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The Adviser's Guide to Health Savings Accounts, Third Edition

Health Savings Accounts (HSAs) are growing in popularity. HSAs offer advantages over other savings vehicles and are not limited to employees of small businesses and the self-employed. Unspent account balances roll over at year-end for further use, and the account is portable because it is owned by the employee.

Before you can begin to advise clients on Health Savings Accounts, you need to understand how HSAs and high-deductible health insurance operate. This guide introduces you to HSAs and gives you an excellent description of all the guidance that the federal government has issued on HSAs and high-deductible health insurance plans. In addition, this comprehensive, well-organized guide gives you information on the law and regulations that focus on:

- establishing the account
- eligibility
- medical coverage and insurance
- contributions and deductions
- rollovers and transfers
- operation and administration
- taxation of distributions
- comparability of employer contributions
- HSAs under a Code Section 125 cafeteria plan
- IRS and DOL reporting
- coordination with flexible spending accounts (FSAs), Archer medical savings accounts (Archer MSAs), and health reimbursement arrangements (HRAs)
- Federal laws affecting HSAs

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ISBN 978-0-87051-715-0



9 780870 517150

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Health Savings Accounts

Third Edition

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS



AICPA®

Gary S. Lesser, Esq.
Christine Keller, Esq.
Susan D. Diehl
William F. Sweetnam, Jr., Esq.

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New York, NY 10036-8775

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1 2 3 4 5 6 7 8 9 0 PP 0 9 8 7 6 5 4

ISBN 978-0-87051-715-0

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Preface

There is a significant trend in employer-provided health care: consumer-directed health plans. In these plans, the decision of how to spend health care dollars rests more with the employee, and his or her health care provider, than with the employer or insurance company. Consumer-directed health plans are part of an overall initiative to help rein in the rising costs of health care and health insurance. This policy goal takes on added importance because an increase in the cost of health insurance means a decrease in the number of people covered by insurance. Employees who participate in consumer-driven health plans become wiser consumers of medical services as a result of their enhanced decision making responsibility. Another advantage is that the lower costs associated with consumer-directed health plans provide more coverage options for individuals who wish to purchase health insurance outside of the employment context.

The inclusion of the health savings account (HSA) provision as part of the Medicare Modernization Act in 2003 is an important part of the trend toward consumer-directed health plans. President George W. Bush was very supportive of including HSAs in this important legislation, which modernized Medicare by adding a prescription drug feature to the Medicare program. Many members of Congress were motivated to vote for the Medicare Modernization Act because of its HSA provision. They expressed concern about rising health care costs and believed that making HSAs available to all Americans would help address those spiraling costs.

It is important to note that as one of the final acts of Representative Bill Thomas, the retiring Chairman of the powerful Committee on Ways and Means in the House Representatives, additional HSA provisions were included in H.R. 6111, the Tax Relief and Healthcare Act of 2006—must-pass legislation that the Congress enacted on December 9, 2006. This bill contained many provisions that plan sponsors and HSA advocates promoted which would make HSAs more workable. Passage of this bill in 2006 was important because leading Democrats in Congress do not believe in HSAs. With Democrats controlling Congress in 2007, there would be no opportunity to advance this pro-HSA agenda in the next few years. I can attest to this since recently I testified before the Senate Small Business Committee, chaired by Senator John Kerry, in support of HSAs and there was much skepticism by Democrats about the benefit of HSAs. Chairman Bill Thomas' leadership in putting these provisions in must-pass legislation has helped the cause of HSAs.

In terms of developing cost-consciousness in medical spending, it is useful to review how medical insurance operates. Traditional health insurance pays for all medical costs once a deductible is met, usually requiring some sort of co-pay with each visit or prescription drug. Health Maintenance Organizations (HMOs) contain costs by limiting the health care professionals and procedures that the HMO will pay for. HSAs require that the HSA owner participate in a high deductible health plan (HDHP) before he or she can contribute to the HSA, and the amount of the maximum HSA contribution cannot exceed the deductible amount under the HDHP. High deductible health insurance is less expensive than traditional health insurance and HMO coverage because it insures only major catastrophic health care expenses; the consumer pays for all other medical services, either directly or through a vehicle such as an HSA. Thus, there are two ways in which high deductible health insurance reduces costs: the premium for such insurance is lower, and there is more prudent health care spending. By their support of the HSA provision in the Medicare Modernization Act, Congress and the Bush administration expressed their belief that the use of HDHPs and HSAs would result in more cost-conscious decisions by consumers of medical services.

The operation of HDHPs is similar to that of other types of insurance (e.g., automobile insurance or homeowners insurance), which make payments only when there is a major problem (e.g., an automobile accident or a house fire). Traditional health insurance generally starts paying claims for medical care, whether routine or not, after a low deductible is reached. This is analogous to having an automobile insurer pay for changing a car's fluids, in addition to providing coverage in case of accidents. Because traditional health

insurance pays for all medical expenses (once the low deductible is reached), the cost of such insurance is higher than the cost of an HDHP, where the consumer pays for routine medical services.

Another important change is that using the HSA with an HDHP provides a tax-effective way to pay for out-of-pocket medical costs, since all contributions made to the HSA that meet the contribution limits are fully tax-deductible by the HSA owner. Compare that to the current system of itemized deduction for out-of-pocket health care expenses. Given the restrictions on the amount of medical deduction (amounts over 7.5 percent of adjusted gross income), individuals rarely get any tax benefit for paying medical expenses themselves. Clearly, the use of an HSA to pay for these medical expenses benefits everyone, no matter what their tax bracket.

The successful implementation of the HSA legislation was an important priority of the Bush administration. As the former Benefits Tax Counsel at the U.S. Department of the Treasury, I was involved in crafting the guidance to help implement HSAs. Our main objective was to offer guidance, consistent with the legislation, which would facilitate the offering of qualifying high deductible health insurance and the accounts themselves. We asked those individuals in the health care and financial services industry who were considering providing HSAs and HDHPs to tell us what issues needed to be addressed and when such guidance would be needed in order to provide a successful rollout of these products. We met with many of the stakeholders to determine how to craft helpful, easy-to-understand guidance that could be used by all employees, including those who were not familiar with the process for issuing tax-related guidance. To that end, Treasury and the Internal Revenue Service issued eight pieces of guidance by July 2004 that addressed many of the important issues surrounding HSAs and high deductible health insurance. In addition, we heard that financial institutions were concerned about the forms that were needed for the establishment of HSAs. Treasury and the IRS provided forms that any financial institution would choose to use for their clients to establish an HSA. *The Advisor's Guide to Health Savings Accounts (HSAs)* provides an excellent description of all the guidance promulgated by the federal government regarding HSAs and HDHPs.

In addition to the guidance, the Bush administration made a very proactive effort to explain the benefits of HSAs and HDHPs to the American public. President Bush had several town-hall meetings promoting the HSA concept, as did Secretary of the Treasury John Snow. Treasury had a separate Web site that contained all of the information regarding HSAs, and the Department answered and continues to answer questions from the public about HSAs. Doubtless, many subscribers to *The Advisor's Guide to Health Savings Accounts (HSAs)* have heard me or my former staff talk at length about the HSA guidance at numerous meetings around the country and on countless conference calls.

Apparently, the Bush Administration was successful in nurturing the HSA concept and Americans are starting to take control of their health spending. According to America's Health Insurance Plans (AHIP), as of January 2007, 4.5 million people were covered by HSAs and HDHPs. This is a great start. Don't let the HSA naysayers say that this take up rate is proof that Americans don't want HSAs. I can look to the 401(k) market and the slow but steady increase in the number of people with 401(k) Plans. The HSA is similar and with time more Americans will see the value of this important innovation in health care. Also many more Americans are getting health insurance coverage with HSAs. Approximately one-third of the people with HSAs are those with new health insurance coverage. The criticisms of those against HSAs say that they are solely for the healthy and wealthy have been refuted by actual market data. HSAs are important new products for controlling health care costs. I hope that those who use *The Advisor's Guide to Health Savings Accounts (HSAs)* will find it useful in promoting HSAs.

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Groom Law Group*
2007

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Chapter 1

Introduction to Health Savings Accounts (HSAs)

The steadily rising cost of health care and premiums for health coverage in this country presents an economic challenge for many individuals, some of whom struggle to maintain coverage, and others who opt to remain uninsured. Also, employers of all sizes who traditionally have provided health benefits for their workforces have become concerned about their ability to continue to offer such coverage on an affordable basis. This was the climate when, as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) enacted on December 8, 2003, a new type of tax-favored savings vehicle for health expenses known as a Health Savings Account (HSA) was created. Three years later, after HSAs had gained some popularity, Congress made significant improvements. On December 20, 2006, President Bush signed into law the Tax Relief and Health Care Act of 2006 (P.L. 109-432) (TRHCA) which included several significant HSA provisions, such as increases to the contribution limits and administrative simplifications. This chapter provides the history of HSAs (including their establishment, improvement, and regulation), and explores the pros and cons of both participating in an HSA arrangement as an individual and offering an HSA arrangement as an employer.

An HSA, described in Code Section 223, is a funded account, similar to an Individual Retirement Arrangement (IRA). Contributions may be made within specified limits by individuals who meet certain eligibility requirements and/or by employers or others on behalf of such individuals. Amounts in an HSA grow on a tax-deferred basis and, if used for qualified medical expenses, may be distributed on a tax-free basis. In order to contribute to an HSA, an individual must be covered under a High Deductible Health Plan (HDHP) and may not participate in any other non-HDHP, subject to certain exceptions.

Predecessor to the HSA: The Archer Medical Savings Account (Archer MSA)

The HSA is based upon and similar to the Archer MSA (discussed more fully later), which became available in 1996 for use by self-employed individuals and employees of small employers (those with 50 or fewer employees). Archer MSAs, however, have not enjoyed widespread use in large part due to a restriction that prohibits employers with more than 50 employees from making the account available to employees. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) placed a cap on the number of individuals (generally 750,000 taxpayers) who could have an Archer MSA. That number was never reached.¹ Also, although Archer MSAs were set up as a temporary program originally due to expire in 2000, Congress extended that deadline four times.²

Two substantive differences between Archer MSAs and HSAs relate to the deductible under the HDHP and the funding of the account.

¹ I.R.S. Ann. 2005-12, 2005-7 I.R.B. 555.

² Tax Relief and Health Care Act of 2006 (P.L. 109-432) § 117(a)-(c); IRC §§ 220(i), 220(j).

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Archer MSAs have required upper and lower limits on the deductible under the HDHP, but HSAs have only a lower limit.

Archer MSAs are not permitted to be funded by both an employer and employee during the same plan year, or with pre-tax salary reductions through an employer's cafeteria plan. HSAs may be funded by both the employer and the employee during the same plan year as well as by any other individual on behalf of the employee. HSAs also may be funded through an employer's cafeteria plan on a pre-tax basis.

HSA – A Consumer-Driven Health Plan

The years immediately preceding the enactment of the MMA were a period during which “consumer-driven” or “defined contribution” health plans emerged, through which employers offered employees a defined amount of health care dollars to be spent or saved for future use, at the employees' discretion. Proponents tout these alternative arrangements as a way to make costs more predictable and provide incentives to employees to make wiser health care spending decisions. HSAs are consistent with the consumer-driven philosophy. Also, many view HSAs with favor because they provide the ability to use amounts in the account for medical purposes on a tax-advantaged basis as well as for nonmedical purposes (subject to income tax and 10% additional tax). With the exception of Archer MSAs, existing vehicles for providing such coverage on a tax-advantaged basis do not allow that flexibility. Finally, because HSAs are based on Archer MSAs, which had been enacted earlier, there was precedent for the approach.

A Method to Reduce Health Care Spending

To participate in an HSA, an individual must be covered by an HDHP. HSA proponents take the position that participants can save money by participating in an HDHP that generally has lower premiums than a non-HDHP. Also, proponents contend that, if participants are given a choice either to save money in an HSA account (which can earn interest tax-free) or to spend it on medical goods and services, they will confine their spending to only necessary purchases and will demand lower prices, more value for their dollar, or both. In contrast, under traditional health plans, the full cost of a service is not as obvious or important to a participant because he or she typically is responsible only for the copayment. Thus, HSA proponents argue that HSAs will reintroduce market forces to the health care system as well as allow savings to accumulate on a tax-free basis to pay for future health care expenses.

Other Defined Contribution or Consumer-Driven Health Accounts

Health Reimbursement Arrangements (HRAs), Health Care Flexible Spending Arrangements (health FSAs), and Archer MSAs are considered defined contribution or consumer-driven health accounts because they all allow employees to decide how the dollars credited or deposited to their accounts are spent.³

All three health account types share a common purpose of making dollars available on a tax-advantaged basis to reimburse medical expenses. However, the way they are required to be structured under federal law differs. The main differences between an HSA, a health FSA, and an HRA include the following:

- An HSA is the only account type that must be funded through a custodial account or trust and accompanied by an HDHP. An HSA also is the only account type for which amounts in the account may be used for nonmedical purposes (although this will require inclusion for income tax purposes and may result in a 10% additional tax).
- A health FSA is the only account type in which amounts unused at the end of the plan year must be forfeited.

³ IRS Notice 2002-45; Rev. Rul. 2002-41; IRC §§ 106(c), 220; Prop. Treas. Reg. § 1.125-2, Q&A-7.

- An HRA is the only account type that must be paid for solely by the employer – and salary reduction contributions are prohibited.

See Appendix B for a detailed comparison of HSAs, health FSAs, and HRAs.

HSA/HDHP Providers

A few companies offered HSAs with *individual* HDHPs effective January 1, 2004, many of whom previously had offered Archer Medical Savings Accounts (Archer MSAs). HSAs with *group* HDHPs were not available widely on January 1, 2004, primarily because most existing HDHPs offered on the group market had to be modified to comply with the requirements under the MMA. For example, many HDHPs offered on the group market were structured to provide prescription drug coverage before the deductible was satisfied. These products were modified and many group health insurers offered HSAs and HDHPs that satisfied the requirements under the MMA effective January 1, 2005.

There are companies that offer services as HSA trustees or custodians only. The number of HSA trustees/custodians has been growing steadily since the MMA HSA legislation passed. In order to qualify as an HSA trustee, a company must be a bank, an insurance company, or a nonbank trustee (see Chapter 2). Each year, the IRS publishes a list of companies approved as nonbank trustees.⁴

HSAs are expected to continue to attract banks and financial institutions to sponsor the accounts and manage the assets in them, particularly because of the increased contribution limits under the TRHCA. The aggregate amount held and invested in HSAs is expected to grow steadily each year. Also, HSA sponsors can charge set-up fees, maintenance charges, and service fees. These factors may make HSAs become as lucrative to these institutions as IRAs, which gained popularity in the mid-1970s.⁵

State Regulation of HSAs

A state may regulate an HSA for state income tax purposes, and, to the extent that the HSA is not considered an ERISA plan, state trust law will apply to the HSA. Also, a state may regulate insured HDHPs that accompany the HSAs. ERISA preemption generally precludes a state from regulating a self-funded health plan (see Chapter 8).

Federal Regulation of and Agency Guidance on HSAs

HSAs are governed by Code Section 223 and therefore are regulated by the Internal Revenue Service (IRS). HSAs also are subject to prohibited transaction rules under Code Section 4975 and therefore are regulated by the Department of Labor (DOL). The authority of the Secretary of the Treasury to issue rulings under Code Section 4975 has been transferred, with certain exceptions, to the Secretary of Labor (under Reorganization Plan No. 4 of 1978, 43 Fed. Reg. 47713 (10/17/1978)). The DOL also regulates whether a particular HSA is subject to the Employee Retirement Income Security Act of 1974 (ERISA) (see Chapter 8). Finally, to the extent that an HSA invests in securities, or is considered a security itself, it is subject to Securities and Exchange Commission (SEC) regulation (see Chapter 8).

The IRS has issued a significant amount of guidance on HSAs in the relatively short period of time since the 2003 enactment of MMA and is expected to issue several items of guidance interpreting the TRHCA, enacted

⁴ IRS Ann. 2005-59, 2005-37 I.R.B. 524 (Sept. 12, 2005).

⁵ See “Health Savings Accounts Attract Wall Street” by Eric Dash, The New York Times (January 27, 2006).

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in late 2006.⁶ Most of this guidance is in the form of Revenue Rulings and Notices, in question-and-answer format, and some guidance provides transitional relief. Also, the IRS has issued final regulations on the comparable contribution requirements under Code Section 4980G that apply to HSAs (see Chapter 4).⁷ The final regulations only apply to employers that make contributions to employee HSAs outside of a cafeteria plan and generally require that an employer make similar contributions for all employees who participate in the employer's qualifying HDHP. If the employer's contributions do not satisfy these rules, the employer will be subject to a 35% excise tax on all HSA contributions that the employer makes for a year. Employers that make HSA contributions through a cafeteria plan, and/or allow employees to make contributions on a pre-tax basis through a cafeteria plan, are subject to new IRS proposed cafeteria plan regulations.⁸

The IRS also has issued new tax forms and instructions (Form 1040, Form W-2, Form 8889, Form 5498-SA, Form 1099-SA), model trust and custodial account agreements (Forms 5305(c) and Form 5305(b)), and Publication 969 describing HSA rules. The DOL has issued Field Assistance Bulletins 2004-01 and 2006-02 (involving ERISA) and Advisory Opinion 2004-09A (involving the prohibited transaction rules). The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), has issued guidance on account-based plans with respect to Medicare Part D, which includes a discussion of HSAs (see Chapter 8). As of the time of publication, the SEC has not issued any guidance.

Two factors likely motivated the IRS to publish guidance quickly after the enactment of the MMA. First, it had an extremely short effective date, being enacted into law on December 8, 2003, with its HSA provisions becoming effective on January 1, 2004. This also was true for the TRHCA, which was enacted on December 20, 2006, with its HSA provisions becoming effective generally on January 1, 2007. Second, issuing guidance to facilitate HSAs was a high priority of the Bush Administration. The IRS indicated in public meetings held shortly after the MMA was enacted that it was interested in helping employers clarify outstanding issues as soon as possible to facilitate their ability to offer HSAs as part of their array of benefits. During guidance drafting period, the IRS requested and received numerous comments from the public.

Advantages of HSA Participation

Individual Perspective

From an individual's perspective, the primary advantages of HSA participation include the following:⁹

- Reduced premiums for health coverage (the cost of HDHP coverage will be lower than non-HDHP coverage);
- More control over medical spending; and
- The ability to set aside money for future use on a tax-favored basis.

It is possible that funds in an HSA will accumulate and be available for use during the account owner's retirement, particularly because the HSA contributions now are higher, enhancing the ability of individuals to accumulate funds for retiree medical expenses. However, the fact that an individual generally must give up all other health coverage except for HDHP coverage makes it likely that a good portion of the amount deposited to the HSA may be used by the account owner to pay his or her medical expenses each year. This will not be true for individuals who are able to use other assets for ongoing health expenses, allowing the funds in their HSA to accumulate. It also may not be true for individuals who fund the HSA up to the maximum amount allowed by law each year.

⁶ See Notice 2007-22, 2007-10 I.R.B. 670 (IRS interpretation of Section 305 of the 2007 TRHCA).

⁷ Treas. Reg. § 54.4980G-1 through 5.

⁸ 72 Fed. Reg. 43938 (August 6, 2007).

⁹ See, also Chapter 2, pg 19 for a comprehensive list of possible advantages of participating in an HSA.

Employer Perspective

From an employer's perspective, offering an HSA option gives it a more predictable financial obligation as well as the opportunity to restructure cost-sharing between the employer and employees. For some employers, particularly small ones, an HSA may provide the opportunity to offer a health plan to employees for the first time. Other employers have the ability to offer the HSA as an additional medical coverage option. Also, an HSA, which is a defined contribution approach to health care rather than a defined benefit approach, may bring an employer's health plans in line with changes that already have been made to the employer's retirement plans. Finally, as noted above, the HDHP premium generally is lower than for a non-HDHP, which will result in a cost savings to the employer to the extent the employer contributes to this cost.

An employer may offer an HSA option as part of its cafeteria plan, allowing an employee to make HSA contributions on a pre-tax basis. Alternatively, an employee also may make contributions on an after-tax basis, with a corresponding deduction available to the employee at year-end on his or her tax return. Similarly, employers may structure employer HSA contributions through a cafeteria plan or make contributions without using a cafeteria plan.

For an employer, there are several advantages to allowing employees to make HSA contributions through its cafeteria plan.

First, employee HSA contributions through a cafeteria plan (within statutory limits) are treated as employer contributions that are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act. Thus, an employer, by allowing its employees to make HSA contributions through the cafeteria plan, will reduce its liability for these taxes as long as it is reasonable for the employer to believe that, at the time a contribution is made, the contribution will not exceed the HSA limits that apply to a particular employee.

Second, offering an HSA through an existing cafeteria plan provides the employer with a convenient way to integrate the HSA into existing benefit options. For example, an employer currently offering a flex dollar system (i.e., where the employer offers employees dollars that can be allocated among different benefits) could allow employees to use flex dollars to fund the HSA.

Finally, if the employer wants to use a creative method for establishing the level of HSA contributions that it will make, such as matching the amounts that an employee contributes or contributing more for employees who participate in wellness programs, an HSA must be offered through a cafeteria plan to avoid violating the Code Section 4980G comparable contribution rules. In that event, the Code Section 125 nondiscrimination requirements would have to be satisfied.

Disadvantages of HSA Participation¹⁰

Individual Perspective

An HSA account owner who is not used to participating in an HDHP may not feel that he or she has adequate coverage, particularly if he or she is responsible for paying all costs below the deductible either from his or her own funds or the HSA. However, HDHPs are permitted to offer "preventive care" coverage before the deductible is satisfied, so a participant in an HDHP with generous preventive care coverage may view the coverage level as adequate. An HSA account owner also may dislike the fact that, if medical expenses are incurred before money is set aside in the HSA for the year, he or she will be required to pay those expenses out-of-pocket. Finally, if there are significant medical expenses, it will be more difficult for an individual to

¹⁰ See Chapter 2, for a comprehensive list of possible disadvantages of participating in an HSA.

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allow HSA funds to carry over from year to year for retiree medical or nonmedical expenses, eliminating one of the HSA's primary advantages.

Employer Perspective

An employer may find that employees view an HSA offering as a cutback of existing benefits, particularly if the employer does not contribute to the HSA on behalf of employees. This is unlikely to be the case, however, if the employer offers an HSA as part of its array of existing benefits. Also, the employer will have to invest administrative resources to implement an HSA arrangement and to educate human resources personnel regarding the benefit. Finally, an employer may offer an HSA arrangement only to discover that the majority of the employees prefer to maintain existing coverage and are unwilling to switch.

Factors to Consider Before Enrolling in or Offering an HSA

Individual Perspective

Factors that an individual should consider before enrolling in an HSA include the following:

- The anticipated level of medical expenses for the year;
- The likelihood that the expenses will be covered under a particular HDHP;
- The level of resources available to the individual to pay for expenses before the deductible is satisfied; and
- The existing coverage of the individual's spouse or domestic partner.

Spouse's Health Coverage Impact

An HSA account owner's ability to contribute to his or her HSA may be affected by his or her spouse's health coverage. Specifically, if a spouse has separate health coverage, the following special rules may apply:

- The HSA account owner could be prohibited from contributing to an HSA at all.
- The HSA account owner could be required to limit the amount contributed to the HSA to the amount of the account owner's HSA contribution limit for family coverage less the amount allocated to the spouse.

These rules, and other variations, are described in Chapter 4. Whether or not the HSA account owner's spouse is covered under the HDHP and/or has other coverage, the spouse's medical expenses will be considered "qualified medical expenses," allowing the account owner to take a tax-free distribution from his or her HSA to pay for such expenses as long as the expenses are not reimbursed by another health plan (see Chapter 6).

Domestic Partner's Health Coverage Impact

Unlike a spouse's health coverage, it appears that a domestic partner's health coverage generally will not affect an HSA account owner's ability to contribute to his or her HSA, even where the employee covers the domestic partner under his or her HDHP. Because no rule requires domestic partners to divide an HSA contribution in the manner that married individuals are required to, it appears that a domestic partner covered under an account owner's HDHP could open his or her own HSA and contribute the full statutory maximum annual contribution.

Further, neither the Treasury nor the IRS has indicated that there is any problem with an account owner covering a domestic partner under an HDHP and having the domestic partner's expenses count toward satisfying the HDHP family coverage deductible, notwithstanding that these individuals are not related. Thus, in the absence of further Treasury or IRS guidance, this appears permissible.

Practice Pointer →

Unlike a spouse's expenses, an account owner may not take a tax-free distribution from his or her HSA to pay for his or her domestic partner's expenses unless the domestic partner is a dependent under Code Section 152.

Employer Perspective

Before offering an HSA with HDHP coverage, an employer should consider what proportion of its workforce is likely to be receptive to HSAs, and the level of resources that it wishes to devote to facilitating an HSA arrangement. Employers that wish to assist employees in establishing HSAs essentially have two options:

- Offer an HDHP that satisfies the HSA requirements and leave it up to employees to establish HSAs on their own; or
- Offer an HDHP/HSA package, which allows employees one-stop shopping. Also, the employer will have to decide whether to give the flexibility to employees to make HSA contributions on a pre-tax basis through the employer's cafeteria plan during the year rather than contributions on an after-tax basis with an accompanying deduction on the individual's tax return.

Potential Consequences of Failing to Follow Applicable HSA Rules

It is important for individuals to become familiar with the rules that apply to HSAs to avoid adverse income tax consequences. An individual who does not maintain adequate records of medical expenditures may be required to pay income tax and a 10% additional tax on amounts distributed from the HSA. In contrast to health FSAs and to HRAs, HSA account owners are required to maintain their own records of medical expenditures and do not submit claims for approval. Thus, on audit, an individual would be required to prove that the level of medical expenses matched those on the filed tax return (Form 1040 and Form 8889). Also, if an individual makes excess contributions to an HSA for one year and fails to withdraw those contributions by April 15 of the following year, he or she will be subject to a 6% excise tax on the excess contributions. Finally, if an employee fails to maintain HDHP coverage for the required 13-month testing period after making certain types of HSA contributions described in Chapter 5, an individual may be required to pay income tax and a 10% additional tax on amounts contributed to the HSA. Similarly, employers should become familiar with applicable rules to avoid potential excise taxes and penalties. An employer that fails to make comparable contributions to employee HSAs may be required to pay an excise tax in the amount of 35% of the aggregate amount contributed by the employer to employee HSAs for the year (as discussed later). Also, an employer that excludes HSA contributions from employees' wages without following applicable IRS guidance, or that violates cafeteria plan nondiscrimination rules, may be held responsible for paying employment taxes and penalties. Finally, an employer also could be found in violation of ERISA rules, which could generate DOL civil penalties or participant lawsuits (see Chapter 8).

Future of HSAs

As part of its fiscal year 2008 budget proposal, the Bush Administration has proposed to completely reform the tax treatment of health insurance coverage and make additional changes to the rules that apply to HSAs.

Following are the current and proposed new standard deduction for health insurance coverage.

Current Tax Treatment for Health Insurance

Under current law, if an individual receives health coverage through his employer, the entire amount of that coverage is excludable for both income and employment tax (Social Security, Medicare, and federal unemployment) purposes. An outgrowth of the exclusion for employer-provided health care is the favorable tax treatment of expenses paid through a cafeteria plan, health FSA, or HRA. Self-employed individuals who purchase health insurance are able to deduct the full cost of health insurance for income tax (but not employment tax) purposes. Individuals who purchase their health insurance on their own rather than through their employer only can deduct their health care premiums for income tax purposes to the extent that they itemize their tax deductions and their health care costs exceed 7.5% of adjusted gross income; they do not receive any tax relief for employment tax purposes. Consequently, certain lower income individuals who purchase insurance on their own may not receive any income or employment tax relief on those purchases.

Administration's Proposal

The Administration proposes to add a new “standard deduction” for those who are covered by health insurance and generally to eliminate the other tax preferences that are available for health coverage. The Administration believes that providing a standard deduction to all individuals who have health insurance—regardless of whether or not it is acquired through one’s employer—will result in an increase in the total number of individuals covered by health insurance. The Administration also believes that providing a uniform standard deduction not based on the amount of health care coverage purchased will provide an incentive for individuals to move to less comprehensive and less costly insurance, including HDHPs with lower premiums. The Administration further believes that this will promote more cost consciousness in health care decision making and make individuals more engaged consumers of health services.

New Standard Deduction for Health Insurance Coverage

The Administration proposes, effective in 2009, that all individuals who have qualifying health insurance coverage be provided a standard deduction of up to \$15,000 for those with family coverage and \$7,500 for those with individual (self-only) coverage, based on the number of months that the individual is covered by the qualifying health coverage. The deduction amount would be indexed to increases in inflation based upon the rise in the consumer price index (CPI) rather than being based upon health care cost inflation.

The amount of the standard deduction would not depend on the cost of the insurance purchased, but the insurance would have to meet certain minimum coverage requirements in order to qualify, including:

- A limit on out-of-pocket exposure for covered expenses that is not higher than that currently allowable for HSAs (e.g., \$5,500 for self-only coverage and \$11,000 for family coverage for 2007; \$5,600 for self-only coverage and \$11,200 for family coverage for 2008);
- A reasonable annual and/or lifetime benefit maximum;
- Coverage for inpatient and outpatient care, emergency benefits, and physician care; and
- Guaranteed renewability by the provider.

Although the health coverage could contain coverage exclusions and limitations—thereby lowering the cost—it would have to “meaningfully limit individual economic exposure to extraordinary medical expenses” under Treasury regulations in order to be considered qualifying health coverage. Coverage under a long-term care plan or under Medicare would not count as qualifying health insurance. The proposal would not preempt state laws mandating certain insurance coverage.

Individuals and their dependents that are enrolled in Medicare, Medicaid, or the State Children’s Health Insurance Program (SCHIP) would not be eligible for the proposed new standard deduction. If an individual were to pay for his or her health insurance through a distribution from an HSA or an Archer MSA, or to use

the health care tax credit to purchase coverage, he or she also would not be eligible for the new standard deduction.

How the Proposed New Standard Deduction Would Operate

The proposed new standard deduction would reduce an individual's income for both income tax and employment tax purposes. Qualifying individuals apparently would be permitted to reduce their tax withholding so that the deduction would be reflected in their regular paycheck rather than having to wait until filing their tax return and receiving a refund. If an employee were to be eligible for the new standard deduction due to health care coverage acquired through the employer, the employer could reduce the employee's employment taxes to reflect the new standard deduction. If an employee were to purchase qualifying health insurance on his or her own outside the employment context, the employer apparently could adjust the employee's employment taxes if the employee provided proof of coverage under qualifying health insurance. Self-employed individuals also could take the standard deduction for both income and employment tax purposes and could adjust estimated tax payments accordingly.

Impact on Current Tax Law

Under the Administration's proposal, employers still could offer health coverage to their employees, but the value of that coverage would have to be included in the employee's wages for income and employment tax purposes. Employees would not be able to purchase health coverage on a pre-tax basis or make contributions to a health FSA through a cafeteria plan. Amounts paid from an HRA for medical expenses would be currently taxable to the individual, which would make HRAs less attractive and likely eliminate their use. Contributions still could be made on a pre-tax basis to an HSA; however, it is not clear whether a contribution could be made through a cafeteria plan. Earnings in the HSA would continue to be tax-deferred and distributions from the HSA for qualified medical expenses still would not be taxable. Self-employed individuals would no longer have a separate deduction for premiums paid for health insurance. Further, the itemized deduction for medical expenses would be eliminated, except for taxpayers enrolled in Medicare. Employers could, however, continue to deduct the premiums paid for employee health insurance as a business expense.

Political Outlook

While there has been much discussion of the Administration's proposal in the news media, key Congressional Democrats generally have been very critical of the proposal. Representative Pete Stark (D-CA), chairman of the House Ways and Means Subcommittee on Health, has stated that he will not even hold a hearing on the proposal. At this point, it appears very unlikely that the proposal will be enacted into law. It is possible, however, that the proposal, when coupled with the lead-up to the upcoming Presidential and Congressional elections, will help jump-start the debate on health care reform.

Expansion of Health Savings Accounts

The Administration, which has been a very strong proponent of HSAs, has proposed the following series of changes to the HSA provisions to provide further incentives for individuals to purchase HDHPs and contribute to HSAs.

Expand Qualifying HDHPs

Under current law, to make a contribution to an HSA, the individual must have a qualifying HDHP, defined as a plan with a deductible for 2007 of at least \$1,100 for self-only coverage and \$2,200 for family coverage and maximum out-of-pocket expense limit for 2007 of no more than \$5,500 for self-only coverage and \$11,000 for family coverage (for 2008, the out of pocket expense limit increases to \$5,600 and \$11,200, respectively). The Administration's proposal would allow plans with 50% or more coinsurance and a minimum out-of-pocket exposure to be considered qualifying HDHPs if, under rules established by the Treasury, the resulting plan had the same premiums as (or lower premiums than) an already-qualifying HDHP.

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Qualifying Medical Expenses

Under current law, qualifying medical expenses only can be paid out of the HSA tax-free if the expenses were incurred after the HSA was established. Under the Administration's proposal, expenses that were incurred after the individual was eligible to contribute to an HSA (i.e., he or she has enrolled in an HDHP and has no other non-HDHP coverage) could support a tax-free distribution as long as the HSA was established before the filing date of the individual's tax return for the year.

Larger Employer Contributions for the Chronically Ill

The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of non-highly compensated employees (NHCEs) in higher amounts (or higher percentages of deductibles) than on behalf of highly compensated employees (HCEs). Under the TRHCA, enacted on December 20, 2006, employers are permitted to make larger HSA contributions on behalf of NHCEs, but still must satisfy the comparability rules as to contributions to NHCEs (i.e., each NHCE must get the same dollar amount (or percentage of deductible) of contributions from the employer). The Administration's proposal would allow employers to make HSA contributions on behalf of employees who are chronically ill or who have spouses or dependents who are chronically ill to be excluded from the comparable contribution rules to the extent that these amounts exceeded the comparable contributions to other employees.

Deductibles in Family Policies

Under current law, the HDHP deductible must be reached by the entire family, rather than on a per-family member basis. However, plans that have an embedded deductible (where a lesser deductible is applied to expenses incurred by each individual family member) will not be considered qualifying HDHPs for HSA purposes unless the minimum individual deductible is at least equal to the minimum deductible for family coverage (\$2,200 for 2007 and 2008). The Administration's proposal would allow these embedded deductibles as long as the deductible was at least the minimum deductible for individual coverage (\$1,100 for 2007 and 2008) and the overall family coverage deductible was at least equal to the family minimum deductible.

Catch-Up Contributions

Under current law, individuals who are age 55 or over are permitted to make an additional contribution to their HSA annually (\$800 for 2007; \$900 for 2008). However if two individuals age 55 or over are married, both individuals must have their own HSAs to make this catch-up contribution. The Administration's proposal would permit both spouses who are eligible to make catch-up contributions to an HSA to make contributions to a single HSA owned by one spouse.

HSA Contributions of Individuals Covered by Health FSA or HRA

Generally, individuals who are covered by a health FSA or an HRA are not eligible to make contributions to an HSA. The Administration's proposal would allow such individuals to make contributions to an HSA, but the maximum allowable HSA contribution would be reduced by the health FSA or HRA coverage amount. The Administration believes that this will make it easier for an individual to transfer to HSA-eligible coverage when he or she previously participated in a health FSA or an HRA.

Political Outlook

Democrats have been skeptical of the benefits of HSAs, believing them to be mainly for the benefit of the healthy and wealthy. Consequently, it is unlikely these proposals will get much traction in the Democratically-controlled Congress.

Legislative Changes

The TRHCA adopts the following changes through its inclusion of H.R. 6134, the leading HSA-related proposal introduced in the 109th Congress and approved by the Ways and Means Committee on September 27, 2007:

Introduction to Health Savings Accounts (HSAs)

- Permits an individual to transfer the balance remaining in his or her health FSA or HRA account as of September 21, 2006 (or, if less, the balance on the transfer date), to a new HSA. The transfer must be made before January 1, 2012.
- Modifies the limit on contributions to HSAs, so that contributions are not limited to the annual deductible of the HDHP; instead, contributions are limited only by the indexed dollar amount (\$2,850 self-only; \$5,650 family for 2007; and \$2,900 and \$5,800 for 2008, respectively).
- Requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year.
- Allows individuals who become covered by an HDHP after January to contribute up to the full annual limit, even if they only were eligible individuals for a portion of the taxable year; however, if they did not maintain an HDHP for the 12-month period beginning with the last month of year (except in the case of death or disability), then they must pay tax on the HSA contributions plus a 10% penalty.
- Allows employers to make contributions to HSAs on behalf of non-highly-compensated employees in higher amounts (or higher percentages of deductibles) than to highly-compensated employees without violating the comparable contribution rules.
- Allows coverage under a health FSA during the 2-1/2 month grace period to be disregarded for eligible individuals who have a zero balance in their HSAs at the end of the previous calendar year.
- Allows individuals to make a one-time contribution of rollover amounts from an IRA to an HSA, subject to the HSA contribution limit.

Chapter 2

HSAs in General

This chapter introduces the concept of Health Savings Accounts (HSAs) under the Internal Revenue Code (Code). Eligibility rules for establishing an HSA and the new definition of the term “dependent” are discussed. This chapter also introduces the term “qualified medical expense.” Individuals who have a High Deductible Health Plan (HDHP) and satisfy the other eligibility rules discussed later are referred to by the term “eligible individuals.”

Only an eligible individual may make and receive an HSA contribution. However, an individual does not have to be an eligible individual to receive a tax-free distribution. Distributions from HSAs are discussed more fully in Chapter 6.

The advantages and disadvantages of HSAs also are included in this chapter. HDHPs are discussed more fully in Chapter 3, and the HSA contribution limits are explained in Chapter 4.

General Rules

An HSA is a trust or custodial account created or organized in the United States exclusively for the purpose of paying the account owner’s qualified medical expenses. The written governing instrument creating the trust or custodial account must meet all the following requirements:¹

1. Regular HSA contributions must be made in cash, although there is an exception for rollovers and trustee-to-trustee transfers (see Chapter 5).²
2. For 2007, the HSA statutory annual maximum contribution is the sum of the monthly allowable amounts for each month that the account owner is an eligible individual, up to a maximum of \$2,850 (\$2,900 for 2008) for individual (self-only) coverage or \$5,650 (\$5,800 for 2008) for family coverage.³

Note: Although the statutory maximum contribution limit does not generally include rollovers and transfers made to an HSA from another HSA, Archer Medical Savings Account (Archer MSA), Health Care Flexible Savings Arrangement (health FSA), or Health Reimbursement Arrangement (HRA), a direct transfer that is rolled over from an Individual Retirement Arrangement (IRA) in a qualified funding distribution (see Chapter 5) is subject to the statutory annual contribution limit when combined with regular contributions made for the year.

3. Regular HSA contributions made for a taxable year beginning before 2007 may not exceed 100% of the highest annual deductible amount under the eligible individual’s HDHP for such year. For taxable years beginning after 2006, individuals are permitted to make contributions up to the statutory limit for the year, even if that limit is higher than the HDHP’s annual deductible.

¹ IRC § 223(d)(1).

² IRC § 223(d)(1)(A)(i); Notice 2004-50, Q&A 73, 2004-33 IRB 196.

³ IRC § 223(d)(1)(A)(ii).

Note: Although the annual amount is computed on a monthly basis, there is no actual monthly limit.⁴

4. The HSA trustee (or custodian) must be a bank as defined in Code Section 408(n), an insurance company as defined in Code Section 816, or an IRS-approved “nonbank” trustee.⁵

Note: Financial organizations authorized to serve as trustee or custodian for an IRA automatically are permitted to serve as an HSA trustee or custodian without additional IRS approval.⁶ An HSA is a newer type of financial product and can be offered by various types of financial organizations that qualify as an HSA trustee or custodian (see Chapter 6).

5. No part of the HSA assets may be invested in life insurance contracts.⁷
6. The balance in the participant’s HSA account must be nonforfeitable.⁸
7. The trust assets may not be commingled with other property except in a common trust fund as defined in Treasury Regulation Section 1.408-2(b)(5)(ii) or common investment fund as defined in Code Section 584(a)(1).⁹

Note: Unless these requirements are satisfied, no contributions may be accepted by the trustee or custodian.¹⁰

Account Beneficiary

The HSA account beneficiary is the individual on whose behalf the account was established.¹¹ The IRS model HSA forms (see Chapter 7) use the term “account owner” to refer to the account beneficiary. Throughout this text, the term “account owner” will be used rather than “account holder,” “beneficiary,” or “participant.”

Effective Date

The HSA rules generally are effective for taxable years beginning after December 31, 2003.¹² Thus, the first date on which an eligible individual could establish an HSA was January 1, 2004.¹³

⁴ IRC § 223(d)(1)(A)(ii).

⁵ Notice 2004-2, Q&A 9, 2004-2 IRB 269.

⁶ IRC § 223(d)(1)(B); Notice 2004-2, 2004-2 IRB 269; IRS Ann 2003-54, 2003-40 IRB 761; IRS Ann 2005-59, 2005-37 I.R.B. 524 (Sept. 12, 2005), containing a list of approved nonbank trustees and custodians.

⁷ IRC § 223(d)(1)(C); Notice 2004-50, Q&A 65, 2004-33 IRB 196.

⁸ IRC § 223(d)(1)(E), Notice 2004-50, Q&A 82, 2004-33 IRB 196.

⁹ IRC § 223(d)(1)(D); Notice 2004-50, Q&A 66, 2004-33 IRB 196.

¹⁰ IRC § 223(d)(1)(A).

¹¹ IRC § 223(d)(3).

¹² Section 1201(k) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides that “The amendments made by this section [amending sections 62, 106, 125, 220, 223, 224, 848, 3231, 3306, 3401, 4973, 4975, 6051, and 6693 and enacting section 4980G of the Code] shall apply to taxable years beginning after December 31, 2003.”

¹³ Notice 2004-2 Q&A 8, 2004-2 IRB 269.

Eligible Individual for Establishing an HSA

The term “eligible individual” means, with respect to any month, any individual who:¹⁴

1. Is covered under an HDHP as of the first day of such month.

Note: For taxable years beginning after 2006, the Tax Relief and Health Care Act of 2006 (TRHCA) allows an HSA account owner to make a full-year HSA contribution even if such individual becomes an HSA-eligible individual after the first day of his or her taxable year (generally January 1st). The exception is discussed in Chapter 4.

2. Is not covered under any other health plan while being covered by the HDHP that:
 - a. Is not an HDHP; and
 - b. Provides coverage for any benefit provided for under the HDHP, subject to certain exceptions.
3. Is not enrolled in Medicare (generally, has not reached age 65).
4. Cannot be claimed as a dependent on another person’s tax return.

To determine if an employee is an eligible individual, the employee’s actual health coverage election is controlling rather than the choices offered by the employer.¹⁵

However, an individual may be eligible to contribute to an HSA if his or her spouse has non-HDHP family coverage, provided the spouse’s coverage does not cover the individual.¹⁶

Example 2-1

Sid and Hilda are a married couple, and both are age 35. Throughout 2007, Sid has HDHP self-only coverage. He has no other health coverage, is not enrolled in Medicare, and may not be claimed as a dependent on another taxpayer’s return. Hilda has non-HDHP family coverage for herself and their two dependents, but Sid is excluded from Hilda’s coverage. Although Hilda has non-HDHP family coverage, Sid is not covered under that health plan. Sid therefore is an eligible individual.

Note: The special rules for married individuals that treat both spouses as having family coverage (see Chapter 4) do not apply because Hilda’s non-HDHP family coverage does not cover Sid. Thus, Sid remains an eligible individual. However, Sid may not make the catch-up contribution because he is not age 55 or older in 2007. Hilda has non-HDHP coverage and therefore is not an eligible individual.

Caution: If a spouse has a health FSA that covers an HSA account owner, the HSA account owner’s eligibility to make HSA contributions may be affected (see Chapter 4).¹⁷

Example 2-2

Same facts as **Example 2-1**, except that Sid has HDHP family coverage for himself and one of their dependents. Hilda has non-HDHP family coverage for herself and their other dependent. Sid is excluded from Hilda’s coverage. Because the non-HDHP family coverage does not cover Sid, the special rules that treat both spouses as having family coverage do not affect Sid’s eligibility to make HSA contributions. Hilda has non-HDHP coverage and therefore is not an eligible individual.

¹⁴ IRC § 223(c)(1)(A); Notice 2004-2, Q&A 2, 2004-2 IRB 269, as modified by Notice 2004-50, 2004-33 IRB 196, see *Effect on Other Documents*.

¹⁵ Notice 2004-50, Q&A 1, 2004-33 IRB 196.

¹⁶ Rev. Rul. 2005-25, 2005 IRB 18.

¹⁷ See, IRS Notice 2004-45, 2004-28 IRB 1.

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Example 2-3

Hubert and Jill are a married couple, and both are age 35. Throughout 2007, Hubert has HDHP family coverage for himself and their two dependents. Also, Jill is not covered under Hubert's health plan and has no other health plan coverage. Hubert is eligible to make HSA contributions. Because Hubert's family coverage does not cover Jill, the special rules do not apply to treat Jill as having family coverage. Nonetheless, Jill has no health plan coverage and therefore is not an eligible individual.

State Mandated Benefits

A state could have laws mandating that certain benefits be included in an insured HDHP. These laws, for example, may require certain benefits to be covered under an HDHP without regard to whether the deductible is satisfied. Unless a state's mandated benefits satisfy the definition of the term "preventive care" for federal purposes (see Chapter 3), this would cause the HDHP to fail to satisfy the Code Section 223 requirements. If so, an individual in a state with those laws could not contribute to an HSA. Other state laws may require that an insurer or Health Maintenance Organization (HMO) must comply with limits on deductibles, which similarly could conflict with federal requirements.

The IRS has addressed this by issuing transitional guidance for months before January 1, 2006, for state requirements in effect on January 1, 2004. The guidance states that during this time period, an HDHP will not be considered to violate federal requirements if the sole reason that it does not comply with federal requirements is because it is complying with state benefit mandates. However, after January 1, 2006, individuals covered by insured HDHPs or HMOs subject to state laws that conflict with Code Section 223 requirements will not be considered "eligible individuals" able to contribute to HSAs.¹⁸

Note: Generally, a health plan may not reduce existing benefits before the plan's renewal date. Thus, even though a state may amend its laws before January 1, 2006, to authorize HDHPs that comply with Code Section 223(c)(2), non-calendar year plans still may fail to qualify as HDHPs after January 1, 2006. See Chapter 3 for a discussion of transitional relief for non-calendar year plans.

Practice Pointer →

Distributions from an HSA to pay for qualified medical expenses of the account owner, the account owner's spouse, or dependents, may be made without regard to their status as eligible individuals. Thus, it is not necessary for an individual to be covered by an HDHP to have his or her qualified medical expenses reimbursed from an HSA on a tax-free basis.¹⁹ However, distributions made for expenses reimbursed by another health plan are not excludable from income, whether or not the other health plan is a HDHP (see Chapter 6).

Coverage Exceptions

There are two exceptions to the rule requiring that the employee not be covered under any other non-HDHP:²⁰

1. Coverage for any benefit provided by "permitted insurance."
2. Coverage, whether through insurance or otherwise, for accidents, disability, dental care, vision care, or long-term care.

¹⁸ See, IRS Notice 2004-43, 2004-27 IRB 10. See Appendix C for a list of states with mandates that could cause an HDHP to fail to satisfy applicable requirements.

¹⁹ Notice 2004-50, Q&A 36, 2004-33 IRB 196.

²⁰ IRC § 223(c)(2)(3); Notice 2004-2, Q&As 5 and 6, 2004-2 IRB 269; Rev. Rul. 2005-25, 2005 IRB 18.

See Chapter 3 for more information related to medical plan coverage, including a description of permitted insurance.

Married Individuals

Although the special rule for married individuals under Code 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.²¹

An HSA may only be established on behalf of one individual. Thus, if a husband and wife are eligible to contribute to an HSA, they both are eligible to establish separate HSAs. Only one person may be the HSA account owner.²²

Practice Pointer →

If both spouses are age 55 or older and both want to make catch-up contributions, they each must establish an HSA.

Where both spouses have family HDHP coverage, but only one spouse has other coverage, the spouses' contribution limits vary depending on the specific circumstances. See the following examples:

Practice Pointer →

A married couple's tax filing status (that is, joint or separate) does not affect a particular spouse's contribution.

Example 2-4

Marvin and Marcy, both age 35, are married and have HDHP family coverage with a \$5,000 deductible. Marvin has no other coverage. Marcy also has self-only coverage with a \$200 deductible. Marcy, who has coverage under a low-deductible plan, is not eligible and cannot contribute to an HSA. For their taxable year beginning in 2007, Marvin may contribute \$5,650 (the 2007 statutory limit) to an HSA.

Note: For 2006, Marvin would have only been able to contribute \$5,000 to an HSA (the lesser of the HDHP deductible for family coverage or \$5,450 (the 2006 contribution limit)).

Example 2-5

Alvin and Evelyn, both age 35, are married and have HDHP family coverage with a \$5,000 deductible. They are calendar year taxpayers. Alvin has no other coverage. Evelyn also has HDHP self-only coverage with a \$2,000 deductible. Both Alvin and Evelyn are eligible individuals. Alvin and Evelyn are treated as only having family coverage. The combined HSA contribution by Alvin and Evelyn cannot exceed \$5,650 (the statutory limit for 2007), to be divided between them by agreement.

Example 2-6

Jake and Janet, both age 35, are married and have family HDHP coverage with a \$5,000 deductible. They are calendar year taxpayers. Jake has no other coverage. Janet also is enrolled in Medicare. Janet is not an eligible individual and cannot contribute to an HSA, but Jake may contribute \$5,650 (the statutory limit for 2007) to an HSA.

²¹ Notice 2004-50, Q&A 31, 2004-33 IRB 196.

²² Notice 2004-50, Q&A 63, 2004-33 IRB 196.

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Example 2-7

Thomas and Yetta, both age 35, are a married couple. Throughout 2007, Thomas has HDHP self-only coverage with an annual deductible of \$2,000 (see Chapter 3). Thomas has no other health coverage, is not enrolled in Medicare, and may not be claimed as a dependent on another taxpayer's return. Yetta has non-HDHP family coverage for Yetta and their two dependents, but Thomas is excluded from Yetta's coverage. Although Yetta has non-HDHP family coverage, Thomas is not covered under that health plan. Thomas therefore is an eligible individual.

Note: The special rules for married individuals treating both spouses as having family coverage do not apply because Yetta's non-HDHP family coverage does not cover Thomas. Thus Thomas remains an eligible individual and may contribute up to \$2,850 (the 2007 contribution limit for self-only coverage). Thomas may not make the catch-up contribution because he is not age 55 in 2007. Yetta has non-HDHP coverage and therefore is not an eligible individual.

Example 2-8

Same facts as in *Example 2-7*, except that Thomas has HDHP family coverage for himself and one of Thomas's and Yetta's dependents with an annual deductible of \$5,000. Yetta has non-HDHP family coverage for herself and their other dependent. Thomas is excluded from Yetta's coverage. Because the non-HDHP family coverage does not cover Thomas, the special rules that treat both spouses as having family coverage do not affect Thomas's eligibility to make HSA contributions up to Thomas's annual HSA contribution limit. Thomas therefore may contribute up to the statutory limit (\$5,650 for 2007) to an HSA. Yetta has non-HDHP coverage and therefore is not an eligible individual.

