Q-35. May an individual who has not made excess HSA contributions treat a distribution from an HSA other than for qualified medical expenses as the withdrawal of excess HSA contributions?

A-35. No. This withdrawal is deemed a withdrawal for non-qualified medical expenses and includable in the individual's gross income under section 223(f)(2). (The additional tax under section 223(f)(4) also applies, unless otherwise excepted).

V. Distributions

Q-36. If an account beneficiary's spouse or dependents are covered under a non-HDHP, are distributions from an HSA to pay their qualified medical expenses excluded from the account beneficiary's gross income ?

A-36. Yes. Distributions from an HSA are excluded from income if made for any qualified medical expense of the account beneficiary, the account beneficiary's spouse and dependents (without regard to their status as eligible individuals). However, distributions made for expenses reimbursed by another health plan are not excludable from gross income, whether or not the other health plan is an HDHP. See Notice 2004-2, Q&A 26.

Q-37. An account beneficiary receives an HSA distribution as the result of a mistake of fact due to reasonable cause (e.g., the account beneficiary reasonably, but mistakenly, believed that an expense was a qualified medical expense and was reimbursed for that expense from the HSA). The account beneficiary then repays the mistaken distribution to the HSA. Is the mistaken distribution included in gross income under section 223(f)(2) and subject to the 10 percent additional tax under section 223(f)(4) or subject to the excise tax on excess contributions under section 4973(a)(5)?

A-37. If there is clear and convincing evidence that amounts were distributed from an HSA because of a mistake of fact due to reasonable cause, the account beneficiary may repay the mistaken distribution no later than April 15 following the first year the account beneficiary knew or should have known the distribution was a mistake. Under these circumstances, the distribution is not included in gross income under section 223(f)(2), or subject to the 10 percent additional tax under section 223(f)(4), and the repayment is not subject to the excise tax on excess contributions under section 4973(a)(5). But see Q&A 76 on the trustee's or custodian's obligation to accept a return of mistaken distributions.

Q-38. If both spouses have HSAs and one spouse uses distributions from his or her HSA to pay or reimburse the section 213(d) qualified medical expenses of the other spouse, are the distributions excluded from the account beneficiary's gross income under section 223(f)?

A-38. Yes. However, both HSAs may not reimburse the same expense amounts.

Q-39. When must a distribution from an HSA be taken to pay or reimburse, on a tax-free basis, qualified medical expenses incurred in the current year?

A-39. An account beneficiary may defer to later taxable years distributions from HSAs to pay or reimburse qualified medical expenses incurred in the current year as long as the expenses were incurred after the HSA was established. Similarly, a distribution from an HSA in the current year can be used to pay or reimburse expenses incurred in any prior year as long as the expenses were incurred after the HSA was established. Thus, there is no time limit on when the distribution must occur. However, to be excludable from the account beneficiary's gross income, he or she must keep records sufficient to later show that the distributions were exclusively to pay or reimburse qualified medical expenses, that the qualified medical expenses have not been previously paid or reimbursed from another source and that the medical expenses have not been taken as an itemized deduction in any prior taxable year. See Notice 2004-2, Q&A 31 and also Notice 2004-25, for transition relief in calendar year 2004 for reimbursement of medical expenses incurred before opening an HSA.

Example. An eligible individual contributes \$1,000 to an HSA in 2004. On December 1, 2004, the individual incurs a \$1,500 qualified medical expense and has a balance in his HSA of \$1,025. On January 3, 2005, the individual contributes another \$1,000 to the HSA, bringing the balance in the HSA to \$2,025. In June, 2005, the individual receives a distribution of \$1,500 to reimburse him for the \$1,500 medical expense incurred in 2004. The individual can show that the \$1,500 HSA distribution in 2005 is a reimbursement for a qualified medical expense that has not been previously paid or otherwise reimbursed and has not been taken as an itemized deduction. The distribution is excludable from the account beneficiary's gross income.

Q-40. May an account beneficiary pay qualified long-term care insurance premiums with distributions from an HSA if contributions to the HSA are made by salary-reduction through a section 125 cafeteria plan?

A-40. Yes. Section 125(f) provides that the term "qualified benefit" under a section 125 cafeteria plan shall not include any product which is advertised, marketed, or offered as longterm care

insurance. However, for HSA purposes, section 223(d)(2)(C)(ii) provides that the payment of any expense for coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)) is a qualified medical expense. Where an HSA that is offered under a cafeteria plan pays or reimburses individuals for qualified long-term care insurance premiums, section 125(f) is not applicable because it is the HSA and not the long-term care insurance that is offered under the cafeteria plan.

Q-41. Do the section 213(d)(10) limits on the deduction for "eligible long-term care premiums" restrict the amount of distributions for qualified medical expenses that may be excluded from income under an HSA?

A-41. Yes. "Eligible long-term care premiums" are deductible medical expenses under section 213, but the deduction is limited to the annually adjusted amounts in section 213(d)(10) (based on age). See Rev. Proc. 2003-85 § 3.18, 2003-49 I.R.B. 1184 for the 2004 limits. Thus, although HSA distributions to pay or reimburse qualified long-term care insurance premiums are qualified medical expenses, the exclusion from gross income is limited to the adjusted amounts under section 213(d)(10). Any excess premium reimbursements are includable in gross income and may also be subject to the 10 percent penalty under section 223(f)(4). Example. In 2004, X, age 41, pays premiums of \$1,290 for a qualified long term care insurance contract. The section 213(d)(10) limit in calendar year 2004 for deductions for persons age 40, but not more than 50, is \$490. X's HSA can reimburse X up to \$490 on a tax- free basis for the long-term care premiums. The remaining \$800 (\$1,290-\$490), if reimbursed from the HSA, is not for qualified medical expenses and is includable in gross income.

Q-42. Are distributions from an HSA for long-term care services qualified medical expenses which are excluded from income?

A-42. Yes. Section 106(c) provides that employer-provided coverage for long-term care services provided through a flexible spending or similar arrangement are included in an employee's gross income. Section 213(d)(1)(C) provides that amounts paid for qualified longterm care services are medical care and section 223(f)(1) provides that amounts paid or distributed out of an HSA used to pay for qualified medical expenses are not includable in gross income. Qualified medical expenses are amounts paid for medical care (as defined in section 213(d)) for the account beneficiary, his or her spouse and dependents. Although section 106(c) applies to benefits provided by a flexible spending or similar arrangement, it does not apply to distributions from an HSA, which is a personal health care savings vehicle used to pay for qualified medical expenses through a trust or custodial account, whether or not the HSA is funded by salary-reduction contributions through a section 125 cafeteria plan.

Q-43. May a retiree who is age 65 or older receive tax-free distributions from an HSA to pay the retiree's contribution to an employer's self- insured retiree health coverage?

A-43. Yes. Pursuant to section 223(d)(2)(B), the purchase of health insurance is generally not a qualified medical expense that can be paid or reimbursed by an HSA. See Notice 2004-2, Q&A 27. However, section 223(d)(2)(C)(iv) provides an exception for coverage for health insurance

once an account beneficiary has attained age 65. The exception applies to both insured and self-insured plans.

Q-44. May an individual who is under age 65 and has end stage renal disease (ESRD) or is disabled receive tax- free distributions from an HSA to pay for health insurance premiums?

A-44. No. Section 223(d)(2)(B) provides that health insurance may not be paid by an HSA. However, section 223(d)(2)(C)(iv) provides that payment of health insurance premiums are qualified medical expenses, but only in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act (i.e., age 65).

Q-45. If a retiree who is enrolled in Medicare receives a distribution from an HSA to reimburse the retiree's Medicare premiums, is the reimbursement a qualified medical expense under section 223(d)(2)?

