

## Part III - Administrative, Procedural, and Miscellaneous

### Health Savings Accounts

#### Notice 2008-59

##### 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 § 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning after December 31, 2003. The Health Opportunity Patient Empowerment Act of 2006, Pub. L. No. 109-432 (HOPE Act), amended § 223 of the Code effective generally for taxable years after December 31, 2006.

Notice 2004-2, 2004-1 C.B. 269, and Notice 2004-50, 2004-2 C.B. 196, provide guidance on HSAs in question and answer format. This notice addresses additional questions relating to HSAs.

##### TABLE OF CONTENTS

The following is an outline of the questions and answers covered in this Notice.

## DEFINITIONS

### I. ELIGIBLE INDIVIDUALS

Q&A-1. Payment of HDHP premiums by an HRA not disqualifying coverage

Q&A-2. Disqualifying benefits before HDHP minimum deductible satisfied

Q&A-3. Employer reimbursement of medical expenses before HDHP minimum deductible satisfied

Q&A-4. HDHP and HSA-compatible HRA or health FSA

Q&A-5. Eligible for Medicare Part D and contributions to HSA

Q&A-6. Enrolled in Medicare Part D and contributions to HSA

Q&A-7. HDHP and other high deductible coverage

Q&A-8. HDHP and HRA or health FSA that reimburses family members before minimum HDHP deductible satisfied

Q&A-9. Disregarded coverage or preventive care through Department of Veterans Affairs

Q&A-10. Access to health care that is free or at charges below fair market value

Q&A-11. Family HDHP coverage and dependents with disqualifying coverage

### II. HIGH DEDUCTIBLE HEALTH PLANS

Q&A-12. Changing from family HDHP to self-only HDHP

Q&A-13. Different deductibles for specific benefits

Q&A-14. Benefits limited to hospitalization or in-patient care

Q&A-15. Expenses that apply towards meeting deductible

### III. CONTRIBUTIONS

Q&A-16. Contribution limits for individuals with family coverage and dependents with non-permitted coverage

Q&A-17. Contribution limits for married couples with different types of HDHP coverage

Q&A-18. Contributions for married couples who each have family HDHP coverage

Q&A-19. Contributions for months when covered by an HDHP

Q&A-20. Rollovers from an existing HSA to a new HSA

Q&A-21. Employer contributions for prior year

Q&A-22. Catch-up contributions for spouses

Q&A-23. Contributions to an employee who was never an eligible individual

Q&A-24. Error resulting in excess contributions

Q&A-25. Contributions to an employee who ceases to be an eligible individual

Q&A-26. Employer contributions to HSA of employee's spouse

### IV. DISTRIBUTIONS

Q&A-27. Debit cards

Q&A-28. Third party authorization

Q&A-29. Payment of Medicare Part D premiums

Q&A-30. Medicare premiums for spouse

Q&A-31. Continuation coverage premiums

Q&A-32. Premiums for a dependent receiving unemployment benefits

Q&A-33. Expenses for a child claimed as a dependent by another

V. PROHIBITED TRANSACTIONS

Q&A-34. Borrowing from HSA

Q&A-35. Loan from trustee to HSA

Q&A-36. Pledging HSA as security for a loan

Q&A-37. Consequences for entering into a prohibited transaction

VI. ESTABLISHING AN HSA

Q&A-38. When an HSA is established

Q&A-39. Not treating as established before state law considers HSA established

Q&A-40. Establishment date for rollovers

Q&A-41. Establishment date for successive HSAs

VII. ADMINISTRATION

Q&A-42. Reporting HSA administration and maintenance fees withdrawn by the trustee from an HSA

DEFINITIONS

The following definitions apply for purposes of this Notice.

Eligible individual means an individual who: (1) is covered by a high deductible

health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain types of limited coverage); (3) is not enrolled in Medicare; and (4) may not be claimed as a dependent on another person's tax return. See § 223(c)(1).

Limited-purpose health flexible spending arrangement (FSA) means a health FSA described in a cafeteria plan that only pays or reimburses permitted coverage benefits (as defined in § 223(c)(2)(C)), such as vision care, dental care or preventive care (as defined for purposes of § 223(c)(2)(C)). See Prop. Treas. Reg. § 1.125-5(m)(3).

Limited-purpose health reimbursement arrangement (HRA) means an HRA that only pays or reimburses permitted coverage benefits (as defined in § 223(c)(2)(C)), such as vision care, dental care or preventive care. See Rev. Rul. 2004-45, 2004-1 C.B. 971.

Post-deductible health FSA means a health FSA in a cafeteria plan that only pays or reimburses medical expenses (as defined in § 213(d)) for preventive care or medical expenses incurred after the minimum annual HDHP deductible under § 223(c)(2)(A)(i) is satisfied. No medical expenses incurred before the annual HDHP deductible is satisfied may be reimbursed by a post-deductible FSA, regardless of whether the HDHP covers the expense or whether the deductible is later satisfied. See Prop. Treas. Reg. § 1.125-5(m)(4).

Post-deductible HRA means an HRA that only pays or reimburses medical expenses (as defined in § 213(d)) for preventive care or medical expenses incurred

after the minimum annual HDHP deductible under § 223(c)(2)(A)(i) is satisfied. No medical expenses incurred before the annual HDHP deductible is satisfied may be reimbursed by a post-deductible HRA, regardless of whether the HDHP covers the expense or whether the deductible is later satisfied. See Rev. Rul. 2004-45.