Example 2-9

Edward and Jill are a married couple, both age 35. Throughout 2007, Edward has HDHP family coverage for himself and their two dependents with an annual deductible of \$5,000. Also, Jill is not covered under Edward's health plan and has no other health plan coverage. Edward may contribute to up to \$5,650 to an HSA (the 2007 contribution limit for family coverage). Because Edward's family coverage does not cover Jill, the special rules do not apply to treat Jill as having family coverage. Jill has no health plan coverage and therefore is not an eligible individual.

Where both spouses have family coverage, but one spouse has other coverage, the contribution limits for the spouses vary depending on the specific circumstances. See the following examples.

Example 2-10

Kenny and Kirsten, both age 35, are married and have family HDHP coverage with a \$5,000 deductible for their 2007 taxable year. Kenny has no other coverage. Kirsten also has HDHP family coverage with a \$3,000 deductible. Both Kenny and Kirsten are eligible individuals. Because the HDHP's annual deductible need not be taken into account in determining the yearly contribution limit after 2006, the HSA combined maximum annual contribution by Kenny and Kirsten is \$5,650, to be divided between them by agreement.

Note: For taxable years ending before 2006, Kenny and Kirsten would only be able to contribute \$3,000, split between them because they are both treated as having HDHP family coverage with the lowest annual deductible (\$3,000). The annual deductible limit was repealed for taxable years beginning after 2006.

Example 2-11

Pat and Paula, both age 35, are married and have HDHP family coverage with a \$5,000 deductible for their 2007 taxable year. Pat has no other coverage. Paula also has family coverage with a \$200 deductible. Pat and Paula are treated as having family coverage with the lowest annual deductible (\$200), which is below the

minimum required deductible amount of \$2,200 for 2007. Neither Pat nor Paula is an eligible individual and neither may contribute to an HSA.

Note: An individual may be eligible to contribute to an HSA if his or her spouse has non-HDHP family coverage, provided the spouse's coverage does not cover the individual.²³

Residents of U.S. Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands

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 would be able to establish HSAs only after statutory provisions were enacted that were similar to Code Sections 223 (relating to HSAs) and 106(d) (relating to employer-provided medical expense coverage).²⁴

Residents of Hawaii

Hawaiian residents are not prohibited from having HSAs. However, an HDHP offered by an employer in Hawaii would have to satisfy Hawaii's Prepaid Health Care Act (PHCA), which sets forth various requirements concerning plan benefits and cost-sharing, and would have to be approved as a qualified plan by Hawaii's Prepaid Health Care Council.²⁵ Hawaii Department of Labor and Industrial Relations (DLIR) staff have informally indicated that, while Hawaii may be willing to approve HDHP/HSA plans as satisfying PHCA requirements, the state likely would require significant HSA employer contributions as a condition for approval. Accordingly, at the time of publication, HSAs generally only are established by Hawaiian recipients who do not have employer-provided health coverage (e.g., sole proprietors, self-employed individuals, and those working as part-time employees).

HDHP Coverage Rules

An eligible individual generally must have HDHP coverage as of the first day of the month. An individual with employer-provided HDHP coverage on a pay period-by-pay period 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.²⁶

Note: For taxable years beginning after 2006, the TRHCA law allows an HSA account owner to make a full year HSA contribution, even if such individual becomes an HSA-eligible individual after January 1st. The exception is discussed in Chapter 5.

Example 2-12. Henry, an employee, begins HDHP coverage on the first day of a biweekly payroll period, which is August 6, 2007, and continues to be covered by the HDHP throughout 2007. For purposes of contributing to an HSA, Henry becomes an eligible individual on September 1, 2007. If Henry uses the exception allowing him to be treated as eligible for the entire year, his maximum contribution amount likely will increase (up to the statutory limit of \$2,850 for 2007); however, Henry will have to remain an eligible individual during a testing period that will not end until December 31st of the following year. Henry must maintain his HDHP and otherwise remain eligible during the testing period (see Chapter 5).

²³ Rev. Rul. 2005-25, 2005 IRB 18.

²⁴ See, Notice 2004-50, Q&A 87, 2004-33 IRB 196.

²⁵ Haw. Rev. Stat., ch. 393.

²⁶ IRC § 223(b)(2); Notice 2004-50, Q&A 11, 2004-33 IRB 196.

Medicare Eligibility

Individuals eligible for Medicare but not enrolled in Medicare Part A or B remain eligible to contribute to an HSA.²⁷

Eligibility for making HSA contributions ends beginning with the month that the HSA account owner becomes eligible for and enrolls in either Medicare Part A or Part B.²⁸ Thus, an otherwise eligible individual not actually enrolled in Medicare Part A or Part B may contribute to an HSA until the month that he or she actually enrolls in Medicare.

Example 2-13

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

Note: Enrollment in Medicare Part A is automatic if an individual begins receiving Social Security retirement benefits.

Example 2-14

In August 2007, Thomas attains age 65 and applies for and begins receiving Social Security benefits. Thomas automatically is enrolled in Medicare Part A. As of August 1, 2007, Thomas no longer is an eligible individual and may not contribute to an HSA. If Thomas were HSA-eligible for the 6-month period ending in June, his maximum contribution would be \$2,225 (the statutory limit \$1,425 $(\$2,850 \div 12 \times 6)$ plus an \$800 catch-up contribution) assuming he was covered under a self-only HDHP for that period.

Example 2-15

Dorothy turned age 65 in July 2007 and enrolled in Medicare. Dorothy had HDHP self-only coverage with an annual deductible of \$1,100. She is eligible for an additional contribution of \$3,650 because of the catch-up provisions applicable for 2007. Dorothy's contribution limit for 2007 is \$1,825 $(\$2,850 + \$800) \div 12$ months $\times 6$ months). Dorothy can make contributions for January through June totaling \$1,825 but cannot make any contributions for July through December. As of July 1, 2007, Dorothy no longer was an eligible individual and may not contribute to an HSA in respect to those months.

Veterans and Active Military Service

Individuals who are eligible for medical benefits through the Department of Veterans Affairs (VA) and who otherwise are eligible for an HSA may contribute to the HSA as long as they have not received such medical benefits from the VA at any time during the preceding three months.²⁹

Active-Duty Military with TRICARE Coverage

TRICARE (formerly CHAMPUS) is the U.S. Military Health System's health care program for active duty military, active duty service families, retirees and their families, survivors, and other beneficiaries as well as for active duty Reservists and National Guardsmen. At the time of publication, TRICARE did not offer an HDHP option, so an individual would not be an eligible individual for establishing an HSA.³⁰ Once TRICARE

²⁷ Notice 2004-50, Q&A-2, 2004-33 IRB 196.

²⁸ IRC § 223(b)(7); Notice 2004-50, Q&A 2, 2004-33 IRB 196.

²⁹ Notice 2004-50, Q&A 5, 2004-33 IRB 196.

³⁰ Notice 2004-50, Q&A 6, 2004-33 IRB 196.

offers an HSA-qualified HDHP, those individuals who select it and otherwise are eligible would be permitted to make contributions to an HSA. To check the current status of TRICARE plans, visit www.tricare.osd.mil/.

Children of Divorced Parents

Different rules apply to determine whether a child of divorced parents can be covered under the HSA or accompanying HDHP on a tax-free basis. These rules are summarized below:

HDHP: A child could receive benefits under his or her divorced parent's health coverage on a tax-free basis—whether or not that parent is the custodial parent—as long as:

- Both parents, together, provide over half the child's support for the year (other than through multiple support agreements under which a group of contributors provides support for a child); and
- One or both parents have custody for more than half the calendar year.³¹

The IRS has taken the informal position that the Code Section 105(b) rule relating to a child of divorced parents described above, should apply for Code Section 106 purposes as well.

Note: Code Sections 105(b) and 106 together allow both the benefit and the premium of employer-provided health coverage to be excluded from an employee's income for federal tax purposes.

HSA: Unless the parties agree otherwise, the parent who has custody for the greater part of the year can make a tax-free HSA withdrawal to pay the child's qualified medical expenses for that year. If the child resides with both parents for equal parts of the year, the parent with the highest AGI is treated as the custodial parent and can make a tax-free HSA withdrawal to pay the child's qualified medical expenses for that year.³²

Alternatively, if the custodial parent signs a written declaration that he or she will not take the deduction, and this written declaration is attached to the noncustodial parent's tax return, the noncustodial parent may withdraw funds from his or her HSA on a tax-free basis for his or her child's qualified medical expenses for that year.³³

HSA Establishment and Effective Dates

An HSA cannot be considered “established” for purposes of receiving tax-free distributions for qualified medical expenses until the date that the eligible individual's HDHP coverage becomes effective. All the paperwork may be completed and the minimum contribution deposited before the effective date that HDHP coverage begins. However, the account is not officially effective until HDHP coverage begins.

In the case of the IRS model forms, “an HSA is established after the form is fully executed by both the account owner and the trustee” (or custodian).³⁴

³¹ IRC § 105(b); 152(e); see, Treas. Reg. § 1.152-4T, Q&A-5.

³² IRC § 152(c)(4)(B).

³³ See IRC § 152(e).

³⁴ See *Purpose of Form, General Instructions, Form 5305-B, Health Savings Trust Account and Form 5305-C, Health Savings Custodial Account*.

Practice Pointer →

Completing the necessary steps before HDHP coverage begins ensures that the HSA will be “established” as early as possible. This is especially important when HDHP coverage is effective on a non-business day.

Note: If HDHP coverage begins on any day other than the first day of the month, the HSA cannot be effective any sooner than the first day of the following month.

Qualified Medical Expenses

Distributions from an HSA used exclusively to pay for qualified medical expenses of the account owner, his or her spouse, or dependents are excludable from gross income (see Chapter 6). In general, HSA funds can be used for qualified medical expenses and will continue to be excludable from the account owner's gross income even if the individual terminates his or her employment status and is not eligible to make contributions to the HSA.

Qualified medical expenses include amounts paid to the account owner or his or her spouse or dependents for “medical care” as defined in Code Section 213(d), provided such amounts are not compensated for by insurance or otherwise. Qualified medical expenses are discussed more fully in Chapter 6.

The term “medical care” includes amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.³⁵ An expenditure that is merely beneficial to an individual's general health, such as an expenditure for a vacation, is not an expenditure for medical care. However, expenditures for “medicines and drugs” are expenditures for medical care.

Caution: The qualified medical expenses must be incurred only after the HSA has been established.³⁶ The IRS granted transitional relief on this issue for 2004.

Payments for Insurance

Generally, qualified medical expenses shall not include payment for insurance. Exceptions to this rule (see also Chapter 6) include coverage under any of the following:³⁷

1. A health plan during any period of continuation coverage required under federal law (Consolidated Omnibus Budget Reconciliation Act (COBRA));
2. A “qualified long-term care insurance contract” as defined in Code Section 7702B(b);
3. A health plan during a period in which the individual is receiving unemployment compensation under any federal or state law; or
4. For individuals over age 65, premiums for Medicare Part A or B, Medicare HMO, and the employee share of premiums for employer-sponsored health insurance, including premiums for employer-sponsored retiree health insurance, but not Medigap premiums.³⁸ For example, in the case of any HSA account owner who has attained the age specified in Section 1811 of the Social Security Act, any health insurance other than a Medicare supplemental policy (as defined in Section 1882 of the Social Security Act).

³⁵ IRC § 213(d)(1); Treas. Reg. § 1.213-1(e)(1)(ii).

³⁶ Notice 2004-2, Q&A 26, 2004-2 IRB 269.

³⁷ IRC § 223(d)(2)(C)(iii); Notice 2004-2, Q&A 27, 2004-2 IRB 2.

³⁸ Notice 2004-2, Q&A-27, 2004-2 IRB 2.

Dependents

The Gulf Opportunity Zone Act of 2005 (GOZA),³⁹ enacted into law on December 21, 2005,⁴⁰ contains tax incentives and other relief to businesses and individuals affected by Hurricanes Katrina, Rita, and Wilma. It also includes a package of technical corrections to several tax laws, including the Working Families Tax Relief Act of 2004 (WFTRA).⁴¹ The tax technical corrections include a correction to the definition of eligible “dependent” with respect to HSAs and to dependent care FSAs. This change is retroactive to the January 1, 2005 effective date of the WFTRA.

WFTRA Change to Definition of “Dependent”

Section 201 of the WFTRA amended the definition of the term “dependent” in Code Section 152, effective for taxable years beginning after December 31, 2004. Under the new definition, more restrictive in some regards, an individual must be either a “qualifying child” or a “qualifying relative” to be a dependent.⁴²

Note: The definition was intended to provide a uniform definition of “dependent” for purposes of the dependency exemption, the child credit, the earned income credit, the child and dependent care credit, and head-of-household filing status, but not for group health plans or HSAs – to which prior law was to apply. Because of an apparent technical oversight, an exception for employer-sponsored group health plans, HSAs, or dependent care assistance plans was not created. In response, with respect to employer-sponsored group health plans, the IRS then issued guidance that essentially restored prior law treatment (the pre-WFTRA definition) to employer-sponsored group health plans.⁴³ However, this guidance did not restore the pre-WFTRA definition for HSAs or dependent care assistance plans.

GOZA Change to the Definition of “Dependent”

The technical corrections contained in the GOZA extended the same relief to HSAs and dependent care FSAs that the Treasury and the IRS extended to health plans through Notice 2004-79, by eliminating the income limitations from the definition of the term “qualifying relative.”⁴⁴ This means that individuals can qualify as dependents for purposes of receiving tax-free HSA distributions without regard to gross income. Similarly, individuals can satisfy the definition of the term “dependent” for dependent care FSA purposes without regard to gross income.

The technical correction also specifies that an individual may qualify as a dependent for HSA purposes without regard to whether such individual is married and files a joint return with another taxpayer or is a dependent of another taxpayer. Thus, an individual treated as a dependent under this rule “is not subject to the general rule that a dependent of a dependent shall be treated as having no dependents....”⁴⁵

The changes in GOZA with respect to the definition of dependent are retroactive to the WFTRA effective date of January 1, 2005.

³⁹ GOZA, H.R. 4440.

⁴⁰ GOZA, P.L. 109-135.

⁴¹ WFTRA, P.L. 108-31

⁴² IRC § 152; Working Families Tax Relief Act of 2004, § 201, Pub. L. No. 108-311, 118 Stat. 1166.

⁴³ Notice 2004-79, 2004-49 I.R.B. 898.

⁴⁴ GOZA § 404(c).

⁴⁵ Joint Committee Report, WFTRA § 404 (J.C.T. Rep. No. JXC-88-05).

Dependent for HSA Purposes

Beginning January 1, 2005, the term “dependent” for HSA purposes means either a “qualifying child” or a “qualifying relative” (*without regard to the gross income limitation under Code Section 152(d)(1)(B)*).⁴⁶ See below.

Note: Before 2005, under the pre-WFTRA Code Section 152 definition, the term “dependent” for HSA purposes generally meant an individual who bears the relationship described above and who received from the taxpayer more than one-half of his or her support for the year. Thus, before the WFTRA amendment, there were no income limits or age limitations. The income limit applicable to HSAs effective January 1, 2005, was removed retroactively by GOZA. Thus, beginning in 2005, the income limits that would have applied to a qualifying relative “dependent” for HSA purposes in 2005 retroactively were removed.⁴⁷

Note: A similar change (removing the income limitation) was made to Code Section 21(b)(1)(B), defining the term “qualifying individual” for dependent care services and reimbursement from a dependent care assistance plan.

Relationship

To be a dependent, the individual must bear one of the following relationships with respect to the taxpayer:⁴⁸

- Son or daughter, or a descendent of either;
- Stepson or stepdaughter;
- Brother, sister, stepbrother, or stepsister;
- Father or mother, or ancestor of either;
- Stepfather or stepmother;
- Son or daughter of a brother or sister;
- Brother or sister of the father or mother;
- Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or
- An individual (other than an individual who at any time during the year was the taxpayer’s spouse) who, for the taxable year of the taxpayer, has the home of the taxpayer as his or her principal place of residence and is a member of the taxpayer’s household.

The terms “brothers” and “sisters” include half-blood relatives.⁴⁹ The term “child” includes a legally adopted child, a child who is placed in the taxpayer’s home by an authorized placement agency for legal adoption, or a foster child.⁵⁰ Special rules apply to missing children presumed by law enforcement authorities to have been kidnapped.⁵¹

A dependent does not include an individual who is not a U.S. citizen or national unless the individual is a resident of the United States or of a country contiguous to the United States. This does not include a child legally adopted by a U.S. taxpayer.⁵²

⁴⁶ IRC § 152(a)(1), 152(a)(2).

⁴⁷ See IRC § 223(d)(2)(A), as amended by GOZA Section 404(c).

⁴⁸ IRC § 152(d)(2)(A)-(F).

⁴⁹ IRC § 152(f)(4).

⁵⁰ IRC § 152(f)(B)-(C), 152(f)(6).

⁵¹ See IRC § 152(f)(6)(A)-(B).

⁵² IRC § 152(b)(3).

Qualifying Child

A “qualifying child,” *for HSA purposes*, is a daughter, son, stepchild, sibling, or stepsibling (or descendent of any of any of these) who has the same principal place of abode as the taxpayer for more than one half of the tax year and who (other than in the case of total disability) has not yet attained a specified age.⁵³

To be treated as a qualifying child, an individual must not have attained age 19 (age 24, if a student) before the close of the calendar year in which the taxable year of the HSA account owner begins.⁵⁴ This rule does not apply if the child is permanently and totally disabled. The term “permanent and total disability” is defined in Code Section 22(e)(3) and need not be for the entire year.

Note: Under prior law (before 2004), there was no age requirement nor was disability an issue.

Attained Age

It would appear that a child attains a specific age on the anniversary of the date of his or her birth. The IRS uses this uniform definition for purposes of the dependent care, adoption, child tax, and earned income credits, and it also applies to dependent care assistance programs, foster care payments, adoption assistance programs, and dependency exemptions.⁵⁵

Note: Code Section 152(c)(3)(A) requires that a child not attain the specified age (age 19 or age 24) “as of the close of the calendar year in which the taxable year of the taxpayer begins.” Thus, an individual is no longer a qualifying child after the calendar year in which the taxpayer’s taxable year began if the individual attained the specified age during the prior calendar year.

Qualifying Relative

For HSA purposes, a “qualifying relative” is a person who satisfies all four of the following requirements:⁵⁶

1. Is not a “qualifying child” of the taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which the taxable year begins.⁵⁷
2. Bears a relationship to the taxpayer.⁵⁸ See the “Relationship” section above.
3. Receives more than half of his or her support from the taxpayer for the calendar year in which the taxable year begins.⁵⁹
4. Does not have gross income for the year less than the Code Section 151(d) dependency exemption amount (\$3,400 in 2007) to be considered a dependent.

Note: This income limit does not apply for purposes of HSAs or HDHPs.

⁵³ IRC § 152(c)(1).

⁵⁴ IRC § 152(c)(3) and 152(c)(3)(B).

⁵⁵ Rev. Rul. 2003-72, 2003-33 IRB 346, that is, IRC §§ 21 (child care credit), 23 (adoption expenses), 24 (child credit), 32 (earned income credit), 129 (dependent care exclusion), 131 (foster care payments), 137 (adoption assistance), and 151 (personal exemptions).

⁵⁶ IRC § 152(d)(1).

⁵⁷ IRC § 152(d)(1)(D).

⁵⁸ IRC § 152(d)(1)(A), 152(d)(2).

⁵⁹ IRC § 152(d)(1)(C), 152(d)(3), regarding multiple support agreements.

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Example 2-16

Myron's taxable year begins on July 1, 2006. His son Harvey, a student, will attain age 24 on December 1, 2006. Harvey is not a qualifying child for Myron's 2006-2007 taxable year because Harvey was age 24 when Myron's taxable year began. However, Myron may satisfy the definition of a qualifying relative.

Under the prior Code Section 152 definition, the term "dependent" generally meant an individual who bears the relationship described previously and who received more than half of his or her support for the year from the taxpayer.

Note: Under Code Section 152, before its amendment, there were no income limits or age limitations. However, because of the corrections made after Code Section 152 was amended (to remove the income limitation under the "qualifying relative" definition), little has changed from prior law because if an individual does not satisfy the definition of "qualifying child," he or she likely can satisfy the definition of "qualifying relative."

Advantages and Disadvantages of HSAs

Advantages

Those individuals who prefer (or already have) a high deductible on their health insurance policies will gain the most benefits, especially those who are more highly compensated – primarily for the tax benefits. Conversely, individuals who have an employer-paid health policy with no (or a low) deductible would not be good candidates for an HSA (nor would they qualify).

An HSA can provide a method for contributing a stream of tax-favored savings for those who are healthy enough and who can afford to do so. Simply stated, the higher the tax bracket, the greater the benefit. On the other hand, lower-paid employees – who generally find it difficult to save for any purpose – may have little enthusiasm for an HSA, even if they otherwise would benefit by establishing an HSA.

Many advantages may accrue from establishing an HSA, including the following:

- *No employer involvement.* Eligible individuals can establish an HSA without employer involvement.
- *Deductions for contributions.* Except for employer contributions, all HSA after-tax contributions (within limits) are deductible. Employer contributions are excluded from income.
- *Contributions by family member permitted.* Unlike a health FSA or a HRA, family members (among others) may make contributions into an eligible individual's HSA.
- *One-Time Transfers Permitted.* A direct trustee-to-trustee transfer from an FSA, an HRA, and a traditional IRA to fund an HSA may be permitted. Special rules apply. See Chapter 5.
- *Deduction or exclusions from gross income.* Employer contributions generally are excludable from gross income. In other cases, contributions made by or on behalf of an eligible individual generally are deductible from gross income.
- *Itemization.* An eligible individual does not have to itemize deductions on Form 1040, Schedule A, Itemized Deductions, to claim a deduction for his or her HSA allowable contribution.
- *Tax-exempt status.* Distributions are exempt from federal income tax (that is, tax-free) if used to pay for qualified medical expenses. In other cases, the growth in the HSA is tax deferred (for example, when payments are not used for qualified medical expenses).
- *Tax-free distributions.* Distributions from the account of all contributions and earnings are tax-free when used to pay for unreimbursed qualified medical expenses.

Example 2-17

Victor, an eligible individual, has a health plan through his employer with no annual deductible for 2007. The insurer charges an annual premium of \$4,000. If Victor were to switch to an HDHP with a \$1,100 annual deductible, the insurer only would charge \$3,200 for the same policy. In addition to saving \$800 in premiums, Victor would get a federal income tax deduction for any contribution that he has made on an after-tax basis to an HSA (up to \$2,850 with self-only coverage). His account funds would grow tax-free, and he would be able to access the HSA funds on a tax-free basis when using them to pay for qualified medical expenses. Victor instead may decide to not use his HSA funds and allow them to grow on a tax-free basis for future medical expenses.

- *Vesting.* All account balances are fully vested (nonforfeitable), without use-it-or-lose-it rules as in a health FSA.
- *Account ownership.* HSAs are owned by the individual (even if employer contributions are made to the HSA).
- *Choice.* The HSA account owner chooses:
 - How much to contribute.
 - When to contribute.
 - The type of financial product(s) to use for investment of account assets.
 - Which financial institution will hold the account.
 - How much to use for medical expenses.
 - Whether to pay for medical expenses from the HSA or to save the account assets for future use.
- *Savings.* HSAs encourage savings for future medical expenses, such as:
 - Long-term care expenses.
 - Noncovered services under future health insurance coverage.
 - Insurance coverage after retirement (and before Medicare coverage begins).
 - Medical expenses after retirement (and before Medicare coverage begins).
 - Out-of-pocket expenses incurred when covered by Medicare.
- *Spousal Ownership.* On the HSA account owner's death, the designated spouse beneficiary automatically is treated as the account owner.
- *Portability.* HSAs are portable regardless of:
 - Whether the account owner is employed or unemployed.
 - Which employer the individual works for.
 - Changes in the account owner's age or marital status.
 - Future medical coverage.

Also, rollovers and transfers from one HSA can be made to another HSA (once per 12-month period). Rollovers and transfers from an Archer MSA to an HSA also are permitted (once per 12-month period).

- *No use-it or lose-it rules.* Again, unlike unused account balances of health FSAs, those of HSAs are not forfeited.
- *Thrift encouraged.* HSA account owners are encouraged to be better consumers by spending their funds more wisely.
- *Lower health-care premiums.* The premium for a health plan with a higher deductible is likely to be less costly than the same health plan with a lower deductible.
- *Cafeteria plan.* Contributions to an HSA may be made by the eligible individual, on behalf of an eligible individual, or by the eligible individual's employer (generally through a cafeteria plan).
- *Higher contribution limits than an Archer MSA.* An Archer MSA limits contributions to 75% of the annual deductible amount (65% for self-only coverage).
- *Catch-up contributions.* An individual age 55 or older generally may contribute additional catch-up amounts (\$800 for 2007; \$900 for 2008).

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- *Dependent treatment.* The account owner's spouse and dependents need not be covered by the HDHP to receive benefits from an HSA on a tax-free basis.
- *Consumer choice and flexibility.* HSAs give individuals and employers flexibility and choice in coverage.
- *Protection.* When coupled with a HDHP, an HSA protects against catastrophic financial loss due to unforeseen illness and injury.
- *No gift tax.* The amount that a beneficiary receives from an HSA is not treated as a taxable gift.
- *Long-term care insurance.* An HSA can make tax-free distributions to pay for long-term care insurance premiums as well as Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage and health continuation insurance while receiving unemployment compensation.
- *Divisibility.* An HSA is divisible upon divorce.
- *Mistake-of-fact.* Distributions made because of a mistake-of-fact may be returned if the trustee or custodian permits.
- *Tax shelter.* High-income individuals are likely to use an HSA as a tax shelter (that is, for accumulations). These individuals will pay all medical expenses from nonsheltered assets.
- *Comparability in employer contributions.* Any employer contributions made to an HSA must be comparable (see Chapter 4), unless offered through a cafeteria plan. This requirement does not apply to an HRA or a health FSA (but highly-compensated/non-highly-compensated nondiscrimination requirements apply to HRAs and health FSAs, which are both self-funded health plans).⁶⁰

The following examples show some of the benefits of having (or not having) an HSA:

Example 2-18

The Two-Ton Scale Corporation offers its employees a family health insurance plan with a \$5,000 deductible. With its insurance cost savings, Two-Ton contributes \$4,000 to each employee's HSA. Harvey, an employee, incurs \$5,000 of medical expenses for the year. All expenses are qualified medical expenses. Harvey's out-of-pocket expenses will not exceed \$1,000 for the year that is covered under the HDHP.

Example 2-19

Same facts as **Example 2-18**, except that Harvey is not an employee of Two-Ton and has a traditional health insurance plan with a 20% copayment (copay) and a \$500 deductible. Harvey would be responsible for \$1,400 [$\$500 + (.20 \times \$4,500)$].

Example 2-20

Same facts as Example 2-18, except that Harvey incurs no medical expenses for the year. The \$4,000 that Two-Ton contributed to Harvey's HSA can be carried forward to next year or can be used in future years when he no longer may have health care coverage.

Disadvantages

An HSA coupled with a HDHP may create a greater risk of accruing medical debts, especially for families with low income levels who generally have fewer resources to draw upon. Also, these considerations are relevant:

- *Possible increase in out-of-pocket costs for less-healthy individuals.* For individuals who incur a high level of medical expenses each year, HDHP participation may not be a wise financial choice because they will have to pay the full deductible each year. These individuals may be better off with a health plan that has a low deductible or no deductible.

⁶⁰ IRC §§ 105(h), 125, 4980G.

- *Decrease in quality of health.* HDHP participation could have an adverse effect on an individual's health if he or she foregoes medication and tests because he or she cannot or does not want to pay expenses.
- *HDHP requirement.* Making contributions to an HSA is dependent on having an HDHP (on the first day of the month).
- *Excess contribution penalty.* Contributions in excess of annual limits may be subject to a 6% cumulative nondeductible excise tax.
- *Cessation of account.* The account ceases to be an HSA upon the account owner's death unless his or her spouse is designated as the HSA beneficiary.
- *Taxation upon death.* The account is taxable to the HSA beneficiary upon the decedent account owner's death if the beneficiary is not the decedent account owner's spouse.
- *If an amount is directly transferred from an FSA, an HRA, or a traditional IRA to an HSA, the individual must remain an eligible individual for a 13-month "testing period" beginning with the month of transfer. Amounts transferred are subject to taxation and an additional 10% penalty if the individual does not remain eligible during the entire testing period (except upon disability or death). See Chapter 5.*
- *Taxation in estate.* If the decedent's estate is the HSA beneficiary, the estate will have to recognize income in respect to a decedent.
- *No deduction for losses.* Because allowable contributions are deductible, a taxpayer cannot claim a loss from declines in the account value.
- *Insufficient build-up.* An individual establishing a new HSA might not have accumulated sufficient funds in the account to pay for medical expenses below the HDHP deductible.
- *Income and penalty taxes.* Amounts distributed from an HSA not used to pay for qualified medical expenses are subject to federal income tax and, if the beneficiary is under age 65, also are subject to an additional 10% penalty, unless another exception applies.
- *Early distribution penalty.* Unless the age 65 exception or another exception applies, a 10% penalty is applied on distributions not used to pay for qualified medical expenses.
- *Responsibility.* The account owner is responsible for determining that HSA payments are used for qualified medical expenses.
- *IRS Reporting.* An HSA account owner generally must file Form 8889, Health Savings Accounts (HSAs), to report HSA contributions, determine HSA deductions, and report HSA distributions. No reporting forms are required of participants in HRAs and FSAs.
- *Record retention.* The HSA account owner must keep records to demonstrate to the IRS, if audited, that distributions were used to pay for qualifying medical expenses.

<p>Note: The insurer still will require policy holders to submit claims so that it can track the plan's deductible.</p>
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- *Medicare enrollment.* Eligibility to contribute to an HSA ends in the month that the account owner enrolls in Medicare.
- *Adverse selection.* Under the theory of adverse selection, healthy people and less-healthy people separate into different insurance arrangements and the cost of insurance for the less-healthy consequently rises. Thus, these individuals may become uninsured or under-insured. For example, employers that provide a choice between comprehensive protection and an HDHP may experience a shift of the healthier employees to the HDHP. Those who remain in the comprehensive plan likely will cause the average cost (for that group) to increase. Healthy workers even might abandon employer-based coverage completely and establish HSAs on their own, especially if they are paying a substantial amount of the premium for the HDHP.

Examples

An individual may be healthy today, have a condition requiring regular medication, or be faced with an unexpected medical condition. The following examples demonstrate how an HSA could work under specific circumstances. Most people cannot recoup the amount of their premium payment for health insurance unless they have a large catastrophic-type claim. An HDHP policy with an HSA may make sense for some individuals because these policy types allow the individual to be covered for large health care expenses at a reduced premium, while “self-insuring” themselves for the small ones with tax-free dollars. If unused funds accumulate in the HSA, the amount that an individual could self-insure increases. This, in turn, could result in lower premium costs when a policy with a higher annual deductible is selected. For those individuals that remain healthy and have low medical expenses, an HSA is a very effective method of saving tax-deductible contributions for future use.

Note: In the following examples, if contributions are made through an employer’s cafeteria plan, there will be a FICA tax savings for both HDHP premium payments and HSA contributions. If the HSA is established outside of the employer’s plan, the individual will have an income tax deduction, but will get no FICA tax savings (unless the Bush Administration proposal, discussed in Chapter 1, is enacted). HSA administrative fees and account earnings are not considered.

Example 2-21

Rocky earns \$32,000. He is young, healthy, and single. Rocky had HDHP self-only coverage during the entire 2007 calendar year.

As a preventive measure, Rocky goes to his doctor’s office in November and receives a routine annual exam. In December, he establishes an HSA into which he deposits \$650 for the year. Rocky also uses his HSA funds to reimburse himself on a tax-free basis for the prescription sunglasses he purchased. As explained in Table 2-1, Rocky saves over \$200 (\$1,870 - \$1,668) with an HDHP and an HSA as compared to a traditional health plan with a lower deductible. In that case, \$320 (\$650 - \$330) rolls over and remains in his HSA for future use.

Table 2-1: Traditional Plan vs. HDHP Plan with HAS Example 1

<i>Plan Benefits</i>	<i>Traditional Plan</i>	<i>HDHP Plan with an HSA</i>
Deductible/person	\$250	\$1,200
Coinsurance (percentages)	80/20	80/20
Out-of-pocket limit	\$1,000	\$3,000
Office copays	\$20	none
Drug copays ¹	\$10/\$20	none
A. Annual Premium:	\$1,700	\$1,200
Medical Expenses:		
Office visit/exam (1 @ \$200)	\$20	\$180
Eyeglasses (1 @ \$150)	\$150	\$150
B. Total Expenses:	\$170	\$330
C. HAS Contribution:	\$0	\$650
D. Contribution Tax Savings	\$0	\$182
(assume 28%):		
Total Cost: ²	\$1, 870	\$1,668

Table 2-1: Traditional Plan vs. HDHP Plan with HAS Example 1 (continued)

<i>Plan Benefits</i>	<i>Traditional Plan</i>	<i>HDHP Plan with an HSA</i>
Less HSA Account Balance	\$0	\$320 (\$650 - \$330)
Net Result:	\$1,870	\$1,348
Savings (1,870 - \$1,348):		\$522³

¹Includes deductible and coinsurance.

²“Total Cost” equals $A. + (\text{greater of } B. \text{ or } C.) - D.$

³The “savings” are only an approximation. Results will vary among individuals depending upon their tax circumstance and actual premium costs.

Example 2-22

Heather earns \$45,000. She goes to her doctor twice during 2007 for a back condition and takes medication for pain. Heather had HDHP self-only coverage during the entire year and contributed \$2,000 to her HSA – the amount of the HDHP deductible for the 2007 year. As explained in Table 2-2, Heather saves \$380 (\$5,200 - \$4,820) with an HDHP and an HSA compared to a traditional health plan with a lower deductible. In that case, \$620 remains in her HSA for future use.

Table 2-2: Traditional Plan vs. HDHP Plan with HAS Example 2

Deductible/person	\$250	\$2,000
Coinsurance (percentages)	80/20	80/20
Out-of-pocket limit	\$1,000	\$3,000
Office copays	\$20	None
Drug copays ¹	\$10/\$20	None
A. Annual Premium:	\$4,800	\$4,000
Medical Expenses:		
Office visit/exam (2 @ \$150)	\$40	\$300
Medication (12 @ \$90)	\$360	\$1,080
B. Total Expenses:	\$400	\$1,380
C. HAS Contribution:	\$0	\$2,000
D. Contribution Tax Savings	\$0	\$560
(assume 28%):		
Total Cost: ²	\$5,200	\$5,440
Less HSA Account Balance	\$0	\$620 (\$2,000 - \$1,380)
Net Result:	\$5,200	\$4,820
Savings (1,870 - \$1,348):		\$380³

¹Includes deductible and coinsurance.

²“Total Cost” equals $A. + (\text{greater of } B. \text{ or } C.) - D.$

³The “savings” are only an approximation. Results will vary among individuals depending upon their tax circumstance and actual premium costs.

Example 2-23

Heather has an accident in June and requires surgery on her bad knee. The surgery costs \$7,000. The deductible and coinsurance are applied and the out-of-pocket maximums are exceeded. As explained in Table 2-3, Heather will have to pay an additional \$160 (\$6,490 - \$6,330). No funds are left in her HSA.

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Table 2-3: Traditional Plan vs. HDHP Plan with HAS Example 3

A. Annual Premium:	\$4,800	\$4,000
Medical Expenses:		
Office visit/exam (2 @ \$150)	\$40	\$300
Medication (12 @ \$90)	\$	\$1,080
Surgery	\$1,250	\$1,620
B. Total Expenses:	\$1,530	\$3,000
C. HAS Contribution:	\$0	\$2,000
D. Contribution Tax Savings (assume 28%):	\$0	\$560
Total Cost: ¹	\$6,330	\$6,440
Less HSA Account Balance	\$0	\$0 (used \$2,000)
Net Result:	\$6,330	\$6,490
Additional Cost:	\$160	

¹“Total Cost” equals $A. + (\text{greater of } B. \text{ or } C.) - D.$

Example 2-24

Same facts as **Example 2-23**, except Heather had \$1,500 in her HSA at the start of the calendar year. Heather could use her HSA funds to absorb the \$160 additional cost of her surgery. In that case, she would have \$1,340 (\$1,500 - \$160) remaining in her HSA for future use.

Practice Pointer →

Instead of using the HSA funds to pay for the medical expenses in the above examples, the account owner could accumulate the funds in the HSA on a tax-free basis for qualified medical expenses incurred in later years. Alternatively, if no deduction was claimed for the current year's qualified medical expenses, the expenses could be reimbursed tax-free in a later year. The taxpayer should be sure to keep proper documentation.

Chapter 3

Medical Coverage and Insurance

This chapter examines medical coverage and insurance for purposes of determining whether the individual is treated as being covered by a High Deductible Health Plan (HDHP) and no other plan that is not a HDHP. Annual deductibles and out-of-pocket expenses are addressed. This chapter also explains the exceptions (for example, for permitted insurance), and transitional rules that may apply in determining whether the HDHP minimum annual deductible requirement is met and whether the HDHP maximum annual out-of-pocket limits are exceeded in a given year. Contributions to Health Savings Accounts (HSAs) are discussed in Chapter 4.

HDHP Requirements

In general, an HDHP is a health plan that satisfies certain requirements as to minimum annual deductibles and maximum annual out-of-pocket expense, discussed later.¹

Maximum Out-of-Pocket Expenses

For HSA contribution purposes, a health plan must meet two main requirements to be considered an HDHP:²

1. *Minimum annual deductible.* The HDHP's minimum annual deductibles for self-only coverage and family coverage for 2007³ and earlier years can be found in Table 3-1.

Table 3-1: HDHP Minimum Annual Deductibles

<i>Coverage Type</i>	2008	2007	2006	2005
Self-Only	\$1,100	\$1,100	\$1,050	\$1,000
Family	\$2,200	\$2,200	\$2,100	\$2,000

2. *Out-of-pocket expenses.* The HDHP annual out-of-pocket expenses, including expenses incurred in satisfying the HDHP deductible and copayments, that are required to be paid for covered benefits may not exceed specified limits. Premiums for HDHP coverage are not subject to the out-of-pocket limit. Special rules apply to deductibles for services performed out of network discussed later). The HDHP maximum out-of-pocket expenses (including copayments) for 2007 and earlier years can be found in Table 3-2.⁴

¹ IRC § 223(c)(2).

² IRC § 223(c)(2)(A)(ii)(I), 223(c)(2)(A)(ii)(II); Rev. Proc. 2007-36, 2007-22 I.R.B. 1335 (May 11, 2007).

³ IRC § 223(c)(2)(A)(i)(I), 223(c)(2)(A)(i)(II).

⁴ IRC §§ 223(c)(2)(A)(ii)(I), 223(c)(2)(A)(ii)(II); Rev. Proc. 2007-36, 2007-22 I.R.B. 1335 (May 11, 2007).

Table 3-2: HDHP Maximum Out-of-Pocket Expenses

<i>Coverage Type</i>	2008	2007	2006	2005
Self-Only	\$5,600	\$5,500	\$ 5,250	\$ 5,100
Family	\$11,200	\$11,000	\$10,500	\$10,200

Contributions to HSAs are discussed more fully in Chapter 4. (See Appendix A regarding HSA limitations.)

Example 3-1

A health plan provides coverage for Lawrence and his family in 2007 (or 2008). The plan provides for the payment of covered medical expenses of any member of Lawrence's family once the member has incurred covered medical expenses during the year in excess of \$1,100, even if the HDHP minimum annual deductible of \$2,200 for family coverage has not been satisfied. If Lawrence incurred covered medical expenses of \$1,500 in a year, the plan would pay \$400. Thus, benefits potentially are available under the plan even if the family's covered medical expenses do not exceed \$2,200. Because the plan provides family coverage with an annual deductible of less than \$2,200, the plan is not an HDHP for 2007 (or 2008).

Example 3-2

Same facts as in *Example 3-1*, except that the plan has a \$5,500 deductible for family coverage and provides payment for covered medical expenses if any member of Lawrence's family has incurred covered medical expenses during the year in excess of \$2,200. The plan satisfies the requirements for an HDHP as to the deductibles for 2007 (or 2008).

Example 3-3

Horatio has self-coverage under his employer's HDHP for 2007 (or 2008) with a \$2,000 annual deductible. This means that Horatio will pay the first \$2,000 of any medical expenses incurred during the year before the health plan will pay any benefits. The HDHP provides that it will pay 80% of the next \$3,000 in medical expenses incurred by Horatio during the year and Horatio will pay 20% of the next \$3,000 (or \$600). The HDHP will pay 100% of the covered medical expenses over \$5,000. Horatio's total maximum annual out-of-pocket expenses (not counting any premiums that Horatio might have to pay) are \$2,600, which is within the 2007 out-of-pocket limit of \$5,500 (or \$5,600 for 2008) for self-coverage. Therefore, the plan is an HDHP. An HDHP can be an insured or self-insured plan.⁵

Note: The HSA can be established through a qualified trustee or custodian that is different from the HDHP provider.⁶

A plan will not be an HDHP if the only coverage it provides is for permitted insurance (described below) and/or coverage for accidents, disability, dental care, vision care, or long-term care.⁷ A state's high-risk health plan (high-risk pool) will qualify as an HDHP for 2007 if the plan does not pay benefits below the HDHP minimum annual deductible of \$1,100 for self-only coverage and \$2,200 for family coverage.⁸

Meaningful Coverage

The fact that Congress clearly specified that a plan that primarily covers "permitted insurance" for accidents, disability, dental care, vision care, or long-term care would not be considered an HDHP for HSA purposes indicates that the HDHP accompanying the HSA must provide meaningful medical coverage for account

⁵ Notice 2004-2, Q&A 7, 2004-2 I.R.B. 269.
⁶ Notice 2004-2, Q&A 10, 2004-2 I.R.B. 269.
⁷ IRC § 223(c)(2)(B).
⁸ Notice 2004-50, Q&A 13, 2004-33 I.R.B. 196.

owners. This is consistent with IRS Notice 2004-50 (2004-33 I.R.B. 196), which allows an HDHP to exclude certain benefits as long as significant benefits remain (discussed later). However, there is no bright line test to determine when HDHP coverage will be considered meaningful and when it will be considered merely a sham. Some employers and insurers may be interested in offering reduced HDHP benefits in exchange for lower premiums. However, there is a limit to the extent that the benefits can be reduced. It would appear that, to be considered an HDHP for HSA purposes, at a minimum an HDHP must exhibit risk-shifting and risk distribution characteristics of insurance and cover major medical and hospital benefits.⁹

State High Risk Plans

A state high-risk health plan (high-risk pool) will qualify as an HDHP for 2007 and 2008 if the plan does not pay benefits below the HDHP minimum annual deductible of \$1,100 for self-only coverage and \$2,200 for family coverage (see Chapter 3).¹⁰

Negotiated Prices

Health plans that negotiate discounted prices for services do not fail to meet the HDHP requirements merely because an HSA owner receives services at the discounted rate before satisfying the plan deductible.¹¹

Inflation Adjustments

The HDHP minimum deductible amount and maximum out-of-pocket expense limits are indexed for inflation using annual cost-of-living adjustments. Any increase is rounded to the nearest multiple of \$50.¹²

For taxable years beginning before 2007, the \$2,250 and \$4,500 limitations that are specified in Code Section 223(b)(2) are adjusted for cost-of-living increases in the consumer price index (CPI) through August of the preceding year relative to the CPI for 1997. The CPI for a year is the average for the 12-month period ending on August 31 for such year. The \$2,250 and \$4,500 base amounts used to compute the monthly limitation on deductions for 2007 can be computed as follows (to the nearest multiple of \$50):

1. $\$2,850 = \frac{\$2,250 \times (\text{average CPI September 2005 to August 2006})}{(\text{average CPI September 1996 to August 1997})}$
2. $\$5,650 = \frac{\$4,500 \times (\text{average CPI September 2005 to August 2006})}{(\text{average CPI September 1996 to August 1997})}$

For the \$1,000 and \$5,000 base amounts in Code Section 223(c)(2)(A), the adjustment uses 2003 instead of 1997. The base amounts used to determine whether a health plan is an HDHP (minimum deductible and maximum out-of-pocket expenses) for 2007 can be computed as follows (to the nearest multiple of \$50):

1. $\$1,100^{13} = \frac{\$1,000 \times (\text{average CPI September 2005 to August 2006})}{(\text{average CPI September 2002 to August 2003})}$
2. $\$5,500 = \frac{\$5,000 \times (\text{average CPI September 2005 to August 2006})}{(\text{average CPI September 2002 to August 2003})}$

⁹ Notice 2004-50, Q&As 14 & 15, 2004-33 I.R.B. 196.

¹⁰ IRS Notice 2004-50, Q&A 13, 2004-33 I.R.B. 196.

¹¹ IRS Notice 2004-50, Q&A 25, 2004-33 I.R.B. 196.

¹² IRC § 223(g)(1)-(2); for 2007, see Rev. Proc. 2007-36, 2007-22 I.R.B. 1335 (May 11, 2007).

¹³ The \$1,000 amount did not change for 2004 or 2005.

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For taxable years beginning after 2007, the date for which the CPI is measured is the 12-month period ending on March 31st instead August 31st. The adjusted amounts for any year are required to be published by June 1 of the preceding calendar year.¹⁴

Deductible Period (Plan Year)

An HDHP need not be offered on a calendar-year basis. Code Section 223(c), which defines the term “high deductible health plan,” states only that an HDHP must have a minimum annual deductible. Neither the Medicare Drug Prescription, Improvement and Modernization Act of 2003 (MMA) nor any Treasury guidance indicates that the deductible must be based on a calendar year. In fact, Notice 2004-50, Q&A-22 (see example), suggests the opposite by including as part of the facts an HDHP that begins on July 1st.¹⁵

Changes to the Deductibles and Out-of-Pocket Expense Limits on Renewal

Any required change to the deductibles and out-of-pocket expense limits may be applied as of the HDHP renewal date 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.¹⁶

Several states currently require that health plans provide certain benefits without regard to a deductible or below the minimum annual deductible (e.g., first-dollar coverage or coverage with a low deductible). These health plans are not HDHPs. An individual covered under this type of health plan is not eligible to contribute to an HSA. However, because of the short period between the enactment of the MMA (December 8, 2003) and the Code Section 223 effective date (taxable years beginning after December 31, 2003), these states did not have sufficient time to modify their laws to conform to the Code Section 223 rules. When the sole reason that the plan is not an HDHP is because of state-mandated benefits, an otherwise eligible individual covered under this type of plan will be treated as an eligible individual and may contribute to an HSA for months before January 1, 2006 (the transition period), for state-mandated benefits in effect on January 1, 2004. [I.R.S. Notice 2004-43, 2004-27 I.R.B. 10.] This transitional rule was extended for certain non-calendar year health plans (see below).

As previously mentioned, a health plan may not reduce existing benefits before the plan's renewal date. Thus, even though a state may amend its laws before January 1, 2006, to authorize HDHPs that comply with Code Section 223(c)(2), non-calendar year plans still may fail to qualify as HDHPs after January 1, 2006, because existing benefits cannot be changed until the next renewal date.

Example 3-4

A state amends its statute effective July 30, 2006, to comply with HDHP requirements under federal law. A fiscal year plan with a year that begins on July 1, 2006, is required to retain the state-mandated low deductible coverage for the plan year July 1, 2006, through June 30, 2007, because the benefits only can be modified on the renewal date. As a result, although the state has amended its statute, the health plan will fail to be an HDHP for months after January 1, 2007 (*i.e.*, for the months of January through June 2007).

¹⁴ IRC § 223(g)(1), as amended by the Tax Relief and Health Care Act of 2006.

¹⁵ See, also, Notice 2005-83, 2005-49 I.R.B. 1(December 5, 2005).

¹⁶ Notice 2004-50, Q&A 86, 2004-33 I.R.B. 196; rule also mentioned in Treasury Press Release JS-2996 (Nov. 11, 2005).

The transition relief in Notice 2004-43¹⁷ was modified to provide that, for any coverage period of 12 months or less beginning before January 1, 2006, a health plan that otherwise qualifies as an HDHP as defined in Code Section 223(c)(2), except for complying on its most recent renewal date before January 1, 2006, with state-mandated requirements (in effect on January 1, 2004) to provide certain benefits without regard to a deductible or with a deductible below the minimum annual deductible, will be treated as an HDHP. The additional transitional relief does not apply after the earlier of the health plan's next renewal date, or December 31, 2006.¹⁸

Example 3-5

An individual obtains HDHP self-only coverage on June 1, 2006, the first day of the plan year, with an annual deductible of \$1,050—the minimum annual deductible allowed for 2006 for self-only coverage. The cost-of-living adjustments require the minimum deductible amount to be increased for 2007 to \$1,100. The plan's deductible is not increased to comply with the increased minimum deductible amount until the plan renewal date of June 1, 2007. The plan satisfies the HDHP requirements with respect to deductibles through May 30, 2007. The plan must provide disclosure information on cost sharing, deductibles, and limitations on coverage to participants in the plan. The IRS is to determine this disclosure information (see Chapter 7).

Plan Deductible

The plan deductible is the amount of covered medical expenses that must be paid by the HSA account owner before the health plan will begin to cover medical expenses.

In the case of a health plan using a provider network, the plan's annual deductible for services provided outside of such network is disregarded (not taken into account) when determining whether the HDHP maximum out-of-pocket limit is satisfied (for 2007, \$5,500 for self-only coverage for and \$11,000 for family coverage and for 2008, \$5,600 and \$11,200, respectively).¹⁹

Practice Pointer →

Although separate in-network and out-of-network deductibles appear to be permitted, an HDHP is not required to have separate deductibles for in-network and out-of-network services. If there is a separate out-of-network deductible, however, it will be disregarded in determining an HSA account owner's maximum annual contribution or deduction for the year under the Code (see Chapter 3).²⁰

Deductible Periods in Excess of 12 Months

If a health plan's deductible period is longer than 12 months, its annual deductible limit must be adjusted to determine whether the maximum annual deductible is exceeded. If that limit is exceeded, the plan is not an HDHP.

Adjustment of Annual Deductible Limit

In the case of self-only coverage, the HDHP minimum annual deductible for 2007 and 2008 must be at least \$1,100. For family coverage, the HDHP minimum annual deductible for 2007 and 2008 must be at least \$2,200. For plans that define the deductible period over a period longer than 12 months, the limits generally

¹⁷ Notice 2004-43, 2004-27 I.R.B. 10.

¹⁸ Notice 2005-83, 2005-49 I.R.B. 1075.

¹⁹ IRC § 223(c)(2)(D), 223(c)(2)(D)(ii.)

²⁰ IRC § 223(c)(2)(D)(ii).

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must be adjusted to determine whether a plan satisfies the HSA requirements (see the following "Transitional Rule" section).²¹ Adjust the limit by taking the following steps:

1. Multiply the plan's minimum annual deductible by the number of months allowed to satisfy the deductible.
2. Divide the amount in Step 1 by 12. This is the adjusted deductible for the longer period that is used to test for compliance.
3. Compare the amount in Step 2 to the plan's deductible. If the plan's deductible equals or exceeds the amount in Step 2, the plan satisfies the minimum deductible requirements.

Note: For months before January 1, 2006, a health plan that otherwise would qualify as an HDHP, but for an annual deductible that does not satisfy the above rules for periods of more than 12 months, may be treated as an HDHP under the transitional rule.

