

Part III - Administrative, Procedural, and Miscellaneous
Notice 2004-50

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.¹

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¹ Specific issues on HSAs are also discussed in Rev. Rul. 2004-45, 2004-22 I.R.B. 971; Rev. Rul. 2004-38, 2004-15 I.R.B. 717; Rev. Proc. 2004-22, 2004-15 I.R.B. 727; Notice 2004-43, 2004-27 I.R.B. 10; Notice 2004-25, 2004-15 I.R.B. 727; Notice 2004-22, 2004-15 I.R.B. 725.

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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);
- (2) the umbrella deductible; or
- (3) the embedded individual deductible multiplied by the number of family members 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 long-term 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 long-term 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 includible 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).