A-45. Yes. Where premiums for Medicare are deducted from Social Security benefit payments, an HSA distribution to reimburse the Medicare beneficiary equal to the Medicare premium deduction is a qualified medical expense.

VI. Comparability

Q-46. Does an employer who offers to make available a contribution to the HSA of each employee who is an eligible individual in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (i.e., "matching contributions") satisfy the requirement under section 4980G that all comparable participating employees receive comparable contributions?

A-46. If all employees who are eligible individuals do not contribute the same amount to their HSAs and, consequently, do not receive comparable contributions to their HSAs, the section 4980G comparability rules are not satisfied, notwithstanding that the employer offers to make available the same contribution amount to each employee who is an eligible individual. But see Q&A 47 on comparable contributions made through a cafeteria plan.

Q-47. If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (i.e., "matching contributions"), are the contributions subject to the section 4980G comparability rules?

A-47. No. The conference report for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that the comparability rules do not apply to contributions made through a cafeteria plan. Conf. Rep. No. 391, 108th Cong., 1st Sess. 840 (2003). Notice 2004-2, Q&A 32 similarly provides that the comparability rules do not apply to HSA contributions made through a cafeteria plan. Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including "matching contributions", to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and

benefits tests and key employee concentration tests). See section 125(b), (c) and (g) and Prop. Treas. Reg. § 1.125-1, Q&A 19.

Q-48. If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the section 4980G comparability rules?

A-48. If all eligible employees do not elect to participate in all the programs and consequently, all employees who are eligible individuals do not receive comparable contributions to their HSAs, the employer contributions fail to satisfy the section 4980G comparability rules. But see Q&A 49 on comparable contributions made through a cafeteria plan.

Q-49. If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA, unless the employee elects cash, are the contributions subject to the section 4980G comparability rules?

A-49. No. The comparability rules under section 4980G do not apply to employer contributions to an HSA through a cafeteria plan.

Q-50. If an employer offers to make available additional HSA contributions to all employees who are eligible individuals and who have attained a specified age or who qualify for the additional contributions under section 223(b)(3) (catch-up contributions), do the contributions satisfy the section 4980G comparability rules?

A-50. No. If all employees who are eligible individuals do not meet the age requirement or do not qualify for the additional contributions under section 223(b)(3), all employees who are eligible individuals do not receive comparable contributions to their HSAs and the employer contributions fail to satisfy the section 4980G comparability rules.

Q-51. How do the comparability rules in section 4980G apply to employer contributions to employees' HSAs if some employees work full-time during the entire calendar year, and other employees work full-time for less than the entire calendar year?

A-51. An employer contributing to HSAs of employees who work full-time for less than twelve months, satisfies the comparability rules if the contribution amount is comparable when determined on a month-to-month basis. For example, if the employer contributes \$240 to the HSAs of each full-time employee who works the entire calendar year, the employer must contribute \$60 to the HSA of a full-time employee who works three months of the year. See section 4980G(b) and section 4980E(d)(2)(B). See also Notice 2004-2, Q&A 32 on comparability rules for part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week).

Q-52. What is the testing period for making comparable contributions to employees' HSAs?

A-52. To satisfy the comparability rule in section 4980G, an employer must make comparable contributions for the calendar year to HSAs of employees who are eligible individuals. See section 4980G and section 4980E(d).

Q-53. Under section 4980G, must an employer make comparable contributions to all employees who are eligible individuals or only to those employees who are eligible individuals and are also covered by an HDHP provided by the employer?

A-53. If during a calendar year, an employer contributes to the HSA of any employee covered under an HDHP provided by the employer, the employer is required to make comparable contributions to all eligible individuals with coverage under any HDHP provided by the employer. An employer that contributes to the HSAs of employees with coverage under the HDHP provided by the employer is not required to make comparable contributions to HSAs of employees who are not covered under the HDHP provided by the employer. However, an employer that contributes to the HSA of any eligible individual with coverage under any HDHP, even if that coverage is not an HDHP of the employer, must make comparable contributions to all eligible individuals whether or not covered under an HDHP of the employer. See also Notice 2004-2, Q&A 32.

Example (1). An employer offers an HDHP to its full-time employees. Most full-time employees are covered under the employer's HDHP and the employer makes comparable contributions only to these employees' HSAs. Employee D, a full-time employee and an eligible individual (as defined in section 223(c)(1)), is covered under his spouse's HDHP and not under his employer's HDHP. The employer is not required to make comparable contributions to D's HSA.

Example (2). An employer does not offer an HDHP. Several full-time employees, who are eligible individuals (as defined in section 223(c)(1)), have HSAs. The employer contributes to these employees' HSAs. The employer must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example (3). An employer offers an HDHP to its full-time employees. Most full-time employees are covered under the employer's HDHP and the employer makes comparable contributions to these employees' HSAs and also to HSAs of full-time employees not covered under the employer's HDHP. Employee E, a full-time employee and an eligible individual (as defined in section 223(c)(1)), is covered under his spouse's HDHP and not under his employer's HDHP. The employer must make comparable contributions to E's HSA.

Q-54. If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the section 4980G comparability rules apply to these amounts?

A-54. No. Section 106(d) provides that amounts contributed by an employer to an eligible employee's HSA shall be treated as employer-provided coverage for medical expenses and excludable from the employee's gross income up to the limit in section 223(b). After-tax employee contributions to the HSA are not subject to section 4980G because they are not

employer contributions under section 106(d). See Notice 2004-2, Q&A 12 on aggregation of HSA contributions.

VII. Rollovers

Q-55. How frequently may an account beneficiary make rollover contributions to an HSA under section 223(f)(5)?

A-55. An account beneficiary may make only one rollover contribution to an HSA during a 1-year period. In addition, to qualify as a rollover, any amount paid or distributed from an HSA to an account beneficiary must be paid over to an HSA within 60 days after the date of receipt of the payment or distribution. But see Q&A 78 regarding trustee's or custodian's obligation to accept rollovers. See also Notice 2004-2, Q&A 23 for additional rules on rollovers.

Q-56. Are transfers of HSA amounts from one HSA trustee directly to another HSA trustee (trustee-to-trustee transfers), subject to the rollover restrictions?

A-56. No. The rules under section 223(f)(5) limiting the number of rollover contributions to one a year do not apply to trustee-to-trustee transfers. Thus, there is no limit on the number of trustee-to-trustee transfers allowed during a year.

VIII. Cafeteria Plans and HSAs

Q-57. Which requirements that apply to health flexible spending arrangements (FSAs) under a section 125 cafeteria plan do not apply to HSAs?

A-57. The following requirements for health FSAs under a section 125 cafeteria plan (which are generally imposed so that health FSAs operate in a manner similar to "insurance-type" accident or health plans under section 105) are not applicable to HSAs: (1) the prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another plan year (See section 125(d)(2)(D)); (2) the requirement that the maximum amount of reimbursement must be available at all times during the coverage period; and (3) the mandatory twelve-month period of coverage.

Q-58. Do the section 125 change in status rules apply to elections of HSA contributions through a cafeteria plan?

A-58. A cafeteria plan may permit an employee to revoke an election during a period of coverage with respect to a qualified benefit and make a new election for the remaining portion of the period only as provided in Treas. Reg. § 1.125-4. Because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, rather than on an annual basis, an employee who elects to make HSA contributions under a cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for the change is received). If an employer places additional restrictions on the election of HSA contributions under a cafeteria plan, the same restrictions must apply to all employees.

Q-59. Can an employer permit employees to elect an HSA mid-year if offered as a new benefit under the employer's cafeteria plan?