Example 3-6

For 2007, a health plan takes into account medical expenses incurred in the last three months of 2006 to satisfy its deductible for calendar year 2007. The plan's deductible for self-only coverage is \$1,500 and covers 15 months (the last three months of 2006 and 12 months of 2007). To determine if the health plan's deductible satisfies the \$1,100 HDHP minimum annual deductible limit for self-only coverage for 2007, the following calculations are performed:

Minimum annual deductible (self-only coverage)	\$1,100
The number of months in which expenses incurred are taken into account to satisfy the deductible	x 15
	= \$16,500
Divide by 12	\$1,375

The HDHP minimum annual deductible for self-only coverage for 15 months must be at least \$1,375. Because the plan's deductible of \$1,500 exceeds \$1,375, the plan's self-only coverage satisfies the plan deductible rule. The HSA maximum annual contribution for an eligible individual with self-only coverage for 2007 is \$2,850 (2007 maximum statutory contribution limit).

Note: For taxable years beginning after 2006, the annual deductible limit no longer applies. As a result, beginning in 2007, contributions up to the annual statutory limit, which is indexed for inflation, will be permitted even though the annual deductible under the HDHP is less than the statutory limit (see Chapter 4).

Example 3-7

Same facts as **Example 3-6**, except the plan's deductible for family coverage for the 15-month period is \$3,000. To determine if the plan's deductible satisfies the \$2,200 the HDHP minimum annual deductible limit for family coverage for 2007, the following calculations are performed:

Minimum annual deductible (family coverage)	\$2,200
The number of months in which expenses incurred are taken into account to satisfy the deductible	x 15
	= \$33,000
Divide by 12	\$2,750

²¹ Rev.Proc.2007-36, 2007-22 I.R.B. 1335 (May 11, 2007); see also Treasury Press Release JS-2996 (Nov. 22, 2005).

The HDHP minimum deductible for family coverage for 15 months must be at least \$2,750. Because the plan's deductible of \$3,000 exceeds \$2,750, the plan's family coverage satisfies the plan deductible rule.

Note: For taxable years beginning after 2006, contributions to the HSA are no longer limited to the amount of the HDHP annual deductible limit. Instead, beginning in 2007, contributions up to the annual statutory limit, which is indexed for inflation, will be permitted even if the deductible under the HDHP is less than the statutory limit.

The HSA maximum annual contribution for an eligible individual with family coverage for 2007 is \$5,650 (\$5,800 for 2008) (the maximum statutory contribution limit).

Note: For 2006, the HSA maximum annual contribution for an eligible individual with family coverage under the above facts would be \$2,400, which is the lesser of (1) $(\$3,000/15) \times 12 = \$2,400$, or (2) \$5,450 (the 2006 maximum statutory contribution limit).

Out-of-Pocket Expenses

The HDHP maximum annual out-of-pocket expenses for covered benefits for 2007 may not exceed \$5,500 (\$5,600 for 2008) for self-only coverage and \$11,000 (\$11,200 for 2008) for family coverage.²²

Out-of-pocket expenses include the plan's annual deductible, copayments, and any coinsurance payments required by the plan, but do not include premiums for covered benefits.²³

Network Coverage

A network plan is a plan that generally provides more favorable benefits for services provided by its network of providers than for services provided outside of the network. In the case of a plan using a provider network, the plan does not fail to be an HDHP (if it otherwise would meet the HDHP requirements) solely because the out-of-pocket expense limits for services provided outside of the network exceed the HDHP maximum annual out-of-pocket expense limits.

Practice Pointer →

The annual out-of-pocket limit need only include amounts spent for covered services within the network. A plan is not required to count out-of-network charges in calculating whether the out-of-pocket limit has been reached.

Amounts paid by the account-covered, in-network medical expenses are applied toward the out-of-pocket limit.

A plan that does not specify a specific out-of-pocket maximum generally is not an HDHP. However, if a plan is structured in such a way that the account owner would never exceed the out-of-pocket limitation, the plan could be considered an HDHP.²⁴

²² Rev. Proc. 2005-70, § 3.22(2), 2005-47 I.R.B. 1 (Nov. 21, 2005); see, also Treasury Press Release, JS-2996 (Nov. 22, 2005).

²³ IRC § 223(c)(2)(A)(ii); Notice 2004-2, Q&A 3, 2004-2 I.R.B. 269; see also Notice 2004-50, Q&A 21, 2004-33 I.R.B. 196.

²⁴ Notice 2004-50, Q&A 17, 2004-33 I.R.B. 196.

Note: In taxable years beginning before 2007, the plan's annual deductible for out-of-network services is not taken into account in determining the annual contribution limit.²⁵ In other words, if there are two separate deductibles (one for network and one for non-network), only the network deductible would be used to determine the HSA contribution and deduction limit in years beginning before 2007.

Example 3-8

A plan requires an HSA account owner with self-only coverage to satisfy a \$2,000 deductible and then pays 100% of covered benefits above the deductible. This plan would not violate the HDHP maximum out-of-pocket limitation.

Example 3-9

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% of the usual, customary, and reasonable (UCR) costs. Because there is no express limit on out-of-pocket expenses, the plan does not qualify as an HDHP because it is possible that the maximum out-of-pocket limitation will be exceeded.

Example 3-10

Same facts as in *Example 3-9*, except that after the 20% coinsurance paid by the covered individual reaches \$3,000, the plan pays 100% 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% of UCR paid by the individual, up to \$3,000. This plan satisfies the out-of-pocket limit even though no express maximum is stated.

Transitional Rule

For months before January 1, 2005, a health plan that otherwise would 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, will be treated as an HDHP. Individuals covered under these health plans will continue to be eligible to contribute to HSAs before January 1, 2005.²⁶

Penalty Payments/Flat Dollar Charges

Penalty payments or flat dollar charges incurred because of a failure to obtain precertification for covered expenses are not required to be treated as out-of-pocket expenses. Therefore, such an HDHP penalty or charge need not be counted toward the HDHP maximum out-of-pocket limits (\$5,500/\$11,000 for 2007; \$5,600/\$11,200 for 2008).²⁷

Example 3-11

A health plan that otherwise qualifies as an HDHP generally requires a 10% coinsurance payment after a covered individual satisfies the deductible. However, if an individual fails to obtain precertification for a specific provider, the plan requires a 20% coinsurance payment. Only the generally applicable 10% coinsurance payment is included in computing the maximum out-of-pocket expenses paid.²⁸ The plan satisfies the HDHP maximum out-of-pocket limitation. This example's result would be the same if the plan imposed a higher coinsurance amount for an out-of-network provider.

²⁵ IRC § 223(c)(2)(D)(ii).

²⁶ Notice 2004-50, 2004-33 I.R.B. 196, see "Transitional Rule" on last page.

²⁷ Notice 2004-50, Q&As 18-19, 2004-33 I.R.B. 196.

²⁸ Notice 2004-50, Q&A 19, 2004-33 I.R.B. 196; see also Notice 2004-2, Q&A 4, 2004-2 I.R.B. 269.

Embedded Deductibles

In general, an HDHP must limit the out-of-pocket expenses paid by the covered individuals, either by design or by its express terms. Although an HDHP may have an umbrella deductible, it also may provide payments for covered medical expenses if any individual member of the family incurs medical expenses in excess of the minimum annual deductible. That limit, which is applied to each family member, is referred to as the “embedded individual deductible.”²⁹ The umbrella deductible is the stated maximum amount of expenses the family could incur before receiving HDHP benefits.³⁰

Example 3-12

In 2007, a plan that otherwise qualifies as an HDHP provides family coverage with a \$2,300 deductible for each family member. The plan pays 100% of covered benefits for each family member after he or she satisfies the \$2,300 deductible. The plan does not provide any express limit on out-of-pocket expenses. The maximum out-of-pocket expense limit is \$11,000 for family coverage. The plan is not an HDHP for a family with five or more covered individuals because the amount that these individuals pay in out-of-pocket expenses exceeds the HDHP maximum out-of-pocket limitation under Code Section 223 ($\$2,300 \times 5$ (\$11,500)) exceeds \$11,000 (the 2007 limit).³¹ However, the out-of-pocket expense limit of \$11,000 for any family with two to four covered individuals is not exceeded because the total amount they pay in out-of-pocket expenses would not exceed the HDHP maximum out-of-pocket limitation under the Section ($\$2,300 \times 4$ (\$9,200)) does not exceed \$11,000 (the 2007 limit).³²

Assume instead it is 2008. The plan is not an HDHP for a family with five or more covered individuals because the amount that these individuals pay in out-of-pocket expenses exceeds the HDHP maximum out-of-pocket limitation under Code Section 223 ($\$2,300 \times 5$ (\$11,500)) exceeds \$11,200 (the 2008 limit). However, the out-of-pocket expense limit of \$11,200 for any family with two to four covered individuals is not exceeded because the total amount they pay in out-of-pocket expenses would not exceed the HDHP maximum out-of-pocket limitation under the Section ($\$2,300 \times 4$ (\$9,200)) does not exceed \$11,200 (the 2008 limit).

Cumulative embedded deductibles under family coverage are not subject to the maximum out-of-pocket limitation if the plan contains an umbrella deductible of \$11,000 or less for 2007. In such case, the plan qualifies as an HDHP for the family, regardless of the number of covered individuals. The out-of-pocket maximum of \$11,000 for 2007 (\$11,200 for 2008) cannot be exceeded.

Example 3-13

In 2007, a plan that otherwise qualifies as an HDHP provides family coverage with a \$2,200 deductible for each family member. The plan pays 100% of covered benefits for each family member after he or she satisfies the \$2,200 deductible. The plan includes an umbrella deductible of \$11,000. The plan reimburses 100% of covered benefits if the family satisfies the \$11,000 in the aggregate, even if no single family member satisfies the \$2,200 embedded deductible. The HDHP out-of-pocket maximum limitation (\$11,000 for 2007) is not exceeded and the plan qualifies as an HDHP for the family, regardless of the number of covered individuals.³³

Assume instead it is 2008. The HDHP out-of-pocket maximum limitation (\$11,200 for 2008) is not exceeded and the plan qualifies as an HDHP for the family, regardless of the number of covered individuals.

²⁹ Notice 2004-50, Q&A 30, 2004-33 I.R.B. 196.

³⁰ Notice 2004-50, Q&A 30, 2004-33 I.R.B. 196.

³¹ \$2,000 times 6 (\$12,000) exceeds \$10,200.

³² Notice 2004-50, Q&A 20 (ex 1), 2004-33 I.R.B. 196.

³³ Notice 2004-50, Q&A 20 (ex 2), 2004-33 I.R.B. 196.

Noncovered Medical Expenses

Amounts incurred for noncovered benefits (including amounts in excess of UCR and financial penalties) are not counted toward the \$1,100/\$2,200 HDHP minimum annual deductibles or the \$5,500/\$11,000 HDHP maximum out-of-pocket limits for 2007. Note, however, that a health plan's out-of-pocket limit includes the deductible, copayments, and other amounts (but not premiums).³⁴

Note: If a plan does not take copayments into account in determining if the deductible is satisfied, the copayments still must be taken into account in determining if the HDHP maximum out-of-pocket limit is exceeded.

Example 3-14

In 2007, a health plan has a \$1,100 deductible for self-only coverage. After the deductible is satisfied, the plan pays 100% of UCR for covered benefits. Also, the plan pays 100% for preventive care, minus a \$20 copayment per screening. The plan does not take into account copayments in determining if the \$1,100 HDHP minimum annual deductible has been satisfied. The copayments must be included in determining whether the plan meets the HDHP out-of-pocket maximum limit of \$5,500 (the 2007 limit for self-only coverage). Unless the plan includes an express limit on out-of-pocket expenses taking into account the copayments, or limits the copayments to \$4,400 (\$5,500 – \$1,100) for 2007, the plan is not an HDHP. If copayments were limited to \$4,400, the \$5,500 limit would not be exceeded with a \$1,100 deductible.

Assume instead it is 2008. The copayments must be included in determining whether the plan meets the HDHP out-of-pocket maximum limit of \$5,600 (the 2008 limit for self-only coverage). Unless the plan includes an express limit on out-of-pocket expenses taking into account the copayments, or limits the copayments to \$4,500 (\$5,600 – \$1,100) for 2008, the plan is not an HDHP. If copayments were limited to \$4,500, the \$5,600 limit would not be exceeded with a \$1,100 deductible.

Deductible Period of Less Than 12 Months

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 may take into account unreimbursed expenses incurred during the prior plan's short plan year (whether or not the prior plan is an HDHP) without violating the \$1,100/\$2,200 HDHP annual minimum deductible limits (for 2007).³⁵

Example 3-15

An employer with a calendar year health plan switches from a non-HDHP plan to a new plan with coverage effective on July 1. The annual deductible under the new plan satisfies the \$1,100/\$2,200 HDHP minimum annual deductible limits. The new plan 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.

Change in Coverage

If an eligible individual changes coverage during the plan year from HDHP self-only coverage to HDHP family coverage, the individual (or any other person covered under the family coverage) will not fail to be covered by an HDHP merely because the HDHP family coverage takes into account expenses incurred while

³⁴ Notice 2004-2, Q&A 3, 2004-2 I.R.B. 269; Notice 2004-50, Q&A 21, 2004-33 I.R.B. 196.

³⁵ Notice 2004-50, Q&A 22, 2004-33 I.R.B. 196.

the individual had self-only coverage. Thus, a family plan does not fail to be an HDHP because it takes into account expenses incurred while an individual had HDHP self-only coverage.³⁶

Example 3-16

Harmony, an eligible individual, has HDHP-qualifying self-only coverage from January 1 through April 30, marries in April, and from May 1 through December 31, has HDHP-qualifying family coverage. The family coverage plan applies expenses incurred by Harmony from January through April toward satisfying the family deductible. Harmony's coverage satisfies the HDHP family coverage requirements. For years beginning before 2008, Harmony's contribution to an HSA is based on four months of self-only coverage (that is, 4/12 of the deductible for the self-only coverage) and eight months of family coverage (8/12 of the deductible for family coverage).

Note: For taxable years beginning after 2007, an individual who becomes covered by a HDHP after the beginning may contribute up to the full annual amount even though he or she was only an eligible individual for part of the taxable year. The individual may have to pay tax on the contribution (plus a 10% penalty) if the individual does not remain an eligible individual for a 13-month period beginning with the last month of the taxable year (generally December), except in the case of death or disability. See Chapter 4.

Limitation on Benefits

An HDHP may impose a reasonable lifetime limit on plan benefits. Amounts paid by a covered individual above the lifetime limit are not required to be treated as out-of-pocket expenses in determining the HDHP maximum annual out-of-pocket limit. However, a lifetime limit on benefits designed to circumvent the maximum annual out-of-pocket amount is not reasonable.³⁷

Example 3-17

Assume a health plan has an annual deductible that satisfies the \$1,100 HDHP minimum annual deductible for self-only coverage and \$2,200 minimum annual deductible for family coverage. After satisfying the deductible, the plan pays 100% of covered expenses, up to a lifetime limit on benefits of \$1 million. The lifetime limit is reasonable and it does not disqualify the health plan from being an HDHP.

If a plan imposes a reasonable annual or lifetime limit on specific benefits, amounts paid by covered individuals beyond the annual or lifetime limits are not subject to the maximum out-of-pocket limits. The \$5,500/\$11,000 maximum out-of-pocket limits for 2007 (\$5,600/ \$11,200 for 2008) only apply to covered benefits.³⁸

Reasonable Benefit Restrictions

A plan 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 plan benefits remain available in addition to the benefits subject to the restriction or exclusion.³⁹

³⁶ Notice 2004-50, Q&A 23, 2004-33 I.R.B. 196.

³⁷ Notice 2004-50, Q&A 14, 2004-33 I.R.B. 196.

³⁸ Notice 2004-50, Q&A 15, 2004-33 I.R.B. 196.

³⁹ Notice 2004-50, Q&A 14, 2004-33 I.R.B. 196.

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Example 3-18

In 2007 (or 2008), a health plan with self-only coverage and a \$1,100 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 fertility treatment benefits, it limits lifetime reimbursements to \$10,000 after the deductible is satisfied. Other than these limits on covered benefits, the plan pays 80% of major medical expenses incurred after satisfying the deductible. When the 20% coinsurance paid by the covered individuals reaches \$4,000, the plan pays 100%. Under these facts, the plan is an HDHP and no expenses incurred by a covered individual, other than the deductible and the 20% coinsurance, are treated as out-of-pocket expenses subject to the HDHP maximum out-of-pocket limit.

Example 3-19

In 2007 (or 2008), a health plan with self-only coverage and a \$1,100 deductible imposes a lifetime limit on reimbursements for covered benefits of \$1 million. While the plan pays 100% 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 plan benefits do not remain available. Under these facts, any expenses incurred by a covered individual after satisfying the \$1,100 deductible are treated as out-of-pocket expenses.

If a plan limits benefits to UCR amounts, amounts paid by covered individuals in excess of UCR are not included in determining the out-of-pocket expenses paid for purposes of calculating the HDHP maximum out-of-pocket limit. Thus, amounts paid by covered individuals in excess of UCR not paid by an HDHP are not included in determining maximum out-of-pocket expenses.⁴⁰

Family Coverage vs. Self-Only Coverage

Self-only coverage under an HDHP is defined as health plan coverage of only one eligible individual.⁴¹ Family coverage under an HDHP is defined as coverage that is not “self-only” coverage.⁴² Thus, family HDHP coverage is health plan coverage of one eligible individual and at least one other individual (whether or not the other individual is an eligible individual).⁴³ However, an individual can be eligible to contribute to an HSA if his or her spouse has non-HDHP family coverage, provided the spouse's coverage does not cover the individual.⁴⁴

In general, except for preventive care, a plan provides HDHP family coverage only if nothing is payable under the HDHP until the family incurs annual covered medical expenses in excess of the plan's minimum annual deductible. However, an exception applies to expenses for preventive care. It does not matter which family member incurs the expenses.⁴⁵

Other Health Plan Coverage

Generally, an eligible individual may not be covered under any other non-HDHP.⁴⁶ However, two exceptions permit other coverage to be disregarded.⁴⁷ Disregarded coverage includes:

⁴⁰ Notice 2004-50, Q&A 16, 2004-33 I.R.B. 196.

⁴¹ Notice 2004-50, Q&A 12, 2004-33 I.R.B. 196.

⁴² IRC § 223(c)(4).

⁴³ Notice 2004-50, Q&A 12, 2004-33 I.R.B. 196.

⁴⁴ Rev. Rul. 2005-25, 2005-18 I.R.B. 971.

⁴⁵ Notice 2004-2, Q&A 3, 2004-2 I.R.B. 269.

⁴⁶ IRC § 223(c)(1)(A)(ii).

⁴⁷ IRC § 223(c)(1)(B).

1. Coverage for any benefit provided by “permitted insurance” (discussed later).⁴⁸
2. Coverage, whether through insurance or otherwise, for accidents, disability, dental care, vision care, or long-term care (discussed later).⁴⁹

A health plan is not an HDHP if substantially all of its coverage is for coverage described in either 1 or 2 above.⁵⁰

Permitted Insurance

For eligibility purposes, certain types of insurance coverage, referred to as “permitted insurance,” are disregarded in determining if an individual is an eligible individual.⁵¹ For example, Medicare supplemental insurance is not on the list of permitted insurance. Permitted insurance includes insurance for which substantially all the coverage provided under such insurance relates to any of the following:⁵²

- Liabilities incurred under workers’ compensation laws
- Tort liabilities
- Liabilities relating to ownership or use of property
- Such other similar liabilities as the Secretary of Treasury may specify
- Insurance for a specified disease or illness⁵³
- Insurance paying a fixed amount per day (or other period) of hospitalization⁵⁴

Note: For example, a plan that provides coverage of which substantially all is for a specific disease or illness is not an HDHP.

Note: Medicare supplemental insurance is not on the list of permitted insurance.

An otherwise eligible individual who is covered both by an HDHP and by insurance contracts for one or more specific diseases or illnesses may contribute to an HSA if the insurance provides benefits before the HDHP deductible is satisfied, provided that the HDHP provides principal health coverage. An eligible individual covered under an HDHP may be covered “for any benefit provided by permitted insurance.” The term “permitted insurance” includes “insurance for a specified disease or illness.” Therefore, an eligible individual may be covered both by an HDHP and by permitted insurance for one or more specific diseases, “such as cancer, diabetes, asthma, or congestive heart failure,” as long as the HDHP provides principal health coverage.⁵⁵

Benefits for permitted insurance – 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 – generally must be provided through insurance contracts and not on a self-insured basis. However, where benefits (such as workers’ compensation

⁴⁸ IRC § 223(c)(1)(B)(i).

⁴⁹ IRC § 223(c)(1)(B)(ii).

⁵⁰ IRC § 223(c)(2)(B).

⁵¹ IRC § 223(c)(3).

⁵² IRC § 223(c)(3)(A)(i)-(iv).

⁵³ IRC § 223(c)(3)(B).

⁵⁴ IRC § 223(c)(3)(C).

⁵⁵ Notice 2004-50, Q&A 7, 2004-33 I.R.B. 196.

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benefits) are provided to satisfy a statutory requirement and any resulting benefits are secondary or incidental to other benefits, the benefits will qualify as permitted insurance even if self-insured.⁵⁶

The IRS has provided additional clarification on how prescription drug programs; medical discount cards; and employer-provided employee assistance, wellness, and disease management programs affect an individual's eligibility to establish an HSA.

Prescription Drug Coverage

An individual who is covered by a health plan that provides prescription drug benefits (separately or through a rider) before the HDHP deductible is satisfied cannot contribute to an HSA.⁵⁷

Transitional Relief

To allow policy providers time to modify HDHP policies to include prescription drug benefits that meet the HDHP requirements, the IRS issued transitional guidance specific to prescription drug coverage.

Under this transitional guidance, for months before January 1, 2006, if an otherwise eligible individual has both an HDHP and another health plan that provides for prescription coverage before the minimum HDHP deductible has been satisfied, the individual will continue to be considered an eligible individual and may make HSA contributions.⁵⁸

Preventive Care Safe Harbor

The safe-harbor for preventive care allows an HDHP to provide certain benefits before the \$1,100/\$2,200 HDHP minimum annual deductible limits for 2007 or 2008 are satisfied.⁵⁹

In Notice 2004-23 (2004-15 I.R.B. 725), the IRS provides a list of services and benefits that qualify as "preventive care" under Code Section 223(c)(2)(C). That section states, "a plan shall not fail to be treated as an HDHP by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary)." An HDHP therefore may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible.

The IRS defined the following medical procedures as safe-harbor items that could be provided as preventive care before the HDHP deductible is met.

The list of preventive care includes, but is not limited to, the following:⁶⁰

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

⁵⁶ Notice 2004-50, Q&A 8, 2004-33 I.R.B. 196.

⁵⁷ Rev. Rul. 2004-38, 2004-15 I.R.B. 717.

⁵⁸ Rev. Proc. 2004-22, 2004-15 I.R.B. 727.

⁵⁹ Notice 2004-23, 2004-15 I.R.B. 725.

⁶⁰ Notice 2004-23, 2004-15 I.R.B. 725.

The following preventive care safe-harbor screening services are included:

Cancer Screening

- Breast cancer (for example, mammogram)
- Cervical cancer (for example, pap smear)
- Colorectal cancer
- Prostate cancer (for example, PSA test)
- Skin cancer
- Oral cancer
- Ovarian cancer
- Testicular cancer
- Thyroid cancer

Heart and Vascular Diseases Screening

- Abdominal aortic aneurysm
- Carotid artery stenosis
- Coronary heart disease
- Hemoglobinopathies
- Hypertension
- Lipid disorders

Infectious Diseases Screening

- Bacteriuria
- Chlamydial infection
- Gonorrhea
- Hepatitis B virus infection
- Hepatitis C
- Human Immunodeficiency Virus (HIV) infection
- Syphilis
- Tuberculosis Infection

Mental Health Conditions and Substance Abuse Screening

- Dementia
- Depression
- Drug abuse
- Problem drinking
- Suicide risk
- Family violence

Metabolic, Nutritional, and Endocrine Conditions Screening

- Anemia, iron deficiency
- Dental and periodontal disease
- Diabetes Mellitus
- Obesity in adults
- Thyroid disease

Musculoskeletal Disorders Screening

- Osteoporosis

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Obstetric and Gynecologic Conditions Screening

- Bacterial vaginosis in pregnancy
- Gestational Diabetes Mellitus
- Home uterine activity monitoring
- Neural Tube defects
- Preeclampsia
- Rh incompatibility
- Rubella
- Ultrasonography in pregnancy

Pediatric Conditions Screening

- Child developmental delay
- Congenital Hypothyroidism
- Lead levels in childhood and pregnancy
- Phenylketonuria
- Scoliosis, Adolescent Idiopathic

Vision and Hearing Disorders Screening

- Glaucoma
- Hearing impairment in older adults
- Newborn hearing

Prescription drugs or medications that are used to prevent a disease or recurrence of a disease from which an HSA owner, spouse, or dependent has recovered are eligible for safe-harbor treatment.⁶¹ Thus, an HDHP may provide coverage for these items before the annual deductible under the HDHP is satisfied. Notice 2004-23 (2005-15 I.R.B 725) sets out a preventive care deductible safe harbor for preventive care.⁶² Solely for this purpose, drugs or medications are preventive care when taken by an individual who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (that is, asymptomatic), or to prevent the reoccurrence of a disease from which an individual has recovered. For example, the treatment of high cholesterol with cholesterol-lowering medications (for example, 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. Also, drugs or medications used as part of procedures providing preventive care services are eligible for safe-harbor treatment.⁶³

The Code does not require that an HDHP provide benefits for preventive care or provide preventive care with a deductible below the HDHP minimum annual deductible limit.⁶⁴

Preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition.⁶⁵ However, 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-

⁶¹ Notice 2004-50, Q&A 27, 2004-33 I.R.B. 196.

⁶² IRC § 223(c)(2)(C).

⁶³ IRS Notice 2004-50, Q&A 27, 2004-33 I.R.B. 196.

⁶⁴ Notice 2004-23, 2004-15 I.R.B. 725.

⁶⁵ Notice 2004-50, Q&A 27, 2004-33 I.R.B. 196.

harbor for preventive care.⁶⁶ For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the HDHP deductible has been satisfied.⁶⁷

Examples of “Permitted Insurance,” “Permitted Coverage,” and “Preventive Care”

The following examples concern whether certain insurance contracts (“Policies, Riders and Optional Benefits”) constitute “permitted insurance,” “permitted coverage,” or “preventive care” within the meaning of IRC Section 223, so that employees who are covered by the Policies, Riders and Optional Benefits and who otherwise are eligible to contribute to an HSA remain eligible to make HSA contributions (PLR 200704010 (Oct. 25, 2006, released Jan. 26, 2007)).

Introduction to Examples

In general, eligible individuals for HSAs are individuals who are covered by an HDHP plan and no other health plan that is not a HDHP. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied. An individual with other coverage in addition to a HDHP still is eligible for an HSA if such other coverage is certain permitted insurance (insurance for a specified disease or illness that pays a fixed amount per day (or other period) of hospitalization)⁶⁸ or permitted coverage (coverage for accidents, disability, dental care, vision care, or long-term care (whether through insurance or otherwise)).⁶⁹

A safe harbor also is provided for the absence of a preventive care deductible, or a preventive care deductible below the minimum annual deductible.⁷⁰

An “eligible individual” who is covered by an HDHP also may be covered for any benefit provided by permitted insurance. The term “permitted insurance” includes “insurance for a specified disease or illness.” An “eligible individual” may be covered by an HDHP and also by permitted insurance for one or more specific diseases or illnesses, such as cancer, diabetes, asthma, or congestive heart failure, as long as the HDHP provides the principal health coverage.⁷¹

Example 3-20

Permitted Insurance. Element Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as an HDHP. In addition to the coverage under the HDHP, Element offers its eligible employees the opportunity to purchase a group policy and makes available several optional riders that are available under that policy. Neither the policy nor the riders by themselves qualify as an HDHP. The group policy covers up to specified amounts for comprehensive cancer treatment, including hospital confinement, drugs, diagnostic testing, in-hospital private nursing care, certain surgeries, ambulance transportation, and hospice care. The policy does not cover conditions or illnesses resulting from cancer or any other diseases.

Rider 1 covers hospitalization in intensive care and ambulance transportation to the intensive care unit for the treatment of cancer.

⁶⁶ Notice 2004-23, 2004-15 I.R.B. 725.

⁶⁷ I.R.S. Notice 2004-50, Q&A 26, 2004-33 I.R.B. 196.

⁶⁸ IRC § 223(c)(3)(B).

⁶⁹ IRC § 223(c)(1)(B); see also Notice 2004-2, Q&A - 6, 2004-1 C.B. 269). H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003).

⁷⁰ IRC § 223(c)(2)(C).

⁷¹ IRC § 223(c)(3)(B); Notice 2004-50, 2004-2 C.B. 196; Rev. Rul. 2004-45, 2004-1 C.B. 971.

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Rider 2 provides hospitalization benefits for the treatment of cancer up to a specified amount that increases progressively every year for the first five years that the policy and rider are in force.

Rider 3 provides a return of premium after the policy is in force for five years. The amount to be returned is determined by a formula based on the individual's age, the length of time the policy is in force, and the amount of any claims paid under the policy.

Rider 4 provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by half when the covered person reaches age 70.

Rider 5 provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by half when the covered person reaches age 70. No benefits are paid if cancer or a specified disease is diagnosed within the initial 30-day waiting period under the policy.

Analysis. The policy offered by Element constitutes a specified disease or illness policy (permitted insurance) within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by Element. All of the riders constitute permitted insurance for a specified disease or illness. An individual who otherwise is an "eligible individual" remains an "eligible individual" if covered under any of the above five riders.

Example 3-21

Permitted Insurance, Specified Amount, Group Policy. Mineral Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Mineral offers its eligible employees the opportunity to purchase a group policy and makes available several optional riders that are available under that policy. Neither the policy nor the riders by themselves qualify as an HDHP. The policy pays a specified amount upon the first occurrence of most types of cancer. The policy covers certain aspects of cancer treatment including continuous hospital confinement and radiation/chemotherapy, up to specified amounts. The policy does not cover conditions or illnesses resulting from cancer or from any other diseases.

Rider 1 covers hospitalization in intensive care and ambulance transportation to the intensive care unit for the treatment of cancer.

Rider 2 provides a return of premium after the policy is in force for five years. The amount to be returned is determined by a formula based on the individual's age, the length of time the policy is in force, and the amount of any claims paid under the policy.

Rider 3 provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by half when the covered person reaches age 70. No benefits are paid if cancer or a specified disease is diagnosed within the initial 30-day waiting period under the policy.

Analysis. The policy offered by Mineral constitutes a specified disease or illness policy (permitted insurance) within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by Mineral. All of the riders constitute permitted insurance for a specified disease or illness. An individual who otherwise is an "eligible individual" remains an "eligible individual" if covered under any of the above three riders.

Example 3-22

Permitted Insurance, Specified Amount, Individual Policy. Argon Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as an HDHP. In addition to the coverage under the HDHP, Argon offers its eligible employees the opportunity to purchase an individual policy and makes available several optional riders that are available under that policy. Neither the policy nor the riders by themselves qualify as an HDHP. The policy covers treatment up to specified amounts for the treatment of the first occurrence of cancer and certain other specified diseases. The policy's covered treatment benefits include hospital confinement, surgery, in-hospital private duty nursing, ambulance transportation, and radiation/chemotherapy.

Rider 1 pays a specified amount upon the initial diagnosis of cancer.

Rider 2 pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including ambulance transportation to the intensive care unit, for the treatment of one of the specified diseases covered by the policy. Benefits are reduced by half when the covered person reaches age 70.

Rider 3 pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including ambulance transportation to the intensive care unit, for the treatment of a specified disease covered by the policy. Benefits are reduced by half when the covered person reaches age 70. *Rider 3* excludes such benefits if the specified disease is diagnosed within the policy's initial 30-day waiting period.

Rider 4 pays up to specified amounts for treatment (such as hospital confinement and surgery) of the specified diseases covered by the policy.

Rider 5 pays a specified amount for the initial diagnosis of cancer. The specified amount increases progressively based on the length of time the rider and policy are in force and pays a surrender value if no cancer diagnosis occurs within the first five years of coverage. The rider terminates after 20 years, at which time the guaranteed value is paid.

Analysis. The policy offered by Argon constitutes a specified disease or illness policy (permitted insurance) within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by Argon. All of the riders constitute permitted insurance for a specified disease or illness. An individual who otherwise is an "eligible individual" remains an "eligible individual" if covered under any of the above five riders.

Example 3-23

Permitted Insurance, Optional Benefits. Matrix Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Matrix offers its eligible employees the opportunity to purchase a group policy and makes available several optional benefits that are available under that policy. The policy pays up to a specified amount for the first occurrence of cancer and certain other specified diseases. Policy coverage includes benefits for hospital confinement, surgery, in-hospital private duty nursing, ambulance transportation, anesthesia, and radiation/chemotherapy.

Optional Benefit 1 pays a specified amount upon the initial diagnosis of cancer, excluding skin cancer.

Optional Benefit 2 pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including a specified amount for ambulance transportation to the intensive care unit for the treatment of one of the specified diseases covered by the policy.

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Optional Benefit 3 covers up to a specified amount for certain cancer screening services, regardless of whether the covered individual is diagnosed with a specified disease. Covered cancer screening services include colonoscopy, chest X-ray and bone marrow testing.

Analysis. The policy offered by Matrix constitutes a specified disease or illness policy (permitted insurance) within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by Matrix. Optional benefits 1 and 2 constitute permitted insurance for a specified disease or illness. Optional benefit 3 constitutes preventive care for purposes of Code Section 223(c)(2)(c). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under any of the three optional benefits.

Example 3-24

Specified amount. League Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as an HDHP. In addition to the coverage under the HDHP, League offers its eligible employees the opportunity to purchase a group policy and makes available several optional riders that are available under that policy. Neither the policy nor the riders by themselves qualify as an HDHP. The policy pays a specified amount for treatment of a heart attack, heart disease, or stroke. The policy does not cover any disease, sickness, or incapacity resulting from a heart attack, heart disease, or stroke. Benefits covered under the policy include hospital confinement, drugs, and in-hospital private nursing.

Rider 1 pays a specified amount for the initial diagnosis of cancer, excluding skin cancer.

Rider 2 pays a per diem amount for confinement in an intensive care unit up to 45 days for the treatment of diseases specified in the policy and ambulance transportation to the intensive care unit for the treatment of such diseases.

Analysis. The policy offered by League constitutes a specified disease or illness policy (permitted insurance) within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by League. All of the riders constitute permitted insurance for a specified disease or illness. An individual who otherwise is an "eligible individual" remains an "eligible individual" if covered under any of the above two riders.

Example 3-25

Specific disease or illness policy. Borax Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Borax offers its eligible employees the opportunity to purchase a non-HDHP group policy and makes available the following optional riders:

Rider 1 pays a per diem amount for every day of hospital confinement for up to one year. Covered confinement may be for the treatment of any sickness or injury that is not a disease specified under the policy.

Rider 2 pays a specified amount for the initial diagnosis of certain types of cancer.

Analysis. The policy offered by Borax constitutes a specific disease or illness policy within the meaning of Code Section 223(c)(3)(B). An individual who otherwise is an eligible individual would remain an "eligible individual" if covered under the policy offered by Borax. Rider 1, which pays a per diem amount for every day of hospital confinement for up to one year, constitutes insurance paying a fixed amount per day (or other period) within the meaning of Code Section 223(c)(3)(B). Rider 2 constitutes a specific disease or illness policy. An individual who otherwise is an eligible individual remains an "eligible individual" if covered under either of the two policy riders.

Example 3-26

Insurance paying a fixed amount per day (or other period). Mountain Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Mountain offers its eligible employees the opportunity to purchase a non-HDHP group policy and makes available several optional riders under that policy. The policy is a group hospital confinement indemnity policy that pays a specified amount for each day of hospital confinement up to a specified number of days, a specified amount for each day of confinement in an intensive care unit, and a premium waiver during such period of hospital confinement.

Rider 1 pays a specified amount for treatment of a covered individual by a physician outside of a hospital up to a specified number of visits a year.

Rider 2 pays a per diem amount for treatment by a physician in a hospital, other than a surgeon, during hospital confinement.

Rider 3 pays a specified amount for medical or surgical treatment in an emergency room up to twice a year.

Rider 4 pays a specified amount for a surgical operation and anesthesia for surgery performed in a hospital or an ambulatory surgical center.

Rider 5 pays a specified amount for a covered individual's initial confinement to a hospital during a calendar year. This amount is in addition to the per diem amount for hospital confinement paid under the policy.

Rider 6 pays a per diem amount for each day that at-home nursing care is required following a covered hospital confinement. Covered at-home nursing care must be authorized by an attending physician.

Analysis. Mountain's policy constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of Code Section 223(c)(3)(C). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under this policy. However, Riders 1 through 5 do not constitute permitted coverage, permitted insurance, or preventative care under Code Section 223. An individual who is covered under Mountain's policy and who also is covered by any of the policy riders 1 through 5 is *not* an eligible individual under Code Section 223.

The PLR makes clear that the IRS views the hospital indemnity exception as unavailable where the rider provides coverage for a treatment. Further, the PLR suggests that payment of an initial lump sum upon confinement to a hospital may be outside the definition of a hospital indemnity policy, even if the payment is not contingent upon receiving treatment. Caution should be exercised when offering this type of coverage to an HSA-eligible individual.

Rider 7 pays a specified amount monthly upon receipt of written proof that the covered individual is totally disabled, has been disabled for 30 days and loses income due to such disability.

Rider 8 pays a specified amount monthly upon receipt of written proof that the covered individual is totally disabled due to cancer, a heart attack or stroke, has been disabled for 30 days, and loses income due to such disability.

Analysis. Riders 7 and 8 constitute permitted accident or disability coverage within the meaning of Code Section 223(c)(1)(B)(ii). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under Rider 7 or 8.

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Rider 9 pays a specified amount for ambulance transportation to a hospital or emergency treatment center and, if treatment can not be obtained locally, a specified amount for non-local transportation.

Analysis. Rider 9 does not constitute permitted coverage, permitted insurance, or preventative care under Code section 223. An individual who is covered under Mountain's policy and also covered by Rider 9 is not an "eligible individual" under Code Section 223.

Example 3-27

Preventive care. Lake Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Lake offers its eligible employees the opportunity to purchase a group hospital confinement indemnity policy that pays a specified amount for each day of hospital confinement up to a specified number of days, a specified amount for each day of confinement in an intensive care unit, a premium waiver during hospital confinement, and a specified amount for initial hospital confinement. Additionally, the policy pays a specified amount for a surgical operation performed in a hospital or ambulatory surgical center, anesthesia for such surgery, inpatient care by a physician other than the surgeon, medical or surgical care in an outpatient emergency treatment center (limited to two visits a year), an outpatient emergency accident benefit, up to five visits a year for any reason for a physician's treatment outside of a hospital, at-home nursing care during the period following hospital confinement, up to three ambulance trips a year to a hospital or emergency treatment center, and non-local transportation required for out-of-area treatment. The policy permits several optional benefits.

Optional Benefit 1 pays "preventive care" up to a specified amount for tests performed for the diagnosis of an injury or sickness suggested by symptoms of an injury or sickness outside of hospital confinement.

Optional Benefit 2 pays "preventive care" up to a specified amount for a routine physical examination or preventive screening services (e.g. bone marrow testing, colonoscopy, chest X-ray) outside of hospital confinement.

Optional Benefit 3 covers up to a specified number of prescription drugs.

Analysis. Lake's policy does not constitute permitted coverage, permitted insurance, or preventative care under Code Section 223. An individual covered by Lake's policy is not an "eligible individual" under Code Section 223 (even if none of the optional riders are selected).

Note: Although Optional Benefits 1 and 2 constitute preventive care, the individual also is covered by Lake's policy (which provides coverage that is disqualifying coverage); thus, the individual is not an eligible individual under Code Section 223.

Analysis. Optional Benefit 3 does not constitute permitted coverage, permitted insurance, or preventative care under Code Section 223. An individual covered by Optional Benefit 3 is not an "eligible individual" under Code Section 223.

Example 3-28

Permitted accident coverage. Meteor Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as an HDHP. In addition to the coverage under the HDHP, Meteor offers its eligible employees an individual policy that pays a specified amount for covered losses sustained from an off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. The policy also pays a specified amount for hospital confinement, ambulance transportation, medical expenses, and payment for total disability resulting from the accident. The policy does not cover loss caused by sickness. The policy contains two optional riders.

Rider 1 pays a specified amount per month for total disability resulting from sickness.

Rider 2 pays a specified amount for each day of hospital confinement due to sickness that does not result from an injury, regardless of whether the covered person is disabled as defined in the policy.

Rider 3 pays a specified amount for treatment by a physician outside of a hospital for any reason and regardless of whether the covered individual is disabled as defined in the policy.

Analysis. Meteor's policy is permitted accident coverage within the meaning of Code Section 223(c)(1)(B)(ii). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under the policy. *Rider 1* is permitted accident coverage within the meaning of Code Section 223(c)(1)(B)(ii). "*Rider 2*" constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of Code Section 223(c)(3)(C). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under *Riders 1* or *2*. *Rider 3* does not constitute permitted coverage, permitted insurance, or preventative care under Code Section 223. An individual who is covered under Meteor's policy and also covered by *Rider 3* is not an "eligible individual" under Code Section 223.

The PLR makes clear that the IRS views the hospital indemnity exception as unavailable where the rider provides coverage for a treatment. Further, the PLR suggests that payment of an initial lump sum upon confinement to a hospital may be outside the definition of a hospital indemnity policy, even if the payment is not contingent upon receiving treatment. Caution should be exercised when offering this type of coverage to an HSA-eligible individual.

Example 3-29

Permitted accident coverage. Galina Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Galina offers its eligible employees an individual policy that pays a specified amount for covered losses sustained from an on-the-job or off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. The policy also pays a specified amount for hospital confinement, ambulance transportation, medical expenses, and payment for total disability resulting from the accident. The policy does not cover loss caused by sickness. Several optional riders are available under the policy.

Rider 1 pays a specified amount per month for total disability resulting from sickness.

Rider 2 pays a specified amount for each day of hospital confinement due to sickness that does not result from an injury, regardless of whether the covered person is disabled as defined in the policy.

Rider 3 pays a specified amount for treatment by a physician outside of a hospital for any reason and regardless of whether the covered individual is disabled as defined in the policy.

Analysis. Galina's policy is permitted accident coverage within the meaning of Code Section. 223(c)(1)(B)(ii). An individual who otherwise is an eligible individual as defined by Code Section 223(c)(1) remains an "eligible individual" if covered under the policy.

Rider 1 is permitted accident coverage within the meaning of Code Section 223(c)(1)(B)(ii).

Rider 2 constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of Code Section 223(c)(3)(C). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under *Riders 1* or *2*.

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Rider 3 does not constitute permitted coverage, permitted insurance, or preventative care under Code Section 223. An individual who is covered under Galina's and also covered by Rider 3 is not an "eligible" individual under Code Section 223.

The PLR makes clear that the IRS views the hospital indemnity exception as unavailable where the rider provides coverage for a treatment. Further, the PLR suggests that payment of an initial lump sum upon confinement to a hospital may be outside the definition of a hospital indemnity policy, even if the payment is not contingent upon receiving treatment. Caution should be exercised when offering this type of coverage to an HSA-eligible individual.

Example 3-30

Orbit Corporation offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a HDHP. In addition to the coverage under the HDHP, Orbit offers its eligible employees an individual policy that pays a specified amount for covered losses sustained from an off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. The policy also pays a specified amount for hospital confinement, ambulance transportation, medical expenses, and payment for total disability resulting from the accident. The policy does not cover loss caused by sickness.

Analysis. Orbit's policy is permitted accident coverage within the meaning of Code Section 223(c)(1)(B)(ii). An individual who otherwise is an eligible individual remains an "eligible individual" if covered under the Orbit's policy.

State Law Considerations

State insurance laws often require health plans to provide certain health care without regard to a deductible or on terms no less favorable than other care provided by the health plan. The determination of whether health care that an HDHP is required to provide by state law without regard to a deductible is "preventive" for purposes of the exception for preventive care is to be based on the Notice 2004-23 standards (2004-15 I.R.B. 725) and other IRS guidance rather than on how that care is characterized by state law.

A state could have laws that mandate certain benefits be included in an insured HDHP. These laws may, for example, require certain benefits to be covered under an HDHP without regard to whether the deductible is satisfied. Unless a state's mandated benefits satisfy the definition of "preventive care" for federal purposes, this would cause the HDHP to fail to satisfy the Code Section 223 requirements. If so, an individual in a state with those laws could not contribute to an HSA. Other state laws may require that an insurer or HMO must comply with limits on deductibles, which similarly could conflict with federal requirements.

The IRS has addressed this by issuing transition guidance for months before January 1, 2006, for state requirements in effect on January 1, 2004.⁷² The guidance states that during this time period, an HDHP will not be considered to violate federal requirements if the sole reason that it does not comply with federal requirements is because it is complying with state benefit mandates. However, after January 1, 2006, individuals who are covered by insured HDHPs or HMOs subject to state laws that conflict with Code Section 223 requirements will not be considered "eligible individuals" who are able to contribute to HSAs. See Appendix C for a list of states with mandates that could cause an HDHP to fail to satisfy applicable requirements.

Note: Code sec. 220(c)(2)(B)(ii) allows an HDHP for Archer Medical Savings Account (Archer MSA) purposes to provide preventive care without a deductible if required by state law. However, that section does not define "preventive care" for HSA purposes.

⁷² Notice 2004-43, 2004-27 I.R.B. 10.

Medical Discount Cards

Discount cards that entitle the holder to obtain discounts for services or products at managed care market rates will not disqualify an individual from making an HSA contribution as long as the individual is required to pay the discounted cost of health care until the HDHP deductible is satisfied.⁷³

Example 3-31

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 card's one-year life, the cardholder receives a 15% to 50% discount off the usual and customary fees charged by the pharmacy, with no dollar cap on the amount of discounts received during the year. The cardholder is responsible for paying the discounted costs of any drugs until the deductible of any other health plan covering the individual is satisfied. An employee who otherwise is eligible for an HSA will not become ineligible solely as a result of having this benefit.

Employee Assistance, Disease Management, and Wellness Programs

Coverage under an employer-provided employee assistance program (EAP), disease management program, or wellness program does not make an individual ineligible to contribute to an HSA, provided that the program does not provide significant benefits in the nature of medical care or treatment. If it does not, the EAP, disease management program, or wellness program will not be considered a health plan for HSA purposes.⁷⁴ To determine whether a program provides significant medical benefits, screening, and preventive care services described in Notice 2004-23 are disregarded.

Example 3-32

Neptune Corporation offers a program that provides employees with EAP benefits, regardless of enrollment in a health plan. The EAP is specifically designed to assist Neptune 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, to provide 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. Neptune's EAP is not a health plan under Code Section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Example 3-33

Accurate Corporation 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. Accurate's disease management program is not a health plan under Code Section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

⁷³ Notice 2004-50, Q&A 9, 2004-33 I.R.B. 196.

⁷⁴ Notice 2004-50, Q&A 10, 2004-33 I.R.B. 196.

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Example 3-34

Stay Fit Corporation offers a wellness program for all employees regardless of whether they participate 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 costs charged to the individual for participating in the services are separate from the individual's health plan coverage. Stay Fit's wellness program is not a health plan under Code Section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment.

Nurse Practitioners

It is likely that a significant component of the services provided by a nurse practitioner will be preventive, and therefore can be provided without regard to the HDHP deductible. Further, to the extent that clinical services are provided, it is likely that such services will be minor in "nature" (e.g., treatment of minor injuries, illness, or first aid) and not provide significant benefits in the nature of medical care or treatment.

Practice Pointer →

There are exceptions under the Employee Retirement Income Security Act of 1974 (ERISA)⁷⁵ and Consolidated Omnibus Budget Reconciliation Act (COBRA)⁷⁶ to exempt on-site facilities from the definition of "medical care." If the services of a nurse practitioner are treated as being outside of ERISA and therefore not subject to COBRA, that would provide additional support for the conclusion that such services are not a disqualifying "health plan" for HSA purposes.

Health Reimbursement Arrangements

An HSA account owner who participates in an HDHP and a post-deductible Health Reimbursement Arrangement (HRA) still may be an eligible individual. The HRA deductible does not need to be the same as the HDHP deductible. However, in no event may the HDHP or other health coverage provide benefits before the HDHP minimum annual deductible is satisfied.⁷⁷

Note: If the HDHP and the other coverage do not have identical deductibles, the HSA contribution is limited to the lowest deductible amount (see Chapter 4).

Example 3-35

In 2007 (or 2008), an individual has HDHP self-only coverage with a deductible of \$2,500. The individual also is covered under a post-deductible HRA that pays or reimburses qualified medical expenses after \$2,000 of the HDHP deductible has been satisfied. In this case, if the individual incurs covered medical expenses of \$2,250, the HRA will pay \$250. Because the HRA deductible of \$2,000 is less than the HDHP deductible of \$2,500, the individual's HSA contribution limit is \$2,000 (see Chapter 4).

Long-Term Care Insurance

An account owner may pay for long-term care premiums from an HSA, as long as such premiums are within the limits necessary to be considered qualified medical expenses (see Chapter 6).⁷⁸

⁷⁵ DOL Reg. § 2510.3-1(c).

⁷⁶ Treas. Reg. § 54.4980B-2, Q&A-1(d).

⁷⁷ Rev. Rul. 2004-45, 2004-22 I.R.B. 971.

⁷⁸ IRS Notice 2004-50, Q&A 41, 2004-33 I.R.B. 196.

Long-Term Care Services

An account owner may pay for long-term care services from an HSA (i.e. services that are provided without regard to insurance) as long as such services are qualified medical expenses (see Chapter 6).⁷⁹

Practice Pointer →

Although Code Section 106(c) generally prohibits payment for long-term care benefits coverage under a Code Section 125 plan (cafeteria plan), this prohibition does not apply to HSA distributions.⁸⁰

Cafeteria Plan under Code Section 125

An HSA may be funded by salary reduction contributions through a cafeteria plan described in Code Section 125.⁸¹ Thus, an employee may elect to have amounts contributed on a pre-tax basis as employer contributions to an HSA.

A cafeteria plan must be in writing and, among other things, must describe the plan benefits and the benefit periods. The HSA, therefore, must be described as a cafeteria plan benefit.⁸² Also, an employer is required to offer more flexibility to change an HSA salary reduction election than for other cafeteria plan benefits. The proposed cafeteria plan regulations contain a new rule regarding salary reduction elections with respect to an HSA. The new rule provides that if a cafeteria plan offers HSA contributions as a qualified benefit, the plan must allow a participant to prospectively make, change or revoke salary contribution elections for HSA contributions before salary becomes currently available on at least a monthly basis. Previous IRS guidance allowed an employer to adopt this rule, but did not require it.⁸³ See chapter 4, Other Employee Health Plans, for more information

Practice Pointer →

Although the IRS does not review cafeteria plan documents and issue determination letters as it does for Code Section 401(a) qualified retirement plans, the IRS on audit would expect an employer to be able to produce a written cafeteria plan that satisfies the requirements stated in the regulations.