## QUESTIONS AND ANSWERS

### I. ELIGIBLE INDIVIDUALS

Q-1. Does an individual fail to be an eligible individual, as defined in § 223(c)(1), merely because the individual is covered by an HRA which, in addition to paying and reimbursing expenses for vision, dental and preventive care, pays and reimburses premiums for coverage by an accident and health plan?

A-1. No. An individual who is otherwise an eligible individual does not fail to be an eligible individual merely because the individual is covered by an HRA which, in addition to paying and reimbursing expenses for vision, dental and preventive care, pays and reimburses premiums for coverage by an accident and health plan. See Notice 2002-45, 2002-2 C.B. 93, and Rev. Rul. 2002-41, 2002-2 C.B. 75, for guidance on HRAs.

Example. In 2008, Employer A provides an HRA which reimburses any § 213(d) medical expense incurred by an employee, employee's spouse and dependents. For 2009, Employer A amends the HRA to limit its benefits to expenses for vision care, dental care, and preventive care and to pay the employee's share of the premiums for the employer-sponsored HDHP. During 2009, A's employees are otherwise eligible individuals.

For 2009, Employer A's employees are eligible individuals even if covered by the HRA.

Q-2. If an individual is covered under a plan that pays for medical expenses

incurred before the minimum HDHP deductible is satisfied and the coverage is not permitted insurance under § 223(c)(3), disregarded coverage under § 223(c)(1)(B)(ii) or preventive care under § 223(c)(2)(C), is that individual an eligible individual as defined in § 223(c)(1)?

A-2. No. To be an eligible individual, an individual must be covered by an HDHP and by no other health plan that provides coverage other than disregarded coverage under § 223(c)(1)(B) or preventive care under § 223(c)(2)(C). See Rev. Rul. 2004-45.

Example. Individual B is covered by an HDHP. In addition, Individual B is covered by a “mini-med” plan that provides the following benefits: a fixed amount per day of hospitalization; a fixed amount per office visit with a physician; a fixed amount per out-patient treatment at a hospital; a fixed amount per ambulance use; and coverage for expenses relating to the treatment of a specified list of diseases.

Although the fixed amount per day of hospitalization benefit and specified disease benefit are allowed in addition to the HDHP as permitted insurance, the other benefits are not disregarded coverage or preventive care and, thus, Individual B is not an eligible individual who can contribute to an HSA.

Q-3. If an employee is covered by an HDHP and the employer pays or reimburses some or all of the employee’s medical expenses incurred before the minimum HDHP deductible is satisfied (other than disregarded coverage under § 223(c)(1)(B) or preventive care under § 223(c)(2)(C)), is the employee an eligible individual under § 223(c)(1)?

A-3. No. To be an eligible individual, an individual must be covered by an HDHP and no other health plan except disregarded coverage or preventive care. If at any time, an employer pays or reimburses, directly or indirectly, all or part of employees’ medical expenses below the minimum HDHP deductible under § 223(c)(2)(A) (other

than for disregarded coverage or preventive care) the employees are not eligible to contribute to an HSA.

Example 1. For 2008, an HDHP with self-only coverage has an annual deductible of \$2,500. The employee pays the first \$250 of covered medical expenses below the deductible. The employer reimburses the next \$1,350 of covered medical expenses below the deductible. The employee is responsible for the last \$900 of covered medical expenses below the deductible. The \$1,350 of medical expenses paid or reimbursed by the employer is not a contribution to an HSA and not disregarded coverage or preventive care.

An employee covered by this type of plan is not an eligible individual under § 223(c)(1) because the employee has disqualifying coverage from a plan that is not an HDHP.

Example 2. For 2008, an HDHP with self-only coverage has an annual deductible of \$4,500. The employee pays the first \$1,100 of covered medical expenses below the deductible. The employer reimburses the next \$3,400 of covered medical expenses below the deductible. The \$3,400 of medical expenses paid or reimbursed by the employer is not a contribution to an HSA and not disregarded coverage or preventive care.

An employee covered by this type of plan is an eligible individual under § 223(c)(1) because the employee is responsible for the minimum annual deductible under § 223(c)(2)(A).

Q-4(a). If an individual has family HDHP coverage under which benefits are paid once the entire family incurs a minimum amount of covered expenses (an umbrella deductible), but which also provides benefits to each individual if that individual incurs expenses in excess of the minimum family HDHP deductible in § 223(c)(2)(A)(i)(II) (the embedded individual deductible), does the individual fail to be an eligible individual merely because of the embedded individual deductible?

A-4(a). No, the individual does not fail to be an eligible individual merely because of an embedded individual deductible that is no less than the minimum family HDHP deductible in § 223(c)(2)(A)(i)(II).



Q-4(b). May a post-deductible HRA or post-deductible health FSA pay or reimburse qualified medical expenses of an individual with family HDHP coverage once the minimum annual deductible in § 223(c)(2)(A)(i)(II) for family HDHP coverage has been satisfied?