A-59. Yes, if the election for the HSA is made on a prospective basis. However, the HSA election does not permit a change or revocation of any other coverage under the cafeteria plan unless the change is permitted by Treas. Reg. § 1.125-4. Thus, while an HSA may be offered to and elected by an employee mid-year, the employee may have other coverage under the cafeteria plan that cannot be changed, (e.g., coverage under a health FSA), which may prevent the employee from being an eligible individual. See Rev. Rul. 2004-45.

Q-60. If an employee elects to make contributions to an HSA through the employer's cafeteria plan, may the employer contribute amounts to an employee's HSA to cover qualified medical expenses incurred by an employee that exceed the employee's current HSA balance?

A-60. Yes. Where an employee elects to make contributions to an HSA through a cafeteria plan, the employer may, but is not required to, contribute amounts to an employee's HSA up to the maximum amount elected by the employee. While any accelerated contribution made by the employer must be equally available to all participating employees throughout the plan year and must be provided to all participating employees on the same terms, the employee must repay the amount of the accelerated contribution by the end of the plan year. But see Q&A 82 on recoupment of HSA contributions by an employer.

Q-61. Can employers provide negative elections for HSAs if offered through a cafeteria plan?

A-61. Yes. See Rev. Rul. 2002-27, 2002-1 C.B. 925.

IX. Account Administration

Q-62. Are there model IRS forms for establishing HSAs?

A-62. Yes. See Form 5305-B "Health Savings Trust Account" and Form 5305-C "Health Savings Custodial Account."

Q-63. May a husband and wife have a joint HSA?

A-63. No. Each spouse who is an "eligible individual" as described in section 223(c)(1) and wants to make contributions to an HSA must open a separate HSA. Thus, only one person may be the account beneficiary of an HSA. But see Q&A 32 concerning allocating contributions between spouses. See also Q&A 38 concerning reimbursements from spousal HSAs.

Q-64. May an eligible individual have more than one HSA?

A-64. Yes. An eligible individual may establish more than one HSA, and may contribute to more than one HSA. The same rules governing HSAs apply (e.g., maximum contribution limit), regardless of the number of HSAs established by an eligible individual. See also Notice 2004- 2,

Q&A 12. Example. For 2004, eligible individual A's maximum contribution to an HSA is \$2,400. For 2004, A's employer contributes \$1,000 to an HSA on behalf of A. A opens a second HSA and contributes \$1,400. If additional contributions are made for 2004 to either of the HSAs, then there are excess contributions to A's HSAs.

Q-65. What are permissible investments for HSAs?

A-65. HSA funds may be invested in investments approved for IRAs (e.g., bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds). HSAs may not invest in life insurance contracts, or in collectibles (e.g., any work of art, antique, metal, gem, stamp, coin, alcoholic beverage, or other tangible personal property specified in IRS guidance under section 408(m)). HSAs may, however, invest in certain types of bullion or coins, as described in section 408(m)(3). The HSA trust or custodial agreement may restrict investments to certain types of permissible investments (e.g., particular investment funds).

Q-66. May HSA funds be commingled in a common trust fund or common investment fund?

A-66. Section 223(d)(1)(D) states that the HSA trust assets may not be commingled except in a common trust fund or common investment fund. Thus, individual accounts maintained on behalf of individual HSA account beneficiaries may be held in a common trust fund or common investment fund. A "common trust fund" is defined in Treas. Reg. § 1.408-2(b)(5)(ii). A "common investment fund" is defined in section 584(a)(1).

Q-67. Are there any transactions which account beneficiaries are prohibited from entering into with an HSA?

A-67. Yes. Section 223(e)(2) provides that rules similar to the rules of section 408(e)(2) and (4) shall apply to HSAs. Therefore, account beneficiaries may not enter into "prohibited transactions" with an HSA (e.g., the account beneficiary may not sell, exchange, or lease property, borrow or lend money, furnish goods, services or facilities, transfer to or use by or for the benefit of himself/herself any assets, pledge the HSA, etc.). Any amount treated as distributed as the result of a prohibited transaction will not be treated as used to pay for qualified medical expenses. The account beneficiary must, therefore, include the distribution in gross income and generally will be subject to the additional 10 percent tax on distributions not made for qualified medical expenses. See Notice 2004-2, Q&A 25.

Q-68. Are HSA trustees and custodians also subject to the rules against prohibited transactions?

A-68. Yes. The same rules that apply to account beneficiaries apply to trustees and custodians.

Q-69. If administration and account maintenance fees (e.g., flat administrative fees) are withdrawn from the HSA, are the withdrawn amounts treated as taxable distributions to the account beneficiary?

A-69. No. Amounts withdrawn from an HSA for administration and account maintenance fees will not be treated as a taxable distribution and will not be included in the account beneficiary's gross income.

Q-70. If administration and account maintenance fees are withdrawn from the HSA, does the withdrawn amount increase the maximum annual HSA contribution limit?

A-70. No. For example, if the maximum annual contribution limit is \$2,000, and a \$25 administration fee is withdrawn from the HSA, the annual contribution limit is still \$2,000, not \$2,025.

Q-71. If administration and account maintenance fees are paid by the account beneficiary or employer directly to the trustee or custodian, do these payments count toward the annual maximum contribution limit for the HSA?

A-71. No. Administration and account maintenance fees paid directly by the account beneficiary or employer will not be considered contributions to the HSA. For example, an individual contributes the maximum annual amount to his HSA of \$2,000. The account beneficiary pays an annual administration fee of \$25 directly to the trustee. The individual's maximum annual contribution limit is not affected by the payment of the administration fee.

X. Trustees and Custodians

Q-72. Is any insurance company a qualified HSA trustee or custodian?

A-72. No. Generally, only a life insurance company as defined in section 816 or bank as defined in section 408(n) can be an HSA trustee or custodian. However, insurance companies other than life insurance companies may request approval to be a trustee or custodian in accordance with the procedures set forth in Treas. Reg. § 1.408-2(e) (relating to IRA nonbank trustees).

Q-73. Is there a limit on the annual HSA contribution which the trustee or custodian may accept?

A-73. Yes. Except in the case of rollover contributions described in section 223(f)(5) or trustee to-trustee transfers, the trustee or custodian may not accept annual contributions to any HSA that exceed the sum of: (1) the dollar amount in effect under section 223(b)(2)(B)(i) (i.e., the maximum family coverage deductible) plus (2) the dollar amount in effect under section 223(b)(3)(B) (i.e., the catch-up contribution amount). All contributions must be in cash, other than rollover contributions or trustee-to-trustee transfers. See section 223(d)(1)(A).

Q-74. Is the HSA trustee or custodian responsible for determining whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary?

A-74. No. This is the responsibility of the account beneficiary, who is also responsible for notifying the trustee or custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. The HSA trustee or custodian is, however, responsible for accepting cash contributions within the

limits in Q&A 73 and for filing required information returns with the IRS (Form 5498-SA and Form 1099-SA).

Q-75. Is the trustee or custodian responsible for tracking the account beneficiary's age?

A-75. Yes. However, the trustee or custodian may rely on the account beneficiary's representation as to his or her date of birth.

Q-76. Must the trustee or custodian allow account beneficiaries to return mistaken distributions to the HSA?

A-76. No, this is optional. If the HSA trust or custodial agreement allows the return of mistaken distributions as described in Q&A 37, the trustee or custodian may rely on the account beneficiary's representation that the distribution was, in fact, a mistake.

Q-77. May an HSA trust or custodial agreement restrict the account beneficiary's ability to rollover amounts from that HSA?

A-77. No. Section 223(f)(5) permits the rollover of amounts in an HSA to another HSA, and transfers from one trustee to another trustee.