Note: The initial release of the 2005 version of IRS Publication 15-B, which provides information on the employment tax treatment of fringe benefits, incorrectly included HSAs in a list of benefits that cannot be offered under a cafeteria plan. The IRS now has posted a corrected version on its website.⁸⁴

An employer's cafeteria plan may provide for negative elections to enroll employees. Negative elections may be used to enroll employees as described in Revenue Ruling 2002-27 and the new proposed cafeteria plan regulations.⁸⁵

⁷⁹ IRS Notice 2004-50, Q&A 42, 2004-33 I.R.B. 196.

⁸⁰ Notice 2004-50, Q&A 42, 2004-33 I.R.B. 196.

⁸¹ Notice 2004-2, Q&A 33, 2004-2 I.R.B. 269.

⁸² Prop. Treas. Reg. § 1.125-1(c)(1), (2007).

⁸³ Prop. Treas. Reg. § 1.125-2(c), (2007).

⁸⁴ www.irs.ustreas.gov/pub/irs-pdf/p15b.pdf; see also www.irs.gov/formspubs/article/0,,id=109875,00.html regarding changes to tax forms and publication.

⁸⁵ Notice 2004-50, Q&A 61, 2004-33 I.R.B. 196; Rev. Rul. 2002-27, 2002-20 I.R.B. 925; Prop. Treas. Reg. § 1.125-2(b).

Flexible Spending Arrangements under Code Section 125

A Flexible Spending Arrangement (FSA) is another benefit that can be offered by an employer under a cafeteria plan. The following requirements must be satisfied for a Health Care Flexible Spending Arrangement (health FSA) to be offered under a Code Section 125 cafeteria plan. These requirements generally are imposed so that health FSAs operate in a manner similar to “insurance-type” accident or health plans under Code Section 105. These requirements do not apply to HSAs:⁸⁶

1. The general 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.⁸⁷ See Chapter 4 regarding coverage during the 2-1/2 month grace period that may affect an individual's eligibility to make HSA contributions and the one-time balance transfer rules.
2. The requirement that the maximum amount of reimbursement must be available at all times during the coverage period.⁸⁸
3. The mandatory 12-month period of coverage.⁸⁹

Health FSA with HSA

The new proposed cafeteria plan regulations also retain the rules permitting a “limited purpose” health FSA (reimbursing only those benefits that are permitted with an HSA such as vision or dental only), a “post deductible” health FSA (reimbursing qualified expenses only after the minimum deductible under Code section 223 has been incurred).⁹⁰ The regulations also contain a new rule which provides that a health FSA could also be structured as a combination limited-purpose/post-deductible health FSA without impacting HSA eligibility.⁹¹ So, for example, a health FSA could function as a limited purpose arrangement until the minimum deductible under Code section 223 is satisfied, and then the FSA could convert to a general purpose FSA.

Change in Status

A cafeteria plan may permit an employee to revoke an election during a coverage period with respect to a qualified benefit and make a new election for the remaining portion of the period only as permitted under Code Section 125 regulations.⁹² Because the HSA eligibility requirements and contribution limits 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 must be permitted to start or stop the election, or increase or decrease the election, at any time as long as the change is effective after the request for the change is received (that is, prospectively).⁹³

An employer can permit employees to elect an HSA mid-year if the HSA is offered as a new benefit under the employer's cafeteria plan, provided the HSA election 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 under Code Section 125 regulations.⁹⁴ This may affect the employee's eligibility to establish an HSA.

⁸⁶ Notice 2004-50, Q&A 57, 2004-33 I.R.B. 196.

⁸⁷ IRC § 125(d)(2)(D); Prop. Treas. Reg. § 1.125-1(b)(5).

⁸⁸ Prop. Treas. Reg. § 1.125-5(a)(2).

⁸⁹ Prop. Treas. Reg. § 1.125-5(e).

⁹⁰ Prop. Treas. Reg. § 1.125-5(m).

⁹¹ Prop. Treas. Reg. § 1.125-5(5).

⁹² See Treas. Reg. § 1.125-4; Notice 2004-50, Q&A 58, 2004-33 I.R.B. 196.

⁹³ Prop. Treas. Reg. § 1.125-2(c).

⁹⁴ See Treas. Reg. § 1.125-4; Notice 2004-50, Q&A 59, 2004-33 I.R.B. 196.

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 or limited (for example, coverage under a health FSA), which may prevent the employee from being an eligible individual.⁹⁵

Accelerated Contributions

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 employer contribution 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.⁹⁶ An employer may not recoup contributions made to an employee's HSA.⁹⁷

Retiree Health Coverage

HSA distributions are qualified medical expenses if used to pay for the retiree portion of health care coverage once the account owner reaches age 65. This exception applies regardless of whether the plan is insured or self-insured.⁹⁸

Status Under Code Section 5000(b)(1)

Code Section 5000(b)(1) imposes upon an employer a 25% excise tax on nonconforming group health plans. If no contributions are made to the HSA by an employer (including a self-employed individual) or employee organization, the HSA is not a group health plan. In other cases, it is unclear whether the HSA would be treated as a group health plan under Code Section 5000, which imposes a 25% excise tax on "nonconforming" group health plans, because distributions can be used for nonmedical purposes.⁹⁹

⁹⁵ See Rev. Rul. 2004-45, 2004-22 I.R.B. 971.

⁹⁶ Notice 2004-50, Q&A 60, 2004-33 I.R.B. 196.

⁹⁷ Notice 2004-50, Q&A 82, 2004-33 I.R.B. 196.

⁹⁸ IRC § 223(d)(2)(C)(iv).

⁹⁹ IRC § 5000(b)(1),(c).

Chapter 4

Contributions and Deductions

This chapter discusses contributions and their deductibility or exclusion from gross income, including the repeal of the plan deductible limitation on HSA contributions and full contributions for months preceding High Deductible Health Plan (HDHP) coverage. The chapter explains the limitations on contributions, special rules for married individuals, and the contribution rules and restrictions relating to employer contributions to (or through a cafeteria plan to) a Health Savings Account (HSA), including the comparability rules for employer contributions. Moreover, the chapter covers IRS reporting by individuals as well as partnership and S corporation considerations. Finally, the chapter discusses what type of HSA coverage an individual is permitted to have and how the Flexible Spending Arrangement (FSA) grace period (2-1/2 month) rules affect HSA eligibility.

Rollover contributions and trustee-to-trustee transfers are discussed more fully in Chapter 5 and distribution taxation in Chapter 6.

Making HSA Contributions

Annual contributions to an HSA must be made in cash. For example, contributions may not be made in the form of stock or other property.¹ An exception is made for rollovers and transfers from an Archer Medical Savings Account (Archer MSA), a Health Reimbursement Arrangement (HRA), an FSA, a traditional Individual Retirement Arrangement (IRA), or another HSA. Rollovers and transfers are discussed more fully in Chapter 5.

The Tax Relief and Health Care Act of 2006 (TRHCA) permits a one-time transfer of the balance remaining in an employee's health FSA or HRA to an HSA to assist individuals in funding these accounts, as long as that balance is no higher than the amount credited to the FSA or HRA on September 21, 2006.² The transfer must be made before January 1, 2012.³ If, at any time during a "testing period," the individual ceases to remain an eligible individual, the transferred amounts are includible in income and subject to an additional tax. The testing period is the 13-consecutive-month period beginning with the month of transfer. The distributions that are transferred into the HSA are called "qualifying HSA distributions."⁴ The amount that is transferred from an FSA or HRA does not count against the HSA annual contribution limit.

For taxable years beginning after 2006, an individual may make a "qualified HSA funding distribution" from an IRA to an HSA.⁵ A qualified HSA funding distribution does count against the annual HSA contribution limit. The contribution must be made in a direct trustee-to-trustee transfer and is irrevocable once made.⁶ Only

¹ Notice 2004-2, Q&A 16, 2004-2 I.R.B. 269.

² The Tax Relief and Health Care Act of 2006 (TRHCA), Section 302 (P.L. 109-432).

³ IRC §§ 106(e), 223(c)(1)(B)(iii), 408(d)(9), added by TRHCA § 302(a)-(c); for rules in effect for taxable years ending before 2007, see Notice 2004-2, Q&A 23, 2004-2 I.R.B. 269, prohibiting such rollovers and transfers.

⁴ *Id.*

⁵ IRC § 408(d)(9), added by TRHCA § 307(a).

⁶ IRC § 408(d)(9)(B), 408(d)(9)(C)(ii)(I).

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one such distribution is permitted to be made in the individual's lifetime.⁷ However, if an individual makes a transfer while enrolled in HDHP self-only coverage and later switches to HDHP family coverage a second qualifying HSA funding distribution representing the difference between the self-only and family limits may be made. Before 2007, rollovers or transfers were not permitted to be made from an IRA to an HSA.

Funding

The HSA maximum annual contribution can be made at the beginning of the year, but not before the start of the year for which the contribution is being made. To contribute the maximum annual contribution, an individual generally must have the same coverage throughout the entire year. For each month that the plan owner fails to be covered as of the first of the month by an HDHP, a deductible contribution for that month generally is not allowed. Where the plan owner is not covered by an HDHP for the entire year, the annual contribution funding generally is limited to a total of the monthly amounts for each month that the individual is covered as of the first day of the month. An exception is provided for an individual who is HSA-eligible during the last month of a taxable year, but did not establish an HDHP until after the beginning of his or her taxable year (generally beginning on January 1st).

Note: There is no actual "monthly limit." Although the HSA maximum annual contribution limit is the sum of the monthly limits (discussed below), contributions may be made at any time. For example, assume an individual has disqualifying coverage and is said to be ineligible for three months ending on March 31, the individual may contribute 9/12ths of the 2007 HSA contribution limit (at any time) during that calendar year, or until the tax filing deadline for that year.

Exception. An exception that allows the full HSA contribution to be made for a year is provided for an individual who became HSA-eligible after the beginning of a calendar year, but did not establish an HDHP for the first month of his or her taxable year (generally January). The exception is intended to "assist individuals to transfer to HDHPs from other types of health plans."⁸ In general, for taxable years beginning after 2006, an individual who becomes covered under an HDHP in a month other than January may be permitted to make the full HSA contribution for the year. An individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual during every month during the taxable year for purposes of computing the amount that may be contributed to the HSA for the year.⁹ As a result, such individual is allowed to make contributions for months before the individual was enrolled in an HDHP.

Note: For the months preceding the last month of the taxable year that the individual is treated as an eligible individual (solely by reason of this exception), the individual is treated as having been enrolled in the same HDHP in which the individual was enrolled during the last month of the taxable year (generally December).¹⁰

However, if an individual makes contributions under the exception and does not remain an eligible individual during the testing period, the amount of the contributions attributable to months preceding the month in which the individual was an eligible individual, which could not have been made but for the provision, is recaptured (includible in gross income). A 10% additional tax also applies to the amount includible. An exception applies if the employee ceases to be an eligible individual by reason of death or disability.¹¹ The testing period is the 13-month period beginning with the month of December in the year of the mid-year enrollment and ending at

⁷ IRC § 408(d)(9)(C)(i)(I).

⁸ Joint Committee on Taxation, Technical Analysis of the Tax Relief and Health Care Act of 2006 (P.L. 109-432) (JCX-50-06).

⁹ IRC § 223(b)(8)(A)(i).

¹⁰ IRC § 223(b)(8)(A)(i).

¹¹ IRC § 223(b)(8)(A)(ii).

the end of the following December. This exception is more fully discussed later in this Chapter (see Mid-Year Commencement of HDHP) and in Chapter 5.

Example 4-1

Paula, age 60, a calendar year taxpayer, is ineligible to contribute to an HSA and make contributions for the 11-month period ending in November 2007 because she participated in a health plan that was not an HDHP in those months. If Paula establishes an HDHP with self-only coverage effective on December 1, 2007, and does not participate in another health plan which is not an HDHP that provides coverage for any benefit which is covered under the HDHP (other than permitted insurance, permitted coverage, or preventive care), she will be eligible for the month of December. As a result, Paula will be treated as an eligible individual for all of 2007. She may contribute \$3,650 (\$2,850, plus a catch-up contribution of \$800). If it were not for the exception, Paula's contributions would be limited for 2007 to \$304.16 (1/12 of the \$3,650 maximum annual contribution limit). If Paula's HDHP were effective on any day after December 1, she would not be an eligible individual for the month of December and the exception treating her as eligible for her entire taxable year (2007) would not apply.

Assume instead that all actions occurred one year later. Paula will be treated as an eligible individual for all of 2008. She may contribute \$3,800 (\$2,900, plus a catch-up contribution of \$900). If it were not for the exception, Paula's contributions would be limited for 2008 to \$316.66 (1/12 of the \$3,800 maximum annual contribution limit). If Paula's HDHP were effective on any day after December 1, she would not be an eligible individual for the month of December and the exception treating her as eligible for her entire taxable year (2008) would not apply.

Caution: Absent the exception discussed above, if the HSA account owner's HDHP coverage changes during the year, (e.g., to coverage with a lower deductible or coverage that is not an HDHP), an HSA that was fully funded at the beginning of the year based upon the assumption that the original HDHP would remain in place for the full year may have excess contributions that will have to be withdrawn on or before the due date (including extensions) for filing the account owner's federal income tax return for the taxable year to avoid the 6% excise tax. In that event, the appropriate contribution limit is determined by prorating the full-year contribution by the number of months in family, self-only, or non-HDHP coverage.

Note: Although an HSA is similar to an IRA in many respects, an IRA cannot be used as an HSA, nor can an HSA be combined in one document with an IRA.¹²

Contribution Deadline

In general, contributions must be made by the due date of the account owner's federal income tax return, not including extensions. Thus, a 2007 HSA contribution generally may be made at any time in 2007 and before April 15, 2008.¹³

For 2005 and thereafter, tax-free distributions may be received from the HSA only for qualified medical expenses incurred on or after the date that the HSA is established.¹⁴

¹² See Notice 96-53, A-9, A-10, 1996-2 CB 219, regarding Archer Medical Savings Accounts.

¹³ IRC § 223(d)(4)(B).

¹⁴ Notice 2004-2, 2004-2 I.R.B. 269.

Note: For 2004, if an HSA was established by the due date (generally April 15, 2005), tax-free distributions could have been received from the HSA for qualified medical expenses incurred on or after the first day of the month that the taxpayer became an eligible individual (see Chapter 2), under a transitional rule that only applied for calendar year 2004.¹⁵ However, that transitional relief was not extended beyond 2004.

Caution: A contribution postmarked after December 31 will be treated as applying to the year that the contribution actually is received by the trustee or custodian unless the taxpayer has designated that the contribution is for the prior year. For example, if an individual is making a contribution in 2008 as to tax year 2007, the contribution form (and preferably the check) should indicate “2007 contribution.”

Note: Farmers must file their federal income tax returns by March 1 (rather than the general April 15 due date), unless estimated taxes are paid by January 18. Therefore, the contribution date for farmers may vary from that of the general rule.

No Compensation Requirement

HSA contributions may be made regardless of whether the eligible individual has compensation. However, where employees fund the HDHP through a pre-tax cafeteria plan with their employer, earnings are required.

Practice Pointer →

Unlike contributions to an Archer MSA, contributions to an HSA may be made by, or on behalf of, eligible individuals even if the individuals have no compensation or the contributions exceed their compensation.

Who May Contribute

Any eligible individual or any other person on an eligible individual's behalf (see Chapter 2) may contribute to an HSA.¹⁶ For example, if an employee establishes the HSA, the employee, the employee's employer, or both may contribute to the HSA. If a self-employed (or unemployed) individual establishes the HSA, the individual may contribute to the HSA. Also, any other individual (e.g., a family member) may make contributions to an HSA of an eligible individual.¹⁷ As explained elsewhere in this chapter, contributions also may be made through a cafeteria plan. Further, a partnership also may contribute to a partner's HSA, and an S corporation may contribute to a more than 2% shareholder-employee's HSA (discussed later in this chapter).

Note: The U.S. Department of Labor (DOL) approved certain cash bonus incentives paid in connection with the establishment of an HSA and an HDHP by a bank and an insurance company to an individual's HSA (see Chapter 6).

Contributions by State Governments

A state government may make an HSA contribution on behalf of an eligible individual. Also, a state government's comprehensive health insurance program for high-risk individuals (state high-risk pool) may qualify as an HDHP if it does not pay benefits below the HDHP minimum annual deductible (\$1,100 for

¹⁵ Notice 2004-2, Q&A-26, 2004-2 I.R.B. 269, modified by Notice 2004-25, 2004-15 I.R.B. 727 (the “transitional relief”).

¹⁶ Notice 2004-2, Q&A 11, 2004-2 I.R.B. 269; IRS Notice 2004-50, Q&A 28, 2004-33 I.R.B. 196.

¹⁷ Notice 2004-50, Q&A 28, 2004-33 I.R.B. 196.

self-only coverage and \$2,200 for family coverage for 2007).¹⁸ In this context, an HSA can be coupled with a state high-risk pool or other comprehensive health insurance program, assuming the program qualifies as an HDHP.

Other Employee Health Plans

HDHP and a Health FSA or an HRA

An employee covered by an HDHP and a health FSA or an HRA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA. However, an employee can make contributions to an HSA while covered under an HDHP for periods in which the individual is covered under any of four types of arrangements:

- A limited-purpose health FSA or an HRA,
- A suspended HRA,
- A post-deductible health FSA or an HRA, or
- A retirement HRA.

Limited-Purpose Health FSA or HRA

The health FSA and/or HRA are limited-purpose arrangements if they only pay or reimburse vision and dental expenses (i.e., permitted coverage) or preventive care benefits. An HRA, because it can be used to reimburse premiums, also could reimburse long-term care premiums, premiums for a specified disease or illness, or premiums for a fixed amount per day or other period of hospitalization (i.e., permitted insurance) as well. In certain circumstances (i.e., when an HRA does not satisfy the definition of an FSA under Code Section 106(c)), the HRA also may reimburse long-term care services. If the covered benefits are limited in this manner, it does not matter whether the health FSA and/or the HRA pays benefits without imposing a deductible.

The individual's eligibility to make HSA contributions is examined in the following examples in which an individual is covered by an HDHP and a health FSA or an HRA.¹⁹

Example 4-2

Kareem is covered by an HDHP. The HDHP has an 80/20 percent coinsurance feature above the deductible. Kareem also is covered by a health FSA under a Code Section 125 cafeteria plan and an HRA. The health FSA and the HRA pay or reimburse all of his medical expenses (within the meaning of Code Section 213) that are not covered by the HDHP (such as copayments, coinsurance, expenses not covered due to the deductible, and other medical expenses not covered by the HDHP). The health FSA and the HRA coordinate the payment of benefits under the ordering rules of Notice 2002-45 (2002-28 I.R.B. 93). Kareem is not entitled to benefits under Medicare and may not be claimed as a dependent on another person's tax return.

Here, Kareem is covered by an HDHP and by a health FSA and an HRA that pay or reimburse medical expenses incurred before the HDHP minimum annual deductible of \$1,100 (the limit for 2007 or 2008) has been satisfied. The health FSA and the HRA pay or reimburse medical expenses that are not limited to the exceptions for permitted insurance, permitted coverage, or preventive care. As a result, Kareem is not an

¹⁸ Notice 2004-50, Q&A 29, 2004-33 I.R.B. 196.

¹⁹ IRC §§ 125(a), 125(d), 125(f), 223(a), 223(b), 223(c)(1)(A), 223(c)(1)(A)(ii), 223(b)(2)(A), 223(b)(2)(B), 223(c)(1)(B), 223(c)(2)(A), 223(c)(2)(C); Rev. Rul. 2004-45 (2004-22 I.R.B. 971); Rev. Rul. 2004-38 (2004-15 I.R.B. 717); Notices 2002-45 (2002-2 CB 93), 2004-23 (2004-15 I.R.B. 725); See, also, H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003); See Notice 2005-86, 2005-49 I.R.B. 1075, (regarding examples 7 and 8); Prop. Treas. Reg. 1.125-5(m).

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eligible individual for the purpose of making contributions to an HSA. This result would be the same if Kareem was covered by a health FSA or an HRA sponsored by his spouse's employer.²⁰

Example 4-3

Same facts as *Example 4-2*, except that the health FSA and the HRA are limited-purpose arrangements that pay or reimburse, under the written plan document, only vision and dental expenses (whether or not the HDHP minimum annual deductible has been satisfied). Also, the health FSA and the HRA pay or reimburse preventive care benefits as described in Notice 2004-23 (2004-15 I.R.B. 725). Although Kareem is covered by an HDHP and by a health FSA and an HRA that pay or reimburse medical expenses incurred before the HDHP minimum annual deductible (\$1,100 for 2007 and 2008) has been satisfied, the medical expenses paid or reimbursed by the health FSA and the HRA include only vision and dental benefits (which are permitted coverage) and preventive care. All these benefits may be covered as a separate health plan, as a separate or optional rider, or as part of the HDHP, and whether or not the HDHP minimum annual deductible has been satisfied. Kareem is an eligible individual for the purpose of making contributions to an HSA.²¹

Example 4-4

Same facts as *Example 4-2*, except that Kareem is not covered by a health FSA. Under his employer's HRA, before the beginning of the HRA coverage period, Kareem elects to forego the payment or reimbursement of medical expenses incurred during that coverage period. The decision to forego the payment or reimbursement of medical expenses does not apply to permitted insurance, permitted coverage, and preventive care (excepted medical expenses). Medical expenses incurred during the suspended HRA coverage period (other than the excepted medical expenses, if otherwise allowed to be paid or reimbursed by an HRA), cannot be paid or reimbursed by the HRA currently or later (that is, after the HRA suspension ends). However, the employer decides to continue to make employer contributions to Kareem's HRA during the suspension period and thus the maximum available amount under the HRA is not affected by the suspension but is available for the payment or reimbursement of the excepted medical expenses incurred during the suspension period as well as medical expenses incurred in later HRA coverage periods.

Although Kareem elected to forego the payment or reimbursement of medical expenses incurred during an HRA coverage period, the suspension of payments and reimbursements by the HRA does not apply to permitted insurance, permitted coverage, and preventive care (if otherwise allowed to be paid or reimbursed by the HRA). Kareem is an eligible individual for the purpose of making contributions to an HSA until the suspension period ends, and he again is entitled to receive from the HRA payments or reimbursements of Code Section 213(d) medical expenses incurred after the suspension period.

Example 4-5

Same facts as *Example 4-2*, except that the health FSA and the HRA are post-deductible arrangements that only pay or reimburse Kareem's medical expenses (including the 20% coinsurance responsibility for expenses above the deductible) after the HDHP minimum annual deductible has been satisfied. Because Kareem's health FSA and HRA pay or reimburse medical expenses (including the 20% coinsurance not otherwise covered by the HDHP) only after the HDHP minimum annual deductible has been satisfied, he is an eligible individual for the purpose of making contributions to an HSA.

Example 4-6

Same facts as *Example 4-2*, except that Kareem is not covered by a health FSA. The employer's HRA is a retirement HRA that only reimburses those medical expenses incurred after the individual retires. Kareem is an eligible individual for the purpose of making contributions to an HSA before retirement because the HRA will pay or reimburse only medical expenses incurred after retirement.

²⁰ Rev. Rul. 2004-45; See also Rev. Rul. 2004-38 (2004-15 I.R.B. 717).

²¹ Rev. Rul. 2004-45; 2004-22 I.R.B. 971.

Note: Also, combinations of these arrangements that are consistent with these requirements would not disqualify an individual from being an eligible individual. For example, if an employer offers a combined post-deductible health FSA and a limited-purpose health FSA, this would not disqualify an otherwise eligible individual from contributing to an HSA.

Suspended HRA

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

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

Post-deductible Health FSA or HRA

Where a post-deductible health FSA or HRA does not pay or reimburse any medical expense incurred before the \$1,100/\$2,200 (for 2007) HDHP minimum annual deductibles are satisfied, the individual is an eligible individual for the purpose of making contributions to the HSA. The deductible for the HRA or health FSA (other coverage) need not be the same as the HDHP deductible, but in no event may the HDHP or other coverage provide benefits before the minimum annual deductible. Where the HDHP and the other coverage do not have identical deductibles, contributions to the HSA are limited to the lower of the deductibles. Also, although the deductibles of the HDHP and the other coverage may be satisfied independently by separate expenses, no benefits may be paid before the minimum annual deductible (\$1,100/\$2,200 for 2007) has been satisfied.

Combination of Limited-Purpose and Post-Deductible Health FSA

The new proposed cafeteria plan regulations contain a new rule which provides that a health FSA could also be structured as a combination limited-purpose/post-deductible health FSA without impacting HSA eligibility.²² So, for example, a health FSA could function as a limited purpose arrangement until the minimum deductible under Code Section 223 is satisfied, and then the FSA could convert to a general purpose FSA.

Cafeteria Plan Grace Period

In Notice 2005-42,²³ the IRS announced that it is permissible for a Code Section 125 plan to provide for a 2-1/2-month “grace period” after the end of a plan year during which a participant with a remaining balance in his or her health FSA (at the end of the plan year) may be reimbursed for eligible expenses incurred up to 2-1/2 months after the plan year’s end. This rule also appears in the new cafeteria plan proposed regulations.²⁴ If a

²² Prop. Treas. Reg. 1.125-5(m)(5).

²³ Notice 2005-42, 2005-23 I.R.B. 1204 (May 18, 2005).

²⁴ Prop. Treas. Reg. § 1.125-1(e).

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plan is not amended to include a grace period, unused FSA balances are forfeited at the end of the plan year under the so-called “use-it-or-lose-it” rule. The adoption of a grace period might prevent a participant from contributing to an HSA for the period (generally three months) that the employee had disqualifying “other coverage.” See the discussion below.

Practice Pointer →

Under the TRHCA, an individual who is HSA-eligible during December (the last month of his or her taxable year, and e.g., not enrolled in Medicare, or does not have disqualifying health care coverage in December) as previously discussed, but did not establish an HDHP for January, may be permitted to make the full deductible HSA contribution for the year. An individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual during every month during the taxable year for purposes of computing the amount that may be contributed to the HSA for the year. Such individual also is treated as having the same HDHP coverage (self-only or family coverage) for the entire taxable year as in the last month of the year. Thus, in such a case, disqualifying coverage during a grace period arguably could be disregarded for an individual that established an HDHP after the beginning of a year.

Example 4-7

Shaquille is a participant in a pre-tax Code Section 125 cafeteria plan. The plan year is the calendar year. In 2007, Shaquille signs up for an election of \$1,500 but only uses \$1,000 during the year. He makes no election for 2008 and has no other health coverage. The plan contains a grace period of 2-1/2 months (under Notice 2005-42) in which Shaquille may submit additional claims for expenses that occurred during the 2-1/2-month grace period. Shaquille is not an HSA-eligible individual during 2007 and the months that include the grace period (January through March 2008). The result would be different if the FSA were a limited-purpose health FSA (see above) for all participants during the grace period. Also, depending upon the deductible amount (say \$2,500 under the FSA) and how it is applied as to 2007 and 2008, if Shaquille was a participant in a post-deductible health FSA, he might not be disqualified from being treated as an eligible individual during the 2-1/2-month period in 2008 (and be permitted to make a contribution).

Cafeteria Plan Grace Period Rules

Carryover of Unused Contributions to a Later Year

Although the IRS generally takes the position that allowing cafeteria plan salary reduction contributions to carry over from one plan year to the next is a prohibited deferral of compensation, Notice 2005-42 (2005-23 I.R.B. 1204) modified this position, and the new proposed cafeteria plan regulations adopted this modified position.²⁵ Under the Notice and regulations, an employer may adopt a grace period in a cafeteria plan so that the “forfeitures” of unused benefits that otherwise might occur at the end of the plan year under the so-called “use-it-or-lose-it rule” can be avoided. Under the Notice, contributions to an HSA generally are not permitted until the first month following the grace period even if a participant’s balance in his or her account were zero because of the disqualifying coverage. A transitional rule also is provided for cafeteria plan years ending before June 5, 2006 (see below).

The TRHCA permits a participant in an FSA that incorporates the 2-1/2 month grace period to contribute to an HSA during the grace period if his or her account balance is zero at the end of previous plan year. In such case, the disqualifying coverage under the FSA is disregarded. The provision is effective on December 20, 2006. Alternatively, if the FSA participant maintains amounts in his or her account balance at the end of the plan year, the participant may make a one-time transfer of the balance to an HSA if permitted by his or her

²⁵ Prop. Treas. Reg. § 1.125-1(e)

employer.²⁶ Adverse tax consequences apply if the individual who makes a transfer does not remain an eligible individual for a 13-month testing period which starts in the month the amount is transferred and ends on the last day of the 12th month following the month of transfer.²⁷ Rollovers and transfers are more fully discussed in Chapter 5.

Caution: Because the *annual* limitation for HSA contributions generally is determined on a monthly basis (discussed later), the adoption of a grace period may have an effect upon an individual's eligibility to fully fund his or her HSA. For example, an individual who is participating in a health FSA with a grace period of 2-1/2 months only may be permitted to contribute 9/12 of the full annual contribution amount because such individual may be considered an "ineligible individual" who has other non-HDHP health coverage for the first three months of the year. Arguably, however, an individual who is HSA-eligible during the last month of a taxable year (e.g., not enrolled in Medicare or does not have disqualifying health care coverage in last month), may be permitted to make the full HSA contribution for the year under the TRHCA provision. As previously discussed, an individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual during every month during the taxable year for purposes of computing the amount that may be contributed to the HSA for the year. Thus, in such a case, disqualifying coverage during a grace period could be disregarded for an individual that established an HSA after the beginning of a year.

Providing a Grace Period

A cafeteria plan document, at the employer's option, may be amended to provide for a grace period immediately following the end of each plan year. For years beginning after 2008, this change must be made prior to the beginning of the applicable plan year.²⁸ Expenses for qualified benefits incurred during the grace period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding plan year. As a practical matter, health FSAs and dependent care FSAs are the only benefits for which an extension of this type appears to make sense, and the extension could be limited to just one of these benefits. The new rule cannot be applied retroactively to earlier plan years.

The IRS has indicated informally that it would be permissible for a plan to impose a cap on the amount of benefits subject to the grace period as long as the cap is applied uniformly to all plan participants. Also, if an employer has more than one cafeteria plan, the extension can be limited to only one cafeteria plan.

The grace period must not extend beyond the 15th day of the third calendar month after the end of the immediately preceding plan year to which it relates (i.e., the 2 and 1/2 month rule). A plan is not required to adopt this rule or to provide the full 2-1/2 month extension (i.e., a lesser period is acceptable). If a cafeteria plan document is amended to include a grace period, a participant who has unused benefits or contributions relating to a particular qualified benefit from the immediately preceding plan year, and who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. The effect of the grace period is that the participant may have as long as 14 months and 15 days (the 12 months in the current cafeteria plan year plus the grace period) to use the benefits or contributions for a plan year before those amounts are "forfeited" under the "use-it-or-lose-it" rule.²⁹

²⁶ IRS Notice 2007-22, 2007-10 I.R.B. 670 (Mar 5, 2007).

²⁷ TRHCA § 320(a)-(c), adding IRC §§ 106(e), 223(c)(1)(B).

²⁸ Prop. Treas. Reg. § 1.125-1(c).

²⁹ Notice 2005-42, 2005-23 I.R.B. 1204.

No Cash-Out or Conversion of Unused Amounts

During the grace period, a cafeteria plan may not permit unused benefits or contributions to be cashed-out or converted to any other taxable or nontaxable benefit. Unused benefits or contributions relating to a particular qualified benefit may be used only to pay or reimburse expenses incurred as to that particular qualified benefit. For example, unused amounts originally elected to pay or reimburse medical expenses in a health FSA may not be used to pay or reimburse dependent care or other expenses incurred during the grace period. To the extent that any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the grace period, those remaining unused benefits or contributions may not be carried forward to any later period (including any later plan year) and are “forfeited” under the “use-it-or-lose-it” rule.

Practice Pointer →

As under current practice, employers may continue to provide a “run-out” period after the end of the grace period during which expenses for qualified benefits incurred during the cafeteria plan year and the grace period may be paid or reimbursed.

Example 4-8

Employer with a cafeteria plan year ending on December 31, 2007, amended the plan document before the end of the plan year to permit a grace period which allows all participants to apply unused benefits or contributions remaining at the end of the plan year to qualified medical expenses incurred during the grace period immediately following that plan year. The grace period adopted by the employer ends on the 15th day of the third calendar month after the end of the plan year (March 15, 2008, for the plan year ending December 31, 2007). Benny, an employee, timely elected salary reduction of \$1,000 for a health FSA for the plan year ending December 31, 2007. As of December 31, 2007, Benny has \$200 remaining unused in his health FSA. Benny timely elected salary reduction for a health FSA of \$1,500 for the plan year ending December 31, 2008. During the grace period from January 1 through March 15, 2008, Benny incurs \$300 of unreimbursed medical expenses. The unused \$200 from the plan year ending December 31, 2007, is applied to pay or reimburse \$200 of Benny’s \$300 of qualified medical expenses incurred during the grace period. Therefore, as of March 16, 2008, Benny has no unused benefits or contributions remaining for the plan year ending December 31, 2007. The remaining \$100 of medical expenses incurred between January 1 and March 15, 2008 is paid or reimbursed from Benny’s health FSA for the plan year ending December 31, 2008. As of March 16, 2008, Benny has \$1,400 remaining in the health FSA for the plan year ending December 31, 2008.

Example 4-9

Same facts as *Example 4-8*, except that Benny incurs \$150 of qualified medical expenses during the grace period (January 1 through March 15, 2008). As of March 16, 2008, Benny has \$50 of unused benefits or contributions remaining for the plan year ending December 31, 2007. The unused \$50 cannot be cashed-out, converted to any other taxable or nontaxable benefit, or used in any other plan year (including the plan year ending December 31, 2008). The unused \$50 is subject to the use-it-or-lose-it rule and is forfeited. As of March 16, 2008, Benny has the entire \$1,500 elected in the health FSA for the plan year ending December 31, 2008.

Note: In the above two examples, Benny may have been able to transfer the remaining balance in his health FSA account to an HSA in a one-time transfer provided the FSA plan is amended to allow such transfers. In such case, he would not be treated as an ineligible individual for the months of January through March because of the grace period (see Chapter 5).

Grace Period Duration

If adopted by an employer, the grace period remains in effect for the entire period even though the participant may terminate employment on or before the last day of the grace period. But an employer may limit the availability of the grace period to only certain cafeteria plan benefits and not others. For example, a cafeteria

plan offering both a health FSA and a dependent care FSA may limit the grace period to the health FSA. In no event may the grace period extend beyond the 15th day of the third calendar month after the end of the immediately preceding plan year to which it relates, but it may be adopted for a shorter period.³⁰

Interaction between HSAs and Health FSAs

An individual who otherwise is eligible for an HSA may be covered under certain types of health FSAs and remain eligible to contribute to an HSA. This result is the same even if the individual is covered by a health FSA sponsored by a spouse's employer.

As discussed previously, one HSA-compatible arrangement is a limited-purpose health FSA, which pays or reimburses expenses only for preventive care and "permitted coverage" (e.g., dental care and vision care). Another HSA-compatible arrangement is a post-deductible health FSA, which pays or reimburses preventive care and for other qualified medical expenses only if incurred after the HDHP minimum annual deductible (\$1,100/\$2,200 for 2007 or 2008) is satisfied. A combination arrangement incorporating both of these features is also permissible. Thus, an otherwise HSA-eligible individual will remain eligible if covered under a limited-purpose health FSA, a post-deductible health FSA, or a combination of both.³¹

Example 4-10

General purpose health FSA during grace period. Constellation amends its cafeteria plan document to provide a grace period but takes no other action as to its general purpose health FSA. Because a health FSA that pays or reimburses all qualified medical expenses constitutes impermissible "other coverage" for HSA eligibility purposes, an individual who did not elect coverage under a general purpose health FSA or other disqualifying coverage for 2008 is HSA eligible on April 1, 2008, and may contribute 9/12ths of the 2008 HSA contribution limit (\$2,900 for self-only coverage or \$5,800 for family coverage). Under Notice 2005-42, the result is the same even if a participant's health FSA has no unused contributions remaining at the end of the immediately preceding cafeteria plan year. However, under the TRHCA, if the individual's balance in his or her health FSA is zero as of the end of the preceding year,³² the individual nonetheless may contribute to an HSA during the grace-period (assuming the individual otherwise is an eligible individual in the months that included the grace period).

Note: It appears that the employer and employee share responsibility for verifying that the FSA has a zero balance. As plan sponsor, the employer has records of claims submitted and paid, and should share this information with the employee. However, the employee has control over whether to submit claims against the amounts in the account, and has responsibility to submit claims so that they can be properly substantiated. If claims are submitted that are not substantiated, an employee may wind up having a balance in the FSA account without intending to. If the employer and employee think that the account has a zero balance as of the end of a particular calendar year but later determine that it did not, the employee will be required to reduce his or her HSA contribution for the calendar year in which the 2-1/2 month grace period was offered (i.e., will only be considered an eligible individual as of the first day of the month following the expiration of the 2-1/2 month grace period).³³

³⁰ Notice 2005-42, 2005-23 I.R.B. 1204.

³¹ Rev. Rul. 2004-45, 2004-1 C.B. 971; Prop. Treas. Reg. § 1.125-5(m).

³² Notice 2007-22, 2007-10 I.R.B. 670 (Mar 5, 2007).

³³ Notice 2007-22, 2007-10 I.R.B. 670 (Mar. 5, 2007).

Historical Note: Transitional Relief. For cafeteria plan years ending before June 5, 2006, an individual participating in a general purpose health FSA that provides coverage during a grace period will be eligible to contribute to an HSA during the grace period if the following requirements are met:³⁴

1. If not for the coverage under a general purpose health FSA, the individual would be an eligible individual during the grace period (in general, is covered under an HDHP and is not, while covered under an HDHP, covered under any impermissible other health coverage); and
2. Either the individual's (and the individual's spouse's) general purpose health FSA has no unused contributions or benefits remaining at the end of the immediately preceding cafeteria plan year, or
In case of an individual who is not covered during the grace period under a general purpose health FSA maintained by the employer of the individual's spouse, the individual's employer amends its cafeteria plan document to provide that the grace period does not provide coverage to an individual who elects HDHP coverage.

Retirement HRA

A retirement HRA allows payments or reimbursements for only those medical expenses incurred after retirement (and no expenses incurred before retirement). An individual who participates in a retirement HRA can be an eligible individual for the purpose of making contributions to the HSA before retirement, but will lose status as an eligible individual at the time the retirement HRA may pay or reimburse Code Section 223(d) medical expenses. Thus, after retirement, the individual no longer is an eligible individual for HSA purposes.³⁵

Contribution Limitations

In general, the maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility, and health plan coverage as of the first day of the month. Although the maximum annual contribution limit is determined on a monthly basis, there is no actual monthly limit on the amount that may be contributed.

After an individual has attained age 65 (generally, the Medicare eligibility age), contributions, including catch-up contributions, no longer are permitted to be made to an HSA if the individual actually is enrolled in Medicare.

As discussed later in this chapter, special rules apply in the case of married individuals, ineligible individuals, embedded deductibles, and post-deductible HRAs.

Self-Only Coverage (Statutory Limits)

The statutory maximum annual contribution limit for eligible individuals with HDHP self-only coverage is \$2,250 (base amount, subject to indexing). However, in taxable years ending before 2007, the maximum annual contribution could not exceed the annual deductible under the HDHP.

For taxable years beginning in 2007, the HSA maximum annual contribution for an eligible individual with self-only coverage is \$2,850 (\$2,900 for 2008). For taxable years beginning before 2007, the annual contribution amount could not exceed annual deductible under the HDHP. The repeal of the annual plan deductible limit is effective for taxable years beginning after 2006.³⁶

³⁴ Notice 2005-86, 2005-49 I.R.B. 1075, amplifying Notice 2005-42, 2005-42 I.R.B. 1204 and Rev. Rul. 2004-45, 2004-22 I.R.B. 971; Treas. Press Release JS-3022 (Nov. 11, 2005).

³⁵ IRC § 223(c)(3); Rev. Rul. 2004-45, 2004-22 I.R.B. 971.

³⁶ IRC § 223(b)(2), as amended by TRHCA § 303(a)(1). For effective date see TRHCA § 303(c).

Note: Fiscal year taxpayer. The maximum annual contribution limit for any taxable year is the annual limit in effect at the beginning of a taxable year. For example, the 2007 maximum annual contribution limit of \$2,850 (for self-only coverage) and \$5,650 (for family coverage), would apply to a fiscal year taxpayer whose taxable year began on July 1, 2007.³⁷

Family Coverage (Statutory Limits)

For taxable years beginning in 2007, the HSA maximum annual contribution for an eligible individual with family coverage is \$5,650 (\$5,800 for 2008). For taxable years beginning before 2007, the annual contribution amount could not exceed annual deductible under the HDHP. The repeal of the annual plan deductible limit is effective for taxable years beginning after 2006.³⁸

In addition to the maximum annual contribution amount, catch-up contributions (discussed later) may be made by or on behalf of individuals age 55 or older who are not enrolled in Medicare.³⁹ An individual must be an eligible individual for the entire taxable year to contribute the maximum annual catch-up contribution of \$800 for 2007; \$900 for 2008.

Note: The base amounts (\$2,250 self-only/\$4,500 family) are the amounts from which the initial 2004 and later year HSA maximum annual contribution limits are derived (see below).

Coordination with Archer MSA

The HSA contribution limitations are reduced (but not below zero) by the aggregate amounts contributed by the account owner to an Archer MSA.⁴⁰ The family coverage limit also is reduced further by any contribution to an Archer MSA.⁴¹

Adjustments for Inflation

The \$2,250 and \$4,500 statutory maximum annual contribution limitations that are specified in Code Section 223(b)(2) are adjusted for cost-of-living increases in the Consumer Price Index (CPI) through August of the preceding year relative to CPI for 1997.⁴² The CPI for a year is the average for the 12-month period ending on August 31 for such year. For 2007, the statutory limit of \$2,250 (for self-only coverage) was increased to \$2,850 and the \$4,500 (for family coverage) was increased to \$5,650. The amounts are adjusted to the nearest multiple of \$50.⁴³ The \$2,250 and \$4,500 base amounts used to compute the monthly limitation on deductions for 2007 can be computed as follows (to the nearest multiple of \$50):

1. $\$2,850 = \underline{\$2,250 \times (\text{average CPI September 2005 to August 2006})}$
(average CPI September 1996 to August 1997)
2. $\$5,650 = \underline{\$4,500 \times (\text{average CPI September 2005 to August 2006})}$
(average CPI September 1996 to August 1997)

³⁷ IRC § 223(g)(1)(B).

³⁸ IRC § 223(b)(2), as amended by TRHCA § 303(a)(1). For effective date see TRHCA § 303(c).

³⁹ Notice 2004-2, Q&A 12, 2004-2 I.R.B. 269, as modified by Notice 2004-50, 2004-33 I.R.B. 196.

⁴⁰ IRC § 223(b)(4)(A).

⁴¹ IRC § 223(b)(5)(B)(i).

⁴² IRC § 223(g)(1).

⁴³ IRC § 223(g)(2); Rev. Proc. 2005-70, § 3.22, 2005-47 I.R.B.979; see also Treasury Press Release, JS-2996 (Nov. 22, 2005).

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Note: For taxable years beginning after 2007, the HSA-related inflation adjustment period will be the 12-month period ending on March 31 of the calendar year (rather than August 31). The Secretary of the Treasury must publish the adjusted amounts for a year no later than June 1 of the preceding year. Thus, the 2009 statutory maximum annual contribution limit and the dollar amounts for the HDHP requirements (minimum annual deductible and maximum out-of-pocket expenses), as adjusted for cost-of-living increases through March of 2008, will be published by June 1, 2008.⁴⁴

The HSA maximum annual contribution amounts (because HSAs were permitted for taxable years beginning in 2004) are shown in Table 4-1.

Table 4-1: HSA Maximum Annual Contribution Amounts (Excluding Catch-Up Contributions) for Self-Only and Family Coverage

<i>Coverage</i>	<i>2007</i>	<i>2006</i>	<i>2005</i>	<i>2004</i>
Self-only coverage (\$2,250)	\$2,850	\$2,700	\$2,650	\$2,600
Family coverage (\$4,500)	\$5,650	\$5,450	\$5,250	\$5,150

Note: For 2008, the maximum HSA annual contribution amounts were increased to \$2,900 (for self-only coverage) and \$5,800 (for family coverage).

The same HSA maximum annual contribution limit applies whether the contributions are made by an employee, an employer, a self-employed person, a family member, or some other person.

The HSA maximum annual contribution limits are reduced (but not below zero) by the aggregate amounts contributed by the account owner to an Archer MSA.⁴⁵ The family coverage limit also is reduced further by any contribution to an Archer MSA.⁴⁶

Multiple HSAs

An eligible individual may establish more than one HSA and may contribute to more than one HSA. The same rules governing HSAs apply (for example, maximum annual contribution limit), regardless of the number of HSAs established by an eligible individual.⁴⁷ However, if an individual has more than one HSA, the aggregate annual contributions to all the HSAs are subject to the limit.⁴⁸

Example 4-11

George, an eligible individual, has an HSA maximum annual contribution limit of \$2,850 for 2007. George's employer contributes \$1,000 to an HSA on behalf of George. George opens a second HSA and contributes \$1,850. If additional contributions are made for 2007 to either of the HSAs, there are excess contributions to George's HSAs.

Example 4-12

Taylor, an eligible individual, has an HSA maximum annual contribution limit of \$2,900 for 2008. George's employer contributes \$1,000 to an HSA on behalf of George. George opens a second HSA and contributes \$1,500. Taylor may contribute up to \$400 more for 2008 to either of the HSAs.

⁴⁴ IRC § 223(g)(1), as amended by TRHCA § 304; Rev. Proc. 2007-36, 2007-22 I.R.B. 1.

⁴⁵ IRC § 223(b)(4)(A).

⁴⁶ IRC § 223(b)(5)(B)(i).

⁴⁷ Notice 2004-50, Q&A 64, 2004-33 I.R.B. 196.

⁴⁸ Notice 2004-2, Q&A 12 2004-2 I.R.B. 269.

Mid-Year Commencement of HDHP Coverage

The HSA maximum annual contribution limit is based generally upon the number of months in the year that an individual is covered by a qualifying HDHP.⁴⁹ An exception is provided for individuals who became eligible after the first month of a taxable year and remain eligible through December 1st of that year (see below).

Example 4-13

Carmen, an eligible individual, begins HDHP self-only coverage on June 1, 2007, with an annual deductible of \$3,000. The 2007 HDHP minimum annual deductible limit is \$2,850. The monthly contribution limit is \$237.50 (\$2,850 / 12). The annual contribution limit is \$1,662.50 (7 x \$237.50).

Example 4-14

Yola, an eligible individual, begins HDHP self-only coverage on June 1, 2008, with an annual deductible of \$3,000. The 2008 HDHP minimum annual deductible limit is \$2,900. The annual contribution limit is \$1,691.67 (\$2,900 x 7 / 12).

Note: Although a monthly limit is used in calculating the annual HSA contribution, as previously discussed, there is no problem with contributing all of an HSA contribution on the first day of eligibility, or otherwise as the account owner decides, up to the due date of the federal income tax return (generally April 15 of the following year). Thus, there is no actual “monthly limit,” only a restriction to the annual maximum contribution amount.

Exception. An exception is provided for an individual who becomes HSA-eligible after the beginning of a taxable year who does not establish an HDHP as of the beginning of such year, generally, January 1st. In general, for taxable years beginning after 2006, an individual who becomes covered under an HDHP in a month other than January may be permitted to make the full HSA contribution for the year. An individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual during every month during the taxable year for purposes of computing the amount that may be contributed to the HSA for the year.⁵⁰ As a result, such individual is allowed to make contributions for months before the individual was enrolled in an HDHP.

If an individual makes contributions under the exception and does not remain an eligible individual during the *testing period*, the amount of the contributions attributable to months preceding the month in which the individual was an eligible individual, which could not have been made but for the provision, is includible in gross income. A 10% additional tax also applies to the amount includible. An exception applies if the employee ceases to be an eligible individual by reason of death or disability.⁵¹

The *testing period* is the period beginning with the last month of the taxable year and ending on the last day of the 12th month following such month. The amount is includible for the taxable year of the first day during the testing period that the individual is not an eligible individual.⁵²

Example 4-15

Janice, a calendar year taxpayer, established an HDHP effective January 1, 2007, but coverage was terminated on November 30, 2007. The exception does not apply to Janice for 2007, because she was not an eligible individual in December. Janice may contribute only 11/12 of the maximum annual contribution, assuming she was an eligible individual during those 11 months.

⁴⁹ Notice 2004-2, Q&A 13, 2004-2 I.R.B. 269.

⁵⁰ IRC § 223(e)(8)(A).

⁵¹ IRC § 223(e)(8)(A)-(B).

⁵² IRC § 223(e)(8)(B).

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Example 4-16

Jose enrolls in an HDHP as of December 1, 2007, and otherwise is an eligible individual in that month. Jose was not an eligible individual in any other month in 2007. Jose may make HSA contributions as if he had been enrolled in the HDHP for all of 2007. If Jose ceases to be an eligible individual (e.g., if he ceases to be covered under the HDHP) in June 2008, an amount equal to the HSA contribution attributable to treating Jose as an eligible individual for January through November 2007 is included in income in 2008. Also, a 10% additional tax applies to the amount includible.

Example 4-17

Same facts as in **Example 4-16**, except Jose turned age 65 and enrolled in Medicare on March 15, 2008. Jose ceases to be an eligible individual (i.e., when he enrolled in Medicare) during the testing period. Therefore, an amount equal to the HSA contribution attributable to treating Jose as an eligible individual from January through November 2007 is included in income in 2008. Also, a 10% additional tax applies to the amount includible.

Note: For the months preceding the last month of the taxable year that the individual is treated as an eligible individual (solely by reason of this exception), the individual is treated as having been enrolled in the same HDHP in which the individual was enrolled on December 1st of the year of a mid-year enrollment.⁵³

Catch-Up Contributions

Catch-Up Eligibility

For individuals (and their spouses covered under the HDHP) who have attained age 55 and who are not enrolled in Medicare, the HSA annual maximum contribution limit is increased by \$800 in calendar year 2007; \$900 for 2008.⁵⁴

Note: Fiscal year taxpayer. The catch-up limit for any taxable year is the annual limit in effect at the beginning of a taxable year. For example, the 2008 catch-up limit of \$900, would apply to a fiscal year taxpayer whose taxable year began on July 1, 2008.⁵⁵

After an individual has attained age 65 (generally, the Medicare eligibility age), contributions, including catch-up contributions, no longer are permitted to be made to an HSA if the individual actually is enrolled in Medicare.

Practice Pointer →

If both spouses are age 55 or older and both want to make catch-up contributions, each must establish an HSA. Catch-up contributions may not be allocated between spouses.⁵⁶

Example 4-18

Claudia otherwise is an HSA-eligible individual who is over age 65 and thus eligible for Medicare, but she is not enrolled in Medicare Part A or Part B. Claudia may make the additional catch-up contributions for individuals age 55 or older.⁵⁷

⁵³ IRC § 223(e)(8)(A)(ii).

⁵⁴ Notice 2004-2, Q&A 14, 2004-2 I.R.B. 269, as modified by Notice 2004-50, 2004-33 I.R.B. 196.

⁵⁵ IRC § 223(b)(3)(B).

⁵⁶ IRC § 223(b)(5)(B), 223(b)(5)(ii).

⁵⁷ Notice 2004-50, Q&A 12, 2004-33 I.R.B. 196; Notice 2004-2, Q&A 3, 2004-2 I.R.B. 269.