A-4(b). Yes, a post-deductible HRA or post-deductible health FSA may pay or reimburse qualified medical expenses of an individual with family HDHP coverage incurred at any time after the minimum annual deductible in § 223(c)(2)(A)(i)(II) for family HDHP coverage has been satisfied.

Example. In 2008, a family with family HDHP coverage has an umbrella deductible of \$3,500, and an embedded individual deductible of \$2,200. A post-deductible HRA reimburses § 213(d) medical expenses incurred after \$2,200 of medical expenses covered by the HDHP have been incurred.

The covered individuals, if otherwise eligible, are eligible individuals.

Q-5. Does an individual fail to be an eligible individual merely because the individual is eligible for, but not enrolled in, Medicare Part D (or any other Medicare benefit)?

A-5. No. However, an individual is not an eligible individual under § 223(c)(1) in any month during which such individual is both eligible for benefits under Medicare and enrolled to receive benefits under Medicare. See also Notice 2004-50, Q&A-2 and 3, regarding Medicare Parts A and B.

Q-6. Does an individual fail to be an eligible individual merely because the individual is enrolled in Medicare Part D, or any other Medicare benefit?

A-6. Yes. Under § 223(b)(7), an individual who is enrolled in Medicare is not an eligible individual in any month during which the individual is enrolled in Medicare.

See also Q&A-29 of this Notice regarding paying Medicare premiums with funds in an HSA.

Q-7. May an otherwise eligible individual covered by an HDHP as defined in § 223(c)(2) also be covered by a health plan that is not an HDHP with a deductible equal to or greater than the statutory minimum HDHP deductible?

A-7. Yes, as long as the deductible of the other coverage equals or exceeds the statutory minimum HDHP deductible, the individual remains an eligible individual.

Example. An otherwise eligible individual has self-only HDHP coverage from January 1 through December 31, 2008, with a deductible of \$2,500 and a life-time limit on benefits of \$1,000,000. In addition to the HDHP, the individual has self-only health plan coverage with a \$1,000,000 deductible and a \$2,000,000 life-time limit on benefits.

The individual is an eligible individual.

Q-8. Is an individual with family HDHP coverage who is also covered by a post-deductible HRA or post-deductible health FSA an eligible individual under § 223(c)(1) if the post-deductible HRA or post-deductible health FSA reimburses § 213(d) medical expenses of a spouse or dependent incurred before the minimum family HDHP deductible under § 223(c)(2)(A)(i)(II) has been satisfied?

A-8. No. If an individual with family HDHP coverage is covered by a post-deductible HRA or post-deductible health FSA that reimburses the § 213(d) medical expenses of any covered individual before the minimum family HDHP deductible under § 223(c)(2)(A)(i)(II) has been satisfied, that individual is not an eligible individual under § 223(c)(1).

Example 1. Employee C has family HDHP coverage. Employee C's spouse and children (but not Employee C) are also covered by non-HDHP family coverage provided by the spouse's employer. Employee C and Employee C's spouse and children are

also covered by a post-deductible health FSA. The health FSA pays for unreimbursed medical expenses of the spouse and child without regard to the satisfaction of the deductible of the family HDHP.

Because the health FSA covering Employee C reimburses medical expenses before the minimum family HDHP deductible is satisfied, Employee C is not an eligible individual.

Example 2. Same facts as Example 1, except the health FSA does not cover Employee C. Employee C is an eligible individual.

Q-9. Is an individual an eligible individual if he or she is eligible for medical benefits through the Department of Veterans Affairs (VA) but only receives medical care that is disregarded coverage or preventive care from the VA and is otherwise an eligible individual?

A-9. Yes. Although an individual actually receiving medical benefits from the VA at any time in the previous three months is generally not an eligible individual, this rule does not apply if the medical benefits consist solely of disregarded coverage or preventive care.

Q-10. Is an otherwise eligible individual who has access to free health care or health care at charges below fair market value from a clinic on an employer's premises an eligible individual under § 223(c)(1)?

A-10. An individual will not fail to be an eligible individual under § 223(c)(1)(A) merely because the individual has access to free health care or health care at charges below fair market value from an employer's on-site clinic if the clinic does not provide significant benefits in the nature of medical care (in addition to disregarded coverage or preventive care).

Example 1. A manufacturing plant operates an on-site clinic that provides the

following free health care for employees: (1) physicals and immunizations; (2) injecting antigens provided by employees (e.g., performing allergy injections); (3) a variety of aspirin and other nonprescription pain relievers; and (4) treatment for injuries caused by accidents at the plant.

The clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

Example 2. A hospital permits its employees to receive care at its facilities for all of their medical needs. For employees without health insurance, the hospital provides medical care at no charge. For employees who have health insurance, the hospital waives all deductibles and co-pays.

Because the hospital provides significant care in the nature of medical services, the hospital's employees are not eligible individuals under § 223(c)(1)(A).

Q-11. If an otherwise eligible individual under § 223(d)(1) has family HDHP coverage that covers dependents, and the dependents have other, disqualifying, non-HDHP coverage, is the individual an eligible individual?

A-11. Yes. See also Rev. Rul. 2005-25. See Q&A-16 of this Notice regarding the contribution limit.