Q-78. Are HSA trustees or custodians required to accept rollover contributions or trustee-to-trustee transfers?

A-78. No. Rollover contributions or trustee-to-trustee transfers from other HSAs or from Archer MSAs are allowed, but trustees or custodians are not required to accept them. See Notice 2004-2, Q&A 23.

Q-79. May an HSA trust or custodial agreement restrict HSA distributions to pay or reimburse only the account beneficiary's qualified medical expenses?

A-79. No. The HSA trust or custodial agreement may not contain a provision that restricts HSA distributions to pay or reimburse only the account beneficiary's qualified medical expenses. Thus, the account beneficiary is entitled to distributions for any purpose and distributions may be used to pay or reimburse qualified medical expenses or for other nonmedical expenditures. Only the account beneficiary may determine how the HSA distributions will be used. But see Notice 2004-2, Q&A 25 on the taxation of HSA distributions not used exclusively for qualified medical expenses. See also Q&A 80 on restrictions on the frequency or minimum amount of HSA distributions.

Q-80. May a trustee or custodian restrict the frequency or minimum amount of distributions from an HSA?

A-80. Yes. Trustees or custodians may place reasonable restrictions on both the frequency and the minimum amount of distributions from an HSA. For example, the trustee may prohibit distributions for amounts of less than \$50 or only allow a certain number of distributions per

month. Generally, the terms regarding the frequency or minimum amount of distributions from an HSA are matters of contract between the trustee and the account beneficiary.

XI. Other Issues

Q-81. Are employers who contribute to an employee's HSA responsible for determining whether the employee is an eligible individual and the employee's maximum annual contribution limit?

A-81. Employers are only responsible for determining the following with respect to an employee's eligibility and maximum annual contribution limit on HSA contributions: (1) whether the employee is covered under an HDHP (and the deductible) or low deductible health plan or plans (including health FSAs and HRAs) sponsored by that employer; and (2) the employee's age (for catch-up contributions). The employer may rely on the employee's representation as to his or her date of birth.

Q-82. May the employer recoup from an employee's HSA any portion of the employer's contribution to the employee's HSA?

A-82. No. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. For example, on January 2, 2005, the employer makes the maximum annual contribution to employees' HSAs, in the expectation that the employees would work for the entire calendar year 2005. On February 1, 2005, one employee terminates employment. The employer may not recoup from that employee's HSA any portion of the contribution previously made to the employee's HSA.

Q-83. Is an HSA distribution subject to the nondiscrimination rules of section 105(h)?

A-83. No. For amounts reimbursed to a highly compensated individual by a self-insured medical reimbursement plan to be fully excludable from the individual's gross income under section 105(b), the self-insured medical reimbursement plan must satisfy the requirements of section 105(h). Section 105(h) is not satisfied if the plan discriminates in favor of highly compensated individuals as to eligibility to participate or benefits. Because the exclusion from gross income for amounts distributed from an HSA is not determined by section 105(b), but by section 223(b), section 105(h) does not apply to HSAs.

Q-84. Is a deduction under section 223(a) for contributions to a self-employed individual's own HSA taken into account in determining net earnings from self-employment under section 1402(a)?

A-84. No. The deduction is an adjustment to gross income under section 62(a)(19), and is reportable on the self-employed individual's Form 1040 as an adjustment to gross income. It is not a deduction attributable to the self-employed individual's trade or business so it is not taken as a deduction on Schedule C, Form 1040, nor is it taken into account in determining net earnings from self-employment on Schedule SE, Form 1040.

Q-85. Does an employer's contribution to an employee's HSA affect the computation of the earned income credit (EIC) under section 32?

A-85. No. An employer's contributions to an employee's HSAs are not treated as earned income for EIC purposes.

Q-86. May an HDHP apply any required cost-of-living adjustments under section 223(g) to the minimum annual deductible amounts or maximum annual out-of-pocket expense limits on the renewal date of the HDHP if that date is after January 1st?

A-86. Yes. Generally, an HDHP is a health plan that satisfies certain requirements with respect to minimum annual deductibles and maximum annual out-of-pocket expense. These annual amounts are indexed for inflation using annual cost-of-living adjustments. Any required change to the deductibles and out-of-pocket expense limits may be applied as of the renewal date of the HDHP in cases where the renewal date is after the beginning of the calendar year, but in no event longer than a 12-month period ending on the renewal date. Thus, a fiscal year plan that satisfies the minimum annual deductible on the first day of the first month of its fiscal year may apply that deductible for the entire fiscal year, even if the minimum annual deductible increases on January 1 of the next calendar year. Example. An individual obtains self-only coverage under an HDHP on June 1, 2004, the first day of the plan year, with an annual deductible of \$1,000. Assume that the cost-of-living adjustments require the minimum deductible amount to be increased for 2005. The plan's deductible is not increased to comply with the increased minimum deductible amount until the plan's renewal date of June 1, 2005. The plan satisfies the requirements for an HDHP with respect to deductibles through May 30, 2005.

Q-87. Are HSAs available to bona fide residents of the Commonwealth of Puerto Rico, American Samoa, the U.S. Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands?

A-87. Bona fide residents of the U.S. Virgin Islands, Guam and the Commonwealth of the Northern Mariana Islands may establish HSAs. However, bona fide residents of Puerto Rico and American Samoa may establish HSAs only after statutory provisions similar to sections 223 and 106(d) are enacted.

Q-88. If a C corporation makes a contribution to the HSA of a shareholder who is not an employee of the C corporation, what are the tax consequences to the shareholder and to the C corporation?

A-88. If a C corporation makes a contribution to the HSA of a shareholder who is not an employee of the C corporation, the contribution will be treated as a distribution under section 301. The distribution is treated as a dividend to the extent the C corporation has earnings and profits. The portion of the distribution which is not a dividend is applied against and reduces the adjusted basis of the stock. To the extent the amount of the distribution exceeds the adjusted basis of the stock, the balance is treated as gain from a sale or exchange of property.

EFFECT ON OTHER DOCUMENTS

Notice 2004-2, 2004-2 I.R.B. 269 is changed as follows: The second sentence of A-2 is changed to read: An "eligible individual" means ... (3) is not enrolled in Medicare" The first sentence of A-9, is changed to read: "Any life insurance company (as defined in section 816) or any bank (including a similar financial institution as defined in section 408(n)) can be an HSA trustee or custodian." The last sentence of A-12 is changed to read: "In addition to the maximum contribution amount, catch-up contributions, as described in [Notice 2004-2] A-14, may be made by or on behalf of individuals age 55 and older, who are not enrolled in Medicare." The first sentence of A-14 is changed to read: "For individuals (and their spouses covered under the HDHP) who have attained 55 and are also not enrolled in Medicare" The first sentence of the Example in A-14 is changed to read: "An individual attains age 65 and becomes enrolled in Medicare"

TRANSITION RELIEF For months before January 1, 2005, a health plan that would otherwise qualify as an HDHP but for the lack of an express maximum on payments above the deductible that complies with the out-of-pocket requirement, as set forth in Q&A 17 and 20 will be treated as an HDHP. Individuals covered under these health plans will continue to be eligible to contribute to HSAs before January 1, 2005. For months before January 1, 2006, a health plan that would otherwise qualify as an HDHP but for an annual deductible that does not satisfy the rule in Q&A 24 (concerning deductibles for periods of more than 12 months) will be treated as an HDHP if the plan was in effect or submitted to approval to state insurance regulators as of the date of publication of this notice in the Internal Revenue Bulletin. Individuals covered under these health plans will continue to be eligible to contribute to HSAs before January 1, 2006.