Catch-Up Contribution Limits

The \$800 catch-up amount (the 2007 limit) will increase in \$100 increments annually, until it reaches \$1,000 in calendar year 2009 and thereafter.⁵⁸ This data can be found in Table 4-2.

Table 4-2: Catch-Up Amounts for Years 2005 through 2009

<i>For Tax Years</i>	<i>Catch-Up Amount</i>
2005	\$ 600
2006	\$ 700
2007	\$ 800
2008	\$ 900
2009	\$1,000

Note: The catch-up amounts are not indexed for inflation.

As with the annual contribution limit, the annual catch-up contribution limit also is computed on a monthly basis, but there is no actual monthly limit.⁵⁹

Example 4-19

Yetta, an eligible individual, is single, age 55, and not enrolled in Medicare in 2007. Her HSA annual maximum contribution limit is increased by \$800. For example, if Yetta has self-only coverage, she can contribute up to the amount of the annual contribution limit \$2,850 plus \$800, or \$3,650 for 2007.

Example 4-20

Same facts as *Example 4-19*, except Yetta is married to an older individual who also is not enrolled in Medicare. They have family coverage. Because both spouses meet the age requirement, the total contribution under family coverage cannot be more than \$7,250 (\$5,650 + \$800 + \$800) for 2007. They each must establish an HSA to make catch-up contributions.

Example 4-21

For 2007, Jerry and his wife Sara both have family coverage under separate HDHPs. Jerry is 58 years old and Sara is 53. Jerry has an HDHP deductible of \$3,000 and Sara has an HDHP deductible of \$2,000. Both are treated as being covered under the HDHP with the \$2,000 deductible. Under the TRHCA, Jerry and Sara both are treated as having an annual HSA contribution limit of \$5,650 which they must divide equally or in another manner they agree upon. Each also is permitted to make a catch-up contribution of \$800 to his or her own HSA.

Note: Before the TRHCA, for taxable years beginning before 2007, Jerry and Sara would be treated as being covered under an HDHP with a \$2,000 deductible and the contribution amount was limited to the annual deductible under the HDHP. The annual deductible limit since has been repealed (see below).

Example 4-22

Samantha has an HDHP with self-only coverage from January 1, 2007, through June 30, 2007. She attains age 65 and becomes eligible for and enrolls in Medicare in July 2007. Samantha no longer is eligible to make HAS contributions (including catch-up contributions) after June 2007. Samantha's monthly contribution limit can be computed as follows:

$$\$2,850 \text{ (deductible)} + \$800 \text{ (catch-up contribution for 2007)} / 12 = \$304.17 \text{ (rounded).}$$

⁵⁸ IRC § 223(b)(3)(B); Notice 2004-50, Q&A 14, 2004-33 I.R.B. 196.

⁵⁹ Notice 2004-2, Q&A 14, 2004-2 I.R.B. 269.

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Samantha may make contributions for January through June totaling \$1,825 (6/12 x \$3,650), but may not make any contributions for July through December 2007.

Example 4-23

Gail has an HDHP with self-only coverage from January 1, 2008, through August 31, 2008. She attains age 65 and becomes eligible for and enrolls in Medicare in September 2008. Gail no longer is eligible to make HSA contributions (including catch-up contributions) after August 2008. Gail makes her 2008 contribution in December 2008. Gail's monthly contribution limit can be computed as follows:

$$\$2,900 \text{ (deductible)} + \$900 \text{ (catch-up contribution for 2008)} / 12 = \$316.67 \text{ (rounded).}$$

Gail may make contributions for January through August totaling \$2,533.33 (8/12 x \$3,800), but may not make any contributions for September through December 2008. Because there is no actual monthly limit, Gail's contribution in respect the months of January through August may be made in December 2008.

Computing Annual Contributions

If an individual was under age 55 at the end of 2007, and was an eligible individual on the first day of every month during 2007, with the same self-only HDHP coverage, the HSA annual maximum contribution limit is \$2,850 for 2007 (\$5,650 for family coverage). For 2008, the maximum annual contribution amount was increased to \$2,900 for 2008 (\$5,800 for family coverage).

Example 4-24

In 2007, Andy and Carla both had HDHP family coverage and were under age 55 at the end of the year. The HDHP pays benefits for any family member whose covered expenses exceed \$2,200 (the embedded individual deductible) and pays benefits for all family members after the covered expenses exceed \$5,000 (the umbrella deductible). The annual contribution is \$5,650 for 2007 and Andy and Carla can divide this amount equally or in any other way they choose. This amount is entered on line 3 of Form 8889, *Health Savings Accounts (HSAs)*. If Andy and Carla were age 55 or older at the end of their taxable year, each may contribute an additional catch-up contribution of \$800 into an HSA.

Note: In taxable years beginning before 2007, the contribution amount could not exceed the annual deductible amount under the HDHP. That limit, the annual deductible limit, since has been repealed (see example below). The following three rules are used for determining the amount of the annual deductible under the HDHP in taxable years beginning before 2007:

1. Use the HSA maximum annual contribution limit for family coverage (e.g., \$5,450 for 2006) if the individual and his or her spouse had more than one HDHP and one of the plans provided family coverage. Disregard any plans with self-only coverage.
2. If the individual and his or her spouse had more than one HDHP with family coverage, use the plan with the lowest annual deductible.
3. If the individual had family coverage with both an umbrella deductible and an embedded deductible for each individual covered by the plan, the annual maximum contribution (and annual deduction for individuals making pre-tax contributions) is the smaller of \$5,450 (for 2006) or the:
 - a. Umbrella deductible; or
 - b. Embedded individual deductible multiplied by the number of family members covered by the plan.

Example 4-25

Same facts as in **Example 4-24**, except Andy and Carla's taxable year began on January 1, 2006. The annual contribution limit is \$4,400 (the smaller of \$5,000 or \$4,400 (\$2,200 x 2)). Andy and Carla's HSA maximum contribution and deduction is \$4,400 (the smaller of \$4,400 or \$5,450 for 2006).

Example 4-26

In 2008, Fred and Laurie both had HDHP family coverage and were under age 55 at the end of the year. The HDHP pays benefits for any family member whose covered expenses exceed \$2,500 (the embedded individual deductible) and pays benefits for all family members after the covered expenses exceed \$4,000 (the umbrella deductible). The annual contribution is \$5,800 for 2008 and Fred and Laurie can divide this amount equally or in any other way they choose. This amount is entered on 3 of Form 8889, *Health Savings Accounts (HSAs)*. If Fred and Laurie were age 55 or older at the end of their taxable year, each may contribute an additional catch-up contribution of \$900 into an HSA.

Annual Contribution Computation Chart

If the individual was not an eligible individual on the first day of the last month of the tax year (generally, December 1), or is an eligible individual (or is treated as an eligible individual) for the entire year and did not have the same coverage on the first day of every month during 2007, the annual contribution limit can be computed by completing the chart (Figure 4-1) for each month of 2007.

A copy of the chart should be kept with the taxpayer's records. Enter the result on the worksheet next to the corresponding month. The amount entered is used to determine allowable HSA contributions, excess contributions, and deductions for contributions on Form 8889, *Health Savings Accounts (HSAs)*.

Caution: For taxable years beginning after 2006, an individual who has HDHP coverage and no other non-HDHP coverage on December 1st may make a full year HSA contribution (but special testing period requirements apply). Funding is discussed earlier in this chapter.

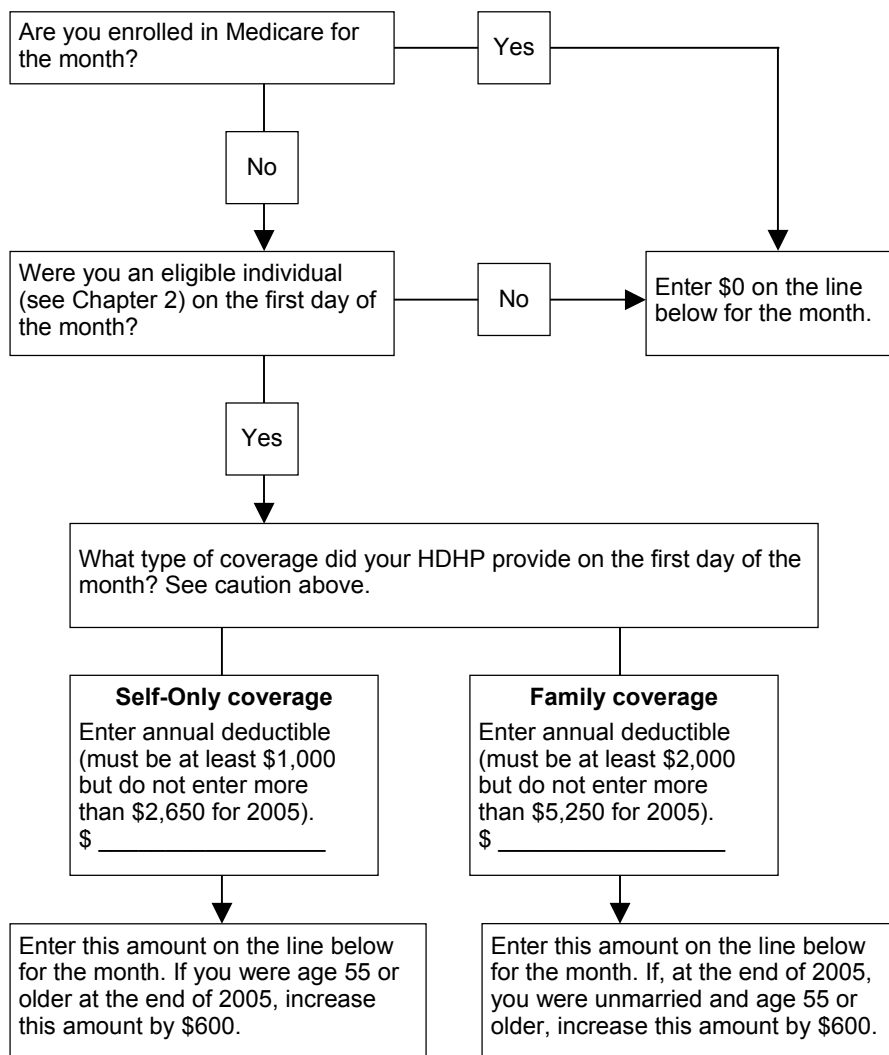
Practice Pointers →

If you were, or were considered, an eligible individual for the entire year and you changed your type of coverage during the year enter on line 3 of Form 8889, the greater of the limitation shown on the last line of the chart below, or the maximum amount (including catch-up contributions if unmarried) that can be contributed based on the type of coverage you had on the last day of your taxable year.

If you are married, the additional catch-up contribution amount is entered on line 7 of Form 8889 and is not included on line 3 of the Form 8889 or on the chart (Figure 4-1).

This amount is the maximum annual contribution limit for the year. The amount is entered on line 3 of Form 8889, *Health Savings Accounts (HSAs)*, used in computing contribution limits, excess contributions, and deduction amounts. If married at the end of the taxable year, the additional catch-up contribution (if any) will be entered on line 7 of Form 8889.

Figure 4-1: Annual Contribution Computation Chart



<i>Month in 2007</i>	<i>Amount From Chart Above</i>
January	\$ _____
February	\$ _____
March	\$ _____
April	\$ _____
May	\$ _____
June	\$ _____
July	\$ _____
August	\$ _____
September	\$ _____
October	\$ _____
November	\$ _____
December	\$ _____
Total for all months	\$ _____
Limitation. Divide the total by 12.	\$ _____

Special Rules for Married Individuals

One or Both Spouses Have Family Coverage

In the case of individuals married to each other, if either spouse has family coverage, both generally are treated as having family coverage.⁶⁰

Example 4-27

Peter and Abigail are married. Both will turn age 55 by the end of 2007. Peter has HDHP self-only coverage with a \$1,100 deductible and Abigail has separate HDHP family coverage with a \$5,000 deductible. Because one spouse has family coverage, both are treated as having family coverage for purposes of determining the annual maximum contribution limit. Peter can contribute \$3,625 to an HSA for 2007 (one-half of the deductible of \$5,650 maximum family contribution plus \$800 catch-up contribution). Abigail can contribute \$3,625 to an HSA for 2007 (one-half of the \$5,650 maximum family contribution plus \$800 catch-up contribution). Peter and Abigail could agree on a different division of the \$5,650.

Example 4-28

Ned and Lynn are married. Both will turn age 55 by the end of 2008. Ned has HDHP self-only coverage with a \$1,100 deductible and Lynn has separate HDHP family coverage with a \$10,000 deductible. Because one spouse has family coverage, both are treated as having family coverage for purposes of determining the annual maximum contribution limit. Ned can contribute \$3,800 to an HSA for 2008 (one-half of the deductible of \$5,800 maximum family contribution plus \$900 catch-up contribution). Lynn can contribute \$3,800 to an HSA for 2008 (one-half of the \$5,800 maximum family contribution plus \$900 catch-up contribution). Ned and Lynn could agree on a different division of the \$5,800.

Note: An individual may be eligible to contribute to an HSA if his or her spouse has non-HDHP family coverage, provided the spouse's coverage does not cover the individual.⁶¹

Example 4-29

Damian and Tanisha are married and both are age 40. Throughout 2007, Damian has HDHP self-only coverage with an annual deductible of \$2,000. Damian has no other health coverage, is not enrolled in Medicare, and may not be claimed as a dependent on another taxpayer's return. Tanisha has non-HDHP family coverage for herself and their two dependents, but Damian is excluded from Tanisha's coverage. Although Tanisha has non-HDHP family coverage, Damian is not covered under that health plan. Damian is, therefore, an eligible individual.

Note: The special rules for married individuals treating both spouses as having family coverage do not apply, because Tanisha's non-HDHP family coverage does not cover Damian. Thus, Damian remains an eligible individual and may contribute up to \$2,850 to an HSA (the self-only contribution limit of \$2,850 for 2007). Damian may not make the catch-up contribution because he is not age 55 or older in 2007. Tanisha has non-HDHP coverage and therefore is not an eligible individual.

⁶⁰ IRC § 223(b)(5)(A).

⁶¹ Rev. Rul. 2005-25, 2005 I.R.B. 18.

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Example 4-30

Same facts as *Example 4-29*, except that Damian has HDHP family coverage for himself and one of their dependents, with an annual deductible of \$5,000. Tanisha has non-HDHP family coverage for herself and their other dependent. Damian is excluded from Tanisha's coverage. Because the non-HDHP family coverage does not cover Damian, the special rules that treat both spouses as having family coverage do not affect Damian's eligibility to make HSA contributions up to his HSA maximum annual contribution limit. Damian therefore may contribute up to the family HDHP maximum contribution limit of \$5,650 for 2007. Tanisha has non-HDHP coverage and therefore is not an eligible individual.

Example 4-31

Kendall and Jazzlyn are married and both are age 35. Throughout 2008, Kendall has HDHP family coverage for himself and their two dependents, with an annual deductible of \$5,000. Also, Jazzlyn is not covered under Kendall's health plan and has no other health plan coverage. Kendall may contribute up to \$5,800 to an HSA (the maximum contribution limit for 2008). Because Kendall's family coverage does not cover Jazzlyn, the special rules do not apply to treat Jazzlyn as having family coverage. Jazzlyn has no health plan coverage and therefore is not an eligible individual for 2008.

Both Spouses with Family Coverage under Separate HDHPs

For taxable years beginning after 2006, an individual with family coverage can contribute up to the maximum annual contribution limit, \$5,650 for 2007. If the individual is married and the spouse is an eligible individual, they can split the \$5,650 equally or agree on a different division.

Note: For taxable years beginning before 2007, if each spouse has family coverage under a separate health plan, both spouses are treated as covered under the plan with the lowest deductible.

Example 4-32

Quincy and Mona are married. Quincy is age 55 and Mona is age 52 at the end of 2007. Quincy and Mona both have family coverage under separate HDHPs. Quincy has an HDHP deductible of \$3,000 and Mona has an HDHP deductible of \$2,200. Quincy can contribute \$3,625 to an HSA (one-half of the \$5,650 family maximum contribution limit, plus an \$800 catch-up contribution) and Mona can contribute \$2,850 to an HSA (unless they agree to a different division of the \$5,650).

Note: In taxable years beginning before 2007, Quincy and Mona would be treated as covered under the HDHP with the \$2,200 deductible (the deductible under the HDHP with the lowest deductible). For 2006, Quincy's contribution to an HSA would be limited to \$1,900 (one-half of the deductible of \$2,200 plus \$800 catch-up contribution) and Mona could have contributed only \$1,100 to an HSA (unless they agreed to a different division of the \$2,200).

Example 4-33

Alvin and Barbara are married. Alvin is 40 and Barbara is 33. Each has HDHP self-only coverage. Alvin has an HDHP deductible of \$1,100 and Barbara has an HDHP deductible of \$1,500. For 2007, Alvin can contribute \$2,825 to an HSA and Barbara can contribute \$2,825 to an HSA. With the same facts for 2008, Alvin can contribute \$2,900 to an HSA and Barbara can contribute \$2,900 to an HSA.

Spousal Contribution Limits

Both spouses may make the catch-up contributions for individuals age 55 or older without exceeding the family coverage limit.⁶²

⁶² IRC § 223(b)(3)(A); Notice 2004-50, Q&A 15, 2004-33 I.R.B. 196.

Example 4-34

Preston and Kristen, each age 55, are married. Preston has an HDHP family coverage with a deductible of \$2,500 for 2007. The contribution limit is \$2,825 for Preston and \$2,825 for Kristen, unless they agree on a different division. If eligible, Preston and Kristen each may make catch-up contributions (up to \$800 for 2007) to their HSAs in addition to the \$5,650 (as allocated) limit.

Note: The family coverage limit is reduced further by any contribution to an Archer MSA.⁶³

The following examples illustrate the contribution limits for a married individual completing Form 8889, *Health Savings Accounts (HSAs)*, for 2007.

Caution: The line numbers shown in the following examples are based upon the 2007 version of Form 8889. The form was revised for 2007 to compute the annual contribution limit for an individual that became covered by an HDHP after January to contribute up to the full annual limit, even if they were only eligible for a portion of the taxable year. In the examples below, the individuals are not eligible individuals in December; therefore, the maximum annual contribution must be computed for each month.

Example 4-35

In 2007, Virginia has HDHP family coverage for the entire months of July through November. The HDHP annual deductible is \$4,000. Virginia attains age 55 on September 5, 2007, and is unmarried at the end of the year. On the worksheet for line 3, Virginia would show \$6,450 (\$5,650 + \$800) for five months (July through November). She would divide the total of those amounts (\$32,250) by 12 to determine her contribution limit (\$2,687.50) for 2007. If Virginia were married at the end of the year, the additional catch-up amount (\$800) would not be reflected on the worksheet for line 3, and would be entered on line 7 of Form 8889 instead.

If the year were 2006, instead of 2007, Virginia's maximum contribution would be limited to the amount of the deductible under her HDHP. Therefore, on the worksheet for line 3 (2006), Virginia would show \$4,800 (\$4,000 + \$800) for five months (July through November). She would divide the total of those amounts (\$24,000) by 12 to determine her contribution limit (\$2,000) for 2006.

If the year were 2008, instead of 2007, Virginia would show \$6,700 (\$5,800 + \$900) for five months (July through November). She would divide the total of those amounts (\$33,500) by 12 to determine her contribution limit (\$2,791.66) for 2008.

Example 4-36

In 2007, Carl has HDHP family coverage for the entire months of July through November. Carl is under age 55. On the worksheet for line 3 in the Form 8889 instructions, Carl enters \$5,650 for each month (July through November) that he is an eligible individual. Carl divides the total of those amounts (\$28,250) by 12 to determine his contribution limit (\$2,354.17) for 2007.

Example 4-37

For 2007, Daniel is an eligible individual with HDHP self-only coverage. Daniel gets married in March and beginning April 1, 2007, Daniel and his spouse have HDHP family coverage through the end of November. Both Daniel and his wife Sasha are under age 55. Sasha is not an eligible individual. On the worksheet for line 3, Daniel would show \$2,850 for the first three months and \$5,650 for the eight months of family coverage. He would divide the total of those amounts (\$53,750) by 12 to determine his contribution limit (\$4,479.17) for the year. See division of contributions by spouses later.

⁶³ IRC § 223(b)(5)(B)(i).

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If the year were 2008, instead of 2007, Daniel would show \$2,950 for the first three months and \$5,800 for the eight months of family coverage. He would divide the total of those amounts (\$55,250) by 12 to determine his contribution limit (\$4,604.17) for the year. See division of contributions by spouses later.

Embedded and Umbrella Deductibles with Family Coverage

The umbrella deductible is the stated maximum amount of expenses that the family could incur before receiving HDHP benefits.⁶⁴ Although an HDHP may have an umbrella deductible for family coverage, it also may provide payments for covered medical expenses if any individual member of the family incurs medical expenses in excess of the HDHP minimum annual deductible (\$2,200 for 2007). That deductible limit, which is applied to each family member, is referred to as the “embedded individual deductible.”⁶⁵

Generally, before 2007, the HSA maximum annual contribution limit for an eligible individual with family coverage under an HDHP (without regard to catch-up contributions) is the lesser of:⁶⁶

1. The HDHP annual deductible; or
2. The statutory maximum annual contribution limit on family coverage (e.g., \$5,450 for 2006).

However, before 2007, the HSA maximum annual contribution limit for an eligible individual who has HDHP family coverage with embedded individual deductibles and an umbrella deductible is the least of the following amounts:

1. The statutory maximum annual contribution limit on family coverage (e.g., \$5,450 for 2006);
2. The umbrella deductible; or
3. The embedded individual deductible multiplied by the number of family members covered by the plan.

Note: The embedded individual deductible must satisfy the HDHP minimum annual deductible for family coverage (e.g., \$2,100 for 2006).⁶⁷

After 2007, it is not necessary to do this calculation to determine the HSA maximum contribution limit. The limit is \$5,650 (the 2007 limit; \$5,800 for 2008) for family coverage regardless of the deductible limit under the HDHP. Spouses who are both eligible individuals must divide this limit equally or can agree on a different division.

Example 4-37

In 2006, Jake and Laurie, a married couple, have HDHP family coverage for themselves and their two dependent children. They will not attain age 55 until 2008. The HDHP will pay benefits for any family member whose covered expenses exceed \$2,500 (the embedded individual deductible), and will pay benefits for all family members after their covered expenses exceed \$7,000. The umbrella deductible is \$7,000. The HSA statutory maximum annual contribution limit is \$5,450 for 2006. The embedded deductible multiplied by the number of family members covered is \$10,000 (4 x \$2,500). Accordingly, the maximum annual contribution that Jake and Laurie can make to their HSAs is \$5,450 (the least of \$7,000, \$5,450, or \$10,000). The \$5,450 limit is divided equally between Jake and Laurie (\$2,825 each), unless they agree to a different division.

⁶⁴ Notice 2004-50, Q&A 30, 2004-33 I.R.B. 196.

⁶⁵ Notice 2004-50, Q&A 30, 2004-33 I.R.B. 196.

⁶⁶ IRC § 223(b)(2)(B), 223(g); Notice 2004-50, Q&A 30, 2004-33 I.R.B. 196.

⁶⁷ Notice 2004-2, Q&A 3, 2004-2 I.R.B. 269.

Example 4-38

Same facts as *Example 4-37*, except the year is 2007. The HDHP provides family coverage for Jake and Laurie and their two dependent children. The HSA statutory maximum annual contribution limit is \$5,650 (the 2007 limit). The maximum annual contribution that Jake and Laurie can make to their HSAs for 2007 is \$5,650, and is divided equally unless they agree on a different division.

Example 4-39

Same facts as *Example 4-37*, except the year is 2008. The HDHP provides family coverage for Jake and Laurie and their two dependent children. The HSA statutory maximum annual contribution limit is \$5,900 (the 2008 limit). The maximum annual contribution that Jake and Laurie can make to their HSAs for 2007 is \$5,900, and is divided equally unless they agree on a different division. Because Jake and Laurie will both attain age 55 in 2008, they may each make additional catch-up contributions of \$900 for 2008.

Ineligible Spouse

If only one spouse is an eligible individual, only that spouse may contribute to an HSA, notwithstanding the special rule for married individuals that generally allows a married couple to divide the maximum HSA contribution between spouses and that designates the treatment of both spouses as having family coverage. The special rules apply only where both spouses are eligible individuals.

For 2007, the HSA maximum annual contribution for a married couple with HDHP family coverage is the statutory maximum of \$5,650.⁶⁸ See the previous discussion of application of embedded deductibles.

Example 4-40

In 2007 and 2008, Raj and Sabrina are a married couple. Assume further that neither is eligible to make catch-up contributions. Raj and Sabrina have HDHP family coverage with a \$5,000 deductible. Raj is an eligible individual and has no other coverage. Sabrina also has self-only coverage with a \$200 deductible. Sabrina, who has coverage under a low-deductible plan, is not an eligible individual. Raj may contribute \$5,650 to an HSA while Sabrina may not contribute to an HSA for 2007. For 2008, Raj may contribute \$5,900 to an HSA while Sabrina may not contribute to an HSA for 2008.

Example 4-41

Same facts as *Example 4-40*, except that in addition to the HDHP family coverage with a \$5,000 deductible, Sabrina has HDHP self-only coverage with a \$2,000 deductible rather than self-only coverage with a \$200 deductible. Both Raj and Sabrina are eligible individuals. Raj and Sabrina are treated as having only family coverage. The maximum combined HSA contribution by Raj and Sabrina is \$5,650 for 2007 and \$5,900 for 2008, to be divided between them by agreement.

Example 4-42

Alex, a single individual, does not qualify for catch-up contributions. Alex is an eligible individual and has a dependent, Lorri. Alex and Lorri have HDHP family coverage with a \$5,000 deductible. Lorri also has self-only coverage with a \$200 deductible. Alex may contribute \$5,650 for 2007 (\$5,900 for 2008) to an HSA while Lorri (a dependent and otherwise ineligible individual) may not contribute to an HSA for 2007 or 2008.

⁶⁸ Notice 2004-50, Q&A 31, 2004-33 I.R.B. 196.

Division of Contribution by Spouses

Code Section 223(b)(5) provides special rules for married individuals, stating 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.⁶⁹

Example 4-43

In 2007 and 2008, Quinn, an eligible individual, has HDHP self-only coverage from January 1 through March 31. In March, Quinn and Kathy marry. Neither Quinn nor Kathy qualifies for the catch-up contribution. From April 1 through December 31, 2007, Quinn and Kathy have HDHP family coverage. Kathy is an eligible individual from April 1 through December 31, 2007.

For 2007, Quinn and Kathy's contribution limit for the nine months of family coverage is \$4,327.50 (nine months of the maximum annual contribution for family coverage, $9/12 \times \$5,650$). Quinn and Kathy divide the \$4,327.50 between them. Quinn's contribution limit to his HSA for the three months of single coverage is \$712.50 (three months of the maximum annual contribution for self-only coverage, $3/12 \times \$2,850$). The \$712.50 limit is not divided between Quinn and Kathy. Kathy can contribute \$2,163.75 ($\$4,327.50 \times .50$) to an HSA and Quinn can contribute \$2,876.25 ($\$2,163.75 + \712.50).

For 2008, Quinn and Kathy's contribution limit for the nine months of family coverage is \$4,350 (nine months of the maximum annual contribution for family coverage, $9/12 \times \$5,800$). Quinn and Kathy divide the \$4,350 between them. Quinn's contribution limit to his HSA for the three months of single coverage is \$725 (three months of the maximum annual contribution for self-only coverage, $3/12 \times \$2,900$). The \$725 limit is not divided between Quinn and Kathy. Kathy can contribute \$2,175 ($\$4,350 \times .50$) to an HSA and Quinn can contribute \$2,900 ($\$2,175 + \725).

Coverage under a Post-Deductible HRA

A post-deductible HRA that does not pay or reimburse any medical expense incurred before the HRA minimum annual deductible is satisfied is described in Revenue Ruling 2004-45. The ruling states that the HRA deductible need not be the same as the HDHP, but in no event may the HRA or other coverage provide benefits before the HDHP minimum annual deductible is satisfied (\$1,100 self-only or \$2,200 family for 2007).

Employer Reporting of Contributions

Employer contributions to an HSA generally must be reported on the employee's Form W-2, *Wage and Tax Statement*.⁷⁰ The IRS has released forms and instructions, similar to those required for Archer MSAs, on how to report HSA contributions, deductions, and distributions.⁷¹ Special considerations apply to partners and a more than 2% shareholder of an S corporation (discussed later). The report (Form W-2) must be received by January 31 of the following year.

⁶⁹ IRC § 223(b)(5); Notice 2004-50, Q&A 32, 2004-33 I.R.B. 196; see also Notice 2004-2, Q&A 15, 2004-2 I.R.B. 269.

⁷⁰ IRC § 6051.

⁷¹ Notice 2004-2, Q&A 34, 2004-2 I.R.B. 269.

An employer's contribution to an HSA is entered in Box 12 of Form W-2 with Code W. Administration and compliance issues are discussed more fully in Chapter 7. This applies regardless of whether the contributions are (1) made from employee contributions deducted under a cafeteria plan election, (2) made by the employer outside of Code Section 125 under the comparability requirements, or (3) made by the employer through the Code Section 125 cafeteria plan.

For Form W-2 reporting purposes, the amount to enter is "determined on a calendar year basis." The HSA trustee would obtain the HSA owner's designation as to the year the contribution is being made for, just like they do for IRA contributions made in the "leeway" period (generally January 1 to April 15).

Practice Pointer →

Most trustees and custodians treat all contributions received after the end of a calendar year as being made for the current year unless the contribution is designated as a prior years' contribution. The HSA owner would also complete Form 8889. The instructions for Form 8889 suggest that the employer's contribution for the current year (2007) is computed in the following manner:

1. Employer contributions reported in box 12 of Form W-2, with code W...\$ _____
2. Employer contributions made in 2007 for tax year 2006...\$ _____
3. Subtract line a. from line b....\$ _____
4. Employer contributions made in 2008 for tax year 2007... _____
5. Employer contributions for 2007. Add lines c. and d. The amount is also entered on line 9 of Form 8889...\$ _____

The reporting of a one-time direct trustee-to-trustee transfer from a health FSA or HRA to an HSA is discussed in Chapter 5.

Deductions for Contributions Funded by Individuals

Generally, after-tax contributions made to an HSA, within permissible limits, by or on behalf of an account owner who is an eligible individual are deductible by the account owner under Code Section 223(a). The deduction is an adjustment to gross income (that is, an above-the-line deduction) under Code Section 62(a)(19). Thus, for an "eligible individual," a deduction is permitted for the taxable year equal to an amount that is the aggregate amount paid in cash during such taxable year to an HSA by either the account owner or any other person. Allowable contributions are deductible whether or not an eligible individual itemizes deductions.⁷²

Practice Pointer →

The medical expense deduction is an adjustment to gross income, but only to the extent that medical and dental expenses are more than 7.5% of adjusted gross income (Form 1040, line 37, based on the 2007 version of the form). The HSA contribution deduction is taken above the line (line 25)—to arrive at gross income—and is not subject to the percentage limitation.

The eligible individual also cannot deduct the HSA contribution as a medical expense under Code Section 213.⁷³

⁷² Notice 2004-2, Q&A 17, 2004-2 I.R.B. 269.

⁷³ Notice 2004-2, Q&A 17, 2004-2 I.R.B. 269.

Exclusion of Employer Contributions

If an employer makes a contribution, within permissible limits, to the HSA on behalf of an employee who is an eligible individual, the contribution generally is excluded from the employee's gross income and wages.⁷⁴ Special rules apply to partners and to a 2% or more shareholder of an S corporation (discussed later).⁷⁵ Thus, employer contributions, including any pre-tax contributions through the employer's cafeteria plan, are not deductible, but instead generally are excludable from the employee's gross income.

Contributions by Self-Employed Individuals

For a self-employed individual, the deduction for making the contribution to his or her own HSA is an adjustment to income on his or her personal income tax return. Because it is not a deduction attributable to a trade or business expense, the deduction is not taken on Form 1040, Schedule C, *Profit or Loss From Business*, and is not taken into account when completing Schedule SE, *Self-Employment Tax*.⁷⁶

Example 4-44

Brian, a self-employed individual has \$10,000 of net earnings from self-employment after all business expenses for 2007. Brian contributes \$2,850 into his HSA (which he has had for the entire year). Although he will claim a deduction for \$2,850 on his Form 1040, Brian's income for self-employment tax purposes will be based on \$10,000 because the contribution is not treated as a trade or business expense.

C Corporation Contribution to a Non-employee Shareholder

If a C corporation makes a contribution to a non-employee shareholder's HSA, the contribution will be treated as a distribution under Code Section 301 regarding distributions of property. The distribution is treated as a dividend to the extent that the C corporation has earnings and profits. The portion of the distribution, not a dividend, is applied against and reduces the adjusted basis of the stock. To the extent that 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.⁷⁷

Contributions by Family Members

Contributions made by a family member (or other person) on behalf of an eligible individual to an HSA (subject to the limits described previously in this chapter) are deductible by the eligible individual in computing adjusted gross income (whether or not the eligible individual itemizes deductions).⁷⁸

No Deduction for Dependent

An individual who may be claimed as a dependent on another person's tax return is not an eligible individual and therefore may not deduct contributions to an HSA.⁷⁹

⁷⁴ IRC §§ 106(d), 223(a).

⁷⁵ See IRC § 1372(b) defining the term "2 percent shareholder."

⁷⁶ Notice 2004-50, Q&A 84, 2004-33 I.R.B. 196.

⁷⁷ Notice 2004-50, Q&A 88, 2004-33 I.R.B. 196.

⁷⁸ Notice 2004-2, Q&A 18, 2004-2 I.R.B. 269.

⁷⁹ IRC § 223(b)(6); Notice 2004-2, Q&A 18, 2004-2 I.R.B. 269.

Community Property Rules

HSA limitations are determined without regard to community property rules.⁸⁰

Employer Contributions

The employer of any eligible individual is permitted to make contributions to an HSA on behalf of the account owner.

Combined Limits

The combined contribution limit to an HSA from all sources (the account owner, a family member, or an employer) cannot exceed the maximum allowable amount for the eligible individual.

Note: If the employer chooses to make HSA contributions, the employer is required to make comparable HSA contributions for all participating employees (that is, eligible employees with comparable coverage) during the same period unless contributions are made through a cafeteria plan (discussed later).

The IRS final comparability regulations (final rules) governing employer contributions to HSAs were issued on July 31, 2006.⁸¹ The final rules clarify the steps employers need to take in order to fall within the “cafeteria plan exception,” allowing the employer’s HSA contributions to be subject to the cafeteria plan nondiscrimination rules under Code Section 125 rather than the comparability rules. In addition, the final regulations add some important flexibility, such as providing an exception for collectively bargained employees and expanding the categories of HDHP coverage for which employers may vary HSA contributions. However, the 2006 final regulations reserved several questions for future determination.

On June 1, 2007, the IRS issued proposed rules on the comparable contribution rules that govern employer contributions made to health savings accounts (“HSA”) outside of a Code section 125 cafeteria plan. The 2007 proposed rules, discussed later, provide guidance for employers where employees fail to establish an HSA or notify their employers of their HSA prior to December 31. The proposed rules also permit employers to make accelerated calendar year contributions for employees who incur qualified medical expenses exceeding current HSA contributions. Prior guidance had limited accelerated payments only to those employees who made HSA contributions through a cafeteria plan under Code Section 125.

Treatment of Employer Payments

Employer payments to an HSA generally are excluded from an employee’s gross income (see below). However, to the extent an employer’s payments to an HSA exceed the maximum annual contribution limit (that is, the \$2,850/\$5,650 statutory maximum annual contribution limit for 2007), the payments are not treated as employer-provided coverage for medical expenses under an accident or health plan under Code Section 106(d). Thus, any amount paid by an employer to an HSA that exceeds the statutory limits would be treated as the payment of compensation to the employee and included in the individual’s gross income in the taxable year for which the amount was contributed.⁸² Although a self-employed individual is an employee within the

⁸⁰ IRC § 223(d)(4)(D).

⁸¹ Treas. Reg. § 54.4980G-1 through 5; 71 Fed. Reg. 43056.

⁸² IRC §§ 106(d)(1), 223(d)(4)(C).

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meaning of Code Section 401(c)(1), any contributions over the statutory contribution limit are not treated as compensation because wages are not involved. However, such amounts would be subject to the 6% excise tax on excess contributions.

Employer Responsibility

Apart from the allowable contribution, as to specific employee's HSA eligibility, the employer is only responsible for determining:⁸³

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).

Note: If the employer chooses to make HSA contributions, the employer is required to make comparable HSA contributions for all participating employees (that is, eligible employees with comparable coverage during the same period) unless such contributions are made through a cafeteria plan.

An employer may rely on the employee's representation about his or her date of birth.⁸⁴

The individual who establishes the HSA is responsible for determining whether the distributions are used exclusively for the payment of qualified medical – so as to be excludible from gross income (see Chapter 6).⁸⁵

Negative Elections

An employer is permitted to structure cafeteria plan elections for all cafeteria plan benefits as negative elections.⁸⁶

Example 4-45

Bonefish Corporation holds an annual open enrollment period and communicates that employees who elected to make salary reduction contributions to the HSA for 2006 through Bonefish Corporation's cafeteria plan and want to keep the same election and contribution for 2007, need not take any action at open enrollment (i.e., their 2006 election would carry over to 2007 unless they make a different election). Sally elected to contribute \$1,000 to her HSA through Bonefish Corporation's cafeteria plan in 2006 and wishes to make this same election for 2007. Sally takes no action at open enrollment and Bonefish Corporation treats Sally as having made a \$1,000 cafeteria plan election to the HSA for 2007. Bonefish Corporation has satisfied applicable cafeteria plan requirements.

Exclusion and Deductibility of Employer Contributions

In the case of an employee who is an eligible individual, employer contributions (within the limits described previously in this chapter) to an employee's HSA are treated as an employer-provided coverage for medical expenses under an accident or health plan and are excludable from the employee's gross income under Code Section 106(d) relating to contributions to HSAs.⁸⁷

⁸³ Notice 2004-50, Q&A 81, 2004-33 I.R.B. 196.

⁸⁴ Notice 2004-50, Q&A 81, 2004-33 I.R.B. 196.

⁸⁵ Notice 2004-2, Q&A 30, 2004-2 I.R.B. 269.

⁸⁶ See Rev. Rul. 2002-27, I.R.B. 2002-27, May 20, 2002; Prop. Treas. Reg. § 1.125-2(b)

⁸⁷ Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

Cafeteria Plans

Contributions to an employee's HSA through a cafeteria plan are treated as employer contributions. However, because pre-tax salary reductions through cafeteria plans are not part of taxable income reported in boxes 1, 3, or 5 of Form W-2, an employee does not get a deduction for these contributions when made to his or her HSA.⁸⁸ Deductions are authorized when contributions are made from after-tax dollars; that is, amounts included in gross income in an employee's tax return.

A one-time direct trustee-to-trustee transfer from a health FSA or an HRA to an HSA is treated as a rollover contribution.⁸⁹ As such, it does not have any effect upon the maximum annual contribution that can be made to the HSA for the year (\$2,850/\$5,650, plus catch-up contributions of up to \$800/\$1,600 for 2007). Such amounts are excludible from gross income and wages for employment tax purposes. The amount transferred is not deductible.⁹⁰

Railroad Retirement Taxes

Employer contributions to an HSA generally are not subject to the Railroad Retirement Tax Act. For purposes of the Act, the term "compensation" does not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude the funds used for the contributions from an employee's gross income under Code Section 106(d), regarding the exclusion of employer contributions to HSAs.⁹¹

Wage Withholding on Income

Employer contributions are not subject to income withholding from wages for federal income tax purposes if it is reasonable to believe at the time of payment that the employee will be able to exclude the funds used for the contributions from an employee's gross income under Code Section 106(d) regarding the exclusion of employer contributions to HSAs.⁹²

Federal Insurance Contributions Act Taxes

Employer contributions to an HSA (within statutory limits) are not subject to the Federal Insurance Contributions Act (FICA) taxes. Also, the employee will not be required to pay his or her share of FICA tax on such contributions. Further, employer contributions made under a cafeteria plan are not subject to FICA taxes if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that if Code Section 125 applied, that section would not treat any wages as constructively received.⁹³

Federal Unemployment Tax Act Taxes

Employer contributions to an HSA (within statutory limits) are not subject to Federal Unemployment Tax Act (FUTA) taxes if it is reasonable to believe at the time of payment that the employee will be able to exclude such payment from income under Code Section 106(d) regarding the exclusion of employer contributions to HSAs from an employee's gross income.⁹⁴

⁸⁸ Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

⁸⁹ IRC § 223(e)(4)(C).

⁹⁰ Joint Committee on Taxation, Technical Analysis of the Tax Relief and Healthcare Act of 2006 (P.L. 109-432) (JCX-50-06).

⁹¹ IRC §§ 106(b)(2), 106(d), 3231(e)(11); Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

⁹² IRC § 3401(a)(21), 3401(a)(22); Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

⁹³ IRC § 3121(a)(5)(G); Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

⁹⁴ IRC §§ 106(b)(2), 106(d), 3306(b)(18); Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

Practice Pointer →

As a practical matter, the FUTA savings is limited, as the employer pays only 6.2% on the first \$7,000 of an employee's wages, so unless the HSA contribution reduces the employee's wages below \$7,000, it will not have an impact.⁹⁵ The FICA savings is more significant – the employer's share for Medicare hospital coverage is 1.45% of all of an employee's wages, and the employer's share for Social Security is 6.2% on the employee's wages up to the taxable wage base amount (\$97,500 for 2007).⁹⁶ So, any reduction of wages directly will reduce the amount of FICA that an employer is required to pay. Similarly, the employee share of FICA is the same as the employer share, so any reduction in wages also will save the employee money in FICA tax.⁹⁷

Employees with Chronic Conditions

An employer may make higher contributions to the HSAs of account owners with chronic health conditions if the contribution is made "through the cafeteria plan." In that event, the comparable contribution rule under Code Section 4980E does not apply, and the employer has flexibility to vary contributions as long as the Code Section 125 nondiscrimination rules are satisfied. The IRS final comparability regulations for employer contributions to HSAs make clear that an employer's contributions will be considered made through a cafeteria plan if: (1) employees are permitted to make their own contributions to an HSA by salary reduction through a cafeteria plan, and (2) the right to make such contributions is described in a written cafeteria plan document.⁹⁸ See also, Notice 2004-50,⁹⁹ which states that the comparable contribution rule does not apply to contributions made through a cafeteria plan. If the contribution is not made through the cafeteria plan and is not the same dollar amount or percentage of deductible for all eligible individuals covered by the employer's HDHP, it would violate the comparable contribution requirements under Code Section 4980G and regulations thereunder.

Note: The Bush administration supports creating a specific exception that would allow employers to make higher contributions to the HSAs of chronically-ill employees (see Chapter 2).

Nonqualified Deferred Compensation Inapplicable

An HSA is not subject to the nonqualified deferred compensation plan rules under Code Section 409A even though all contributions are fully vested and nonforfeitable. Code Section 409A provides that all amounts deferred under a nonqualified deferred compensation plan for all tax years currently are includible in gross income to the extent they are not subject to a substantial risk of forfeiture and are not previously included in gross income, unless certain requirements are met. These rules are not limited to arrangements between an employer and employee. However, there is a specific exemption for HSAs under IRS guidance, which provides that the term "nonqualified deferred compensation plan" does not include an HSA under Code Section 223. Thus, an HSA is not treated as a nonqualified deferred compensation plan under Code Section 409A(d)(1)(B).¹⁰⁰

Practice Pointer →

IRS guidance similarly provides that an Archer MSA under Code Section 220 and a medical reimbursement arrangement, including an HRA, that satisfies the requirements of Code Sections 105 and 106, is not treated as a nonqualified deferred compensation plan under Code Section 409A(d)(1)(B).

⁹⁵ IRC § 3306(b)(1).

⁹⁶ IRC § 3111(a)-(b).

⁹⁷ IRC § 3101(a)-(b).

⁹⁸ Treas. Reg. § 54.4980G-5, Q&A-1-3.; 71 Fed. Reg. 43056 (July 31, 2006).

⁹⁹ Notice 2004-50, Q&A-47;49, 2004-33 I.R.B. 196.

¹⁰⁰ See Notice 2005-1, Q&A 3(c), 2005-2 I.R.B. 274; Treas. Reg. § 1.409A-1(a)(5).

No Deduction for Employer Contributions

An employee may not deduct employer contributions made on his or her behalf on his or her federal income tax return, either as HSA contributions or as medical expense deductions under Code Section 213.¹⁰¹

Tax Treatment of an HSA

An HSA generally is exempt from tax (like an IRA or Archer MSA), unless it has ceased to be an HSA (see Chapter 6 regarding prohibited transactions). Earnings on amounts in an HSA are not includable in gross income while held in an HSA (that is, inside buildup is not taxable).¹⁰² See Chapter 6 regarding the taxation of distributions from the HSA.

An HSA, however, is subject to tax on its unrelated business taxable income under Code Section 511. Although there is a specific exemption of \$1,000, this tax may apply if the account is used for purposes inconsistent with its exempt purpose (for example, an HSA trust operates a “for profit” bait and tackle shop, as opposed to an investment in stock of an unrelated company operating a bait and tackle shop).¹⁰³

Note: An HSA filing a return to report unrelated business taxable income must have an employer identification number (EIN).

Timing of HSA Contributions

Contribution Deadline

Contributions for the taxable year can be made at any time before the time prescribed by law (without extensions) for filing the eligible individual’s federal income tax return for that year, but not before the beginning of that year. For calendar year taxpayers, the deadline for contributions to an HSA generally is the taxpayer’s due date of his or her tax return without extension, usually April 15 following the year for which the contributions are made. Although the maximum annual contribution is determined monthly, the maximum contribution may be made on the first day of the year. Excess contributions are discussed in the following section.

Example 4-46

Gretta has HDHP self-only coverage with a deductible of \$1,500 and also has an HSA. Gretta’s employer contributes \$200 to her HSA at the end of every quarter in 2007 and at the end of the first quarter in 2008 (March 31, 2008). Gretta can exclude from income in 2007 all the employer contributions of \$1,000 (5 x \$200) because Gretta’s exclusion for all contributions does not exceed the HSA maximum annual contribution limit of \$2,850 (\$3,650 if age 55 or older in 2007) for 2007.¹⁰⁴ The trustee or custodian of Gretta’s HSA will require that contributions for the prior year be designated as such. Nonetheless, Gretta’s employer will only report the amount contributed with Code “W” in box 12 of Form W-2 for 2007 that it contributed in 2007 (i.e., on a calendar year basis).

¹⁰¹ Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

¹⁰² IRC § 223(e)(1); Notice 2004-2, Q&A 20, 2004-2 I.R.B. 269.

¹⁰³ IRC §§ 223(e)(1), 511, 512.

¹⁰⁴ Notice 2004-2, Q&A 21, 2004-2 I.R.B. 269.

Excess Contributions

In general, an excess contribution results when contributions to all of an individual's HSAs exceed the maximum amount that may be deducted under Code Section 223(a) and excluded from gross income under Code Section 106(d) in a taxable year, collectively.¹⁰⁵ An excess also could result from a direct transfer or rollover from another HSA that does not qualify to be rolled over or transferred. A one-time transfer from an IRA to an HSA also could create an excess contribution because such transfers are subject to the annual contribution limit for the year, either \$2,850 or \$5,650.

For any year, the term "excess contribution" to an HSA means the sum of:¹⁰⁶

1. The aggregate amount contributed for the taxable year to the accounts (other than rollover contribution and direct transfers discussed in Chapter 5) that is neither excludable from gross income under Code Section 106(d) regarding employer-provided coverage nor allowable as an HSA deduction for such year; and
2. The amount of any excess contribution for the preceding tax year, reduced by the sum of:
 - Distributions out of the accounts that were included in gross income because they were not used for qualified medical expenses, and¹⁰⁷
 - The excess (if any) of:
 - The maximum amount allowable as an HSA deduction without regard to the source of contributions, over
 - The amount contributed to the accounts for the taxable year.

Example 4-47

In 2006, Henry made an excess contribution of \$500 to his HSA and paid a 6% excise tax for the year on Form 5329. The following year, Henry is age 45 and has self-only coverage under an HDHP. He otherwise is an eligible individual for 2007. The following contributions were made to Henry's HSA for 2007:

- Henry contributes \$2,000.
- Henry's employer contributed \$800.
- During 2007, Henry made a qualifying HSA distribution of \$3,000 from his health FSA that was transferred to his HSA.
- Henry rolled over \$750 from an HSA to another HSA during the year in a qualifying rollover distribution.

Other than the rollover contribution, the only distribution from Henry's HSA accounts was \$100 that was not used for a qualified medical expense. Because Henry does not remove the excess contribution of \$450 by the due date of his 2007 tax return he will have to report an excess contribution on Form 5329 of \$450 and pay the 6% excise tax. The \$450 excess amount can be computed as follows:

1. \$2,000 (individual contribution)
 \$ 800 (employer contribution)
 \$2,800 (total contributions)
2. (\$100) (taxable distribution)
 \$500 (excess from prior year)
 50 (the \$2,850 maximum contribution limit less \$2,800 of total contributions)
 \$450 excess contribution.

¹⁰⁵ IRC § 223(f)(3)(B).

¹⁰⁶ IRC §§ 220(f)(5), 223(f)(5), 4973(g)(1)-(2).

¹⁰⁷ IRC § 223(f)(2).

Neither the qualifying HSA distribution of \$1,000 nor the \$750 rollover contribution is taken into account in computing an excess amount.¹⁰⁸ The result would not change even if Henry became ineligible during the testing period following the transfer from his health FSA. If Henry became ineligible during the testing period, the \$3,000 would not be treated as an excess contribution (although it would be subject to income tax and a penalty tax.)

Note: A contribution that is distributed from the HSA to correct an excess contribution before the due date (including extensions) of an individual's federal income tax return is not treated as an amount contributed for the current year.¹⁰⁹

If an excess HSA contribution is made by an employer and not included in income, the amount must be reported as "Other income" on the individual's tax return. An individual may not claim an exclusion for an excess contribution.

No Deduction for Excess Contributions

Contributions by an individual to an HSA, or made on behalf of an individual to an HSA, are not deductible to the extent that they exceed the maximum annual contribution limits.¹¹⁰

Contribution to Ineligible Individual

A contribution by an employer on behalf of an employee who is not an eligible individual (or that exceeds the amount allowed to be contributed to the HSA) would be considered taxable wages to the employee and is not deductible by the employee.¹¹¹ Unless a correcting distribution is made, the employee may be subject to an excess contribution penalty tax.

Excise Tax on Excess Contributions

In general, a 6% excise tax for each taxable year is imposed on the account owner for excess individual and employer contributions.¹¹²

Avoiding the Excess Contribution Penalty Tax

The 6% cumulative penalty can be avoided if the excess contributions for a taxable year and the net income attributable to such excess contributions (collectively, the "net income distributions") are paid to the account owner before the last day prescribed by law (including extensions) for filing the account owner's federal income tax return for the taxable year. The net income can be positive or negative.¹¹³ Chapter 7 discusses the IRS reporting requirement regarding excess contributions. Correction after the due date is discussed later.

The net income attributable to the excess contributions is included in the account owner's gross income for the taxable year in which the correcting distribution is received. The distribution of the excess contribution itself, however, is not subject to tax as long as the original contribution was made on an after-tax basis by the individual and/or not excluded from income if made by an employer.¹¹⁴ The net income calculation only is performed on the account containing the particular contribution being returned.¹¹⁵

¹⁰⁸ IRC § 223(f)(3)(B).