## II. HIGH DEDUCTIBLE HEALTH PLANS

Q-12. If an individual switches from a family HDHP to a self-only HDHP, does the individual fail to be an eligible individual during the period of self-only coverage merely because the self-only HDHP, for the purpose of satisfying the self-only deductible, takes into account expenses incurred while the individual had family HDHP coverage?

A-12. A self-only HDHP may use any reasonable method to allocate the covered expenses incurred during the period of family coverage for the purpose of satisfying the deductible for self-only coverage. For example, subject to state law requirements, the

plan may allocate to the self-only deductible only the expenses incurred by that individual. Alternatively, the plan may allocate the expenses incurred during family HDHP coverage on a per-capita basis according to the number of persons covered by the family HDHP. If the family deductible was satisfied before the change to self-only coverage, the plan may also treat the individual as having satisfied the self-only deductible for that plan year. In all cases, each expense must be allocated on a reasonable and consistent basis and, except in the case of COBRA continuation coverage, each expense may be allocated to only one individual, and the plan year must be 12 months. For individuals switching from self-only HDHP coverage to family HDHP coverage, see Notice 2004-50, Q&A-23. If COBRA continuation coverage is required to be made available, the HDHP must comply with the requirements of Q&A-2 of § 54.4980B-5 for those individuals receiving COBRA continuation coverage.

Example 1. Employer D offers its employees a calendar year health plan otherwise qualifying as an HDHP. Employee E and E's spouse are covered by Employer D's family coverage HDHP with a \$6,000 deductible. Employee E incurs \$2,500 in covered expenses; Employee E's spouse incurs \$2,000 in covered expenses. On July 1, Employee E and Employee E's spouse each change to self-only HDHP coverage with a \$3,000 deductible and Employee E's spouse is no longer covered under the plan.

For the period from July 1 through December 31, the plan may credit Employee E's self-only deductible with either: (1) \$2,500 (the actual amount of expenses Employee E incurred under family coverage), or (2) \$2,250 ( $\$4,500/2$ ), Employee E's per-capita share of expenses incurred by the two individuals covered by family coverage. In this case the HDHP must credit Employee E's spouse with at least \$2,000 toward the satisfaction of the deductible; the HDHP also complies with the requirements of Q&A-2 of § 54.4980B-5 by crediting Employee E's spouse with \$2,250 toward the satisfaction of the deductible.

Example 2. The same facts as Example 1, except that Employee E's spouse is entitled to elect, and elects, COBRA continuation coverage under the HDHP. In this case, the HDHP must comply with the requirements of Q&A-2 of § 54.4980B-5.

Example 3. The same facts as Example 2, except that the amounts incurred by Employee E and Employee E's spouse are reversed: Employee E incurred \$2,000 of medical expenses and Employee E's spouse incurred \$2,500.

If the HDHP credits Employee E's spouse with \$2,250 toward the satisfaction of the deductible, this would not satisfy the requirements of Q&A-2 of § 54.4980B-5. Employee E's spouse must be credited with at least \$2,500 toward the satisfaction of the deductible to comply with the requirements of Q&A-2 of §54.4980B-5.

Example 4. Employer F offers its employees a calendar year health plan, otherwise qualifying as an HDHP. As of January 1, 2008, Employee G, and Employee G's spouse and child are covered by Employer F's family coverage HDHP with a \$6,000 deductible. From January 1 through September 30, 2008, Employee G incurs \$2,500 in covered expenses; Employee G's spouse incurs \$500 in covered expenses, and Employee G's child incurs \$3,000 in covered expenses. Employee G and spouse are divorced, effective October 1, 2008. On that date, Employee G changes to self-only HDHP coverage with a \$3,000 deductible and the child and ex-spouse elect COBRA continuation coverage in Employer F's family HDHP coverage.

The plan may (1) credit Employee G's individual deductible with \$2,500 and reduce the expenses allocated to the child and ex-spouse in family coverage by \$2,500; or (2) credit Employee G's self-only deductible with \$2,000 and reduce the expenses allocated to the child and ex-spouse by \$2,000 (allocating one-third of the \$6,000 in expenses to Employee G's individual deductible and two-thirds of the \$6,000 in expenses to the former spouse and child remaining in family coverage). Coverage of the child and former spouse is COBRA continuation coverage. However, if the pro rata allocation of expenses of the family to the child and former spouse were less than the actual expenses incurred by the child and former spouse, then allocation of only the ratable share of the family expenses would not comply with the requirements of Q&A-2 of § 54.4980B-5; (3) credit Employee G with no expenses and continue to credit the child and ex-spouse with all expenses incurred under family coverage; or (4) treat Employee G as having satisfied the \$3,000 individual deductible while treating the former spouse and child as having satisfied the \$6,000 family deductible.

Q-13. If a health plan imposes a separate or higher deductible for specific benefits, are amounts paid by covered individuals to satisfy the separate or higher deductible treated as out-of-pocket expenses under § 223(c)(2)(A)?

A-13. If significant other benefits remain available under the plan in addition to the specific benefits subject to the separate or higher deductible, amounts paid to

satisfy the separate or higher deductible are not treated as out-of-pocket expenses under § 223(c)(2)(A).