DRAFTING INFORMATION The principal author of this notice is Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Ms. Tanner on (202) 622-6080 (not a toll-free call).

HSA Frequently Asked Questions

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The Basics of HSAs

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What is a Health Savings Account (“HSA”)?

A Health Savings Account is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

You must be covered by a High Deductible Health Plan (HDHP) to be able to take advantage of HSAs. An HDHP generally costs less than what traditional health care coverage costs, so the money that you save on insurance can therefore be put into the Health Savings Account.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or a health insurer. You will also decide what types of investments to make with the money in the account in order to make it grow.

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What Is a “High Deductible Health Plan” (HDHP)?

You must have an HDHP if you want to open an HSA. Sometimes referred to as a “catastrophic” health insurance plan, an HDHP is an inexpensive health insurance plan that generally doesn’t pay for the first several thousand dollars of health care expenses (i.e., your “deductible”) but will generally cover you after that. Of course, your HSA is available to help you pay for the expenses your plan does not cover.

In order to qualify to open an HSA, your HDHP minimum deductible must be at least \$1,000 (self-only coverage) or \$2,000 (family coverage). The annual out-of-pocket (including deductibles and co-pays) cannot exceed \$5,100 (self-only coverage) or \$10,200 (family coverage). HDHPs can have first dollar coverage (no deductible) for preventive care and apply higher out-of-pocket limits (and copays & coinsurance) for non-network services.

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How can I get a Health Savings Account?

Consumers can sign up for HSAs with banks, credit unions, insurance companies and other approved companies. Your employer may also set up a plan for employees as well.

How much does an HSA cost?

An HSA is not something you purchase; it’s a savings account into which you can deposit money on a tax-preferred basis. The only product you purchase with an HSA is a High Deductible Health Plan, an inexpensive plan that will cover you should your medical expenses exceed the funds you have in your HSA.

Who Can Have an HSA

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[My employer offers an FSA, can I have both an FSA and an HSA?](#)

[My employer offers an HRA, can I have both and HRA and an HSA?](#)

NEW [My Spouse has an FSA or HRA through their employer, can I have HSA?](#)

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NEW [Does my income affect whether I can have an HSA?](#)

[Can I start an HSA for my child?](#)

NEW [I'm a single parent with HDHP coverage but have child/relative that can be claimed as a dependent for tax purposes, and this dependent also has non-HDHP coverage, am I still eligible for an HSA?](#)

Who is eligible for a Health Savings Account?

To be eligible for a Health Savings Account, an individual must be covered by a HSA-qualified High Deductible Health Plan (HDHP) and must not be covered by other health insurance that is not an HDHP. Certain types of insurance are not considered "health insurance" (see below) and will not jeopardize your eligibility for an HSA.

Can I get an HSA even if I have other insurance that pays medical bills?

You are only allowed to have auto, dental, vision, disability and long-term care insurance at the same time as an HDHP. You may also have coverage for a specific disease or illness as long as it pays a specific dollar amount when the policy is triggered. Wellness programs offered by your employer are also permitted if they do not pay significant medical benefits.

I don't have health insurance, can I get an HSA?

Unfortunately, you cannot establish and contribute to an HSA unless you have coverage under a HDHP.

I'm on Medicare, can I have an HSA?

You are not eligible for an HSA after you have enrolled in Medicare. If you had an HSA before you enrolled in Medicare, you can keep it. However, you cannot continue to make contributions to an HSA after you enroll in Medicare.

I am a Veteran, can I have an HSA?

If you have received any health benefits from the Veterans Administration or one of their facilities, including prescription drugs, in the last three months, you are not eligible for an HSA.

I'm active-duty military and have Tricare coverage, can I have an HSA?

At this time, Tricare does not offer an HDHP options so you are not eligible for an HSA.

My employer offers an FSA, can I have both an FSA and an HSA?

You can have both types of accounts, but only under certain circumstances. General Flexible Spending Arrangements (FSAs) will probably make you ineligible for an HSA. If your employer offers a "limited purpose" (limited to dental, vision or preventive care) or "post-deductible" (pay for medical expenses after the plan deductible is met) FSA, then you can still be eligible for an HSA.

My employer offers an HRA, can I have both an HRA and an HSA?

You can have both types of accounts, but only under certain circumstances. General Health Reimbursement Arrangements (HRAs) will probably make you ineligible for an HSA. If your employer offers a "limited purpose" (limited to dental, vision or preventive care) or "post-deductible" (pay for medical expenses after the plan deductible is met) HRA, then you can still be eligible for an HSA. If your employer contributes to an HRA that can only be used when you retire, you can still be eligible for an HSA.

NEW - My spouse has an FSA or HRA through their employer, can I have HSA?

You cannot have an HSA if your spouse's FSA or HRA can pay for any of your medical expenses before your HDHP deductible is met.

I don't have a job, can I have an HSA?

Yes, if you have coverage under an HDHP. You do not have to have earned income from employment – in other words, the money can be from your own personal savings, income from dividends, unemployment or welfare benefits, etc.

NEW - Does my income affect whether I can have an HSA?

There are no income limits that affect HSA eligibility. However, if you do not file a federal income tax return, you may not receive all the tax benefits HSAs offer.

Can I start an HSA for my child?

No, you cannot establish separate accounts for your dependent children, including children who can legally be claimed as a dependent on your tax return.

NEW - I'm a single parent with HDHP coverage but have child/relative that can be claimed as a dependent for tax purposes, and this dependent also has non-HDHP coverage. Am I still eligible for an HSA?

Yes, you are still eligible for an HSA. Your dependent's non-HDHP coverage does not affect your eligibility, even if they are covered by your HDHP

Contributing to an HSA

[How much can I contribute to my HSA each year?](#)

NEW [I have a very high deductible, is there a limit on how much I can contribute?](#)

[Do my HSA contributions have to be made in equal amounts each month?](#)

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[I'm over 55 and would like to make catch-up contributions to my HSA, like I've done with my IRA. Is that possible?](#)

[I turned 55 this year. Can I make the full "catch-up" contribution?](#)

[If both spouses are 55 and older, can both spouses make "catch-up" contributions?](#)

NEW [If each spouse has self-only HDHP coverage \(neither spouse has family coverage\), how much can we contribute?](#)

NEW [If both spouses have family HDHP coverage but one spouse has other coverage, are both spouses eligible for an HSA? How much can each spouse contribute?](#)

NEW [Does tax filing status \(joint vs. separate\) affect my contribution?](#)

NEW [I'm a single parent with HDHP coverage, but have a child/relative that can be claimed as a dependent for tax purposes, and this dependent also has non-HDHP coverage. Am I still eligible for an HSA?](#)

NEW [May a self-employed person contribute to an HSA on a pre-tax basis?](#)

How much can I contribute to my HSA each year?

Your annual HSA contribution cannot exceed the deductible of your HDHP. For example, if you choose a plan with a deductible of \$1,000, you may not deposit more than \$1,000 in your HSA for that year. If you want to save more, you must choose an HDHP with a higher deductible. If you are age 55 or older, you can also make additional "catch-up" contributions (see below).

NEW - I have a very high deductible, is there a limit on how much I can contribute?

The most you can put into your account for 2005 is \$2,650 if you have single coverage and \$5,250 for a family. These amounts will be increased for inflation in future years.

Do my HSA contributions have to be made in equal amounts each month?

No, you can contribute in a lump sum or in any amounts or frequency you wish. However, your account trustee/custodian (bank, credit union, insurer, etc.) can impose minimum deposit and balance requirements.

Can my employer contribute to my HSA?

Contributions to HSAs can be made by you, your employer, or both. All contributions are aggregated to determine whether you have contributed the maximum allowed. If your employer contributes some of the money, you can make up the difference.