¹⁰⁹ IRC § 4973(g).

¹¹⁰ Notice 2004-2, Q&A 22, 2004-2 I.R.B. 269.

¹¹¹ IRC § 223(a); Notice 2004-2, Q&A 22, 2004-2 I.R.B. 269.

¹¹² IRC § 4973(a)(5); Notice 2004-2, Q&A 22, 2004-2 I.R.B. 269.

¹¹³ IRC § 223(f)(3)(A)(i).

¹¹⁴ IRC § 223(f)(3)(A); Notice 2004-2, Q&A 22, 2004-2 I.R.B. 269.

¹¹⁵ Treas. Reg. § 1.408-11.

Note: If the net income is not distributed in a correcting distribution made before the tax return due date, the amount distributed, including earnings, is treated as a regular distribution and the 6% excise tax will apply.¹¹⁶

Extension for Timely Filers

If an individual with an excess HSA contribution timely files his or her return without withdrawing the excess contributions, the individual still can make the withdrawal no later than six months after the due date of his or her tax return, excluding extensions. To do so, the individual files an amended return with "Filed pursuant to section 301.9100-2" written at the top, reports any related earnings along with the returned contribution on the amended return, and includes an explanation of the withdrawal. The individual also must make any other necessary changes on the amended return (for example, if contributions were reported as excess contributions on the original return, the individual includes an amended Form 5329 reflecting that the withdrawn contributions no longer are treated as having been contributed).

Calculating Earnings

Earnings attributable to excess HSA contributions are computed in exactly the same manner as excess IRA contributions under Treasury Regulation Section 1.408-11.¹¹⁷ Beginning after 2003, the new formula for calculating the net income on a returned excess contribution under the final regulations is:

$$\text{Net Income}^1 = \text{Contribution}^2 \times (\text{ACB}^3 \text{ minus AOB}^4) / \text{AOB}$$

¹Net Income can be positive or negative.

²The amount of the contribution that is being returned.

³The Adjusted Closing Balance (see following section).

⁴The Adjusted Opening Balance (see following section).

Adjusted Closing Balance

The Adjusted Closing Balance (ACB) is the fair market value of the HSA at the end of the computation period plus the amount of any distributions or transfers made from the HSA during the computation period discussed below. Thus, the ACB is the value just before the distribution or recharacterization.

Adjusted Opening Balance

The Adjusted Opening Balance (AOB) is the fair market value of the HSA at the beginning of the computation period plus the amount of any contributions (including the contribution that is being returned) or transfers made to the HSA during the computation period.

Where a series of regular contributions was made, the contribution being returned is deemed to be the last contribution made, up to the amount of the contribution identified as the amount to be distributed.

Note: The final regulations do not clarify whether the individual or trustee (or custodian) is responsible for calculating the net income on an excess contribution. Some trustees (and custodians) do not perform this computation.

¹¹⁶ IRC § 223(f)(3)(A)(ii).

¹¹⁷ Notice 2004-50, Q&A 34, 2004-33 I.R.B. 196; see also Notice 2004-2, Q&A 22, 2004-2 I.R.B. 269.

Computation Period

The computation period is the period beginning immediately before “the time” that the contribution being returned was made to the HSA and ending immediately before the removal of the contribution.

➤ **Caution:** The preamble to the final regulations implies that if the account is valued on a daily basis, for purposes of determining the AOB, the computation period begins the exact day before the contribution that is being returned was made. If the account is not valued on a daily basis, for purposes of determining the AOB, the fair market value at the beginning of the computation period is deemed to be the most recent, regularly determined, fair market value of the account as of a date that coincides with or precedes the first day of the computation period (that is, the most recent statement value).

Correcting Excess after Due Date

Unless the timely filer extension previously explained is used, the excess contribution amount will be taxable and, absent an exception, also subject to the 6% penalty. The 6% penalty may not exceed the value in the account at the close of the taxable year.¹¹⁸ If the correction is made before the due date of the return or within the timely filer extension rules, the 6% penalty will not apply to the excess contribution.¹¹⁹ After the due date of the return, the correcting distribution rules do not provide for or require that net earnings (positive or negative) be distributed.¹²⁰

Example 4-48

Tammy, an eligible individual, made an excess after-tax contribution to an HSA of \$300 for 2007. She removes \$310, the excess contribution and net income thereon, on February 10, 2008. The net income of \$10 is taxable in 2008 and reported as “Other income” on the individual’s federal tax return. The returned excess of \$300 is not subject to income tax¹²¹ nor is any part if the correcting distribution (\$310) subject to the 10% penalty. The 6% penalty does not apply for 2007 because the excess amount was withdrawn (with net income) before the due date of Tammy’s federal income tax return (including extensions) for the year.

Example 4-49

Aaron, an eligible individual, made an excess after-tax contribution to an HSA of \$500 for 2007. His federal income tax return is due on Wednesday, April 15, 2008. He does not have a filing extension. Assume Aaron removes \$600 (the excess contribution plus another \$100 related to earnings) on April 25, 2008. The correcting distribution (made after April 15) was not timely made. Aaron must pay a 6% penalty tax on the \$500 excess contribution. Unless the amount is used to pay for qualified medical expenses, the amount distributed, \$600, also will be taxable and, unless an exception applies, also subject to a 10% penalty tax. Assuming no excess contributions are made for 2008, the 6% excess contribution penalty tax no longer will apply in respect to 2007.

Contributions Mistakenly Made

An individual may not elect to treat a distribution as a correction of an excess contribution unless the individual’s contribution limit is exceeded.¹²² Any such withdrawal is deemed a withdrawal for nonqualified medical expenses and includable in the individual’s gross income. The 10% additional tax also applies, unless an exception applies (see Chapter 5).¹²³

¹¹⁸ IRC § 4973(a).

¹¹⁹ IRC § 223(f)(3)(A) and (B).

¹²⁰ IRC § 223(f)(3)(A)(ii). Any net income distributed in a correcting distribution (as is required before the tax filing deadline) is included in income in the year in which it is received.

¹²¹ Excess contributions and gain thereon are returned under IRC § 223(f)(3). The 10% tax applies to amounts includable in gross income under another provision. See IRC § 223(f)(4)(A), referring to § 223(f)(2).

¹²² Notice 2004-50, Q&A 35, 2004-33 I.R.B. 196.

¹²³ Notice 2004-50, Q&A 35, 2004-33 I.R.B. 196.

ERISA Considerations

An employer can make contributions to an eligible individual's HSA without being considered to have established or maintained the HSA as a plan covered under the Employee Retirement Income Security Act of 1974 (ERISA), provided that the employer's involvement with the HSA is limited. Chapter 8 discusses ERISA issues more fully.¹²⁴

COBRA Continuation Coverage

An employer's contribution to an HSA is not considered to be part of a group health plan.¹²⁵ Thus, an employer is not required to make continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) available as to an HSA.¹²⁶ It should be noted, however, that an ERISA-covered HSA (that is, an employee welfare benefit plan) may be subject to COBRA (see Chapter 8).¹²⁷

Funded Welfare Benefit Plan Excise Tax

Contributions by an employer to an HSA are not subject to the rules under Code Section 419 regarding funded welfare benefit plans. An HSA is a trust or custodial account that is exempt from tax under Code Section 223. Thus, an HSA is not a fund under Code Section 419(e)(3) and therefore is not a welfare benefit fund under Code Section 419(e)(1).¹²⁸ Neither are contributions subject to the excise tax as to funded welfare benefit plans that provide disqualified benefits.¹²⁹

Minimum Funding Standards

Code Section 412 regarding minimum funding standards only applies to certain types of qualified plans under Code Sections 401(a) or 403(a).¹³⁰ Thus, employer contributions to an HSA are not subject to the excise tax relating to minimum funding standards.¹³¹

Nondeductible Penalty Tax

The excise tax on nondeductible employer contributions under Code Section 4972 does not apply to an HSA.¹³² It should be noted that employer contributions to an HSA generally are excluded from an employee's gross income.

¹²⁴ Field Assistance Bulletin 2004-01 (April 7, 2004) and Field Assistance Bulletin 2006-02 (October 27, 2006); DOL Reg §§ 2510.3-1(j)(1)-(4); see also DOL Reg. § 2509.99-1 relating to payroll deduction IRAs.

¹²⁵ IRC § 106(b)(5), 106(d)(2); see also Treas. Reg. § 54.4980B-2, Q&A 1, regarding Archer MSAs.

¹²⁶ Notice 2004-2, Q&A 35, 2004-2 I.R.B. 269.

¹²⁷ ERISA § 607(i).

¹²⁸ Notice 2004-2, Q&A 36, 2004-2 I.R.B. 269.

¹²⁹ IRC § 4976(a)(1).

¹³⁰ IRC § 412(a).

¹³¹ IRC §§ 412(a), 4971(a).

¹³² IRC §§ 4972(a), 4972(d).

Employer Participation

Comparability of Employer Contributions

In July 2006, the IRS published final comparability regulations governing employer contributions to HSAs.¹³³ The final regulations are effective for employer contributions made on or after January 1, 2007.

On June 1, 2007, the IRS issued proposed rules on the comparable contribution rules that govern employer contributions made to HSAs outside of a Code Section 125 cafeteria plan. The proposed rules, discussed later, provide guidance for employers where employees fail to establish an HSA or notify their employers of their HSA before December 31. The proposed rules also permit employers to make accelerated calendar year contributions for employees who incur qualified medical expenses exceeding current HSA contributions. Prior guidance had limited accelerated payments only to those employees who made HSA contributions through a cafeteria plan under Code Section 125.

In general, if an employer chooses to make HSA contributions, the employer is required to make comparable HSA contributions for all participating employees (that is, eligible employees with comparable coverage, explained later) during the same period.¹³⁴ If 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 during a calendar year. An employer that contributes to the HSAs of employees who are covered 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 covered under any HDHP, even if that coverage is not under an HDHP provided by the employer, must make comparable contributions to all eligible individuals whether or not they are covered under an HDHP provided by the employer.¹³⁵

Example 4-50

Kitten Corporation offers its employees three health plans, including HDHP self-only coverage with a \$2,000 deductible. For each employee electing the HDHP self-only coverage, Kitten contributes \$1,000 per year on behalf of the employee to an HSA. Kitten makes no HSA contributions for employees who do not elect the HDHP coverage. Kitten's HSA contributions satisfy the comparability rule.

Comparable Contributions

A comparable HSA employer contribution is: (1) the same dollar amount or (2) the same percentage of the HDHP annual deductible covering the employees divided into groups of "comparable coverage." Special HSA comparability rules apply contributions made to cafeteria plans (discussed later).

Example 4-51

Interocitor offers an HDHP to its full-time employees. Most full-time employees are covered under Interocitor's HDHP, and Interocitor makes comparable contributions only to the HSAs of its employees who also are covered under the HDHP sponsored by Interocitor. Daniel, a full-time employee and eligible individual, is covered under his spouse's HDHP and not under the Interocitor HDHP. Interocitor is not required to make comparable contributions to Daniel's HSA.

¹³³ Treas. Reg. § 54.4980G-1 through 5; 71 Fed. Reg. 43056 (July 31, 2006).

¹³⁴ IRC § 4980G; Treas. Reg. § 54.4980G-1 through 5.

¹³⁵ Treas. Reg. § 54.4980G-3, Q&A 7; Notice 2004-50, Q&A 53, 2004-33 I.R.B. 196; See also Notice 2004-2, Q&A 32, 2004-2 I.R.B. 269.

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Example 4-52

Fly-by-Night does not offer an HDHP. Several full-time employees, who are eligible individuals, have HSAs. Fly-By-Night contributes to these employees' HSAs. Fly-by-Night must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example 4-53

Giants offers an HDHP to its full-time employees. Most full-time employees are covered under Giants' HDHP, and Giants makes comparable contributions to these employees' HSAs and also to HSAs of full-time employees not covered under the employer's HDHP. Jasmine, a full-time employee and an eligible individual, is covered under her spouse's HDHP and not Giants' HDHP. Giants must make comparable contributions to Jasmine's HSA.

Classes of Employees

In determining whether the comparability rules are met, the employee population is broken down into subcategories:

- Current full-time employees;
- Current part-time employees, and
- Former employees.

Former employees who are covered under the HDHP because they elected COBRA continuation coverage are not treated as former employees for testing purposes. This means that different contribution amounts can be made for full-time and part-time employees, as well as former employees, without violating the comparability rules.¹³⁶

A full-time employee is one who customarily is employed for 30 or more hours per week; a part-time employee is one who customarily is employed for fewer than 30 hours per week. If an employee is considered part-time for part of the year and full-time for the remainder of the year, whether the comparability rules are satisfied is determined on a month-by-month basis.¹³⁷

Comparable Categories of Coverage

In general, if an employer makes comparable contributions, the contributions must be comparable for all comparable participating employees. Comparable participating employees are eligible individuals who are in the same category of employees and who have the same category of HDHP coverage. The final regulations allow several categories of HDHPs. HDHP coverage can be divided into the following categories:

- Self-only,
- Self plus 1,
- Self plus 2,
- Self plus 3, and
- Family HDHP coverage categories.¹³⁸

The employer is not required to contribute the same amount or percentage of the deductible for employees with different categories of HDHP coverage. An employer that contributes to the HSAs of employees who are eligible individuals with HDHP family coverage is not required to contribute any (or the same) amount or percentage to the HSAs of employees who are eligible individuals with HDHP self-only coverage. However,

¹³⁶ Treas. Reg. § 54.4980G-3, Q&A 5.

¹³⁷ Treas. Reg. § 54.4980G-3, Q&A 5(b).

¹³⁸ Treas. Reg. § 54.4980G-1, Q&A 2.

the employer's contribution as to the self plus 2 category may not be less than the employer's contribution for the self plus 1 category, and the self plus 3 category contribution may not be less than the self plus 2 contribution.¹³⁹ Note that if all employees are covered under the employer's HDHP and the employer only contributes to one class of comparable participating employee, the comparability rules are not satisfied unless that class of employee can be distinguished based on full-time, part-time, or former employee status.¹⁴⁰

The comparable contribution rules generally preclude an employer from making contributions to HSAs on behalf of non-highly-compensated employees (NHCEs) in higher amounts (or higher percentages of deductibles) than to highly-compensated employees (HCEs). However, beginning in taxable years after 2006, the TRHCA allows employers to make contributions to HSAs on behalf of NHCEs in higher amounts (or higher percentages of deductibles) than to HCEs without violating the comparable contribution rules.¹⁴¹ Under the new provision, employers are permitted to make greater HSA contributions on behalf of NHCEs, but must satisfy the comparability rules with respect to contributions to HCEs. For example, an employer may make a \$1,000 contribution on behalf of each NHCE without making any contributions to HCEs. For these purposes, HCEs are defined under Code Section 414(q), which generally means for 2007, an individual who earned less than \$100,000 (the 2007 limit) in the preceding year (2006) and was not a more than 5% owner during that year or the current year.

However, the comparability rules would not be satisfied if the employer contributed a different amount or rate to some, but not all, of the NHCE (even though HCEs received nothing or a lower amount or percentage than HCEs).

Testing Period

To satisfy the comparability rule in Code Section 4980G, an employer must make comparable contributions for the calendar year to HSAs of employees who are eligible individuals.¹⁴²

Matching Contributions

If all employees who are eligible individuals do not contribute the same amount to their HSAs and consequently do not receive comparable matching contributions to their HSAs, the Code 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 comparability under a cafeteria plan, later in this chapter).¹⁴³

Example 4-54

Sample Company offers employees the ability to participate in an HDHP with a \$1,000 deductible and to make after-tax HSA contributions through a payroll-deduction program. Don contributes \$1,000 and John contributes \$500 on an after-tax basis through the payroll deduction program. No employer contributions are being made; therefore, the comparability rules do not apply.

Example 4-55

Same facts as ***Example 4-54***, except Sample offers to match employee contributions on a dollar-for-dollar basis. Don and John's contributions are not the same dollar amount or percentage of the deductible under the HDHP; thus the comparability rules are not satisfied.

¹³⁹ Treas. Reg. § 54.4980G-4, Q&A 1.

¹⁴⁰ Treas. Reg. § 54.4980G-3, Q&A 9.

¹⁴¹ IRC § 4980G(d), added by TRHCA § 306(a).

¹⁴² IRC §§ 4980E(d), 4980G; Treas. Reg. § 54.4980G-1, Q&A 3; Notice 2004-50, Q&A 52, 2004-33 I.R.B. 196.

¹⁴³ Treas. Reg. § 54.4980G-4, Q&A 8; Notice 2004-50, Q&A 46, 2004-33 I.R.B. 196.

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Example 4-56

Same facts as in *Example 4-55*, except Don and John both contribute \$1,000 and there are no other eligible employees eligible to make HSA contributions. The comparability rules are satisfied because all eligible employees are making identical contributions and receive identical matching contributions.

Example 4-57

Sample Company offers employees the ability to participate in an HDHP with the ability to elect self-only coverage or family coverage. Sample contributes \$1,000 to employees with HDHP self-only coverage and \$1,500 to employees with HDHP family coverage. Sample Company's contributions satisfy the comparability rules.

Example 4-58

Garden Corporation permits employees to choose whether they want a \$1,100 or \$2,000 deductible for self-only coverage, or a \$2,200 or \$3,000 deductible for family coverage. The employer contributes the same percentage (say, 10%) of the deductible to the HSAs of all eligible employees for 2007. The comparability rules are satisfied because Garden contributes the same percentage of the HDHPs' deductible.

Comparability of Contributions Made Through a Cafeteria Plan

The comparability rules do not apply to contributions made through a cafeteria plan.¹⁴⁴ The final regulations make clear that an employer's contributions will be considered made through a cafeteria plan if: (1) employees are permitted to make their own contributions to an HSA by salary reduction through a cafeteria plan, and (2) the right to make contributions is described in a written cafeteria plan document.

The significance of this rule is that contributions made through a cafeteria plan are subject to the nondiscrimination requirements of Code Section 125 rather than the comparable contribution requirements of Code Section 4980G. This means that an employer is prohibited from favoring HCEs or key employees as to cafeteria plan eligibility or benefits, including HSA contributions, but the employer is not required to contribute similar amounts to employees' HSAs. This should allow employers more flexibility and creativity in benefit design structures. For example, by using a cafeteria plan, employers can provide matching contributions to match employees' contributions to their HSAs (i.e., employer contributions that are equal to or a percentage of the employee's contribution). Employers also can make HSA contributions contingent upon participation in health risk assessments, disease management programs, or wellness programs. None of these contribution structures would pass the Code Section 4980G comparable contribution requirement without this exception because all employees will not elect to make the same HSA contribution or to participate in the same program and, therefore, will receive different amounts of employer contributions.¹⁴⁵

Under Code Section 125, if a cafeteria plan discriminates in favor of highly compensated individuals, the highly compensated participants must include in income an amount equal to the highest value of benefits he or she could have elected to receive under the discriminatory cafeteria plan. Similarly, if key employees elect more than 25% of the aggregate benefits elected by all employees under a cafeteria plan, key employees must include amounts that could have been elected in income.

In August 2007, the IRS issued new proposed regulations providing guidance on cafeteria plans. The new proposed regulations provide more detail than the previous proposed regulations concerning how to determine whether a cafeteria plan complies with these nondiscrimination rules. However, more specific guidance and

¹⁴⁴ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Conf. Rep. No. 391, 108th Cong., 1st Sess. 840 (2003); Notice 2004-2, Q&A 32, 2004-2 I.R.B. 269; Treas. Reg. § 54.4980G-5, Q&A-1-3; Prop. Treas. Reg. § 1.125-7(n)

¹⁴⁵ Treas. Reg. § 54.4980G-5, Q&A-1-3; Notice 2004-50, Q&A 46, 2004-33 I.R.B. 196; see also IRC § 125(b), (c) and (g); see, also, Prop. Treas. Reg. § 1.125-1, Q&A 19.

examples are critical in order to fully understand these requirements, particularly with respect to HSA contributions. The following is a summary of the new proposed cafeteria plan nondiscrimination rules:

- *Highly Compensated Individuals.* For purposes of applying the nondiscrimination rules for cafeteria plans, “highly compensated individuals” are those who in the current year are (i) an officer, (ii) a 5% or more shareholder in the employer or (iii) a highly compensated employee.¹⁴⁶ While similar to the rules used for determining who is a highly compensated employee under the tax-qualified plan nondiscrimination rules, the definitions under the cafeteria plan rules are not the same. This will require employers to separately track who constitutes a highly compensated employee for different nondiscrimination testing purposes.

An employee is an “officer” for purposes of these nondiscrimination tests based on the duties and responsibilities of the individual, requiring an analysis of what an individual’s job position entails.¹⁴⁷ There is no minimum compensation requirement for being considered an officer or no overall limit on how many employees can be counted as officers.

An employee is a “highly compensated employee” for purposes of these nondiscrimination tests if the employee’s compensation is over \$100,000 (for 2007) in the preceding plan year (or the current year in the case of the first year of employment).¹⁴⁸ In contrast, the qualified plan rules do not include someone as highly compensated in their first year of employment. The alternate rule in qualified plan nondiscrimination testing for determining whether someone is highly compensated—limiting the group to the top 20% of employees in terms of compensation during the year—may also be used to determine who is highly compensated under the cafeteria plan nondiscrimination testing rules.

■ **Caution.** The definition of “highly compensated individual” for purposes of the new proposed cafeteria plan nondiscrimination rules is not the same as the definition that applies for purposes of the qualified retirement plan rules under Code Section 414(s).

- *Nondiscrimination in Eligibility.* A cafeteria plan cannot discriminate in favor of highly compensated employees with regard to eligibility to participate in the cafeteria plan or with respect to the contributions and benefits provided in a cafeteria plan.¹⁴⁹ The new proposed regulations provide some detail as to how the various nondiscrimination tests are to be applied but the requirements are still not entirely clear.

The nondiscrimination rules regarding eligibility to participate follow the reasonable classification test provided for in the tax-qualified plan nondiscrimination rules. This rule consists of a two-part test. First, an employer can only limit eligibility to certain “reasonable classifications” of employees, such as those based on job categories, salaried or hourly job categories, geographic location, and other bona fide business classifications. Second, the percentage of non-highly compensated employees who are able to participate in the cafeteria plan as a percentage of the entire employee population must meet or exceed various safe harbor percentages. In making this determination, employers who do not allow employees to participate in the cafeteria plan until they have completed 3 years of employment can disregard such employees in determining whether eligibility for the plan discriminates in favor of highly compensated employees.¹⁵⁰ Also excluded from this determination are employees covered by a collective bargaining agreement (except key employees), nonresident aliens with no earned income in the United States from the employer and those employees who are participating in the cafeteria plan

¹⁴⁶ Prop. Treas. Reg. § 1.125-7(a)(3) and (a)(8).

¹⁴⁷ Prop. Treas. Reg. § 1.125-7(a)(7).

¹⁴⁸ Prop. Treas. Reg. § 1.125-7(a)(9), referring to I.R.C. § 414(q)(1)(B).

¹⁴⁹ Prop. Treas. Reg. § 1.125-7(b)(1) and (c)(1).

¹⁵⁰ Prop. Treas. Reg. § 1.125-7(b)(1) and (3).

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due to COBRA. Of course, a cafeteria plan that allows every employee to participate will not be considered discriminatory with respect to eligibility.¹⁵¹

Note: The proposed regulations do not include much needed examples to illustrate how the reasonable classification test should be applied in the cafeteria plan context.

- *Nondiscrimination in Contributions and Benefits.* A cafeteria plan also must not discriminate with regard to benefit availability and the benefits elected. The new proposed regulations provide that each similarly situated employee must have the same opportunity to elect qualified cafeteria plan benefits and those benefits must not be disproportionately elected by highly compensated participants.¹⁵²

In this regard, the new proposed regulations state that the dollar amount of benefits elected by all highly compensated participants in the plan divided by the aggregate compensation of those employees (expressed as a percentage) cannot exceed the dollar amount of benefits elected by all non-highly compensated participants divided by the aggregate compensation of those employees (also expressed as a percentage). Regarding contributions to the cafeteria plan, similarly situated participants also must be given the same opportunity to elect employer contributions under the cafeteria plan. Also, highly compensated participants cannot disproportionately use the cafeteria plan contributions for qualified benefits; whether this has occurred is determined in manner similar to that used to determine whether benefit election disproportionately benefited highly compensated participants.¹⁵³

Note: Examples are needed in the final regulations to illustrate how the contribution and benefits test should be applied in the cafeteria plan context, and with respect to contributions to an HSA.

- *Key Employee Concentration Test.* A cafeteria plan is also considered to be discriminatory if more than 25% of the aggregate benefits provided under a cafeteria plan go to key employees. Generally this will not affect cafeteria plans of larger employers, because the number of key employees is limited to 50 employees and shareholders of 5% or more and 1% shareholders who have compensation is in excess of \$145,000. However, it is not clear how to measure benefits for purposes of this test, particularly with respect to HSAs.¹⁵⁴

Note: Examples are needed to illustrate how the key employee test should be applied in the cafeteria plan context, including with respect to contributions to an HSA.

- *Safe Harbors.* The new proposed regulations provide two safe harbors from the non-discrimination rules.¹⁵⁵ One safe harbor, which is provided in the statute itself, states that contributions on behalf of each participant are at least equal to (i) 100% of the cost of the health plan coverage of the plan that benefits the majority of highly compensated participants; or (ii) 75% of the cost of the highest cost health benefit in the plan, and any contributions in excess of the 100% or 75% amount must bear a uniform relationship to compensation. It is not clear how to apply this safe harbor, and the new proposed regulations do not provide any clarification or helpful examples. The second safe harbor, which is new, provides that premium only plans also are considered a safe harbor design if they pass the nondiscrimination test regarding eligibility.

¹⁵¹ Prop. Treas. Reg. § 1.125-7(b)(3)(ii).

¹⁵² Prop. Treas. Reg. § 1.125-7(c)(1) and (2).

¹⁵³ Prop. Treas. Reg. § 1.125-7(c)(2).

¹⁵⁴ Prop. Treas. Reg. § 1.125-7(d)(1).

¹⁵⁵ Prop. Treas. Reg. § 1.125-7(e).

Note. Examples are needed to show how the safe harbors should be applied, including with respect to contributions to an HSA.

- *Other Rules.* The new proposed regulations state that the actual operation of the plan must not discriminate in favor of highly compensated participants in operation.¹⁵⁶ However, there are no helpful illustrations of how this requirement would apply. Also, the new proposed regulations provide rules for aggregating and disaggregating cafeteria plans for purposes of determining whether the plan is discriminatory, but again, contain no illustrations of these rules.¹⁵⁷

The new proposed regulations provide that the nondiscrimination tests must be conducted annually as of the last day of the plan year and must include any non-excludible employees who were employees at any time during the year. There is much less flexibility in the timing and manner of the nondiscrimination testing of cafeteria plans than is permitted for qualified plans.¹⁵⁸

Note: The timing and manner of nondiscrimination testing for purposes of these rules is not the same as the timing and manner of nondiscrimination testing that applies for purposes of the qualified retirement plan rules.

Comparability Rules for Collectively Bargained Employees

If health benefits were the subject of good faith bargaining between employee representatives and the employer, employees and former employees covered by such collective bargaining agreement are not subject to the comparability rules. Therefore an employer who makes HSA contributions to any of its non-collectively bargained employees may agree to: (1) not make HSA contributions to any of its non-collectively bargained employees, (2) make HSA contributions under some collective bargaining agreements and not others, or (3) provide different levels of HSA contributions under different collective bargaining agreements.¹⁵⁹

Retroactive Contributions

The original proposed regulations on comparable contribution provided that, if an employee had not established an HSA at the time that the employer funded its employees' HSAs, the employer was required to contribute comparable amounts plus reasonable interest to each employee's HSA when the employee did establish the HSA, taking into account each month that the employee was a comparable participating employee. The proposed regulations contained an exception to this rule for employees who did not establish an HSA by December 31st, which provided that the employer is not required to make contributions for such employees for that year. The final regulations retained the rule regarding retroactive contributions, but did not adopt the December 31st exception. Instead, the final regulations contained a new reserved subsection under the heading "Employee has not established an HSA by the end of the calendar year."¹⁶⁰

Employee Fails to Notify Employer of HSA or to Establish HSA by December 31st. In June 2007, the IRS issued proposed rules that add a new requirement for employers in complying with the comparability rules when employees fail to establish an HSA before the end of the calendar year or to notify their employer that an HSA has been established.¹⁶¹ The previous final comparability rules required an employer to make a comparable contribution (calculating interest and months of eligibility) to an employee who opened an HSA

¹⁵⁶ Prop. Treas. Reg. § 1.125-7(k).

¹⁵⁷ Prop. Treas. Reg. § 1.125-7(g) and (h).

¹⁵⁸ Prop. Treas. Reg. § 1.125-7(j).

¹⁵⁹ Treas. Reg. § 54.4980G-3, Q&A-6.

¹⁶⁰ Treas. Reg. § 54.4980G-4, Q&A 6.

¹⁶¹ 72 Fed. Reg. 30501 (June 1, 2007); Prop. Treas. Reg. §54.4980G-4, Q&A-14.

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after January 1, but reserved the question of whether contributions are required for employees who fail to establish an HSA during the calendar year.¹⁶²

Under the new 2007 proposed rules, when employees fail to establish an HSA before the end of the calendar year, an employer must provide these employees with a written notice by January 15th of the following calendar year notifying the employees that if they both establish an HSA and notify their employer or notify their employer of an existing HSA before the end of February, the employee will receive a comparable contribution to the HSA. The notice may be provided as early as 90 days before the first employer contribution for that year and no later than January 15th of the following year. If required, the employer must make a contribution to the employee's HSA by April 15th. The contribution must take into account the number of months that the employee was eligible for contributions and add reasonable interest in factoring the contribution amount. The notice may be provided electronically. The proposed regulations also provide a model notice that employers may use for this purpose (see below). If, after receiving the notice, an employee still fails to open an HSA, the employer is not required to make a contribution to the employee's HSA. This proposed rule places new administrative burdens on employers. Under the prior rules, if an employee failed to open an HSA before the end of the calendar year, no contribution was required. Employers will now need to track employee HSAs and draft and deliver notices according to the proposed timeline, in addition to calculating interest on the delayed contributions.¹⁶³ The 2007 proposed regulations may be relied on pending the issuance of final regulations. However, an employer may continue to rely on the 2005 proposed regulations that provide that an employer is not required to make a comparable contribution for a calendar year to an employee's HSA if the employer has not established an HSA by December 31 pending the issuance of final regulations.¹⁶⁴

Caution. While the majority of employers do not have to comply with these proposed comparable contribution rules because such employers make HSA contributions through their cafeteria plans, these employers should still take note.

An employer may use the sample language found in Figure 4-2 as a basis for preparing their own notices. The notice may be provided electronically.¹⁶⁵

Example 4-59

In a calendar year, Heart Partnership contributes to the HSAs of current employees who are eligible individuals covered under any HDHP. For the 2009 calendar year, Heart contributes \$50 per month on the first day of each month, beginning January 1st, to the HSA of each employee who is an eligible employee on that date. For the 2009 calendar year, Heart provides written notice satisfying the content requirements on October 16, 2008 to all employees regarding the availability of HSA contributions for eligible employees. For eligible employees who are hired after October 16, 2008, Heart provides such a notice no later than January 15, 2010. Heart's notice satisfies the notice requirements of the 2007 proposed regulations.

¹⁶² See Treas. Reg. §54.4980G-4, Q&A-6.

¹⁶³ Prop. Treas. Reg. § 54.4980G-4, Q&A-14(a).

¹⁶⁴ Prop. Treas. Reg. § 54.4980G-4, Q&A-16.

¹⁶⁵ Prop. Treas. Reg. § 54.4980G-4, Q&As-14(b) and 14(e).

Figure 4-2: Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from **[employer]** if you are covered by a High Deductible Health Plan (HDHP). **[Employer]** provides contributions to the Health Savings Account (HSA) of each employee who is **[insert employer’s eligibility requirements for HSA contributions]** (“eligible employee”). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) Establish an HSA on or before the last day in February of **[insert year after the year for which the contribution is being made]** and;

(2) Notify **[insert name and contact information for appropriate person to be contacted]** of your HSA account information on or before the last day in February of **[insert year after year for which the contribution is being made]**. **[Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, on a certain form, etc.)]**.

If you establish your HSA on or before the last day of February in **[insert year after year for which the contribution is being made]** and notify **[employer]** of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for **[insert year for which contribution is being made]** by April 15 of **[insert year after year for which contribution is being made]**. If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for **[insert applicable year]**. You may notify us that you have established an HSA by sending an **[e-mail or]** a written notice to **[insert name, title and, if applicable, e-mail address]**. If you have any questions about this notice, you can contact **[insert name and title]** at **[insert telephone number or other contact information]**.”

Example 4-60

Orange Corporation’s written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Orange automatically contributes a non-elective matching contribution to the HSA of each employee who makes a pre-tax HSA contribution. Because Orange’s HSA contributions are made through the cafeteria plan, the comparability requirements do not apply to the HSA contributions made by Orange. Consequently, Orange is not required to provide written notice to its employees regarding the availability of this matching HSA contribution.

Example 4-61

In a calendar year, Steel Corporation maintains an HDHP and only contributes to the HSAs of eligible employees who elect coverage under its HDHP. For the 2009 calendar year, Steel employs 10 eligible employees. For the 2009 calendar year, all 10 employees have elected coverage under Steel’s HDHP and have established HSAs. For the 2009 calendar year, Steel makes comparable contributions to the HSAs of all 10

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employees. Steel satisfies the comparability rules. Thus, Steel is not required to provide written notice to its employees regarding the availability of HSA contributions for eligible employees.

Example 4-62

In a calendar year, Tibor contributes to the HSAs of current full-time employees with family coverage under any HDHP. For the 2009 calendar year, Tibor provides timely written notice satisfying the content requirements to all employees regardless of HDHP coverage. Tibor makes identical monthly contributions to all eligible employees (meaning full time employees with family HDHP coverage) that establish HSAs. Tibor contributes comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest to the HSAs of the eligible employees that establish HSAs and provide the necessary information after the end of the year but on or before the last day of February, 2010. Tibor makes no contribution to the HSAs of employees that do not establish an HSA and provide the necessary information on or before the last day of February, 2008. Tibor satisfies the comparability requirements.

Example 4-63

For 2007, Tulip Corporation contributes to the HSAs of current full time employees with family coverage under any HDHP. Tulip has 500 current full time employees. As of the date for Tulip's first HSA contribution for the 2007 calendar year, 450 employees have established HSAs. Tulip provides timely written notice satisfying the content requirements only to those 50 current full time employees who have not established HSAs. Tulip makes identical quarterly contributions to the 450 employees who established HSAs. Tulip contributes comparable amounts to the eligible employees who establish HSAs and provide the necessary information after the end of the year but on or before the last day of February, 2008. Tulip makes no contribution to the HSAs of employees that do not establish an HSA and provide the necessary information on or before the last day of February, 2008. Tulip satisfies the comparability rules.

Reasonable Interest

The final regulations contain a Q&A stating that the determination of whether interest is "reasonable" will be based on all of the facts and circumstances, but that the federal short-term rate as determined by the Secretary of Treasury in accordance with Code Section 1274(d) will be deemed reasonable. In addition to the retroactive contribution scenario described above, an employer also is required to contribute "reasonable" interest if the employer violates the comparable contribution requirements and wishes to correct the violation by contributing additional amounts to employees' HSAs.¹⁶⁶

Locating Former Employees

If an employer contributes to a former employee's HSA without requiring that the former employee be covered under that employer's HDHP, then the employer has to make comparable contributions to all former employees who are eligible employees covered under any HDHP (except those former employees who are covered under an HDHP as a result of a COBRA election). In such a case, an employer must take "reasonable actions" to locate such eligible former employees. Reasonable actions include the use of certified mail, the Internal Revenue Service's Letter Forwarding Program, or the Social Security Administration's Letter Forwarding Service. As a practical matter, the final regulations do not provide guidance regarding how an employer would go about determining whether any former employees might be covered under an HDHP other than one sponsored by that employer. The administrative burden of locating former employees and making this determination may result in employers limiting or eliminating HSA contributions to former employees.¹⁶⁷

¹⁶⁶ Treas. Reg. § 54.4980G-4; Q&A-13.

¹⁶⁷ Treas. Reg. § 54.4980G-3, Q&A 10(b).

Timing of Employer Contributions

Employers can make HSA contributions using a pay-as-you-go, look-back, or pre-funding method. As long as the chosen method is applied on a reasonable and consistent basis for all eligible employees, the comparable contribution requirements will be satisfied.¹⁶⁸

Where the pay-as-you go and look-back methods are used, an employer must establish, on a reasonable and consistent basis, periods for which contributions will be made (such as quarterly) as well as a specific date (such as the first day of the quarter). Presumably, these rules are intended to clarify that employers are not required to deviate from their scheduled funding of HSA accounts to accommodate employees who terminate employment before the end of the year or begin work after the start of the year (as long as comparable contributions for that employee are made up as part of the next scheduled funding). Alternatively, the employer may make a pre-funding contribution at the beginning of the year to employees participating in the HDHP at the beginning of the year.¹⁶⁹

For those hired after the beginning of the year, the employer may make contributions on a pre-funding basis, a pay-as-you-go basis, or a look-back basis. However, the same basis must be used for all employees hired after the beginning of the year. Also, if an employer makes a pre-funding contribution at the beginning of the year, the fact that an individual may leave employment during the year will not adversely impact the comparability testing.¹⁷⁰

Example 4-64

An employer contributes \$240 on January 1, 2007 to the HSAs of each full-time employee who has HDHP coverage on that date (pre-funding). On September 15, 2007, one new full-time employee is hired, and enrolls in HDHP coverage as of October 1, 2007. This employee maintains HDHP coverage for October, November, and December. The employer must contribute \$60 to the HSA of this full-time employee.¹⁷¹ The employer may contribute the entire \$60 on October 1, 2007 (pre-funding), may contribute \$20 in October, \$20 in November, and \$20 December (pay-as-you-go), or may contribute \$60 on December 31, 2007 (look-back).

Accelerated Employer Contributions. In June 2007, the IRS issued proposed rules that allow an employer to accelerate HSA contributions for all HSA eligible employees who have incurred qualified medical expenses that exceed the employer's current calendar year contributions.¹⁷² Prior guidance had limited accelerated payments only to those employees who made HSA contributions through a Code Section 125 cafeteria plan.¹⁷³

Under the new rules, if an employer elects to accelerate contributions, such contributions must be available on an equal and uniform basis to all eligible employees throughout the calendar year. The employer is required to establish reasonable uniform methods and requirements for determining acceleration eligibility and procedures for providing accelerated contributions. An employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because employees who incur qualifying medical expenses exceeding the employer's cumulative HSA contributions at that time have received more contributions in a given period than comparable employees who do not incur such expenses, provided that all comparable employees receive the same amount or the same percentage for the calendar year. Also, an employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment before the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. An employer is not

¹⁶⁸ Treas. Reg. § 54.4980G-4, Q&A 5.

¹⁶⁹ Treas. Reg. § 54.4980G-4, Q&A 4.

¹⁷⁰ Treas. Reg. § 54.4980G-4, Q&A 2 and 4.

¹⁷¹ IRC §§ 4980E(d)(2)(B), 4980G(b).

¹⁷² 72 Fed. Reg. 30501 (June 1, 2007); Prop. Treas. Reg. § 54.4980G-4, Q&A-15 (June 1, 2007).

¹⁷³ See IRS Notice 2004-50, 2004-33 I.R.B. 10, Q&A-60 (July 6, 2004).

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required to contribute reasonable interest on either accelerated or non-accelerated HSA contributions.¹⁷⁴ This proposed rule offers additional flexibility for employers who are interested in accommodating employee needs as they arise. Because of the additional administrative effort involved, however, it remains to be seen whether this new rule will be broadly used. The proposed regulations may be relied on pending the issuance of final regulations.¹⁷⁵

Note: The comparability rules do not apply to amounts rolled over from an employee's HSA or Archer MSA, or to contributions made through a cafeteria plan.¹⁷⁶

After-Tax Contributions

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, the Code Section 4980G comparability rules do not apply. Code 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 Code Section 223(b). After-tax employee contributions to the HSA are not subject to Code Section 4980G because they are not employer contributions under Code Section 106(d).¹⁷⁷

Penalty and Corrections

If employer contributions do not satisfy the comparability rule during a period, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.¹⁷⁸

It may be possible for an employer to correct a violation for the comparability rules. Contributions already made to an HSA may not be recouped by an employer. However, additional contributions could be made to employees who did not receive a comparable contribution. The additional contributions must be made by April 15th of the following year. A reasonable interest factor must be included on these correcting contributions. However, an employer is not required to contribute additional contributions that are in excess of the HSA maximum annual contribution limits.¹⁷⁹

The excise tax also may be waived in situations where the excise tax imposed is excessive relative to the failure involved.¹⁸⁰

Tax Treatment of Contributions

IRS Reporting by Individuals

Form 8889, Health Savings Accounts (HSAs), is used to report HSA contributions (including those made on the account owner's behalf and employer contributions). Form 8889 also is used to report distributions from an HSA. The taxpayer's deduction for contributions to an HSA is claimed on Form 1040, line 25 or Form 1040NR, line 25 (based on 2007 version of those forms).

¹⁷⁴ Prop. Treas. Reg. § 54.4980G-4, Q&A-15.

¹⁷⁵ Prop. Treas. Reg. § 54.4980G-4, Q&A-16.

¹⁷⁶ Treas. Reg. § 54.4980G-2, Q&A-1; Notice 2004-2, Q&A 32, 2004-2 I.R.B. 269.

¹⁷⁷ Treas. Reg. § 54.4980G-2, Q&A-2; Notice 2004-50, Q&Q 54, 2004-33 I.R.B. 196.

¹⁷⁸ IRC §§ 4980E(b), 4980G; Notice 2004-2, Q&A 32, 2004-2 I.R.B. 269.

¹⁷⁹ Treas. Reg. § 54.4980G-4, Q&A 12.

¹⁸⁰ Treas. Reg. § 54.4980G-5, Q&A 4; IRC§ 4980G(b); 4980E(c); IRS Notice 2004-2, Q&A 32, 2004-2 I.R.B. 269.

Note: The HSA maximum annual contribution deduction effectively is reduced on Form 8889 for employer contributions to an HSA that are excluded from the employee's gross income and for a direct trustee-to-trustee transfer of an amount in a traditional IRA (other than a Simplified Employee Pension-IRA (SEP-IRA) or a Savings Incentive Match Plan for Employees-IRA (SIMPLE-IRA) to an HSA (see Chapter 5).

Form 8889 is filed as an attachment to the taxpayer's federal income tax return, Form 1040. The form must include all contributions, including cafeteria plan pre-tax contributions, made for the year (including those made after the end of the year designated as made for the prior year). Contributions made by an employer, although generally excluded from an employee's gross income, also must be reflected on the form.

Note: The amount contributed during the year will be reflected on Form 5498-SA, *HSA, Archer MSA, or Medicare Advantage MSA Information*, that is received from the HSA trustee or custodian. An employer's contribution (if any) will be shown in box 12 of Form W-2, *Wage and Tax Statement*, and coded W.

Individual Must File Form 8889

An individual must file Form 8889, Health Savings Accounts (HSAs) if any of the following apply:

- The individual made contributions to an HSA for the year (including a direct trustee-to-trustee transfer from a traditional IRA (not including a SEP-IRA or a SIMPLE-IRA)).
- The individual's employer made contributions (even if through a cafeteria plan or a health FSA on a pre-tax basis).
- Someone on the individual's behalf (including an employer) made contributions for the year.
- The individual received distributions from an HSA during the year.
- The individual acquired an interest in an HSA because of the account owner's death.

Partnership Considerations

A partnership may make contributions to an HSA on behalf of a partner or guaranteed payment partner. See the examples in the following sections.

Generally, when an employer makes a contribution, within permissible limits, to the HSA on behalf of an employee who is an eligible individual, the contribution is excluded from the employee's gross income and wages.¹⁸¹ However, contributions by a partnership to a bona fide partner's HSA are not treated as contributions by an employer to an employee's HSA.¹⁸²

Treatment of Contributions—Partnerships

A partner is not an employee and therefore the comparable contribution rules do not apply to contributions made by a partnership to a bona fide partner's HSA. Instead, the contributions either are treated as distributions under Code Section 731 or guaranteed payments under Code Section 707(c), as described below.¹⁸³

Distributions under Code Section 731

Contributions by a partnership to a partner's HSA that are treated as distributions to the partner under Code Section 731 (regarding the extent of recognition or gain or loss on partnership distributions):

¹⁸¹ IRC § 106(d).

¹⁸² See Rev. Rul. 69-184, 1969-1 CB 256.

¹⁸³ Treas. Reg. § 54.4980G-3, Q&A 3.

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1. Are not deductible by the partnership;
2. Do not affect the distributive shares of partnership income and deductions;
3. Are reported by the partnership as distributions of money on Form 1065, *Schedule K-1*, Partner's Share of Income, Credits, Deductions, etc.;¹⁸⁴
4. Are not included in the partner's net earnings from self-employment (NESE) under Code Section 1402(a) because the distributions under Code Section 731 do not affect a partner's distributive share of partnership income or loss under Code Section 702(a)(8); and
5. Are deductible by the partner to the extent of allowable contributions made to the partner's HSA during the taxable year as an adjustment to gross income on his or her federal income tax return provided that the partner is an eligible individual (generally has an HSA and is covered under an HDHP).¹⁸⁵

Guaranteed Payments under Code Section 707(c)

Contributions by a partnership to a partner's HSA for services rendered to the partnership that are treated as guaranteed payments under Code Section 707(c) are:

1. Deductible by the partnership under Code Section 162 regarding trade or business expenses, provided the requirements of that section are satisfied taking into account the rules of Code Section 263 (regarding capital expenditures).¹⁸⁶
2. Included in a partner's gross income. The contributions are not excludible from the partner's gross income under Code Section 106(d) because the contributions are treated as a distributive share of partnership income under Treasury Regulation Section 1.707-1(c) for purposes of all Code Sections other than Code Sections 61(a) and 162(a).¹⁸⁷
3. Reported as guaranteed payments on Form 1065, *Schedule K-1*, Partner's Share of Income, Credits, Deductions, etc.¹⁸⁸
4. Included in the partner's net earnings from self-employment under Code Section 1402(a) on the partner's Schedule SE (Form 1040). The contributions are guaranteed payments that are derived from the partnership's trade or business and are for services rendered to the partnership.¹⁸⁹
5. Deductible by the partner to the extent of the allowable contributions made to the partner's HSA during the taxable year as an adjustment to gross income on his or her federal income tax return, provided the partner is an eligible individual (generally, has an HSA and is covered under an HDHP).¹⁹⁰

Example 4-65

Partnership is a limited partnership with three equal individual partners, Garth (a general partner), Lou (a limited partner), and Laszlo (a limited partner). Laszlo is to be paid \$500 annually for services rendered to Partnership in his capacity as a partner and without regard to Partnership income (a guaranteed payment under Code Section 707(c)). The \$500 payment to Laszlo is derived from Partnership's trade or business. Partnership has no employees. Garth, Lou, and Laszlo are eligible individuals (as defined in Code Section 223(c)(1)) and each has an HSA. During Partnership's Year 1 taxable year, Partnership makes the following contributions: a \$300 contribution each to Garth's and Lou's individual HSAs, which are treated by Partnership as Code Section 731 distributions to Garth and Lou; and a \$500 contribution to Laszlo's HSA in lieu of paying Laszlo the guaranteed payment directly.

¹⁸⁴ See Rev. Rul. 91-26, 1991-1 CB 184, analysis of situation 1, last paragraph.

¹⁸⁵ IRC §§ 62(a)(19), 223(a).

¹⁸⁶ IRC § 162(a), 707(c); Notice 2005-8, Q&A 2, 2005-4 I.R.B. 368; see Rev. Rul. 69-184, 1969-1 CB 256.

¹⁸⁷ IRC § 106(d), 707(c); See Rev. Rul. 91-26, 1991-1 CB 184; Notice 2005-8, Q&A 2, 2005-4 I.R.B. 368.

¹⁸⁸ Notice 2005-8, Q&A 1, 2005-4 I.R.B. 368.

¹⁸⁹ Notice 2005-8, Q&A 2, 2005-4 I.R.B. 368.

¹⁹⁰ IRC §§ 62(a)(19), 223(a), 223(c)(1); Notice 2005-8, Q&A 2, 2005-4 I.R.B. 368.

Partnership's contributions to Garth's and Lou's HSAs are not deductible by Partnership and, therefore, do not affect Partnership's calculation of its taxable income or loss.¹⁹¹ Garth and Lou are entitled to an above-the-line deduction under Code Sections 223(a) and 62(a)(19) for the amount of the contributions made to their HSAs. The Code Section 731 distributions to Garth's and Lou's HSAs are reported as cash distributions to Garth and Lou on Garth's and Lou's Schedule K-1 (Form 1065). The distributions to Garth's and Lou's HSAs are not includible in Garth's and Lou's net earnings from self-employment under Code Section 1402(a) because distributions under that Code Section do not affect a partner's distributive share of the partnership's income or loss under Code Section 702(a)(8).

Partnership's contribution to Laszlo's HSA, which is treated as a guaranteed payment under Code Section 707(c) for services rendered to the partnership, is deductible by Partnership under Code Section 162 (if the requirements of that section are satisfied (taking into account the Code Section 263 rules)) and is includible in Laszlo's gross income. The contribution is not excludible from Laszlo's gross income under Code Section 106(d) because the contribution is treated as a distributive share of partnership income for purposes of all Code Sections other than Sections 61(a) and 162(a), and a guaranteed payment to a partner is not treated as compensation to an employee.¹⁹² The payment to Laszlo's HSA should be reported as a guaranteed payment on Schedule K-1 (Form 1065). Because the contribution is a guaranteed payment that is derived from the partnership's trade or business and is for services rendered to the partnership, the contribution constitutes net earnings from self-employment to Laszlo under Code Section 1402(a), which should be reported on Schedule SE (Form 1040). Laszlo is entitled under Code Sections 223(a) and 62(a)(19) to deduct as an adjustment to gross income the amount of the contribution made to Laszlo's HSA.

S Corporation Consideration

Under Code Section 1372, for purposes of applying the provisions of Subtitle A that relate to fringe benefits, an S corporation is treated as a partnership.¹⁹³

Contribution to an HSA of a More Than 2% Shareholder-Employee

Under Code Section 1372, for purposes of applying the Subtitle A provisions that relate to fringe benefits, a (more than) 2% shareholder of the S corporation is treated as a partner of such partnership.¹⁹⁴

Practice Pointer →

The term "2 percent shareholder" means any person who owns, or is considered to own through attribution, on any day during the tax year of the S corporation, more than 2% of the outstanding stock of such corporation or stock possessing more than 2% of the total combined voting power of all stock of such corporation.¹⁹⁵ The Code Section 318 attribution rules are used for the purpose of determining ownership.

When an S corporation, which is treated as a partnership, makes contributions to a more than 2% shareholder-employee's HSA in consideration for services rendered, the contributions are:

1. Treated as guaranteed payments under Code Section 707(c).¹⁹⁶
2. Deductible by the S corporation under Code Section 162, provided the requirements of that section are satisfied taking into account the rules of Code Section 263 (regarding capital expenditures).¹⁹⁷

¹⁹¹ See Rev. Rul. 91-26, 1991-1 CB 184.