Example. In 2008, a self-only health plan with a \$3,000 deductible imposes a lifetime limit of \$1,000,000 on reimbursements for covered benefits. The plan pays 100 percent of covered expenses after the \$3,000 deductible is satisfied. Although the plan provides benefits for substance abuse treatment, the substance abuse treatment benefits are subject to a separate \$5,000 deductible, and these benefits are limited to \$10,000, after the separate deductible is satisfied.

The plan is an HDHP and no expense incurred by a covered individual other than the \$3,000 general deductible is treated as an out-of-pocket expense under § 223(c)(2)(A).

Q-14. If a health plan meeting the minimum deductible of § 223(c)(2)(A) restricts benefits to expenses for hospitalization or in-patient care, is the plan an HDHP?

A-14. No. A plan must provide significant benefits to be an HDHP. A plan may also be designed with reasonable benefit restrictions limiting the plan's covered benefits. See Notice 2004-50, Q&A-15. However, if a plan only provides benefits for expenses of hospitalization or in-patient care, significant other benefits do not remain available under the plan in addition to the benefits subject to exclusion. Therefore, any expenses incurred by a covered individual after satisfying the deductible are treated as out-of-pocket expenses under § 223(c)(2)(A).

Example. In 2008, a self-only health plan with a \$2,000 deductible includes a \$3,000,000 lifetime limit on covered benefits. Generally, the plan only provides benefits for medical services provided while a covered individual is admitted to a hospital as an overnight patient or provided at a "same day" surgery facility. A same day surgery facility does not include a hospital emergency room, a trauma center, a physician's office or a clinic. Covered medical services for individuals admitted to a hospital or same day surgery facility include room accommodations, miscellaneous medical services and supplies necessary for treatment, primary surgery, pathology charges and the administration of anesthesia while at the hospital or center, and charges by the primary attending physician for one visit per day while at the hospital. In addition, the plan provides: an organ transplant benefit, a hospice care benefit, and home health care

visits. The home health care benefit is subject to a 60 visit per year limit, and must be in connection with the hospitalization. The plan also pays for certain preventive care screening and ambulance service. The plan pays for no visits to physician's offices nor any other out-patient care other than those noted above. The maximum dollar amount that the covered individual pays for covered benefits under the plan for 2008 is \$5,500.

The restriction of benefits to medical services provided while the covered individual is admitted to a hospital or at a same day surgery facility is not reasonable because significant other benefits do not remain available under the plan after application of the restriction. Any expenses incurred by a covered individual for out-patient care or visits to physician's offices are treated as out-of-pocket expenses under § 223(c)(2)(A). Because the plan maximum for amounts paid by a covered individual does not restrict payments for those out-of-pocket expenses, the plan fails to qualify as an HDHP.

Q-15. What medical expenses may be taken into account in determining when the HDHP deductible is satisfied for purposes of a post-deductible HRA or post-deductible health FSA?

A-15. Only medical expenses described in § 213(d) and covered by the HDHP may be taken into account in determining whether the HDHP deductible, or the minimum deductible in § 223(c)(2)(A)(i), has been satisfied. For example, if the HDHP does not cover chiropractic care, expenses incurred for chiropractic care do not count toward satisfying the HDHP deductible or the minimum deductible in § 223(c)(2)(A)(i). For self-only HDHP coverage, only the covered medical expenses of the covered individual count toward satisfying the HDHP deductible or the minimum deductible in § 223(c)(2)(A)(i)(I).

Example. In 2008, an individual, spouse and child have family HDHP coverage with a \$2,500 deductible. The HDHP does not provide benefits for vision or dental care. They are also covered by a combination limited purpose/post-deductible HRA that pays or reimburses § 213(d) medical expenses incurred by each family member after the family incurs \$2,500 in covered medical expenses, and pays or reimburses vision and dental expenses before and after the HDHP deductible is satisfied. On February 15, 2008, the family incurs \$2,500 in vision and dental expenses that are reimbursed by the



HRA. On March 17, 2008, the family then incurs \$400 in expenses covered by the HDHP (but for the deductible). The family must incur an additional \$2,100 in covered medical expenses before the HDHP deductible is satisfied.

The HRA may not reimburse the family for the \$400 of expenses because the family had not incurred \$2,500 in covered expenses when the \$400 was incurred.

### III. CONTRIBUTIONS

Q-16. How do the maximum annual HSA contribution limits apply to an eligible individual with family HDHP coverage for the entire year if the family HDHP covers spouses or dependent children who also have coverage by a non-HDHP, Medicare, or Medicaid?

A-16. The eligible individual may contribute the § 223(b)(2)(B) statutory maximum for family coverage. Other coverage of dependent children or spouses does not affect the individual's contribution limit, except that if the spouse is not an otherwise eligible individual, no part of the HSA contribution can be allocated to the spouse.

Q-17. How do the maximum annual HSA contribution limits apply to a married couple if both spouses are eligible individuals and one spouse has self-only HDHP coverage and the other spouse has family HDHP coverage?

A-17. The maximum annual HSA contribution limit for a married couple if one spouse has family HDHP coverage and the other spouse has self-only HDHP coverage is the § 223(b)(2)(B) statutory maximum for family coverage. The contribution limit is divided between the spouses by agreement. See § 223(b)(5) and Notice 2004-50, Q&A-32. This is the result regardless of whether the family HDHP coverage includes the spouse with self-only HDHP coverage. See Notice 2004-2, Q&A-15. If only one spouse is an eligible individual, see Rev. Rul. 2005-25.