NEW - Do my contributions provide any tax benefits?

Your personal contributions offer you an "above-the-line" deduction. An "above-the-line" deduction allows you to reduce your taxable income by the amount you contribute to your HSA. You do not have to itemize your deductions to benefit. Contributions can also be made to your HSA by others (e.g., relatives). However, you receive the benefit of the tax deduction.

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NEW - If my employer contributes to my HSA, does that also provide me any tax benefit?

If your employer makes a contribution to your HSA, the contribution is not taxable to you the employee (excluded from income).

NEW - Can I make contributions through my employer on a "pre-tax" basis?

If your employer offers a "salary reduction" plan (also known as a "Section 125 plan" or "cafeteria plan"), you (the employee) can make contributions to your HSA on a pre-tax basis (i.e., before income taxes and FICA taxes). If you can do so, you cannot also take the "above-the-line" deduction on your personal income taxes.

Can I claim both the "above-the-line" deduction for an HSA and the itemized deduction for medical expenses?

You may be able to claim the medical expense deduction even if you contribute to an HSA. However, you cannot include any contribution to the HSA or any distribution from the HSA, including distributions taken for non-medical expenses, in the calculation for claiming the itemized deduction for medical expenses.

Can I take a tax deduction for my HDHP premium?

Not at this time. President Bush has proposed allowing individuals not covered by an employer plan to deduct their HDHP premiums as well as their HSA contributions. However, this proposal will not be effective until enacted by Congress.

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I'm over 55 and would like to make catch-up contributions to my HSA, like I've done with my IRA. Is that possible?

Yes, individuals 55 and older who are covered by an HDHP can make additional catch-up contributions each year until they enroll in Medicare. The additional "catch-up" contributions to HSA allowed are as follows:

2004 - \$500
2005 - \$600
2006 - \$700
2007 - \$800
2008 - \$900
2009 and after - \$1,000

I turned 55 this year. Can I make the full "catch-up" contribution?

If you had HDHP coverage for the full year, you can make the full catch-up contribution regardless of when your 55th birthday falls during the year. If you did not have HDHP coverage for the full year, you must pro-rate your "catch-up" contribution for the number of full months you were "eligible", i.e., had HDHP coverage.

If both spouses are 55 and older, can both spouses make "catch-up" contributions?

Yes, if both spouses are eligible individuals and both spouses have established an HSA in their name. If only one spouse has an HSA in their name, only that spouse can make a "catch-up" contribution.

NEW - If each spouse has self-only HDHP coverage (neither spouse has family coverage), how much can we contribute?

Each spouse is eligible to contribute to an HSA in their own name, up to the amount of the deductibles under their respective policies. However, each spouse's contribution cannot exceed the contribution limit of \$2,650 for individuals for 2005.

NEW - If both spouses have family HDHP coverage but one spouse has other coverage, are both spouses eligible for an HSA? How much can each spouse contribute?

The following examples describe how much can be contributed under varying circumstances. Assume that neither spouse qualifies for "catch-up contributions".

Example 1: Husband and wife have family HDHP coverage with a \$5,000 deductible. Husband has no other coverage. Wife also has self-only coverage with a \$200 deductible. Wife, who has coverage under a low-deductible plan, is not eligible and cannot contribute to an HSA. Husband may contribute \$5,000 to an HSA.

Example 2: Husband and wife have family HDHP coverage with a \$5,000 deductible. Husband has no other coverage. Wife also has self-only HDHP coverage with a \$2,000 deductible. Both husband and wife are eligible individuals. Husband and wife are treated as having only family coverage. The combined HSA contribution by husband and wife cannot exceed \$5,000, to be divided between them by agreement.

Example 3: Husband and wife have family HDHP coverage with a \$5,000 deductible. Husband has no other coverage. Wife also has family HDHP coverage with a \$3,000 deductible. Both husband and wife are eligible individuals. Husband and wife are treated as having family HDHP coverage with the lowest annual deductible (\$3,000). The maximum combined HSA contribution by husband and wife is \$3,000, to be divided between them by agreement.

Example 4: Husband and wife have family HDHP coverage with a \$5,000 deductible. Husband has no other coverage. Wife also has family coverage with a \$200 deductible. Husband and wife are treated as having family coverage with the lowest annual deductible (\$200). Neither husband nor wife is an eligible individual and neither may contribute to an HSA.

Example 5: Husband and wife have family HDHP coverage with a \$5,000 deductible. Husband has no other coverage. Wife also is enrolled in Medicare. Wife is not an eligible individual and cannot contribute to an HSA. Husband may contribute \$5,000 to an HSA.

NEW - Does tax filing status (joint vs. separate) affect my contribution?

Tax filing status does not affect your contribution.

NEW - I'm a single parent with HDHP coverage but have child/relative that can be claimed as a dependent for tax purposes, and this dependent also has non-HDHP coverage. Am I still eligible for an HSA?

Yes, you are still eligible for an HSA. Your dependent's non-HDHP coverage does not affect your eligibility, even if they are covered by your HDHP. You can contribute up to the amount of your HDHP deductible to your HSA.

NEW - May a self-employed person contribute to an HSA on a pre-tax basis?

No. Self-employed persons may not contribute to an HSA on a pre-tax basis and may not take the amount of their HSA contribution as a deduction for SECA purposes. However, they may contribute to an HSA with after-tax dollars and take the above-the-line deduction.

Using Your HSA

[Does an HSA pay for the same things that regular insurance pays for?](#)

[How do I know what is included as "qualified medical expenses"?](#)

[Who decides whether the money I'm spending from my HSA is for a "qualified medical expense"?](#)

[What happens if I don't use the money in the HSA for medical expenses?](#)

[Are dental and vision care qualified medical expenses under a Health Savings Account?](#)

[Can I use the money in my HSA to pay for medical care for a family member?](#)

[Can I use my HSA to pay for medical services provided in other countries?](#)

[Can I pay my health insurance premiums with an HSA?](#)

[Can I purchase long-term care insurance with money from my HSA?](#)

NEW [I have an HSA but no longer have HDHP coverage. Can I still use the money that is already in the HSA for medical expenses tax-free?](#)

[Who will be the "bookkeeper" for my HSA?](#)

[Do unused funds in a Health Savings Account roll over year after year?](#)

[What happens to the money in a Health Savings Account after you turn age 65?](#)

NEW [Can I use my HSA to pay for medical expenses incurred before I set up my account?](#)

NEW [How do I use my HSA to pay my physician when I'm at the physician's office?](#)

Does an HSA pay for the same things that regular insurance pays for?

HSA funds can pay for any "qualified medical expense", even if the expense is not covered by your HDHP. For example, most health insurance does

not cover the cost of over-the-counter medicines, but HSAs can. If the money from the HSA is used for qualified medical expenses, then the money spent is tax-free.

How do I know what is included as “qualified medical expenses”?

Unfortunately, we cannot provide a definitive list of “qualified medical expenses”. A partial list is provided in IRS Pub 502 (available at www.irs.gov). There have been thousands of cases involving the many nuances of what constitutes “medical care” for purposes of section 213(d) of the Internal Revenue Code. A determination of whether an expense is for “medical care” is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. The determination often hangs on the word “primarily.”

Who decides whether the money I’m spending from my HSA is for a “qualified medical expense?”

You are responsible for that decision, and therefore should familiarize yourself with what qualified medical expenses are (as partially defined in IRS Publication 502) and also keep your receipts in case you need to defend your expenditures or decisions during an audit.

What happens if I don’t use the money in the HSA for medical expenses?

If the money is used for other than qualified medical expenses, the expenditure will be taxed and, for individuals who are not disabled or over age 65, subject to a 10% tax penalty.