¹⁹² See Rev. Rul. 91-26, 1991-1 CB 184.

¹⁹³ IRC § 1372(a)(1), 1372(b).

¹⁹⁴ IRC § 1372(a)(2), 1372(b); Notice 2005-8, Q&A 3, 2005-4 I.R.B. 368.

¹⁹⁵ IRC § 1372(b).

¹⁹⁶ IRC §§ 707(c), 1372(a).

¹⁹⁷ IRC §§ 162(a), 707(c); Notice 2005-8, Q&A 3, 2005-4 I.R.B. 368.

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3. Includible in the more than 2% shareholder-employee's gross income. A more than 2% shareholder-employee is not entitled to exclude these contributions from gross income under Code Section 106(d).¹⁹⁸
4. Treated as paid to an employee and are subject to FICA tax. However, if the requirements for the exclusion under Code Section 3121(a)(2)(B) are satisfied (as previously discussed), the S corporation's contributions to a 2% shareholder-employee's HSA are not wages subject to FICA tax, even though the amounts must be included in wages for income tax withholding purposes on the more than 2% shareholder-employee's Form W-2, *Wage and Tax Statement*.¹⁹⁹

Practice Pointer →

Code Section 3121 generally does not include payments for "medical or hospitalization expenses in connection with sickness or accident disability" as wages.²⁰⁰

5. Not subject to the Self-Employment Contributions Act (SECA) tax.²⁰¹
6. Deductible by the partner under Code Sections 223(a) as an adjustment to gross income.²⁰²

¹⁹⁸ See Rev. Rul. 91-26, 1991-1 CB 184.

¹⁹⁹ Notice 2005-8, Q&A 3, 2005-4 I.R.B. 368.

²⁰⁰ IRC § 3121(a)(2)(B).

²⁰¹ See Ann 92-16, 1992-5 I.R.B. 53, clarifying the FICA (Social Security and Medicare) tax treatment of accident and health premiums paid by an S corporation on behalf of a 2 percent shareholder-employee.

²⁰² Notice 2005-8, Q&A 3, 2005-4 I.R.B. 368; see Notice 2004-2, Q&A 19, 2004-2 I.R.B. 269.

Chapter 5

HSA Rollovers and Transfers

This chapter examines rollovers and trustee-to-trustee transfers, which generally are permitted to be made between Health Savings Accounts (HSAs) of an account owner or between HSAs of a designated surviving spouse beneficiary. Likewise, the rules relating to rollovers and direct transfers between trustees and custodians from an Archer Medical Savings Account (Archer MSA) to an HSA also are examined. This chapter also reviews nontaxable transfers from an HSA to a surviving spouse under a divorce or separation instrument. Further, this chapter includes the special rules that apply to a nonspouse beneficiary or an estate. The 60-day and special one-year rules applicable to rollovers to and from HSAs are explained.

Also, this chapter discusses the modifications made by the Tax Relief and Health Care Act of 2006 (TRHCA) that allow an individual to transfer the balance remaining in his or her Flexible Spending Arrangement (FSA) or Health Reimbursement Arrangement (HRA) to an HSA and to make a one-time rollover from a traditional Individual Retirement Arrangement (IRA) to fund an HSA.

General Rules

If an individual account owner receives a distribution from an HSA, he or she generally may roll over all or part of the distribution as a contribution to an HSA (which may or may not be the same distributing HSA). Trustee-to-trustee transfers between HSAs also are permitted.¹ The “60-day” and “one rollover per year” rules are discussed in the following sections.

A distribution from an Archer MSA generally may be rolled over to an HSA. A nonspouse beneficiary, however, may not roll over a distribution from an Archer MSA.²

Rollovers are not subject to the HSA maximum annual contribution limits.³ The portion of a distribution that is not rolled over may be subject to tax and penalty if it is not used to pay for qualified medical expenses (see Chapter 6).

A distribution from one HSA or an Archer MSA may be rolled over as a contribution to another HSA, but the total amount distributed is not required to be rolled over. Form 8889, *Health Savings Accounts*, is used to calculate the taxable portion of an HSA distribution and any penalties that may apply. See Chapter 6 for more information.

Rollover from IRA and Roth IRA Permitted

In taxable years beginning after 2006, a one-time rollover from a traditional IRA or a Roth IRA to an HSA generally is permitted subject to the maximum contribution limits.⁴ The special rules that apply to one-time transfers are discussed later in this chapter.

¹ IRC § 223(f)(5); Notice 2004-2, Q&A 23, 2004-2 IRB 269; Notice 2004-50, Q&A 77, 2004-33 IRB 196.

² IRC § 220(f)(5), 220(f)(8).

³ Notice 2004-2, Q&A 23, 2004-2 IRB 269.

⁴ I.R.C. §§ 223(b)(4)(C), 408(d)(9), added by the Tax Relief and Health Care Act of 2006 (TRHCA) § 307(a)-(c) (P.L. 109-432); for rules in effect for tax years prior 2007, see Notice 2004-2, Q&A 23, 2004-2 IRB 269, prohibiting such rollovers and transfers.

Rollover from HRA or FSA Permitted

An HRA allows employees to use employer contributions for medical expenses. A health FSA allows employees to use their own pre-tax wages to pay medical expenses. Unlike an FSA, an HRA is not subject to the use-it-or-lose-it rule. After December 20, 2006, a qualified distribution from an HRA or an FSA generally may be rolled over, by direct transfer, to an HSA.⁵ The special rules that apply to transfers from an HRA or FSA are discussed later in this chapter.

No Deduction Allowed

Because the amount rolled over to an HSA generally is not included in gross income, an individual may not claim a deduction for that amount.⁶

Rollover of Property

Rollover contributions to an HSA need not be in cash.⁷ The same property that is distributed from the first HSA or from an Archer MSA must be rolled over. Proceeds from the sale of the property distributed may not be rolled over.⁸

Partial Rollover Permitted

There is no requirement that the entire amount of cash or other property distributed from an HSA (or an Archer MSA) to an account owner be rolled over. Form 8889 is used to calculate the taxable portion of an HSA distribution and any penalties that may apply. The portion of a distribution not rolled over to an HSA may be subject to tax and penalty if it is not used to pay for qualified medical expenses. See Chapter 6 for more information.

Right to Transfer

The HSA rules under Code Section 223 permit the rollover of amounts in one HSA to another HSA, and transfers from one trustee to another trustee. Thus, the trust or custodial agreement may not contain restrictions on the right to transfer from one HSA to another HSA.⁹

Acceptance by Trustee or Custodian

An HSA trustee or custodian is not required to accept rollover contributions.¹⁰ If the trustee or custodian does accept such contributions, rollover contribution restrictions might apply (for example, not accepting property in connection with a rollover contribution).

⁵ I.R.C. §§ 223(b)(4)(C), 408(d)(9), added by TRCHA § 307(a)-(c); for rules in effect for taxable years ending before 2007, see Notice 2004-2, Q&A 23, 2004-2 IRB 269, prohibiting such rollovers and transfers.

⁶ IRC §§ 219(d)(2), 223(d)(4)(A).

⁷ IRC § 223(d)(1)(A); Notice 2004-50, Q&A 73, 2004-33 IRB 196.

⁸ IRC §§ 220(f)(5)(A), 223(f)(5)(A).

⁹ IRC § 223(f)(5); Notice 2004-50, Q&A 77, 2004-33 IRB 196.

¹⁰ Notice 2004-50, Q&A 78, 2004-33 IRB 196.

The One-Year Rule

An HSA owner may make only one rollover contribution from one HSA to another HSA during a one-year period.¹¹ That period begins on the date that an amount distributed from an HSA, not included in income by reason of a prior rollover, was received. Thus, if a rollover is made from one HSA to another HSA, another rollover cannot be made from either HSA (or any other HSA) until 12 months from the date that the individual received the rolled over distribution.¹²

Practice Pointer →

The HSA one-year rule is more restrictive than the traditional IRA one-year rule. The traditional IRA rule limits the number of distributions from the same IRA that may be rolled over and appears to be based on proposed regulations.¹³

Example 5-1

In 2003, Abigail established two traditional IRAs: IRA-A and IRA-B. She never has received a distribution from either IRA. On January 5, 2007, she rolls over IRA-A to IRA-C. On February 5, 2007, she rolls over IRA-B to IRA C. The one-year rule has not been violated because the rule applies separately to each IRA. IRA-C may not be rolled over until the 12-month period has elapsed.

Example 5-2

Same facts as *Example 5-1*, except Abigail established two HSAs instead of traditional IRAs. The rollover of HSA-B to HSA-C violates the HSA one-year rule, because only one rollover may be made to an HSA by an owner during the one-year period beginning on the date that an amount distributed from an HSA, not included in income by reason of a prior rollover, was received.

If a second rollover is made from the HSA before the HSA one-year period has expired, the later rollover cannot be treated as a tax-free rollover, and may be subject to tax and penalty if not used to pay for qualified medical expenses in the year the distribution occurred (see Chapter 6).¹⁴

Example 5-3

Rachel received a distribution from HSA-1 on January 15, 2007, that she rolled over to HSA-2 within the 60-day period (explained later). On January 14, 2008, Rachel received another distribution from HSA-1 (or HSA-2) and rolled over the entire amount distributed into HSA-3. Rachel may have to include the amount she received on January 14, 2008, in income because it was received within the one-year period that began on the date that the amount initially rolled over was received (January 15, 2007). An excess contribution to the HSA has been made (see Chapter 4).

Note: Rollovers between Archer MSAs are subject to a separate Archer MSA one-year rule.¹⁵

Example 5-4

Heathcliff received distributions from an HSA and an Archer MSA during the same year. Subject to the 60-day rules, both the HSA and the Archer MSA may be rolled over into an HSA.¹⁶ The same HSA may be used to receive both rollovers.

¹¹ IRC § 223(f)(5)(B); Notice 2004-23, Q&A 55, 2004 IRB 725.

¹² Notice 2004-50, Q&A 55, 2004-33 IRB 196.

¹³ Prop. Treas. Reg. § 1.408-4(b)(4)(ii).

¹⁴ IRC § 223(f)(5).

¹⁵ IRC § 220(f)(5)(B).

¹⁶ IRC §§ 220(f)(5), 223(f)(5).

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The one-year period applicable to an HSA begins when an amount in the HSA (which is later rolled over) is distributed from the HSA.

Example 5-5

Lana only has one HSA from which no distributions have been made. She received a distribution from an Archer MSA and promptly rolled it over into her HSA. Three weeks later, Lana withdrew the balance in her HSA and promptly rolled the amount into another HSA. The one-year period applicable to rollovers between HSAs has not been violated because the rollover from the Archer MSA to the first HSA is not counted.

Example 5-6

Same facts as *Example 5-5*, except Lana later received another distribution from her Archer MSA within the one-year period. She may not roll over any portion of this distribution into either an HSA or another Archer MSA because the one-year rule applicable to Archer MSAs has not expired.¹⁷

The 60-Day Rule

The rollover must be completed within 60 days. To qualify as a rollover, any amount paid or distributed to the HSA account owner must be paid over to an HSA within 60 days after the date of receipt of the payment or distribution.¹⁸ This requirement also applies to a spouse beneficiary who inherits an HSA. Similar rules apply to the rollover of an Archer MSA to an HSA.¹⁹

The property itself received in a distribution must be rolled over. There is no provision that permits property distributed from the HSA (or Archer MSA) to be sold and the proceeds rolled over in its place.²⁰

Reporting Rollover Contributions

The HSA Account Owner

The total of all distributions to the account owner, including rollover contributions, is reported in Part II, line 14(a), of Form 8889. See Chapter 7 for additional information.

Note: A separate Part II must be completed when a joint return is filed and each spouse has a "separate HSA."²¹ The rollover rules now apply to that spouse as the HSA account owner.

Any distributions received in 2007 that qualify as a rollover contribution to another HSA should be included. These amounts should be shown in box 1 of Form 1099-SA. Form 8889 should be attached to Form 1040, U.S. Individual Income Tax Return.

Practice Pointer →

It may be necessary to complete Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, if required, before completing Form 8889.

¹⁷ IRC § 220(f)(5).

¹⁸ IRC § 223(f)(5)(A); Notice 2004-23, Q&A 55, 2004 IRB 725.

¹⁹ IRC § 220(f)(5)(A).

²⁰ IRC § 223(f)(5)(B); see also IRC § 408(d)(3)(A).

²¹ See Form 8889, Health Savings Accounts, Part II. It does not appear that separate forms are required when a spouse, as designated beneficiary, is treated as the account owner.

An account ceases to be an HSA as of the decedent account owner's date of death, unless the sole designated beneficiary is the decedent's surviving spouse (see Chapter 6). The fair market value of the former HSA becomes taxable to the nonspouse beneficiary. However, if any portion of the HSA passes to a nonspouse beneficiary, the entire account becomes taxable to all beneficiaries. Earnings on the account after the date of death are reported as income by the designated beneficiary(ies) unless the sole designated beneficiary is the surviving spouse. Earnings on the account after the date of death are not subject to the 10% additional tax.

Form 1099-SA Reporting by Trustee or Custodian

A trustee or custodian that makes a distribution from an HSA must report the distribution on Form 1099-SA, *Distributions from an HSA, Archer MSA, or Medicare Advantage MSA* in box 1.²² Earnings on excess contributions are reported separately in box 2. A code identifying the distribution is to be entered in box 3.

The following distribution codes are used for identifying and reporting HSA distributions in box 3 of Form 1099-SA:

1. Normal distribution
2. Excess contributions
3. Disability (within the meaning of Code Section 72(m)(7))
4. Death distributions to the account owner's estate made in or after the year of death (do not use Code 6)
5. Prohibited transactions²³
6. Death distribution after the year of death to the nonspouse beneficiary, other than an estate (do not use Code 4).

Box 4 is used for reporting fair market value on the date of death. The HSA checkbox in box 5 is used to indicate that the distribution was from an HSA. See Chapter 7 for additional information.

Form 1099-SA must be filed with the IRS and a copy provided to each person for whom the trustee or custodian maintained an HSA for the year by May 31.

Form 5498-SA Reporting by Trustee or Custodian

The trustee or custodian that receives a rollover contribution must report the amount in box 4 of Form 5498-SA, *HSA, Archer MSA, or Medicare Advantage MSA Information*. See Chapter 7 for additional information.

Note: Trustee-to-trustee transfers from one HSA or an Archer MSA to another HSA are not reported.

For 2007, Form 5498-SA must be filed with the IRS by May 31, 2008, for each person for whom the trustee or custodian maintains an HSA. A separate Form 5498 is required for each plan type (i.e., HSA, Archer MSA, or Medicare Advantage MSA).

If a trustee or custodian is required to file Form 5498-SA, a statement (generally Copy B) must be provided to the account owner by May 31, 2008. This form also may be used to report the December 31, 2007, fair market value of the HSA if provided by January 31, 2008.

²² Box numbers are based on the 2007 version of the Form 1099-SA.

²³ See IRC §§ 220(e)(2), 223(e)(2).

Inherited HSAs

If the surviving spouse is designated as the HSA beneficiary, the spouse automatically is treated as the account owner thereafter.²⁴

Form 8889 Reporting by Beneficiary

If the decedent account owner's surviving spouse is the sole designated beneficiary, the surviving spouse is treated as the account owner for HSA purposes. The surviving spouse completes Form 8889 as though the HSA belonged to him or her.

Practice Pointer →

If a surviving spouse who is the sole designated beneficiary of an HSA remarries and designates his or her new spouse as the HSA's sole designated beneficiary, it appears that the new spouse could become the HSA account owner in the same manner. However, the issue is not specifically addressed by the HSA statute, legislative history, or IRS guidance.

If the designated beneficiary is not the decedent account owner's surviving spouse, if the beneficiaries include a nonspouse beneficiary, or if no beneficiary has been designated, the account ceases to be an HSA as of the decedent account owner's date of death. In such case, the beneficiary completes Form 8889 as follows:

- Enter "Death of HSA account owner" across the top.
- Enter the name(s) and Social Security number as shown on the federal tax return in the spaces provided at the top of the form and skip Part I.
- On line 14a, enter the HSA's fair market value as of the date of death.
- On line 15, for a beneficiary other than the estate, enter unreimbursed qualified medical expenses incurred by the account owner before the date of death paid within one year after the date of death.
- Complete the remainder of Part II.

Example 5-7

Paul and Paula are married. Paul has an HSA designating his wife and daughter, Sarah, as equal-share beneficiaries of his HSA. Paul dies. Neither Paula nor Sarah may roll over their shares into another HSA. Paula and Sarah each must include their half share of the fair market value of Paul's HSA in their respective gross income. The account ceased to be an HSA as of Paul's date of death.

If the account owner's estate is the beneficiary, the HSA's fair market value as of the date of death is included on the decedent account owner's final income tax return.

HSA Transfers

Because the Code Section 223(f)(5) rules limiting the number of rollover contributions to one per year do not apply to trustee-to-trustee transfers, there is no limit on the number of trustee-to-trustee transfers allowed during a year.²⁵ HSA trustees are not required to accept trustee-to-trustee transfers from an HSA (or an Archer MSA).²⁶

²⁴ IRC § 223(f)(8)(A).

²⁵ Notice 2004-50, Q&As 56 and 77, 2004-33 IRB 196.

²⁶ Notice 2004-50, Q&A 78, 2004-2 IRB 196.

Trustee-to-trustee transfers between HSAs are not treated as distributions so long as no payment is made to the account owner or to any medical services provider. The amount transferred directly from one trustee or custodian to another trustee or custodian is not included in income, not deducted as a contribution, and not included as a contribution on line 14(a) of Form 8889.

Transfer Incident to Divorce

The transfer of an individual's interest in an HSA to his or her spouse or former spouse under a divorce or separation instrument described in Code Section 71(b)(2)(A) will not be considered a taxable transfer. The transfer must be a direct trustee-to-trustee or custodian-to-custodian transfer. Direct transfers between custodians and trustees, and vice versa, are also permitted. A rollover of a distribution does not qualify "as a transfer incident..." Thus, it is not possible for a spouse or former spouse to retain a portion of any cash or property that directly is transferred.²⁷

Divorce or Separation Instrument

For HSA purposes, a "divorce or separation instrument" must be:

1. A decree of divorce or separate maintenance or a written instrument incident to such a decree;
2. A written separation agreement; or
3. A decree requiring a spouse to make payments for the support or maintenance of the other spouse.

Consequently, if an individual divides his or her HSA under a private separation agreement that is not incident to either a divorce or a legal separation, the individual will be taxed under the Code Section 223(f) general rule.²⁸ The transfer of an individual's interest in an HSA to an individual's spouse or former spouse under a divorce or separation instrument described in Code Section 71(b)(2)(A) is not considered a taxable transfer.

Treatment After Transfer

After an interest in an HSA is transferred incident to divorce to another HSA, the transferee spouse is treated as the account owner of the transferred HSA interest.²⁹

The interest transferred is not treated as a taxable distribution and the transferee spouse becomes the HSA account owner as to the portion transferred under the divorce or separation instrument.

Health Coverage Tax Credit

The Health Coverage Tax Credit (HCTC) under Code Section 35 regarding health insurance costs of eligible individuals is not available for premiums paid with tax-free distributions from an HSA.³⁰

The HCTC is available to certain individuals who receive a pension benefit from the Pension Benefit Guaranty Corporation (PBGC), are eligible to receive certain Trade Adjustment Assistance (TAA), or are eligible for the Alternate Trade Adjustment Assistance (ATAA) program.³¹

²⁷ IRC §§ 223(f)(7), 408(a).

²⁸ IRC §§ 71(b)(2)(A), 223(f)(7).

²⁹ IRC § 223(f)(7).

³⁰ IRC § 35(g)(3); Rev. Proc. 2004-12, 2004-9 IRB 528.

³¹ See Pub 502, Medical and Dental Expenses (Including the Health Coverage Tax Credit).

Qualified HSA Funding Distributions: One-Time Transfer From an IRA to an HSA

For taxable years beginning after 2006, an individual may make a “qualified HSA funding distribution” from an IRA to an HSA.³² The contribution must be made in a direct trustee-to-trustee transfer and is irrevocable once made.³³ Only one such distribution is permitted to be made in the individual’s lifetime.³⁴ Before 2007, rollovers or transfers were not permitted to be made to an HSA from an IRA.

A qualified HSA funding distribution cannot be made from an IRA that is used in connection with a Simplified Employee Pension (SEP) plan or Savings Incentive Match Plan for Employees – Individual Retirement Arrangement (SIMPLE-IRA) plan.³⁵ However, an individual may rollover or transfer funds in a SEP plan to a separate traditional IRA and then make a qualified HSA funding distribution from that IRA into an HSA.

Note: Code Section 408(d)(9)(B) prohibiting qualified HSA distributions from a SEP plan states that a qualified HSA funding distribution “means a distribution from an individual retirement plan (other than a plan described in subsection (k) or (p)) relating to SEP plans and Salary Reduction Simplified Employee Pension (SARSEP) plans, respectively. The identical language is used to prohibit qualified charitable contributions from being made from an IRA that is a SEP plan or SIMPLE-IRA plan.³⁶ In that regard, the IRS issued Notice 2007-7,³⁷ which provides that the exclusion for qualified charitable contributions applies to an IRA that is “neither an ongoing SEP IRA...nor an ongoing SIMPLE-IRA....” The notice states:

“For this purpose, a SEP IRA or a SIMPLE IRA is treated as ongoing if it is maintained under an employer arrangement under which an employer contribution is made for the plan year ending with or within the IRA owner’s taxable year in which the charitable contributions would be made.”

It is possible that future guidance may permit qualified HSA funding distributions to be made from a SEP plan or a SIMPLE-IRA plan that is not treated as “ongoing.”

Tax Treatment

No deduction is allowed for the amount contributed from an IRA to an HSA in a qualified HSA funding distribution.³⁸

Amounts distributed from an IRA under the provision are not includible in income to the extent that the distribution otherwise would be includible in income under a special rule (see below). Also, such distributions are not subject to the 10% additional tax on early distributions.³⁹

A qualified HSA funding distribution counts toward the account owner’s HSA contribution limit for the year.⁴⁰

³² I.R.C. § 408(d)(9), added by TRHCA § 307(a).

³³ I.R.C. § 408(d)(9)(B), 408(d)(9)(C)(ii)(I).

³⁴ I.R.C. § 408(d)(9)(C)(i)(I).

³⁵ I.R.C. § 408(d)(9)(B).

³⁶ I.R.C. § 408(d)(8)(B).

³⁷ Notice 2007-7, Q&A A-36, 2007-5 I.R.B. 1 (Jan. 10, 2007).

³⁸ Joint Committee on Taxation, Technical Analysis of the Tax Relief and Health Care Act of 2006, page 79 (P.L. 109-432) (JCX-50-06).

³⁹ I.R.C. § 72; See I.R.C. § 408(9)(9)(A).

⁴⁰ I.R.C. § 408(d)(9)(C)(i).

If the account owner does not remain an eligible individual during the “testing period” (described below), the amount of the distribution and contribution is includible in the account owner’s gross income and subject to an additional 10% tax. The amount is includible for the taxable year that includes the first day during the testing period that the account owner is not an eligible individual. A 10% additional tax also applies to the amount includible.

No Pro-Rata Recovery

In determining the extent to which amounts distributed from the IRA otherwise would be includible in income, the aggregate amount distributed from the IRA is treated as includible in income to the extent of the aggregate amount which would have been includible if all amounts were distributed from all IRAs of the same type (i.e., in the case of a traditional IRA, there is no pro-rata distribution of basis).⁴¹ Thus, the amount transferred will be treated as coming first from the taxable portion of the IRA. This is another exception to the normal pro-rata recovery rules that generally apply to IRAs. As under present law, this rule is applied separately to Roth IRAs and other IRAs.

Practice Pointer →

If an IRA contains any basis, a qualified HSA funding distribution will likely reduce the taxable portion of amounts subsequently distributed from an IRA under the pro-rata recovery rules which generally would apply.

Example 5-8

Henry, age 60, has two traditional IRAs. Over the past few years, Henry contributed, but did not deduct, \$6,000 in contributions he made to IRA-1 which is now worth \$6,900. He also contributed and deducted a \$3,000 contribution he made to IRA-2, which is now worth \$3,100. No other contributions were made to any IRA or Roth IRA. If Henry removes \$1,000 from an IRA he will not have to pay tax on \$600 which is treated as a return of basis. [$\$1,000 \text{ times } (\$6,000 \text{ of nondeductible contributions (basis) divided by } \$10,000 (\$6,900 + \$3,100))$] Henry’s remaining basis is \$5,400 ($\$6,000 - \600). Henry will have to include \$400 in his gross income for the year of the distribution.

Example 5-9

Same facts as in *Example 5-8*, except Henry’s IRA trustee (or custodian) transfers the \$1,000 to Henry’s HSA in a qualified funding distribution instead. If Henry removed all assets from all IRAs he would pay tax on \$4,000 ($\$10,000 \text{ of FMV minus } \$6,000 \text{ of basis}$). Although no amount of the qualified funding distribution is included in income, the amount transferred is treated as coming first from the taxable portion of the IRA. Thus, his remaining basis in the IRA, after the qualified funding distribution, remains at \$6,000. Having a larger basis (compared to \$5,400 in Example 1), will reduce the taxable portion (under the pro-rata recovery rule) of subsequent distributions made from the IRA.

Maximum Distribution

The amount that can be distributed from the IRA and contributed to an HSA is limited to the otherwise maximum contribution amount to the HSA, which is determined by the type of coverage (self-only coverage or family coverage) under the HDHP at the time of the contribution. The amount that otherwise could be contributed to the HSA for that year is reduced by the amount contributed from the IRA in a qualified HSA funding distribution.⁴²

⁴¹ I.R.C. § 408(d)(9)(E).

⁴² I.R.C. § 408(d)(9)(C)(i).

One Lifetime Distribution Rule

In general, only one distribution and contribution may be made during the account owner's lifetime. However, if a distribution and contribution are made during a month in which an account owner has self-only coverage as of the first day of the month, an additional distribution and contribution may be made during a later month within any taxable year in which the account owner has family coverage. The limit applies to the combination of both contributions.

Testing Period

If the account owner who makes an IRA transfer to an HSA does not remain an eligible individual during the testing period, the amount of the distribution and contribution is includible in the account owner's gross income. This rule is nearly identical to the 13-month rules described later in this chapter for transfers from an HRA or FSA to an HSA. An exception applies if an employee ceases to be an eligible individual by reason of death or disability. The testing period is the period beginning with the first day of the month of the HSA contribution and ending on the last day of the 12th month following such month. If the testing period requirement is not satisfied, the transferred amount is includible for the taxable year that includes the first day during the testing period that the account owner is not an eligible individual. A 10% additional tax also applies to the amount includible.⁴³

Caution: Failing to remain an eligible individual does not appear to require the withdrawal of the qualified HSA funding distribution, and the amount is not an excess contribution. (See Notice 2007-22, involving FSA/HRA/HSA qualified distributions.) However, any HSA withdrawal not used for qualified medical expenses is included in income and subject to an additional 10% tax (with certain exceptions), regardless of whether the HSA received a qualified HSA funding distribution that was previously included in the account owner's income and subject to the additional 10% tax.⁴⁴

Qualifying HSA Distributions: One-Time HRA and FSA Transfers to an HSA

General Rule

The Tax Relief and Health Care Act of 2006 (TRHCA) permits a one-time transfer of the balance remaining in an employee's health FSA or HRA account to an HSA to assist individuals in funding HSA accounts. Under prior law, no transfer from an FSA or an HRA to any other type of account, including an HSA, was permitted.

On February 15, 2007, the IRS issued much-anticipated guidance, Notice 2007-22,⁴⁵ describing the steps that an employer and employee must follow to transfer amounts from a health FSA or an HRA to an HSA on a tax-free basis. Although the statute⁴⁶ that created the transfer rights is relatively straightforward, the Notice imposes detailed timing and account balance requirements that must be followed to avoid adverse tax consequences for the HSA account owner. The new proposed cafeteria plan regulations implement the changes made in the Tax Relief and Health Care Act of 2006, and adopt the administratively cumbersome requirements for tax-free rollovers described in Notice 2007-22.⁴⁷

⁴³ I.R.C. § 408(d)(9)(D)(i)-(iii).

⁴⁴ I.R.C. § 223(f)(4)(B).

⁴⁵ Notice 2007-22, 2007-10 I.R.B. 670(March 5, 2007).

⁴⁶ Section 302(a) of The Tax Relief and Health Care Act of 2006 ("Act") amended Internal Revenue Code section 106 by creating a new subsection (e), which allows for a tax-free transfer from an FSA or HRA to an HSA.

⁴⁷ Prop. Treas. Reg. § 1.125-5(n).

In general, the transfer must be made before January 1, 2012.⁴⁸ If, at any time during a “testing period” the individual ceases to remain an eligible individual, the transferred amounts are includible in income and subject to a 10% additional tax. The distributions that are transferred into the HSA are called “qualifying HSA distributions.”⁴⁹

Note: Eligible individuals for HSAs generally are individuals who are covered by an HDHP and not covered by any other health plan that is not an HDHP and which provides coverage for any benefit which is covered under the HDHP (see Chapter 2).

The TRHCA, which refers to Code Sections 106 and 105, does not carve out or otherwise distinguish limited purpose or post-deductible FSA/HRA arrangements from general purpose arrangements. Accordingly, transfers from limited purpose or post-deductible FSA/HRA arrangements also should be permitted. Similarly, the transfer rule also should apply to variations of the HRA, such as an HRA that is limited to retirees, or an HRA that may be used only to pay premiums. It is not clear whether the detailed timing and account balance requirements of Notice 2007-22 apply to these arrangements; however, the IRS is expected to issue further guidance addressing this issue.

Caution: The qualifying HSA distribution transfer provisions do not apply to a dependent care FSA, which is subject to Code Section 129. The transfer rules are limited to a health FSA or a HRA, which are subject to Code Sections 106 and 105.

An employer allowing any employee to make qualifying HSA distributions must make the option available to all eligible individuals covered by the employer’s HDHP. The transfer provisions are limited to one distribution as to each health FSA or HRA of the individual. The employer determines if and when a qualified HSA distribution may be made from an HRA or an FSA to an HSA.

Plan Amendment Required

An employer is not required to allow employees to transfer amounts from an HRA or an FSA. However, if the employer wants to add this design feature to the plan, the employer may do so. This would require a plan amendment to the FSA and/or HRA plan document.⁵⁰ Further, the employer could offer the transfer opportunity on a one-time basis, and there would be no obligation to offer it again in future years.

The TRHCA does not require an employer who wishes to allow for qualified HSA distributions to do so for both an FSA and an HRA. It merely provides that a plan shall not fail to be treated as a FSA or an HRA under Code Section 106 (which allows employer contributions to be excluded from income) or 105 (which allows reimbursements from health plans to be excluded from income) if the employer makes a distribution from an FSA or an HRA to an HSA, subject to balance restrictions (see below), and before January 1, 2012.⁵¹ Accordingly, the employer can choose to allow a transfer from just the FSA or HRA arrangement, to allow a transfer from both arrangements, or to allow no transfer at all.

Practice Pointer →

The employer could amend the FSA for 2007 or a later plan year (before 2012) if that FSA has a grace period to allow participants to transfer the amount credited to their FSA on a future date or, if less, the amount that was credited to their FSA as of September 21, 2006. For example, an employer could choose to allow a one-time FSA transfer of the

⁴⁸ I.R.C. §§ 106(e), 223(c)(1)(B)(iii), 408(d)(9), added by TRHCA § 302(a)-(c); for rules in effect for taxable years ending before 2007, see Notice 2004-2, Q&A 23, 2004-2 IRB 269, prohibiting such rollovers and transfers.

⁴⁹ *Id.*

⁵⁰ See I.R.C. § 106(e)(1).

⁵¹ I.R.C. § 106(e)(1).

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amount credited to the account as of the last day of any plan year before 2012, and thereby allow FSA participants to not lose all of the amounts credited to the FSA. Note that if any amounts credited to the FSA on the last day of the plan year exceed the balance on September 21, 2006, it would be impossible to satisfy the requirement in Notice 2007-22 that the transfer result in a zero balance in the FSA. Thus, in that circumstance, a tax-free transfer could not be made.

A qualified HSA distribution does not have to be made in cash, and may be made in property acceptable to the trustee or custodian.⁵²

Treatment of Qualified HSA Distributions

A qualified HSA distribution is treated as an employer contribution and as a rollover contribution. Thus, it is excludable from gross income and wages for employment tax purposes.⁵³ Also, a qualified HSA distribution is not taken into account for purposes of determining the HSA annual contribution limitation (i.e., \$2,850 for self-only coverage and \$5,650 for family coverage for 2007). No deduction is permitted for a qualified HSA distribution which is transferred to an HSA.

Comparability Rule

An employer that allows any employee to make a transfer from an HRA or FSA to an HSA must offer the same right to all eligible individuals covered under an HDHP offered by the employer. If not, the failure is treated as a violation of the comparability rules and subject to a 35% excise tax.⁵⁴ Qualified HSA distributions otherwise are not subject to the comparability rules.⁵⁵ An employer would not be required to offer a transfer to any employees who have HDHP coverage that the employer does not sponsor.

Consent Required

An employer may not decide unilaterally to make qualified HSA distributions. An employee must “elect” do a tax-free transfer in such a manner.⁵⁶

Maximum Transfer Amount

For an HRA, the amount that can be transferred is the actual dollar amount (balance) that was credited to the account on September 21, 2006 or, if less, the balance in the account on the date of the transfer. The legislative history indicates that the balance as of any date is determined on a cash basis (i.e., expenses incurred that have not been reimbursed as of the date that the determination is made are not taken into account).⁵⁷ Thus, pending and unsubmitted claims are not taken into account, regardless of when the expense was incurred.⁵⁸

For an FSA, the amount that could be transferred to an HSA is the actual dollar amount that was credited to the account as of September 21, 2006 or, if less, the balance in the FSA account on the last day of the plan year for which the transfer is elected.

⁵² I.R.C. § 223(d)(1)(A); Notice 2004-50, Q&A 73, 2004-33 IRB 196.

⁵³ Joint Committee on Taxation, Technical Analysis of the Tax Relief and Health Care Act of 2006 (P.L. 109-432) (JCX-50-06).

⁵⁴ I.R.C. § 106(e)(5)(B)(ii); Notice 2007-22, 2007-10 I.R.B. 670 (March 5, 2007).

⁵⁵ I.R.C. § 106(e)(5)(B)(i).

⁵⁶ Notice 2007-22, 2007-10 I.R.B. 670 (March 5, 2007).

⁵⁷ Joint Committee on Taxation, Technical Analysis of the Tax Relief and Health Care Act of 2006, page 75 (P.L. 109-432) (JCX-50-06).

⁵⁸ Notice 2007-22, 2007-10 I.R.B. 670 (March 5, 2007).

■ **Caution:** The transfer rules only apply to existing FSAs and HRAs on September 21, 2006, and only to those which are amended or contain provisions for such transfers. An FSA or HRA established after that date would have had a zero balance on September 21, 2006.

Note: Congress intended to apply the FSA transfer rule not only to FSA elections made in 2006, but to future FSA elections through 2011. So, as long as an individual had an FSA with a balance on September 21, 2006, it appears that individual can make a future FSA election and transfer a portion of that future FSA into an HSA (capped at the September 21, 2006, account balance).

Treasury has confirmed that the September 21, 2006 balance may not be determined based on the balance in the FSA or HRA account of a former employer.⁵⁹

Minimum Transfer Amount

The full account balance under the FSA or HRA on the last day of the plan year must be transferred in a qualified HSA distribution in order for the transfer to be tax-free.

In determining what requirements an employer must satisfy to comply with new Code Section 106(e), the IRS has taken a surprisingly narrow reading of the statute that results in several complex and restrictive rules. For example, the IRS has determined that it is generally not possible for an employee to do a tax-free transfer during the year but rather the transfer must take place during the 2-1/2 month period following the close of the year and the employer must “freeze” the balance that is left in the account as of the last day of the plan year. For an FSA, this means that the employer must adopt a grace period extension in order to make a tax-free transfer (so that the disqualifying coverage under the FSA or HRA during the grace is disregarded). The IRS further determined that any transfer must result in a zero balance in a general purpose health FSA or HRA in order to be tax-free to the HSA account owner. As a result, the amount that must be transferred from a general purpose health FSA or HRA cannot be less than the amount in the account on the date of distribution. Thus, any individual with a balance in his or her general purpose health FSA or HRA account on the date of the transfer that exceeds the balance on September 21, 2006, cannot do a tax-free transfer.

Practice Pointer →

If the FSA or HRA arrangement is a limited purpose or other arrangement described in Revenue Ruling 2004-45, it appears that the transfer could be made at any time during the plan year, and need not result in a zero balance. The IRS is expected to issue further guidance addressing this. Unfortunately, the Notice indicates that employer may not convert a general purpose HRA or FSA to an HSA-compatible arrangement only for HSA-eligible individuals who elect transfers. Rather, such arrangement would have to be converted for all employees.

Note: If future guidance were to allow conversions to an HSA-compatible arrangement for just those employees who elect transfers, the qualified HSA distribution rules would be much easier to administer.

Testing Period

If, at any time during the 13-month period beginning with the first day of the month of the transfer, an account owner is covered by a non-HDHP, an account owner no longer is an eligible individual (e.g., is no longer covered by an HDHP, is enrolled in Medicare, or can be claimed as a dependent on another’s person’s tax return), the transferred amounts are includible in income and subject to a 10% additional tax. The rule does not

⁵⁹ Notice 2007-22, 2007-10 I.R.B. 670 (March 5, 2007).

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apply if the account owner ceases to be an eligible individual by reason of death or disability.⁶⁰ Except for these two circumstances, the decision to take a qualified HSA distribution effectively locks the account owner into maintaining an HDHP for the following 12 months.

The *testing period* is the period beginning with the month that the qualified HSA distribution is contributed to the HSA and ends on the last day of the 12th month following such month.⁶¹ If applicable, income tax applies for the taxable year that includes the first month of the testing period in which the account owner ceased to be an eligible individual.

Example 5-10

Karla intends to enroll in Medicare when she attains age 65 in December of 2008. In December 2007, Karla's employer makes a qualified HSA distribution from her HRA (which has a fiscal year ending on October 31, 2007) which is transferred to her HSA. Karla enrolls in Medicare in December 2008. As a result, Karla did not remain eligible for the entire testing period – the 12 month period following the month the qualified HSA distribution was made. Karla must include the qualified HSA distribution in her income in 2008 (the taxable year that included the month she became ineligible). Had Karla made the qualified HSA distribution in November 2007, she could enroll in Medicare as she planned in December (the month following the end of the testing period of November 2007 to November 2008) because she remained an HSA eligible individual for the entire testing period. Alternatively, if Karla waits one month and enrolls in Medicare in January 2009, the testing period rules would be satisfied.

Access to Funds

Subject to any reasonable restrictions imposed by the HSA custodian or trustee, the employee should have immediate ability to access the HSA funds that are transferred. This is true whether or not the employee is enrolled in a qualified HDHP at the time of the qualified HSA distribution. Of course, if the employee is not enrolled in an HDHP at the time of the transfer or during the 13-month period beginning with the month of the distribution, there would be income tax and a 10% additional tax imposed on the account owner.

Disregarded FSA Coverage

The TRHCA added an exception for a “zero balance” FSA and for an HSA qualified distribution of the remaining year-end balance. If such a transfer is made, the disqualifying coverage under that FSA would be disregarded (see discussion of Notice 2007-22 below).

Note: Before the TRHCA, an individual that participated in a health FSA with a grace period was not treated as an eligible individual even if the individual's health FSA had no unused benefits as of the end of the prior year (i.e., the balance in the health FSA was zero as of the last day of the plan year).⁶² IRS Notice 2005-86⁶³ provided transitional “grace period” relief and allowed an employer to amend its cafeteria plan health FSA to provide that disqualifying coverage during the grace period does not apply (would not be provided) to an individual that elected HDHP coverage. The transitional relief also applied to an individual who had no unused benefits or contributions remaining at the end of the prior year. Thus, an otherwise eligible individual would not be treated as having disqualifying coverage under the FSA.

It should be noted that coverage by an HSA-compatible health FSA or HRA (limited-purpose health FSA or HRA, post-deductible health FSA or HRA, retirement HRA, or suspended HRA) does not affect an

⁶⁰ I.R.C. § 106(e)(3)(B). For this purpose, the I.R.C. § 72(m)(7) definition of disability is used.

⁶¹ I.R.C. § 106(e)(4)(A).

⁶² Notice 2005-86, 2005-2 C.B. 1075.

⁶³ IRS Notice 2005-86, 2005-49 I.R.B. 1075.

employee's eligibility to make a qualified HSA distribution, or affect an individual's eligibility to contribute to an HSA, including coverage during a health FSA grace period.⁶⁴

New Requirements under Notice 2007-22

In general, it is not possible for an employee to do a tax-free transfer during the year but rather the transfer must take place during the 2-1/2 month period following the close of the year and the employer must "freeze" the balance that is left in the account as of the last day of the plan year. For an FSA, this means that the employer must adopt a grace period extension in order to make a tax-free transfer. Also, any transfer must result in a zero balance in the FSA or HRA in order to be tax-free to the HSA account owner. Thus, any individual with a balance in his or her FSA or HRA account on the date of the transfer that exceeds the balance on September 21, 2006, cannot do a tax-free transfer. The additional steps that an employer and employee must follow in order to ensure that a transfer is tax-free are summarized below.

If the steps identified in Notice 2007-22 are not followed, the transfer will be includable in the employee account owner's income and subject to a 10% additional tax. The circumstances that may cause an HSA transfer to be taxable to the HSA account owner and subject to an additional 10% tax include the following:

- Failure to transfer entire balance from a general purpose health FSA or an HRA.
- Transfer before or after 2-1/2 month period following the end of the FSA or HRA plan year.
- A transfer which occurs during a month in which the individual was not covered by HDHP coverage as of the first of the month.
- Disqualifying coverage under HRA or FSA after the transfer, which includes reimbursing expenses out of the account after the end of the plan year.
- Failure to remain an eligible individual during the 13-month testing period following the transfer.

Participants with zero balances. A participant in a general purpose health FSA with a grace period who has a zero balance on the last day of the plan year does not fail to be an eligible individual as of the first day of the immediately following health FSA plan year because of coverage during a grace period.

Failure to remain eligible during the testing period. Failing to remain an eligible individual during the testing period does not require the withdrawal of the transferred amount, and the amount is not an excess contribution and does not need to be withdrawn in order to avoid incurring the 6% excise tax that generally applies to excess contributions made to an HSA.⁶⁵

Employer responsibility. Employers are not responsible for reporting whether an employee who makes an FSA or HRA transfer remains an eligible individual during the testing period. It is not required that an employee be an eligible individual with HDHP coverage in order to have a transfer made on the employee's behalf. However, as a practical matter, the employer should verify eligible individual status before making the transfer, because otherwise the transfer will be taxable to the employee and subject to a 10% additional tax.

⁶⁴ Rev. Rul. 2004-45, 2004-1 CB 971.

⁶⁵ Notice 2007-22, 2007-10 I.R.B. 640 (March 5, 2007), Example 11, 2007-10 IRB 670. A *qualified HSA distribution* "is treated as a rollover contribution" under I.R.C. § 223(f)(5). The definition of *excess contribution* (to an HSA) does not include a rollover contribution described in I.R.C. § 223(f)(5). See I.R.C. § 223(f)(3)(B), and I.R.C. § 106(e)(4)(C) referencing I.R.C. § 223(f)(5); see to, I.R.C. § 4973 regarding the 6% tax.

Practice Pointer →

Employers do not have any obligation to monitor an employee's coverage during the testing period following a transfer. However, it appears that if the requirements of Notice 2007-22 are not satisfied at the time of transfer, the employer may be required to report the transferred amount as wages on the employee's Form W-2. It would be helpful if the IRS clarified this point, however.⁶⁶

Transition Rule Examples

Plan-Year-End Transfers Permanent Rule⁶⁷ Checklist

Under the permanent rule that starts on March 16, 2007 and ends on December 31, 2011, an employer, before the end of a plan year, must:

- Amend the FSA and HRA written plan document to allow a qualified HSA distribution.
- For an FSA, amend the plan to include a grace period so that participants are not required to forfeit account balances on the last day of the plan year.
- Provide employees an election form to elect a transfer if they:
 - Have established an HSA in that plan year and are or will be eligible individuals by the first day of the month of the transfer due to coverage under the employer's HDHP;
 - Had an FSA or an HRA on September 21, 2006, with a positive balance; and
 - Have an FSA or an HRA with funds credited to it (or may have such account before the end of the plan year).
- Provide the following information to employees regarding the requirements of making a transfer:
 - Explain how the transfer amount is calculated (i.e., on a cash basis based upon account balance on last day of plan year).
 - Explain that the maximum amount that can be transferred is the lesser of the balance that was in the account on September 21, 2006 or on the date of the transfer.
 - Explain that if balance in the FSA or the HRA at the time of transfer is greater than the balance on September 21, 2006, a tax-free transfer cannot be made because the transfer would not result in a zero balance as required by IRS guidelines.
 - Provide an overview of the testing period requirements to ensure employees have a basic understanding of the risk of failing to maintain status as an eligible individual (although the employer is not required to report this information to the HSA trustee/custodian or the IRS).
- Collect election forms from employees on or before the last day of the plan year.
- Freeze the FSA/HRA account balances for employees who elect the transfer, effective on the last day of the plan year (i.e., for calendar-year plans).
- Do not process any claims after the freeze date.
- Make the transfer for employees who return election forms on or before the last day of the plan year by transferring funds from the FSA or HRA directly to the HSA trustee/custodian by the 15th day of the 3rd month following the end of that plan year but after the employee is an eligible individual. Inform the HSA trustee/custodian that the amounts are intended to be qualified HSA distributions.

⁶⁶ The law that created HSAs also amended the FUTA and income tax withholding sections of the Code (sections 3306 and 3401, respectively) to provide that FUTA and income tax withholding requirements do not apply to "any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d)." This standard would not appear to apply because the FSA/HRA transfer would be made under Code § 106(e). Accordingly, it is not entirely clear what an employer's obligations are with respect to reporting transferred amounts as wages on the employee's W-2 if the requirements of the Notice are not satisfied.

⁶⁷ Notice 2007-22, 2007-10 I.R.B. 640 (Mar. 5, 2007).

Permanent Rule Examples

The following examples illustrate the permanent rule for qualifying HSA distributions (i.e., those made after March 15, 2007). All references to balances in the following examples are determined on a cash basis. All grace periods satisfy the requirements of Notice 2005-42. None of the employees in the examples are disabled.

Example 5-11

For 2007, Zest Corporation maintains a calendar year general purpose health FSA with a grace period ending March 15, 2008. For 2007, Albert, an employee, timely elects salary reduction of \$500 for the general purpose health FSA. Zest offers employees the option of electing HDHP coverage for the plan year beginning January 1, 2008. On or before December 31, 2007, Albert elects HDHP coverage beginning January 1, 2008. On December 31, 2007, Albert has a zero balance in the health FSA. Albert otherwise is an eligible individual on January 1, 2008.

Albert does not fail to be an eligible individual on January 1, 2008, merely because of the health FSA grace period.

Example 5-12

For 2007, Yellowstone Corporation has a calendar year general purpose health FSA with a grace period ending on March 15, 2008. Yellowstone offers employees the option of electing HDHP coverage for the plan year beginning January 1, 2008.

Before January 1, 2008, Yellowstone amends the health FSA to allow for qualified HSA distributions. The amended plan allows an employee electing HDHP coverage also to elect to have any health FSA balance at year-end, determined on a cash basis, contributed directly to an HSA trustee for the employee. For this purpose, the year-end balance is the balance of the health FSA without regard to any expenses incurred but not paid. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2007, regardless of when the underlying expense was incurred nor are any claims paid after December 31, 2007, even if submitted before December 31, 2007.

- A. Betty, an employee of Yellowstone, has a balance of \$950 in the health FSA on September 21, 2006, and a balance of \$700 on December 31, 2007. On or before December 31, 2007, Betty elects HDHP coverage beginning January 1, 2008. Betty also elects to have a qualified HSA distribution of the \$700 remaining in the health FSA on December 31, 2007. Yellowstone contributes \$700 to an HSA on behalf of Betty on or before March 15, 2008. Betty otherwise is an eligible individual as of January 1, 2008. Betty does not fail to be an eligible individual as of January 1, 2008, because after the qualified HSA distribution, she has a zero balance in the health FSA.
- B. Charles, Can employee of Yellowstone, has a balance of \$850 on December 31, 2007. On or before December 31, 2007, Charles elects HDHP coverage for 2008. Charles does not elect to have a qualified HSA distribution of the \$850 remaining in the health FSA on December 31, 2007. Charles otherwise is an eligible individual. Charles is an eligible individual on April 1, 2008. His coverage during the grace period makes him ineligible during the months of January, February, and March.

Example 5-13

For 2007, Water Corporation has a calendar year general purpose HRA. Water offers employees the option of electing HDHP coverage for the plan year beginning January 1, 2008.

Before January 1, 2008, Water amends the HRA to allow for qualified HSA distributions. The amended HRA allows an employee electing HDHP coverage for the plan year also to elect to have the lesser of the balance in the HRA on September 21, 2006, or the HRA balance at year-end, determined on a cash basis, contributed directly to an HSA trustee for the employee. For this purpose, the year-end balance is the balance of the HRA

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without regard to any expenses incurred but not paid. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2007, regardless of when the underlying expense was incurred, nor will the HRA reimburse any claim submitted but unpaid as of December 31, 2007. The amendment also provides that an employee who elects a qualified HSA distribution also may elect to waive participation in the HRA.

- A. Darla, an employee of Water, has a balance of \$300 in the HRA on September 21, 2006, and a balance of \$175 on December 31, 2007. On or before December 31, 2007, Darla elects HDHP coverage for 2008. Darla also elects to have a qualified HSA distribution of the \$175 remaining in the HRA on December 31, 2007 and to waive participation in the HRA effective after December 31, 2007. Water contributes \$175 to an HSA on behalf of Darla on or before March 15, 2008. Darla otherwise is an eligible individual as of January 1, 2008.

Darla does not fail to be an eligible individual as of January 1, 2008, because after the qualified HSA distribution, she has a zero balance in the HRA and does not participate in any non-HSA compatible HRA.

- B. Eunice, an employee of Water, has a balance of \$300 in the HRA on September 21, 2006, and a balance of \$550 on December 31, 2007. On or before December 31, 2007, Eunice elects HDHP coverage for 2008. Eunice also elects to have a qualified HSA distribution of the \$300 that was in the HRA on September 21, 2006. Water contributes \$300 to an HSA on behalf of Eunice on March 15, 2008. Eunice otherwise is an eligible individual as of January 1, 2008.

Eunice fails to be an eligible individual after the qualified HSA distribution, because she has a balance exceeding zero in the HRA after the distribution. Eunice must include \$300 in gross income in 2008, as well as pay an additional 10% tax.

- C. Frank, an employee of Water, has a balance of \$400 in the HRA on September 21, 2006. On or before December 31, 2007, Frank elects HDHP coverage for 2008. On June 15, 2008, Frank has a balance of \$275 in the HRA, and elects to have a qualified HSA distribution of the \$275. Water contributes \$275 to an HSA on behalf of Frank on August 20, 2008. Frank otherwise is an eligible individual as of January 1, 2008.