Example. For 2008, H and W are married. Both are 40 years old. H and W are otherwise eligible individuals. H has self-only HDHP coverage. W has an HDHP with family coverage for W and their two children.

The combined contribution limit for H and W is \$5,800, which is the § 223(b)(2)(B) statutory contribution limit for 2008. H and W divide the \$5,800 contribution limit between them by agreement.

Q-18. How do the maximum annual HSA contribution limits apply to a married couple if both spouses are eligible individuals and each spouse has family HDHP coverage that does not cover the other spouse?

A-18. The maximum HSA contribution limit for a married couple where both spouses have family HDHP coverage is the § 223(b)(2)(B) statutory maximum. This rule applies regardless of whether each spouse's family coverage covers the other spouse. The contribution limit is divided between the spouses by agreement.

Example. In 2008, H, who is 37, and W, who is 32, are married with two dependent children. H has HDHP family coverage for H and their two children with an annual deductible of \$3,000. W has HDHP family coverage for W and their two children with a deductible of \$3,500.

The combined contribution limit for H and W is \$5,800, the maximum annual contribution limit. H and W divide the \$5,800 contribution limit between them by agreement.

Q-19. May an individual who ceases to be an eligible individual during a year still contribute to an HSA with respect to the months of the year when the individual was an eligible individual?

A-19. Yes. An individual who ceases to be an eligible individual may, until the date for filing the return (without extensions) for the year, make HSA contributions with respect to the months of the year when the individual was an eligible individual.

Example. J has a self-only HDHP, and is an eligible individual for the first four

months of 2008. J has until April 15, 2009 (the date for filing the 2008 return, without extensions) to contribute 4/12 x \$2,900 (\$967) to an HSA.

Q-20. May an individual who is not an eligible individual make a rollover contribution from his or her existing HSA to a new HSA?

A-20. Yes.

Q-21. May employer contributions to employees' HSAs made between January 1 and the date for filing the employee's return, without extensions, be allocated to the prior year?

A-21. Yes. For employer contributions (including salary reduction contributions) made between January 1 and the date for filing the employees' returns without extension, the employer must notify the HSA trustee or custodian if the contributions relate to the prior year. The employer must also inform the employee of the designation. However, the contributions designated as made for the prior year are still reported in box 12 with code W on the employees' Form W-2 for the year in which the contributions are actually made.

Example. In January 2009, Employer K contributes \$500 to each employee's HSA and notifies the HSA trustee (and provides a statement to the employees) that the contributions are for 2008. Subsequently, in 2009, Employer K contributes \$250 to each employee's HSA on March 31, June 30, September 30 and December 31. For each employee whose HSA received these contributions, Employer K reports a total contribution of \$1,500 in box 12 with code W on the Form W-2 for 2009.

In completing the Form 8889 for 2008, to compute Employer K's contributions, the employees add the \$500 to any employer contributions reported in box 12, code W on the 2008 Form W-2. In completing the Form 8889 for 2009, the employees subtract the \$500 from the box 12 code W amount on the 2009 Form W-2 and add to the remaining \$1,000 any contributions for 2009 made by Employer K between January 1, 2009 and his or her filing date without extensions. See Instructions to Form 8889.

Q-22. If a husband and wife are each eligible to make catch-up contributions

under § 223(b)(3), must each spouse contribute their catch-up contributions to their own HSA?

A-22. Yes. An individual who is eligible to make catch-up contributions may only make such contributions to his or her own HSA. See also Notice 2004-50, Q&A-32. If both spouses are eligible for the catch-up contribution, each spouse must make catch-up contributions to his or her own HSA.

Q-23. If an employer contributes to the account of an employee who was never an eligible individual, can the employer recoup the amounts?

A-23. If the employee was never an eligible individual under § 223(c), then no HSA ever existed and the employer may correct the error. At the employer's option, the employer may request that the financial institution return the amounts to the employer. However, if the employer does not recover the amounts by the end of the taxable year, then the amounts must be included as gross income and wages on the employee's Form W-2 for the year during which the employer made the contributions.

Example 1. In February 2008, Employer L contributed \$500 to an account of Employee M, reasonably believing the account to be an HSA. In July 2008, Employer L first learned that Employee M's account is not an HSA because Employee M has never been an eligible individual under § 223(c).

Employer L may either request that the financial institution holding Employee M's account return the balance of the account (\$500 plus earnings less administration fees directly paid from the account) to Employer L. If Employer L does not receive the balance of the account, Employer L must include the amounts in Employee M's gross income and wages on his Form W-2 for 2008.

Example 2. The same facts as Example 1, except Employer L first discovers the mistake in July 2009. Employer L issues a corrected 2008 Form W-2 for Employee M, and Employee M files an amended income tax return for 2008.

Q-24. If an employer contributes amounts to an employee's HSA that exceed the

maximum annual contribution allowed in § 223(b) due to an error, can the employer recoup the excess amounts?

A-24. If the employer contributes amounts to an employee's HSA that exceed the maximum annual contribution allowed in § 223(b) due to an error, the employer may correct the error. In that case, at the employer's option, the employer may request that the financial institution return the excess amounts to the employer. Alternatively, if the employer does not recover the amounts, then the amounts must be included as gross income and wages on the employee's Form W-2 for the year during which the employer made contributions. If, however, amounts contributed are less than or equal to the maximum annual contribution allowed in § 223(b), the employer may not recoup any amount from the employee's HSA.