Are dental and vision care qualified medical expenses under a Health Savings Account?

Yes, as long as these are deductible under the current rules. For example, cosmetic procedures, like cosmetic dentistry, would not be considered qualified medical expenses.

Can I use the money in my HSA to pay for medical care for a family member?

Yes, you may withdraw funds to pay for the qualified medical expenses of yourself, your spouse or a dependent without tax penalty. This is one of the great advantages of HSAs.

Can I use my HSA to pay for medical services provided in other countries?

Yes.

Can I pay my health insurance premiums with an HSA?

You can only use your HSA to pay health insurance premiums if you are collecting Federal or State unemployment benefits, or you have COBRA continuation coverage through a former employer.

Can I purchase long-term care insurance with money from my HSA?

Yes, if you have tax-qualified long-term care insurance. However, the amount considered a qualified medical expense depends on your age. See IRS Publication 502 for the amounts deductible by age.

NEW - I have an HSA but no longer have HDHP coverage. Can I still use the money that is already in the HSA for medical expenses tax-free?

Once funds are deposited into the HSA, the account can be used to pay for qualified medical expenses tax-free, even if you no longer have HDHP coverage. The funds in your account roll over automatically each year and remain indefinitely until used. There is no time limit on using the funds.

Who will be the “bookkeeper” for my HSA?

It is your responsibility to keep track of your deposits and expenditures and keep all of your receipts. If you run out of HSA funds (and therefore need to use your HDHP), you may need to send those receipts to your insurer.

Do unused funds in a Health Savings Account roll over year after year?

Yes, the unused balance in a Health Savings Account automatically rolls over year after year. You won’t lose your money if you don’t spend it within the year.

What happens to the money in a Health Savings Account after you turn age 65?

You can continue to use your account tax-free for out-of-pocket health expenses. When you enroll in Medicare, you can use your account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare. If you have retiree health benefits through your former employer, you can also use your account to pay for your share of retiree medical insurance premiums. The one expense you cannot use your account for is to purchase a Medicare supplemental insurance or “Medigap” policy.

Once you turn age 65, you can also use your account to pay for things other than medical expenses. If used for other expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a 10% penalty on the amount withdrawn.

NEW - Can I use my HSA to pay for medical expenses incurred before I set up my account?

No. You cannot reimburse qualified medical expenses incurred before your account is established. We recommend you establish your account as soon as possible.

NEW - How do I use my HSA to pay my physician when I’m at the physician’s office?

If you are still covered by your HDHP and have not met your policy deductible, you will be responsible for 100% of the amount agreed to be paid by your insurance policy to the physician. Your physician may ask you to pay for the services provided before you leave the office. If your HSA custodian has provided you with a checkbook or debit card, you can pay your physician directly from the account. If the custodian does not offer these features, you can pay the physician with your own money and reimburse yourself for the expense from the account after your visit.

If your physician does not ask for payment at the time of service, the physician will probably submit a claim to your insurance company, and the insurance company will apply any discounts based on their contract with the physician. You should then receive an "Explanation of Benefits" from your insurance plan stating how much the negotiated payment amount is, and that you are responsible for 100% of this negotiated amount. If you have not already made any payment to the physician for the services provided, the physician may then send you a bill for payment.

Setting Up Your HSA

NEW [What do I have to do to "establish" my account?](#)

[Who can help me establish my account?](#)

[My bank/credit union doesn't offer HSAs, can I be my own trustee or custodian?](#)

[I can't find a bank or credit union to open my account, what can I do?](#)

NEW [What is the difference between an HSA "custodian" and an HSA "trustee"?](#)

[Can couples establish a "joint" account and both make contributions to the account, including "catch-up" contributions?](#)

NEW [Must couples open separate accounts?](#)

NEW [How soon can I open my account?](#)

NEW [I want to make sure my HSA is "established" as soon as possible. Can I establish my account before my HDHP coverage begins?](#)

NEW - What do I have to do to "establish" my account?

Your account trustee/custodian will determine what you need to do, which may include completing and processing appropriate paperwork, and making a minimum deposit.

Who can help me establish my account?

Insured banks and credit unions are automatically qualified to handle HSAs. Any bank, credit union or any other entity that currently meets the IRS standards for being a trustee or custodian for an IRA or Archer Medical Savings Account (MSA) can be an HSA trustee or custodian. The law also allows insurance companies to be HSA trustees or custodians.

My bank/credit union doesn't offer HSAs, can I be my own trustee or custodian?

No, you must establish your HSA with an approved institution.

I can't find a bank or credit union to open my account, what can I do?

Unfortunately, we cannot maintain a list of banks, credit unions or other institutions offering HSAs. We recommend checking websites like www.hsainsider.com for companies who are willing to establish your account regardless of where you live.

NEW - What is the difference between an HSA "custodian" and an HSA "trustee"?

The differences between a "custodian" and a "trustee" are minor. A trust is a legal entity under which assets are actually owned and held on behalf of a beneficiary. The trustee has some level of discretionary fiduciary authority over the assets of the fund. The trustee must exercise that authority in the best interests of the beneficiary. A custodial arrangement, on the other hand, is like a trust, but the custodian simply holds the assets on behalf of the owner of the assets. Other than holding the assets and doing as the owner orders, the custodian has no fiduciary obligations to the owner. The determination of what constitutes a trust or custodial arrangement is a determination made under state law.

Can couples establish a "joint" account and both make contributions to the account, including "catch-up" contributions?

"Joint" HSA accounts are not permitted. Each spouse should consider establishing an account in their own name. This allows you to both make catch-up contributions when each spouse is 55 or older.

NEW - Must couples open separate accounts?

If both husband and wife are eligible to contribute to an HSA, they are both eligible to establish separate HSAs. However, if both spouses want to make "catch-up" contributions when they are age 55+, they must establish separate accounts.

NEW How soon can I open my account?

Your account can be established as early as the effective date of your HDHP coverage. However, if your coverage begins on any day other than the first day of the month, you cannot establish your account until the first day of the following month.

NEW - I want to make sure my HSA is "established" as soon as possible. Can I establish my account before my HDHP coverage begins?

You can complete all the paperwork and make a minimum deposit to your account prior to the effective date of your HDHP coverage. However, your

account is not officially “established” until your HDHP coverage begins. But completing the necessary steps before your coverage begins ensures that your HSA will be “established” as early as possible. This is especially important when your HDHP coverage is effective on a non-business day.

Managing Your HSA

[Who has control over the money invested in a Health Savings Account?](#)

[Can the funds in an HSA be invested?](#)

[Will my bank notify me if I've exceeded my allowable contribution amount?](#)

[Can I borrow against the money in my HSA?](#)

[Can I roll the money in a Health Savings Account over into an IRA?](#)

[Can I roll over an IRA, 401\(k\) or other retirement plan into an HSA?](#)

[Can I roll funds in my Archer MSA into my HSA?](#)

[What happens to the money in my HSA when I die?](#)

Who has control over the money invested in a Health Savings Account?

The account holder controls all decisions over how the money is invested. You can also choose not to invest your funds.

Can the funds in an HSA be invested?

Yes, you can invest the funds in your HSA. The same types of investments permitted for IRAs are allowed for HSAs, including stocks, bonds, mutual funds, and certificates of deposit.

Will my bank notify me if I've exceeded my allowable contribution amount?

No, it is your sole responsibility to keep track of the amounts deposited and spent from your account, just like a normal savings or checking account.

Can I borrow against the money in my HSA?

No. You may not borrow against it or pledge the funds in it. For more information on prohibited activities, see Section 4975 of the Internal Revenue Code.