Q-25. If an employer contributes to the HSA of an employee who ceases to be an eligible individual during a year, can the employer recoup amounts that the employer contributed after the employee ceased to be an eligible individual?

A-25. No. Employers generally cannot recoup amounts from an HSA other than as discussed above in Q&A-23 and Q&A-24. See Notice 2004-50, Q&A-82.

Example. Employee N was an eligible individual on January 1, 2008. On April 1, 2008, Employee N is no longer an eligible individual because Employee N's spouse enrolled in a general purpose health FSA that covers all family members. Employee N first realizes that he is no longer eligible on July 17, 2008, at which time Employee N informs Employer O to cease HSA contributions.

Employer O's contributions into Employee N's HSA between April 1, 2008 and July 17, 2008 cannot be recouped by Employer O because Employee N has a nonforfeitable interest in his HSA. Employee N is responsible for determining if the contributions exceed the maximum annual contribution limit in § 223(b), and for withdrawing the excess contribution and the income attributable to the excess contribution and including both in gross income.

Q-26. Are employer contributions to the HSA of an employee's spouse (who is not an employee of this employer) excluded from the employee's gross income and wages?

A-26. No. The exclusion under § 106(d)(1) is limited to contributions by an employer to the HSA of an employee who is an eligible individual. Any contribution by an employer to the HSA of a non-employee (e.g., a spouse of an employee or any other individual), including salary reduction amounts made through a § 125 cafeteria plan, must be included in the gross income and wages of the employee.

#### IV. DISTRIBUTIONS

Q-27. May an HSA be administered through a debit card that restricts payments and reimbursements to health care?

A-27. Yes, if the funds in the HSA are otherwise readily available. For example, in addition to the restricted debit card, the HSA account beneficiary must also be able to access the funds other than by purchasing health care with the debit card, such as through online transfers, withdrawals from automatic teller machines or check writing. Employers must notify employees that other access to the funds is available. See also Notice 2004-50, Q&A-77 and 79.

Q-28. May an HSA account beneficiary authorize someone else to withdraw funds from his or her HSA?

A-28. Yes. Although an HSA is an individual account, an HSA account beneficiary can designate other individuals to withdraw funds pursuant to the procedures of the trustee or custodian of the HSA. Distributions are subject to tax if

they are not used to pay for qualified medical expenses for the HSA account beneficiary, the account beneficiary's spouse, or dependents. See Notice 2004-2, Q&A-25. But see Q&A-34, Q&A-35, and Q&A-36 of this Notice regarding prohibited transactions.

Q-29. If the account beneficiary has attained age 65, are Medicare Part D premiums qualified medical expenses?

A-29. Yes. If an account beneficiary has attained age 65, premiums for Medicare Part D for the account beneficiary, the account beneficiary's spouse, or the account beneficiary's dependents are qualified medical expenses. See also Notice 2004-2, Q&A-27, and Notice 2004-50, Q&A-4 and 45, regarding Medicare Parts A and B. See Q&A-6 of this Notice regarding eligibility of Medicare enrollees to contribute to an HSA.

Q-30. If the account beneficiary has not attained age 65, are Medicare premiums for coverage of an account beneficiary's spouse (who has attained age 65) qualified medical expenses?

A-30. No. If the account beneficiary has not attained age 65, Medicare premiums are generally not qualified medical expenses.

Q-31. Are premiums for continuation coverage required under Federal law for the spouse or dependent of an account beneficiary qualified medical expenses?

A-31. Yes. Although qualified medical expenses generally exclude payments for insurance, § 223(d)(2)(C)(i) provides an exception for the expense of coverage under a health plan during any period of continuation coverage.

Q-32. Are premiums for health coverage for a spouse or dependent during a period when the spouse or dependent is receiving unemployment compensation under any Federal or state law qualified medical expenses?

A-32. Yes. Although qualified medical expenses generally exclude payments for insurance, § 223(d)(2)(C)(iii) provides an exception for the expense of coverage under a health plan during a period in which an individual is receiving unemployment compensation under any Federal or state law.

Q-33. Do qualified medical expenses for HSA purposes include the § 213(d) medical expenses incurred by an account beneficiary's child who is claimed as a dependent by the account beneficiary's former spouse?

A-33. Yes. See §§ 152(e) and 213(d)(5).

#### V. PROHIBITED TRANSACTIONS

Q-34. If an account beneficiary borrows funds from his or her HSA, is this a prohibited transaction under § 4975?

A-34. Yes. An HSA is a plan as defined in § 4975(e)(1)(E). An HSA account beneficiary is a disqualified person under § 4975(e)(2). A loan or extension of credit between a plan and a disqualified person is a prohibited transaction. Section 4975(c)(1)(B). Thus, any direct or indirect extension of credit between the account beneficiary and his or her HSA is a prohibited transaction.

Q-35. If a trustee of an HSA lends money to the HSA, is this a prohibited transaction under § 4975?