Can I roll the money in a Health Savings Account over into an IRA?

You cannot roll the HSA funds over into an IRA. They will stay in the HSA or be rolled into another HSA.

Can I roll over an IRA, 401(k) or other retirement plan into an HSA?

You cannot directly roll funds in an IRA, 401(k) or other retirement plan into an HSA. You can withdraw funds from one of these accounts, pay applicable taxes (and penalties) on the amount you withdraw, and then use the remaining funds to make a contribution to your HSA. However, the amount you contribute to your HSA is still limited by the annual contribution limits.

Can I roll funds in my Archer MSA into my HSA?

Yes, if you do so within 60 days of withdrawing the funds from the Archer MSA.

What happens to the money in my HSA when I die?

If married, your spouse becomes the owner of the HSA when you die. If unmarried, the HSA becomes part of your taxable estate.

Employer Participation in HSAs

[As an employer, do I own my employees' HSAs? Can I control how they spend the money in them?](#)

[My employees want to contribute to their HSAs but want to make sure they get a tax benefit out of doing so. How does that work?](#)

[How much do I have to contribute to my employees' HSA, as an employer?](#)

[Do HSA contributions have to be made in equal amounts each month?](#)

[As an employer, do I have to contribute the same amount to every employee's HSA?](#)

[Our company offers benefits through a Section 125 plan, do contributions have to be comparable under these plans as well?](#)

[Our company wants to offer "matching" contributions, can we do that?](#)

[I don't offer health insurance, but some of my employees have opened HSAs and I'd like to help them out, what can I do?](#)

NEW [How are contributions treated for owners and shareholders of S corps?](#)

[How are contributions treated for partners in a partnership or limited liability company \(LLC\)?](#)

NEW [May a self-employed person contribute to an HSA on a pre-tax basis?](#)

As an employer, do I own my employees' HSAs? Can I control how they spend the money in them?

No, you do not own your employees' HSAs. The employee fully owns the contributions to the account as soon as they are deposited, just as with a personal checking or savings account to which you would deposit their compensation.

My employees want to contribute to their HSAs but want to make sure they get a tax benefit out of doing so. How does that work?

Employee contributions can be made to HSAs on either after-tax or pre-tax basis. If made on an after-tax basis they should be counted as an above-the-line deduction on their tax return, effectively making their contributions tax-free. If they want to make the contribution pre-tax it can be done through a Section 125 (also called a "salary reduction" or "cafeteria plan").

How much do I have to contribute to my employees' HSA, as an employer?

As much or as little as you want (while staying below the legal limit on the account of \$2,600 or \$5,150 for employees with family coverage).

Do HSA contributions have to be made in equal amounts each month?

No, you can contribute in a lump sum or in any amounts or frequency you wish. However, keep in mind that the funds belong to the employee after they are deposited.

As an employer, do I have to contribute the same amount to every employee's HSA?

Employer contributions must be "comparable", that is they must be in the same dollar amount or same percentage of the employee's deductible for all employees in the same "class". You can vary the level of contributions for "full-time" vs. "part-time" employees, and employees with "self-only" coverage vs. "family coverage". You do not need to consider employees who do not have HDHP coverage as they are not eligible for HSA contributions.

Our company offers benefits through a Section 125 plan, do contributions have to be comparable under these plans as well?

Section 125 plans (also known as "salary reduction" or "cafeteria" plans) must meet a different set of rules. Under these plans, contributions (both from employer and/or employee) must meet "non-discrimination" rules. These rules require the employer to ensure that contributions do not favor higher compensated employees.

Our company wants to offer "matching" contributions, can we do that?

Yes, but your company can only offer "matching" contributions through a Section 125 plan. Remember that the non-discrimination rules still apply.

I don't offer health insurance, but some of my employees have opened HSAs and I'd like to help them out, what can I do?

Your company can make pre-tax contributions to your employees' HSAs as long as you do so for all eligible employees. However, the comparability rules apply. If you have a Section 125 plan, then the non-discrimination rules apply.

NEW - How are contributions treated for owners and shareholders of S corps?

Owners and officers with greater than 2% share of a Subchapter S corporation cannot make pre-tax contributions to their HSAs through the company by salary reduction. In addition, any contributions made to their HSAs by the corporation are taxable as income. However, they can make their own personal contributions to their HSAs and take the "above-the-line" deduction on their personal income taxes.

How are contributions treated for partners in a partnership or limited liability company (LLC)?

Partners in a partnership or LLC cannot make pre-tax contributions to their HSAs through the partnership by salary reduction. However, they can make their own personal contributions to their HSAs and take the "above-the-line" deduction on their personal income taxes.

NEW - May a self-employed person contribute to an HSA on a pre-tax basis?

No. Self-employed persons may not contribute to an HSA on a pre-tax basis and may not take the amount of their HSA contribution as a deduction for SECA purposes. However, they may contribute to an HSA with after-tax dollars and take the above-the-line deduction.

Trustees/Custodians

NEW [We are a bank/credit union, do we have to seek approval to offer HSAs?](#)

NEW [We are not a bank or a credit union, who else is allowed to offer HSAs?](#)

NEW [What is the difference between an HSA “custodian” and an HSA “trustee”?](#)

NEW [Do we have to use specific forms to establish these accounts?](#)

NEW [What information must be reported?](#)

NEW [What rules can we set regarding account administration?](#)

NEW [Can HSA accounts be invested?](#)

NEW [Do we have to verify that distributions from an HSA were used only for “qualified medical expenses”?](#)

NEW - We are a bank/credit union, do we have to seek approval to offer HSAs?

Banks and credit unions are automatically approved to offer HSAs to their customers as either a trust or a custodial account.

NEW - We are not a bank or a credit union, who else is allowed to offer HSAs?

Insurance companies and other entities who are approved trustees/custodians of IRAs are approved to offer HSAs. Additional entities wishing to become approved trustees/custodians of HSAs can apply to the IRS to do so.

NEW - What is the difference between an HSA “custodian” and an HSA “trustee”?

The differences between a “custodian” and a “trustee” are minor. A trust is a legal entity under which assets are actually owned and held on behalf of a beneficiary. The trustee has some level of discretionary fiduciary authority over the assets of the fund. The trustee must exercise that authority in the best interests of the beneficiary. A custodial arrangement, on the other hand, is like a trust, but the custodian simply holds the assets on behalf of the owner of the assets. Other than holding the assets and doing as the owner orders, the custodian has no fiduciary obligations to the owner. The determination of what constitutes a trust or custodial arrangement is a determination made under state law.

NEW - Do we have to use specific forms to establish these accounts?

Banks or credit unions can modify their existing IRA enrollment forms to reflect HSAs, or use the model IRS forms. These model forms are available from the IRS or can be downloaded from the Treasury & IRS web sites.

NEW - What information must be reported?

Reporting requirements are straightforward. Form 5498 is used to report total contributions made to the account during the year and the value of the account at the end of the year. Form 1099-SA reports the total distributions taken from the account during the year. Both forms must be sent to the account owner and the IRS. Both forms and instructions for completing the forms are available from the IRS or can be downloaded from the Treasury and IRS web sites.

NEW - What rules can we set regarding account administration?

Minimum deposit, minimum balance requirements, minimum distribution requirements, distribution timing requirements, and account fees can be set by the trustee/custodian (i.e., the HSA rules do not apply any additional conditions on an HSA trustee or custodian).

NEW - Can HSA accounts be invested?

HSA funds can be invested in the same types of investments as IRAs. You do not have to offer all investment options to account holders.

NEW - Do we have to verify that distributions from an HSA were used only for “qualified medical expenses”?

Substantiation that distributions were used for qualified medical expenses is not required.