A-35. Yes. An HSA is a plan as defined in § 4975(e)(1)(E). An HSA trustee is a



disqualified person under § 4975(e)(2). A loan or extension of credit between a plan and a disqualified person is a prohibited transaction. Section 4975(c)(1)(B). Thus, any direct or indirect extension of credit between the HSA trustee and the HSA is a prohibited transaction.

Example 1. Bank X is the trustee of an HSA. Bank X extends a line of credit to the HSA. The line of credit is a prohibited transaction under § 4975.

Example 2. Bank Y is the trustee of an HSA. The account beneficiary accesses the funds in the HSA through a debit card. In addition, Bank Y extends a line of credit to the account beneficiary, which is not secured by the account beneficiary's HSA, and amounts in the HSA cannot be used to repay the line of credit.

The line of credit is not a prohibited transaction.

Q-36. If an account beneficiary pledges his or her HSA as security for a loan, is this a prohibited transaction under § 4975?

A-36. Yes. An HSA is a plan as defined in § 4975(e)(1)(E). An HSA account beneficiary is a disqualified person under § 4975(e)(2). A loan or extension of credit between a plan and a disqualified person is a prohibited transaction. Section 4975(c)(1)(B). Thus, any direct or indirect extension of credit between the account beneficiary and his or her HSA is a prohibited transaction.

Example. Individual P is an account beneficiary of an HSA. Bank Z is the trustee of the HSA. Bank Z extends to Individual P a line of credit secured by the HSA.

The pledge securing the line of credit is a prohibited transaction under § 4975.

Q-37. What are the consequences if account beneficiaries or other disqualified persons enter into a prohibited transaction with an HSA?

A-37. Section 223(e)(2) provides that rules similar to the rules of §§ 408(e)(2) and (4) 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, pledge the HSA, furnish goods, services or facilities, transfer to or use by or for the benefit of himself/herself any assets of the HSA, etc.). If an account beneficiary engages in a prohibited transaction with his or her HSA the sanction, in general, is disqualification of the account. Thus, the HSA stops being an HSA as of the first day of the taxable year of the prohibited transaction. The assets of the beneficiary's account are deemed distributed, and the appropriate taxes, including the 10 percent additional tax under § 223(f)(4) for distributions not used for qualified medical expenses, apply.

If the employer sponsoring the account (or other disqualified person) is the party engaging in a prohibited transaction, then the employer (or other party) is liable for the excise tax, but the account beneficiary is not.

## VI. ESTABLISHING AN HSA

Q-38. When is an HSA established?

A-38. An HSA is an exempt trust established through a written governing instrument under state law. Section 223(d)(1). State trust law determines when an HSA is established. Most state trust laws require that for a trust to exist, an asset must be held in trust; thus, most state trust laws require that a trust must be funded to be established. Whether the account beneficiary's signature is required to establish the trust also depends on state law.

Q-39. May a trustee treat an HSA as established before the date of establishment determined under state law, such as the date when HDHP coverage

began?

A-39. No. But see Q&A-40 and Q&A-41 of this Notice concerning the establishment date for HSAs in connection with rollovers, or where a previous HSA was established.

Q-40. When is an HSA established if the funds in the HSA were rolled over or transferred from an Archer MSA or another HSA?

A-40. An HSA that is funded by amounts rolled over or transferred from an Archer MSA or another HSA is established as of the date the prior account was established. Qualified HSA distributions under § 106(e) or qualified HSA funding distributions under § 408(d)(9) do not affect the HSA establishment date. See also Notice 2004-2, Q&A-23.

Example. An account beneficiary established an Archer MSA on October 17, 2000. On May 13, 2004, the account beneficiary rolled the entire amount held in the Archer MSA into an HSA. On January 1, 2008, the account beneficiary has the HSA trustee make a direct transfer of the entire HSA to an HSA with a new trustee.

The establishment date of the HSA with the new trustee is October 17, 2000.

Q-41. On what date is an HSA established if the account beneficiary had previously established an HSA?

A-41. If an account beneficiary establishes an HSA, and later establishes another HSA, any later HSA is deemed to be established when the first HSA was established if the account beneficiary has an HSA with a balance greater than zero at any time during the 18-month period ending on the date the later HSA is established.

Example 1. An account beneficiary established an HSA on March 1, 2007. On June 15, 2007, he withdrew all the funds from the HSA, resulting in a zero balance. On November 21, 2008, he established a second HSA.

Because the second HSA was established within 18 months of June 15, 2007, the second HSA is deemed to be established on March 1, 2007.

Example 2. The same facts as Example 1, except that the account beneficiary establishes a third HSA on January 1, 2009. On that date, the second HSA has a balance greater than zero.

The third HSA is deemed to be established on March 1, 2007.

## VII. ADMINISTRATION

Q-42. How are HSA administration and maintenance fees withdrawn by the trustee from an HSA reported by the trustee?

A-42. HSA administration and maintenance fees withdrawn by the trustee are reflected on the Form 5498-SA in the fair market value of the HSA at the end of the taxable year. These fees are not reported as distributions from the HSA.

## EFFECT ON OTHER DOCUMENTS

Notice 2004-2, 2004-1 C.B. 269, Notice 2004-50, 2004-2 C.B. 196, and Notice 2007-22, 2007-10 I.R.B. 670, are amplified.

## DRAFTING INFORMATION

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