Frank fails to be an eligible individual after the qualified HSA distribution, because Frank remains a participant in an HRA that is not HSA-compatible until the end of the HRA plan year. The result is the same regardless of whether Frank waived participation in the HRA after June 15, 2008. Thus, Frank must include \$275 in gross income in 2008, as well as pay an additional 10% tax.

Example 5-14

Same facts as ***Example 5-13***, except Water converted the general purpose HRA to an HSA-compatible retirement HRA for all employees effective January 1, 2008.

George, an employee of Water, has a balance of \$275 in the HRA on September 21, 2006, and a balance of \$700 on December 31, 2007. On or before December 31, 2007, George elects HDHP coverage beginning January 1, 2008. George otherwise is an eligible individual as of January 1, 2008. George also elects to have a qualified HSA distribution of the \$275 that was in his HRA on September 21, 2006. Water treats George's remaining \$425 HRA balance as part of a retirement HRA.

George is an eligible individual as of January 1, 2008, because the HRA he participates in is HSA-compatible.

Example 5-15

Victory Corporation has a fiscal year general purpose health FSA with a grace period. The fiscal year of the health FSA is October 1 to September 30. The grace period ends on December 15. For the plan year beginning October 1, 2007, Victory offers employees the option of electing HDHP coverage.

On September 1, 2007, Victory amends the health FSA to allow for qualified HSA distributions. The amended plan allows an employee electing HDHP coverage for the plan year also to elect to have any health FSA balance at the end of the plan year, determined on a cash basis, contributed directly to an HSA trustee for the employee. For this purpose, the plan-year-end balance is the balance of the health FSA without regard to any expenses incurred but not paid. If an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after September 30, 2007, regardless of when the underlying expense was incurred. The health FSA does not reimburse claims submitted but unpaid as of September 30, 2007.

Horace, an employee of Water, has a balance of \$600 in the health FSA on September 21, 2006, and a balance of \$500 on September 30, 2007. On or before September 30, 2007, Horace elects HDHP coverage for the plan year beginning October 1, 2007. Horace also elects to have a qualified HSA distribution of the \$500 remaining in the health FSA on September 30, 2007. Victory contributes \$500 to an HSA on behalf of Horace on or before December 15, 2007. Horace otherwise is an eligible individual as of October 1, 2007.

Horace does not fail to be an eligible individual as of October 1, 2007, because after the qualified HSA distribution, he has a zero balance in the health FSA.

Example 5-16

Same facts as *Example 5-15*, except Victory has a limited purpose health FSA.

Ingrid, an employee of Victory, has a balance of \$2,000 in the limited purpose health FSA on September 21, 2006, and a balance of \$3,000 on September 30, 2007. On or before September 30, 2007, Ingrid elects HDHP coverage for the plan year beginning October 1, 2007. Ingrid also elects to have an HSA qualified distribution of \$2,000 that was in the health FSA on September 21, 2006. Victory contributes \$2,000 to an HSA on behalf of Ingrid on or before December 15, 2007. Ingrid has a balance of \$1,000 in a limited purpose health FSA. Ingrid otherwise is an eligible individual as of October 1, 2007.

Ingrid does not fail to be an eligible individual because she participates in an HSA-compatible health FSA.

Example 5-17

For 2007, United Corporation has a calendar year general purpose health FSA with a grace period ending on March 15, 2008. United has a fiscal year health plan that begins July 1, 2007. For the plan year beginning July 1, 2007, United offers employees the option of electing HDHP coverage.

Before January 1, 2008, United amends the health FSA to allow for qualified HSA distributions. The amended plan allows an employee electing HDHP coverage also to elect to have any health FSA balance at year-end, determined on a cash basis, contributed directly to an HSA trustee for the employee. For this purpose, the year-end balance is the balance of the health FSA without regard to any expenses incurred but not paid. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2007, regardless of when the underlying expense was incurred. The health FSA does not pay claims submitted but unpaid as of December 31, 2007.

Jose, an employee of United, has a balance of \$500 in a health FSA on September 21, 2006, and a balance of \$400 on June 30, 2007. On or before June 30, 2007, Jose elects HDHP coverage for the immediately following health plan year. Jose also elects to have a qualified HSA distribution of \$400 that was in his health FSA on June 30, 2007. United contributes \$400 to an HSA on behalf of Jose on or before September 15, 2007. Jose otherwise is an eligible individual as of July 1, 2007.

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Jose fails to be an eligible individual after the distribution because Jose's participation in a health FSA is not disregarded coverage until January 1, 2008, even though the qualified HSA distribution reduces the balance of the health FSA to zero. Jose must include \$400 in his gross income for 2007, and pay an additional 10% tax. Jose is an eligible individual on January 1, 2008.

Example 5-18

For 2007, Everglades Corporation has a calendar year general purpose health FSA with a grace period ending on March 15, 2008. Everglades offers employees the option of electing HDHP coverage for the plan year beginning January 15, 2008.

Before January 1, 2008, Everglades amends the health FSA to allow for qualified HSA distributions. The amended plan allows an employee electing HDHP coverage also to elect to have any health FSA balance at year-end, determined on a cash basis, contributed directly to an HSA trustee for the employee. For this purpose, the year-end balance is the balance of the health FSA without regard to any expenses incurred but not paid. Under the amendment, if an employee elects the qualified HSA distribution, the employee cannot submit any additional claims after December 31, 2007, regardless of when the underlying expense was incurred. The health FSA does not pay claims submitted but unpaid as of December 31, 2007.

- A. Karla, an employee of Everglades, has a balance of \$1,000 in a health FSA on September 21, 2006, and a balance of \$700 on December 31, 2007. On or before December 31, 2007, Karla elects HDHP coverage for the plan year beginning January 15, 2008. Karla also elects to have a qualified HSA distribution of the \$700 remaining in her health FSA on December 31, 2007. Everglades contributes \$700 to an HSA on behalf of Karla after February 1, 2008, but before March 15, 2008. Karla otherwise is an eligible individual as of January 15, 2008.

Karla does not fail to be an eligible individual because she has a zero balance in the health FSA after the qualified HSA distribution. Karla is eligible to contribute to the HSA as of February 1, 2008.

- B. Larry, an employee of Everglades, has a balance of \$175 in a health FSA on September 21, 2006, and a balance of \$150 on December 31, 2007. On or before December 31, 2007, Larry elects HDHP coverage for the plan year beginning January 15, 2008. Larry also elects to have a qualified HSA distribution of the \$150 remaining in the health FSA on December 31, 2007. Everglades contributes \$150 to an HSA on behalf of Larry on January 25, 2008.

Larry is not an eligible individual at the time of the distribution because he does not have HDHP coverage on the first day of January. Larry must include \$150 in gross income in 2008, and pay an additional 10% tax. As of February 1, 2008, Larry is an eligible individual because Larry has HDHP coverage and no other health plan coverage that is not an HDHP, is not enrolled in Medicare, and cannot be claimed as a dependent on another person's tax return.

Examples of Additional 10% Tax

The following examples illustrate the application of the 10% additional tax. All references to balances in the following examples are determined on a cash basis. None of the employees in the examples are disabled.

Example 5-19

Paula, who is 32 years old, has HDHP coverage as of January 1, 2008. Paula elects to have an HSA qualified distribution on or before December 31, 2007. On or before March 15, 2008, Paula's employer contributes \$250 from a general purpose health FSA to an HSA on behalf of Paula in a qualified HSA distribution. Following the qualified HSA distribution, Paula has a balance of zero in the general purpose health FSA.

In July 2008, Paula terminates employment with the employer maintaining the HDHP and begins employment with a new employer that does not offer an HDHP. Paula obtains health coverage under a low deductible health plan, and ceases to be an eligible individual for HSA purposes. Paula must include the \$250 qualified HSA distribution in her gross income for 2008, and pay an additional 10% tax under Code Section 106(e)(3). Paula does not have to withdraw the \$250 from her HSA, and the amount in the HSA may grow tax-free.

Note: The additional 10% tax in *Example 5-19* is for the failure to maintain high-deductible health plan coverage. In *Example 5-20*, the additional 10% tax is for a distribution not used for qualified medical expenses.

Example 5-20

Same facts as *Example 5-19*, except in February 2009, Paula uses \$200 from her HSA for a nonqualified medical expense. The \$200 is included in Paula's gross income for 2009 and is subject to an additional 10% tax on that amount under Code Section 223(f)(4).

Example 5-21

Same facts as *Example 5-20*, except Paula uses \$200 from her HSA for a qualified medical expense. The \$200 distributed from the HSA is not included in Paula's gross income, and there is no additional tax.

HRA/FSA Compatible Coverage Rules

The rules described above presume that the FSA or HRA is a "general purpose" arrangement, which would be disqualifying coverage for an HSA-eligible individual. If the FSA or HRA arrangement presumably is a limited purpose or other arrangement described in Rev. Rul. 2004-45, the transfer could be made at any time during the plan year, and need not result in a zero balance. Unfortunately, the Notice indicates that an employer may not convert a general purpose HRA or FSA to an HSA-compatible arrangement only for HSA-eligible individuals who elect transfers. Rather, such an arrangement would have to be converted for all employees.

Practice Note: It is not clear why the IRS has adopted this rule for HSAs. There is no statutory basis for the rule, and Notice 2007-22 is the only guidance that contains this prohibition.

Reporting FSA/HRA Transfers

An HSA qualified funding distribution is not taken into account for purposes of determining the HSA annual contribution limitation (i.e., \$2,850 for self-only coverage and \$5,650 for family coverage for 2007), and is excludable from income and wages for FICA tax purposes. Also, a transfer is not deductible as an HSA contribution on an individual's Form 1040.

It should be noted that employers must report a transfer of an HSA qualified distribution as rollover contributions to the HSA trustee/custodian, who, in turn, is required to report this information to the IRS on Form 5498-SA. Accordingly, this is an area that the IRS has some ability to monitor. Plan sponsors therefore should exercise caution in determining that all requirements described in the Notice 2007-22 have been satisfied before making the transfer.

Chapter 6

Distributions

This chapter examines distributions that are made from a Health Savings Account (HSA) and the taxation of those distributions. The chapter also discusses the treatment of the account and distributions from the account to the spouse, estate, or other beneficiary after death as well as the income tax withholding rules. Further, the chapter examines the return of contributions mistakenly made and the coordination of HSAs with the medical expense deduction. Finally, the chapter reviews distributions resulting from prohibited transactions or upon the account ceasing to be an HSA upon a pledge or security for a loan.

General Rules

An individual is permitted to receive distributions from an HSA at any time.¹ No rules require that an HSA be distributed when the account owner reaches a stated age. Thus, an HSA is not subject to any required minimum distributions at a stated age (for example, 70½).

Tax-free distribution status does not depend upon the individual who receives distributions being an “eligible individual” (see Chapter 2). Thus, tax-free distributions still may be made from an HSA to pay or reimburse the qualified medical expenses of an account owner, spouse, or dependent within the meaning of Code Section 152, whether or not such individuals currently are eligible individuals. For example, an individual who is over age 65 and entitled to Medicare benefits or who no longer has a High Deductible Health Plan (HDHP) still can receive tax-free distribution treatment as long as the distributions are used to pay qualified medical expenses.² Amounts not used for qualified medical expenses may be subject to a 10% additional tax unless an exception applies, such as when the account owner reaches age 65.

No Reversion

Because the account owner’s interest in an HSA is nonforfeitable, an employer may never request a distribution from an employee’s HSA, even to recoup a portion of a contribution that the employer made to the employee’s HSA in error or where the employee terminates employment.³

Example 6-1

On January 2, 2007, the Motor Corporation makes the maximum annual contribution to Jake’s HSA (its only employee’s HSA) with the expectation that Jake would work for the entire 2007 calendar year. On February 1, 2007, Jake terminates employment. The employer may not recoup from Jake’s HSA any portion of its previous contribution.

Example 6-2

Interociter Corporation held an open enrollment period in fall 2007 for plan year 2008 during which time employees were given the opportunity to elect either an HDHP/HSA option or an indemnity option, both of which could be paid for on a pre-tax basis under Interociter’s Code Section 125 cafeteria plan. On January 1,

¹ Notice 2004-2, Q&A 24, 2004-2 IRB 269.

² Notice 2004-2, Q&A 25, 2004-2 IRB 269.

³ IRC § 223(d)(1)(E); Notice 2004-50, Q&A 82, 2004-33 IRB 196.

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2008, the effective date of HDHP coverage, Interociter made \$500 contributions to the HSAs for all employees who had elected the HDHP option during open enrollment and timely completed the HSA paperwork. On January 2, 2008, Rod, an Interociter employee, notified the Human Resources department that he had “changed his mind” and wanted to switch to the indemnity option. Under these facts, Interociter may not permit Rod to change his election for HDHP coverage, because the election was made on a pre-tax basis through Interociter’s cafeteria plan, and none of the mid-year change events in Treasury Regulation Section 1.125-4 has occurred. “Changing one’s mind about an election” is not a permissible mid-year change event. Further, even if Interociter was able to allow Rod to change to the indemnity option on a pre-tax basis, Interociter could not withdraw the \$500 contribution made to Rod’s HSA because such contribution is nonforfeitable.

Note: If Rod had alleged that a “mistake” was made in electing the HSA/HDHP coverage, there still is no direct authority that would allow Interociter to change the amount of Rod’s salary reduction election or to recover the \$500 contribution.

Taxation of Distributions

Distributions from an HSA exclusively used to pay for qualified medical expenses of the account owner or his or her spouse or dependents generally are excludable from gross income.⁴

Distributions used for other purposes are includable in the account owner’s gross income and also may be subject to a 10% additional tax (discussed later). This tax-free distribution treatment applies to payments made directly from the HSA to the medical service provider, payments from the HSA to the account owner as reimbursement for qualified medical expenses incurred, or payments that the account owner uses to pay the service provider.⁵

Any amounts distributed from an HSA account that are not used exclusively to pay for qualified medical expenses of the account owner, spouse, and dependent (within the meaning of Code Section 152) are included in the account owner’s gross income and may be subject to a 10% additional tax.⁶ The account owner must report all HSA distributions that are not used exclusively for qualified medical expenses on Form 8889, *Health Savings Accounts* (HSAs). The taxable portion is to be included in the total on Form 1040, line 21 (or Form 1040NR, line 21), with “HSA” entered on the dotted line next to line 21.

If applicable, the 10% additional tax is computed on Form 8889 and reported on line 17(b), and the form is filed with Form 1040 (or 1040 NR). The additional tax is reported on line 63 of Form 1040 (line 58 on Form 1040NR), with “HSA” entered on the dotted line next to line 63.

Caution: Distributions from an HSA for expenses that have been previously paid or otherwise reimbursed from another source or that have been taken as an itemized deduction must be included in the account owner’s gross income and may be subject to a 10% additional tax.⁷ Distributions from an HSA made for expenses reimbursed by another health plan are not excludable from gross income, whether or not the other health plan is an HDHP.⁸

As with traditional Individual Retirement Arrangements (IRAs), an HSA is a trust or custodial account maintained by the account holder subject to its own tax rules. Accordingly, any gains on HSA investments are not taxable to the account owner. In turn, any losses on HSA assets are not deductible by the account owner.

⁴ IRC § 223(f)(1).

⁵ IRC § 223(f)(1); Notice 2004-2, Q&A 25, 2004-2 I.R.B. 269.

⁶ IRC § 223(f)(4).

⁷ Notice 2004-50, Q&A 39, 2004-33 IRB 196.

⁸ Notice 2004-50, Q&A 36, 2004-33 IRB 196; See, also, Notice 2004-2, Q&A 26, 2004-2 IRB 269.

Practice Pointer →

The taxation of reimbursements from an HSA are governed by Code Section 223, and not by Code Section 105 regarding amounts received under employer-sponsored accident and health plans or Code Section 106 regarding contributions by employers to accident and health plans. Thus, it is not necessary to rely on Code Section 105(b) to exclude an HSA distribution for medical care from income.

Losses Not Deductible

In the case of an HSA funded through a cafeteria plan, the account owner is entitled to deduct or exclude the allowable HSA contributions when they are made. Therefore, no loss on investments would be permitted because the basis in an HSA is zero, even after the account is closed. Also, because distributed amounts are not necessarily taxable, no tax loss results when the account earnings fluctuate, and none can be recognized.⁹

Example 6-3

Josephine establishes an HSA on January 1, 2007, and invests her HSA contribution of \$2,500 in one of the riskier options offered by the HSA trustee. Before Josephine withdraws any of the funds, her investment is declared worthless and her HSA account reflects a zero balance. Josephine terminates her HSA. Josephine may not claim an investment loss; she already has received a tax benefit in the form of a deduction for contributions previously made.

Note: Amounts withdrawn from an HSA for administration and account maintenance fees (for example, flat administrative fees) are not treated as a taxable distribution and are not included in the account owner's gross income (see Chapter 7).¹⁰

Responsibility

The individual who establishes the HSA is responsible for determining whether the distributions are used exclusively to pay qualified medical expenses so as to be excludible from gross income.¹¹

Individuals who establish HSAs should maintain records of their medical expenses sufficient to show that the distributions have been made exclusively for qualified medical expenses and are therefore excludable from gross income.¹² It should be noted that employers are not responsible for determining whether a particular expense is a qualified medical expense for Code Section 223 purposes.

Practice Pointer →

HSA trustees and custodians are not required to determine whether HSA distributions are used for qualified medical expenses.

Restrictions on Distributions

As a general rule, an account owner must have the ability to request a withdrawal from the HSA at any time and for any reason. However, a trustee or custodian 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

⁹ IRC § 212; Treas. Reg. § 1.212-1.

¹⁰ Notice 2004-50, Q&A 69, 2004-33 IRB 196.

¹¹ Notice 2004-2, Q&A 29, 2004-2 IRB 269.

¹² Notice 2004-2, Q&A 29, 2004-2 IRB 269; Notice 2004-50, Q&A 39, 2004-50 IRB 196.

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regarding the frequency or minimum amount of distributions from an HSA are matters of contract between the trustee and the account owner and should be specified in the trust or custodial agreement.¹³

An HSA trust or custodial agreement may not contain a provision that limits HSA distributions only to those that are used to pay or reimburse the account owner's qualified medical expenses (or the qualified medical expenses of a spouse or dependent). Thus, the account owner is entitled to distributions for any purpose and distributions can be used to pay or reimburse qualified medical expenses or other nonmedical expenditures. Only the account owner can determine how the HSA distributions will be used.

HSA Establishment

In general, qualified medical expenses may be paid or reimbursed by an HSA only if incurred after the HSA has been established.¹⁴ A transitional rule was established for 2004.

Example 6-4

Zachary, an eligible individual, establishes and contributes \$1,000 to an HSA on January 1, 2007. Shortly thereafter, on February 1, 2007, Zachary incurs a \$1,500 qualified medical expense. His HSA balance at that time is \$1,025, but he does not take a distribution. On January 1, 2008, he contributes another \$1,000 to his HSA, bringing the balance in the HSA to \$2,025. In June, 2008, Zachary takes an HSA distribution of \$1,500 to reimburse him for the \$1,500 medical expense incurred in the prior year (2007). If Zachary can show that the \$1,500 HSA distribution in 2008 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 his gross income.

Example 6-5

Same facts as *Example 6-4*, except Zachary does not establish the HSA until December 31, 2007. Under those facts, the medical expense from February 1, 2007, was incurred before the HSA was established. Thus, assuming Zachary had no other qualifying medical expenses during 2008; the \$1,500 distributed to Zachary in 2008 is includable in Zachary's gross income and may be subject to a 10% additional tax.

Transitional Rule

Because of the short period between the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (December 8, 2003), which created HSAs, and the effective date of Code Section 223 (tax years beginning after December 31, 2003), many taxpayers who otherwise would be eligible to establish and contribute to HSAs (that is, generally, individuals covered by an HDHP) were unable to do so early in 2004 because they were unable to locate trustees or custodians that were willing and able to open HSAs at that time. The IRS provided transitional relief which expired on April 15, 2005.¹⁵

For calendar year 2004, qualified medical expenses incurred on or after the later of January 1, 2004, or the first day of the month that the individual became eligible for an HSA (that is, covered under the HDHP) may be reimbursed from the HSA on a tax-free basis, as long as the HSA is established on or before April 15, 2005. In all other cases, qualified medical expenses only may be paid or reimbursed by an HSA if incurred after the HSA has been established.

¹³ Notice 2004-50, Q&A 80, 2004-33 IRB 196.

¹⁴ Notice 2004-2, Q&A 26, 2004-2 IRB 269.

¹⁵ Notice 2004-25, 2004-15 IRB 727, modifying Notice 2004-2, Q&A 26, 2004-2 IRB 269.

Both Spouses Have an HSA

In the case of married account beneficiaries, each spouse owns his or her own HSA (no joint HSA between a married couple is possible) and qualified medical expenses of either spouse may be paid from either HSA. However, both HSAs may not reimburse the same expenses.¹⁶

No Time Limit

There is no time limit for taking a distribution from an HSA to pay for a qualified medical expense incurred during any year after the date that the HSA is established. In other words, a qualified medical expense incurred in Year 1 could provide the basis for a tax-free HSA distribution in Year 10. However, the account owner must keep sufficient documentation to show later that amounts distributed were used for qualified medical expenses and were not previously paid or reimbursed from another source or claimed as an itemized deduction in a prior year.¹⁷

Code Section 105(h) Discrimination Rules

A self-insured medical reimbursement plan must satisfy the requirements of Code Section 105(h). That section is not satisfied if the plan discriminates in favor of highly-compensated individuals (generally, the top-paid 25% of the employer's workforce) as to their participation or benefit eligibility. Because the exclusion from gross income for amounts distributed from an HSA is not determined by Code Section 223(b), Code Section 105(h) does not apply to HSAs.¹⁸

Medical Care Paid From an HSA

Qualified medical expenses for HSA purposes are those expenses – incurred by the account owner, his or her spouse, and dependents – that generally would qualify for the medical and dental expense deduction under Code Section 213(a), except for health coverage premiums, which only are considered qualified medical expenses in limited circumstances described below).¹⁹ Examples include amounts paid for doctors' fees, prescription medicines, and necessary hospital services not paid for by insurance. A "prescribed drug" is a drug or biological that requires a prescription from a physician for its use by an individual. Also, nonprescription medicines are qualified medical expenses (notwithstanding that such amounts are not deductible).²⁰ Qualified medical expenses and deductions for medical expenses are described more fully below.

Medical Expenses

Code Section 213(a) allows a deduction for uncompensated expenses for medical care of an individual, the individual's spouse, or a dependent to the extent the expenses exceed 7.5% of Adjusted Gross Income (AGI). The term "medical care" means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of

¹⁶ Notice 2004-50, Q&A 38, 2004-50, 2004-33 IRB 196.

¹⁷ Notice 2004-50, Q&A 39, 2004-33 IRB 196.

¹⁸ IRC §§ 105(h), 223(b); Notice 2004-50, Q&A 83, 2004-33 IRB 196.

¹⁹ IRC § 223(d)(3). See also, Publication 969, *Health Savings Accounts and Other Tax-Favored Plans (for 2006)*, p 6; IRS Publication 502, *Medical and Dental Expenses*.

²⁰ See Notice 2004-2, Q&A 26, 2004-2 IRB 269.

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disease, or for the purpose of affecting any structure or function of the body, and includes related transportation, lodging, and premium expenses.²¹

Practice Pointer →

If an expense is not deductible under Code Section 213(a) because the 7.5% threshold is not satisfied, that expense still may be considered a qualified medical expense for HSA purposes.

Caution: Even though premiums for health coverage are deductible under Code Section 213, such amounts generally are not qualified medical expenses for HSA purposes (except for limited exceptions, discussed later).

Coordination with the Medical Expense Deduction

To prevent double dipping, any distribution for qualified medical expenses from an HSA that is not includible in the account owner's income will not be permitted to be used for purposes of determining whether the taxpayer has a deduction for medical expenses in excess of 7.5% of AGI under Code Section 213.²²

The deduction for medical care expenses is confined strictly to expenses incurred primarily to prevent or alleviate a physical or mental defect or illness. Whether an expenditure is "primarily for" medical care is a question of fact. An expense that is merely beneficial to an individual's general health is not an expense for medical care.²³

Note: Code Section 262 provides that, except as otherwise expressly provided by the Code, no deduction is allowed for personal, living, or family expenses.

Medical care expenditures that are deductible and therefore can be paid from an HSA include:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (discussed later);
2. Expenses for transportation primarily for and essential to medical care referred to above (discussed later); and
3. Amounts paid for certain lodging while away from home primarily for and essential to medical care (discussed later).

Transportation Expenses

The term "medical care" also includes transportation that is "primarily for and essential to" medical care referred to in Code Section 213.

Example 6-6

Victoria, for purely personal reasons, travels to another locality to obtain an operation and other medical care prescribed by a doctor. Because the travel expenses were not "primarily for and essential to" medical care, Victoria may not deduct the costs of transportation as a medical expense.²⁴

²¹ IRC §§ 213(a), 213(d), 213(d)(1).

²² IRC § 223(f)(6).

²³ Treas. Reg. § 1.213-1(e)(1)(ii).

²⁴ IRC § 213(d)(1); Treas. Reg. § 1.213-1(e)(1)(iv).

Example 6-7

Sheila, a child, lives away from home at a psychiatric center. Her parents incur transportation costs to visit Sheila at regular intervals on the advice of the child's doctors and as an essential part of the child's therapy. The transportation costs are "primarily for and essential to" medical care and are deductible.²⁵

Lodging Expenses

The cost of lodging (up to \$50 per night) while away from home that is primarily for and essential to medical care is deductible if:²⁶

1. The medical care is provided by a physician in a licensed hospital or a related or equivalent facility, and
2. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

Meal Expenses

Meal expenses are deductible as expenses for medical care if they are provided at a hospital or similar institution at which the taxpayer, the taxpayer's spouse, or dependent is receiving medical care.²⁷

Example 6-8

Upon the recommendation of a physician, Georgina takes a cruise to relax. She incurs transportation expenses to get to the cruise and pays for the cost of the cruise. While on the cruise, a group of doctors provide both instructional seminars relating to nutrition, exercise, and adequate sleep, and certain medical services such as counseling. The seminars are to preserve Georgina's general health only and the medical services are available in Georgina's hometown. Therefore, the transportation costs and costs of the cruise are not primarily for and essential to medical care, and thus they are not deductible.²⁸

Example 6-9

Daniel, a taxpayer, resides in City Q and is the parent of Dorothy, who is his dependent. Dorothy suffers from a chronic disease and is being treated by physician C. At C's recommendation and for the purpose of obtaining medical information that may be useful in making decisions concerning Dorothy's treatment or in providing care to Dorothy, Daniel travels to City W to attend a conference sponsored by an association that supports research and education concerning the disease. The conference is attended by medical practitioners and individuals with the disease and their families. Daniel spends the majority of his time at the conference attending sessions that disseminate medical information concerning Dorothy's disease. Other conference sessions involve presentations or discussions on legal issues, family finances, and other matters commonly arising in families in which a member has the disease. While in City W, Daniel's social and recreational activities outside of the conference are secondary to Daniel's attendance at the conference.

Daniel pays the following expenses in connection with the conference:

1. Transportation to City W.
2. Local transportation to the conference site.
3. A registration fee.
4. Meals while attending the conference.
5. Lodging at a hotel while attending the conference.

²⁵ IRC § 213; Rev. Rul. 58-533, 1958-2 CB 108.

²⁶ IRC § 213(d);(d)(1)(A).

²⁷ Treas. Reg. § 1.213-1(e)(1)(iv) and (v).

²⁸ Rev. Rul. 76-79, 1976-1 CB 70.

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Under these facts, the registration fee paid by Daniel to attend the conference is primarily for medical care, and Daniel's travel is primarily for and essential to medical care. Accordingly, Daniel may deduct the registration fee and transportation expenses under Code Section 213 (subject to that section's limitations). Daniel may not deduct the cost of meals and lodging while attending the conference because neither Daniel, his spouse, nor a dependent is receiving medical care from a physician at a licensed hospital or similar institution.²⁹ The result would be the same if Daniel, and not his dependent, was the individual with the disease. Thus, amounts paid by an individual for expenses of admission and transportation to a medical conference relating to the chronic disease of the individual's dependent are deductible as medical expenses under Code Section 213 (subject to that section's limitations), if the costs are primarily for and essential to the medical care of the dependent. The cost of meals and lodging while attending the conference are not deductible as medical expenses under Code Section 213.³⁰

Cosmetic Surgery

The term "medical care" generally does not include cosmetic surgery unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

In Private Letter Ruling 200344010, the IRS ruled that the costs of an individual's repeated cosmetic surgeries, performed to reduce a facial deformity arising out of earlier surgeries to treat several congenital abnormalities, are deductible medical expenses.³¹

Nonprescription Drugs

The term "qualified medical expenses" includes nonprescription drug expenses for medical care paid by the account owner, his or her spouse, or dependents (as defined in Code Section 152).³²

The definition of "nonprescription drugs" for this purpose is contained in Revenue Ruling 2003-102 and includes only those drugs that are used to alleviate an injury or medical condition (for example, pain reliever, antacid, allergy medicine, or cold medicine) and not merely to improve general health (for example, vitamins).³³ Such expenses only are qualified medical expenses to the extent the expenses are not covered by insurance or otherwise.

Example 6-10

Regina established an HSA. She buys a nonprescription antacid, allergy medicine, pain reliever, and cold medicine from a pharmacy. The items are either for personal use or use by her spouse or dependents to alleviate or treat personal injuries or sickness. She also buys dietary supplements—vitamins—without a prescription to maintain general health. Regina is not compensated for the expenses by insurance or other sources. Her expenses for everything but the vitamins were for medical care and are qualified medical expenses. The vitamins were merely beneficial to her general health and not an expense for medical care.³⁴

²⁹ See IRC § 213(d)(2); Treas. Reg. § 1.213-1(e)(1)(iv).

³⁰ Rev. Rul. 2000-24 (2000-1 CB 963), Rev. Rul. 76-79, 1976-1 CB 70 is distinguished.

³¹ IRC §§ 213(a), 213(d)(1)(A), 213(d)(9)(A), 213(d)(9)(B); PLR200344010 (March 27, 2003).

³² Notice 2004-2, Q&A 26, 2004-2 IRB 269.

³³ Rev. Rul. 2003-102, 2003-38 IRB 559; Notice 2004-2, Q&A 26, 2004-2 IRB 269.

³⁴ Rev. Rul. 2003-102, 2003-38 IRB 559; See, also Rev. Rul. 2003-58, 2003-22 IRB 959, regarding expenses for certain nonprescription equipment, supplies, or diagnostic devices. See, also, next example.

Health Insurance Premiums

Amounts in the HSA generally may not be used to pay health insurance premiums on a tax-free basis. The account owner would be subject to income tax and a 10% penalty for doing so. The four exceptions³⁵ to this rule are for:

1. HSA account owners who are age 65 and over (see Chapter 2)
2. Consolidated Omnibus Budget Reconciliation Act (COBRA) beneficiaries (see Chapter 2)
3. Individuals receiving unemployment compensation (see Chapter 3), and
4. Long-term care premiums (see Chapter 3)

Medicare Premiums Deducted From Social Security Benefits

HSA distributions used to reimburse a retiree Medicare beneficiary for premiums deducted from his or her Social Security benefits are qualified medical expenses.³⁶

Medigap Premiums

Premiums for Medigap policies are not qualified medical expenses.³⁷ Medigap policies are Medicare supplement insurance policies sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Medigap Plan A through Medigap Plan L. Medigap policies only work with the Original Medicare Plan.³⁸

Retiree Health Insurance

An HSA may not be used to pay for health insurance premiums on a tax-free basis unless the account owner has attained the age specified in Section 1811 of the Social Security Act (that is, age 65), is a COBRA beneficiary, or is an individual receiving unemployment compensation.³⁹ Thus, a retiree who is age 65 or older may receive tax-free distributions from an HSA to pay the retiree’s contribution to an employer’s self-insured retiree health coverage.⁴⁰ The exception applies to both insured and self-insured plans but not to Medigap coverage (see previous section).⁴¹ Also, even if an account owner is not age 65 or older, he or she, his or her spouse, and dependents can receive tax-free HSA distributions for health insurance premiums if he or she is a COBRA beneficiary or an individual receiving unemployment compensation (discussed earlier). Further, long-term care premiums may be purchased with HSA funds on a tax-free basis at any time to the extent such premiums would be a deductible medical expense.

Accident or Disability Premiums

Accident or disability insurance premiums generally cannot be paid out of an HSA. For example, even for an account owner who is age 65 or older, the tax-free reimbursement of insurance premiums from HSA funds is limited to insurance that covers “medical care” as defined in Code Section 213(d)(1)(D) (i.e., insurance premiums that can be deducted). The Code Section 213 regulations make clear that an insurance policy providing an indemnity for loss of income (i.e., due to disability) or for loss of life, limb, or sight (i.e., due to

³⁵ IRC §§ 223(d)(2)(B); 223(d)(2)(C).

³⁶ Notice 2004-50, Q&A 45, 2004-33 IRB 196.

³⁷ Notice 2004-2, Q&A 27, 2004-2 IRB 269.

³⁸ See www.Medicare.gov/glossary/search.asp (search Medigap Policy).

³⁹ IRC § 223(d)(2)(B), 223(d)(2)(C)(iv); Notice 2004-50, Q&A 44, 2004-33 IRB 196.

⁴⁰ IRC § 223(d)(2)(B), 223(d)(2)(C)(iv); see Notice 2004-2, Q&A 27, 2004-2 IRB 269.

⁴¹ Notice 2004-50, Q&A 43, 2004-33 IRB 196.

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accident) shall not be treated as covering expenses for medical care, unless such insurance contains a separate medical care component separately stated in the contract or furnished to the policyholder in a separate statement.⁴²

Expenses for Equipment, Supplies, and Diagnostic Devices

Expenses for equipment, supplies, and diagnostic devices that may be purchased without a prescription from a physician are qualified medical expenses for HSA purposes.

Example 6-11

George, who is a diabetic with an injured leg, uses crutches, bandages, and a blood sugar test kit, and takes aspirin on the recommendation of his doctor. Code Section 213(b) only allows deductions for prescribed drugs and insulin. However, for HSA purposes, expenses for medical care includes amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.⁴³

Because aspirin is a drug and does not require a physician's prescription, its cost is not deductible as a medical expense, even if a physician recommends its use to a patient. However, the cost of the aspirin may be paid from the HSA on a tax-free basis. In this case, the crutches and bandages mitigate the effect of George's injured leg and the blood sugar test kit monitors and assists in treating George's diabetes. Therefore, the costs of these items are deductible as amounts paid for medical care and are qualified medical expenses.⁴⁴

Medicine and Drugs

The term "medicine and drugs" only includes items that are legally procured and generally accepted as falling within the category of medicine and drugs. Toiletries (for example, toothpaste), cosmetics (for example, face creams), and sundry items are not medicines and drugs and amounts expended for these items are not expenditures for "medical care."⁴⁵

Medicines and drugs qualify as medical care under Code Section 213(d) only if they are "legally procured" and meet other IRS restrictions. Beginning with the 2004 version of IRS Publication 502, *Medical and Dental Expenses*, the IRS added the following item entitled, "Medicines and Drugs from Other Countries":⁴⁶

In general, you cannot include in your medical expenses the cost of a prescribed drug brought in (or ordered shipped) from another country, because you can only include the cost of a drug that was imported legally.

Exceptions

Publication 502 contains the following two exceptions from the general prohibition:

1. Prescribed drugs that the Food and Drug Administration (FDA) announces can be legally imported by individuals; and
2. Prescribed drugs purchased and consumed in another country, if the drugs are legal in both the United States and the other country.

⁴² Treas. Reg. § 1.213-1(e)(4).

⁴³ IRC § 213(d)(1).

⁴⁴ Rev. Rul. 2003-58, 2003-22 IRB 959, distinguished by Rev. Rul. 2003-102; 2003-38 IRB 559.

⁴⁵ Treas. Reg. § 1.213-1(e)(2).

⁴⁶ IRS Pub. 502 (for 2006, p 15).

Consequently, whether an HSA can reimburse claims for prescription drugs imported from Canada generally will depend upon whether the FDA has declared importation of that particular drug to be legal.

The FDA takes the position that “virtually all shipments of prescription drugs imported from a Canadian pharmacy will run afoul of the Federal Food, Drug and Cosmetic Act.”⁴⁷

The Secretary of Health and Human Services and the Secretary of Commerce indicate that very significant safety and economic issues must be addressed before prescription drug importation is permitted.⁴⁸

Long-Term Care Services

Code Section 213(d) provides that amounts paid for qualified long-term care services are considered medical care. These amounts are “qualified medical expenses” for HSA purposes. Amounts paid or distributed out of an HSA to pay for qualified medical expenses are not includible in gross income.⁴⁹ The long-term care deduction is limited to an annually adjusted amount under Code Section 213(d)(10), which is based on age.⁵⁰

The term “qualified long-term care insurance contract” is defined in Code Section 7702B(2).

Note: Employer-provided coverage for long-term care services provided through a flexible spending or similar arrangement are included in an employee’s gross income under Code Section 106.⁵¹ Although that section applies to benefits provided by a Flexible Spending Arrangement or a 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 Code Section 125 cafeteria plan.⁵²

Cafeteria Plan

Code Section 125(f) provides that the term “qualified benefit” under a Code Section 125 cafeteria plan does not include any product that is advertised, marketed, or offered as long-term care insurance. However, for HSA purposes, the payment of any expense for coverage under a qualified long-term care insurance contract is a qualified medical expense.⁵³

Note: Where an HSA that is offered under a cafeteria plan pays or reimburses individuals for qualified long-term care insurance premiums, the cafeteria plan rules are not applicable. This is because it is the HSA, and not the long-term care insurance, that is offered under the cafeteria plan.

Limitations on Long-Term Care Insurance Premiums

Code Section 213(d)(10) limits the deduction for long-term care insurance premiums, thus, the amount of distributions for qualified medical expenses that may be excluded from an account owner’s income under an HSA may be less than the actual premium paid (see **Example 6-12** below).⁵⁴

⁴⁷ See *FDA Position on Foreign Drug Imports* available at www.fda.gov/ora/import/.

⁴⁸ See *HHS Report on Prescription Drug Importation*, available at www.hhs.gov/importtaskforce/.

⁴⁹ IRC §§ 213(d)(1)(C), 223(f)(1); Notice 2004-2, Q&A 27, 2004-2 IRB 2; Notice 2004-50, Q&A 42, 2004-33 IRB 196.

⁵⁰ IRC § 213(d)(10); Notice 2004-50, Q&A 40 & 41, 2004-33 IRB 196.

⁵¹ IRC § 106(c).

⁵² IRC § 223(f)(1).

⁵³ Notice 2004-50, Q&A 40, 2004-33 IRB 196.

⁵⁴ IRC § 213(d)(10); Notice 2004-50, Q&A 41, 2004-33 IRB 196.

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Note: Although eligible long-term care insurance premiums are deductible medical expenses under Code Section 213, the deduction is limited to the annually adjusted amounts in Code Section 213(d)(10), which are based on age. Thus, HSA distributions to pay or reimburse qualified long-term care insurance premiums are qualified medical expenses, but the exclusion from gross income (tax-free distribution) is limited to the adjusted amounts. The Code Section 213(d)(10) limitations regarding eligible long-term care premiums includible in the term "medical care" for 2007 and 2008 are shown in Table 6-1.⁵⁵

Any excess premium reimbursements are includable in gross income and also may be subject to the 10% additional tax (discussed later).

Eligible Long-Term Care Premiums

Table 6-1: Eligible Long-Term Care Premiums⁵⁶

<i>Attained Age Before the Close of the Tax Year</i>	<i>Limitation on Premiums</i>	
	<i>2007</i>	<i>2008</i>
40 or less	\$ 290	\$ 310
More than 40 but not more than 50	\$ 550	\$ 580
More than 50 but not more than 60	\$1,110	\$1,150
More than 60 but not more than 70	\$2,950	\$3,080
More than 70	\$3,680	\$3,850

Example 6-12

In 2007, Carla, age 41, pays premiums of \$710 for a qualified long-term care insurance contract. The Code Section 213(d)(10) limit in calendar year 2007 for deductions for persons age more than 40, but not more than 50, is \$550. Carla's HSA can reimburse Carla up to \$550 on a tax-free basis for the long-term care premiums. The remaining \$160 (\$710 - \$550), if reimbursed from the HSA, is not for qualified medical expenses and is includable in gross income. It also may be subject to an additional 10% tax.

Deemed Distributions Due to Prohibited Transactions

If an account owner (or his or her account beneficiary) engages in a prohibited transaction during a taxable year involving the HSA, the account ceases to be an HSA as of the first day of the taxable year and is deemed distributed at that time. The deemed distribution will be treated as not being used for qualified medical expenses. Therefore, the taxpayer will be subject to income taxes and to the 10% additional tax applicable to HSA distributions that are not used for qualified medical expenses.⁵⁷ Because the account ceases to be an HSA, the prohibited transaction penalty tax does not apply.

⁵⁵ Rev. Proc. 2004-71, § 3.19, 2004-50 IRB 1; Rev. Proc. 2003-85, § 3.18, 2003-49 IRB 1184.

⁵⁶ For 2008, see Rev. Proc. 2007-66 § 3.21, 2007-45 I.R.B. ___ (Oct. 18, 2007). For 2007, see Rev. Proc. 2006-53, § 3.19, 2006-48 I.R.B. 996 (Nov. 27, 2006). For 2006, see Rev. Proc. 2005-70, § 3.19, 2005-47 I.R.B. 979 (Nov. 21, 2005).

⁵⁷ IRC §§ 223(f)(2), 408(e)(2); Notice 2004-2, Q&A 25, 2004-2 IRB 269.

Note: Notwithstanding whether an HSA is a plan within the meaning of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (see Chapter 8), the Code Section 4975 prohibited transaction provisions are applicable to an HSA.⁵⁸ However, if the account ceases to be an HSA as of the first day of the year because the account owner engages in a prohibited transaction, the 15% prohibited transaction penalty tax does not apply. Neither will the tax apply if the account is treated as distributing all its assets on the first day of the year because of the account owner's pledging the account or a portion of the account as security for a loan.⁵⁹

Prohibited Transaction

A prohibited transaction includes any direct or indirect:⁶⁰

- Sale, exchange, or lease of any property between a plan⁶¹ and a disqualified person⁶²;
- Loan of money or other extension of credit between a plan and a disqualified person;
- Provision of goods, services, or facilities between a plan and a disqualified person;
- Transfer to, or use by or for the benefit of, a disqualified person of the income or assets of a plan;
- Act by a disqualified person who is a fiduciary⁶³ whereby he or she deals with the income or assets of a plan in his or her own interest or for his or her own account; or
- Receipt of any consideration for his or her own personal account by any disqualified person who is a fiduciary from any party dealing with the plan in connection with a transaction involving the income or assets of the plan.

Prohibited Transaction Penalty Tax

The penalty for initial violations is 15% of the amount involved for prohibited transactions occurring after August 5, 1997. If the transaction is not corrected, there is a second-tier excise tax of 100% of the amount involved.⁶⁴ The penalty tax does not apply, however, if the account ceased to be an HSA as of the first day of the year on account of the account owner engaging in a prohibited transaction or pledging the HSA account as security for a loan.⁶⁵ Excise taxes are not deductible.

Waiver of Prohibited Transaction Rules

The Secretary of Labor has established a procedure under which a conditional or unconditional exemption from all or part of the prohibited transaction rules may be granted to any disqualified person or transaction or to any class of disqualified persons or transactions.⁶⁶ The Secretary of Labor generally may not grant an exemption unless he or she finds that such an exemption is:

⁵⁸ IRC §§ 223(e)(2), 408(e), 4975(e)(1).

⁵⁹ IRC § 4975(c)(6).

⁶⁰ IRC § 4975(c); ERISA § 406; see DOL Interpretive Bulletin 94-3, 59 FR 66735 (1994) (in-kind contributions to satisfy statutory or contractual funding obligations); *Marshall v Snyder*, 430 F Supp 1224 (E.D.N.Y. 1977), aff'd in part and remanded in part, 572 F. 2d 894 (2d Cir. 1978) (furnishing of goods, services, or facilities); *Leigh v. Engle*, 727 F. 2d 113 (7th Cir 1984) (self-dealing); *New York State Teamsters Council Health & Hospital Fund v. Estate of De Perno*, 816 F. Supp. 138 (N.D.N.Y. 1993), aff'd in part and remanded, 18 F. 3d 179 (2d Cir. 1994) (self-dealing, financial loss to trust fund not necessary); See, also, DOL Advisory Opinions 86-01A, 88-03A, 89-089A, 93-06A (direct expenses of salary and related cost of employees that work on plans).

⁶¹ As defined in IRC § 4975(e)(1) to include an HSA account.

⁶² As defined in IRC § 4975(e)(2).

⁶³ As defined in IRC § 4975(E)(3).

⁶⁴ IRC § 4975(a); SBJPA § 1453(a); TRA '97 § 1074(a).

⁶⁵ IRC § 4975(c)(6).

⁶⁶ DOL Reg. § 2570.30-2570.52.

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1. Administratively feasible;
2. In the interests of the plan and its participants and beneficiaries; and
3. Protective of the rights of plan participants and beneficiaries.⁶⁷

The Secretary of Labor has delegated this authority, along with most other responsibilities under ERISA, to the Assistant Secretary for the Employee Benefits Security Administration (EBSA).⁶⁸

Disqualified Persons and Parties-in-Interest

Disqualified Person under the Code

For purposes of the Code, the term “disqualified person” refers to any of the following:⁶⁹

1. A fiduciary (see below);
2. A person providing services to a plan;
3. An employer, any of whose employees are covered by a plan;
4. An employee organization, any of whose members are covered by a plan;
5. An owner, direct or indirect, of 50% or more of the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation, the capital interest or the profits interest of a partnership, or the beneficial interest of a trust or unincorporated enterprise that is an employer or an employee organization described in 3. or 4.;
6. A member of the family (spouse, ancestor, lineal descendant, or any spouse of a lineal descendant) of a person described in 1., 2., 3., or 5.;
7. A corporation, partnership, or trust or estate of which (or in which) 50% or more of the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation, the capital interest or profits interest of such partnership, or the beneficial interest of such trust or estate is owned directly or indirectly or held by a person described in 1., 2., 3., 4., or 5.;
8. An officer or director (or an individual having powers or responsibilities similar to those of an officer or a director), a 10% or more shareholder, or a highly compensated employee (earning 10% or more of the yearly wages of an employer) of a person described in 3., 4., 5., or 7.; or
9. A 10% or more (in capital or profits) partner or joint venturer of a person described in 3., 4., 5., or 7.

Note: ERISA prohibits certain transactions between a plan and a party-in-interest. Under the Code, the term “disqualified person” is used instead of “party-in-interest” and is defined slightly differently.

Party-in-Interest under ERISA

For purposes of ERISA, the term “party-in-interest” refers to the following:⁷⁰

1. Any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of an employee benefit plan;
2. A person providing services to a plan;⁷¹
3. An employer, any of whose employees are covered by a plan;
4. An employee organization, any of whose members are covered by a plan;

⁶⁷ IRC § 4975(c)(2); Reorg Plan No. 4 of 1978, 43 Fed Reg 47, 713 (Oct 17, 1978) (transferring the authority of the Secretary of the Treasury to issue rulings under Code Section 4975 to the Secretary of Labor).

⁶⁸ Secretary of Labor's Order 1-87, 52 FR 13, 139 (April 28, 1987).

⁶⁹ IRC § 4975(e)(2).

⁷⁰ ERISA § 3(14).

⁷¹ See *Harris Trust and Savings Bank v. Solomon Smith Barney*, 530 U.S. 238 (2000) (broker-dealer providing nondiscretionary equity trades to a plan automatically classified as a party in interest).

5. An owner, direct or indirect, of 50% or more of the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation, the capital interest or the profits interest of a partnership, or the beneficial interest of a trust or unincorporated enterprise that is an employer or an employee organization described in 3. or 4.;
6. A relative (spouse, ancestor, lineal descendant, or any spouse of a lineal descendant) of any person described in 1., 2., 3., or 5.;
7. A corporation, partnership, or trust or estate of which (or in which) 50% or more of the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation, the capital interest or profits interest of such partnership, or the beneficial interest of such trust or estate is owned directly or indirectly or held by persons described in 1., 2., 3., 4., or 5.;
8. An employee, an officer or director (or an individual having powers or responsibilities similar to those of an officer or a director), a 10% or more shareholder, or a highly compensated employee (earning 10% or more of the yearly wages of an employer) of a person described in 3., 4., 5., or 7.; or
9. A 10% or more (in capital or profits) partner or joint venture of a person described in 3., 4., 5., or 7.

ERISA Fiduciary

Under ERISA, the term “fiduciary” refers to any person who:⁷²

1. Exercises any discretionary authority or discretionary control respecting management of a plan or exercises any authority or control respecting management or disposition of its assets;
2. Renders investment advice for a fee or other compensation, direct or indirect, as to any monies or other property of a plan, or has any authority or responsibility to do so (except as provided under the exemptions for personalized investment advice, discussed below); or
3. Has any discretionary authority or discretionary responsibility in the administration of a plan.

Because the plan administration is the responsibility of the plan administrator under ERISA, the plan administrator is a fiduciary and thus is subject to the fiduciary duties imposed by ERISA.

Prohibited Transaction HSA Guidance

The U.S. Department of Labor (DOL) Field Assistance Bulletin (FAB) 2006-02 (October 27, 2006), clarifies the following issues as to the application of the Code Section 4975 prohibited transaction rules to HSAs:

- HSA providers may offer cash incentives that are put directly into accounts, without violating the prohibited transaction rules.
- An employer must promptly transmit an account owner’s HSA contributions to the HSA provider; otherwise fiduciary and prohibited transaction issues could be raised for the employer.
- An employer who selects an HSA vendor may not receive a discount on another product from the HSA vendor.
- Certain ERISA prohibited transaction class exemptions that apply to owners of IRAs do not apply to HSA account owners. In particular, the DOL has issued a number of class exemptions that permit the aggregation of IRAs and non-IRA accounts for purposes of qualifying for discounted or no cost services. By their terms, these exemptions do not apply to all “plans” subject to Section 4975, and instead are specifically limited to IRAs (including Simple Employee Pension – IRA (SEP-IRA) plans and Savings Incentive Match Plan for Employees – IRA (SIMPLE-IRA) plans. As such, the DOL’s guidance as to Prohibited Transaction Exemptions (PTEs) 97-11, 93-33, and 93-1 is not surprising. What is less clear, however, is the availability of other exemptions that apply to all “plans” under Code Section 4975 for HSAs. For example, PTEs 75-1 and 84-24 may cover investment advice to plans and should cover HSAs, as well as IRAs, because HSAs are “plans” under Section 4975.

⁷² ERISA § 408(a)(1).

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- An HSA account owner may direct the payment of HSA funds to a credit line vendor to reimburse the vendor for HSA expenses paid with a credit card, but certain other transactions involving a line of credit associated with an HSA could raise prohibited transaction issues.

Personalized Investment Advice

The Pension Protection Act of 2006 (PPA)⁷³ added a new category of prohibited transaction exemption—under ERISA Section 408(b)(14) and Code Section 4975(d)—applicable to the provision of investment advice through an “eligible investment advice arrangement” to beneficiaries who direct the investment of their accounts under a plan subject to Code Section 4975, including an HSA. If the exemption’s requirements are met, the following are exempt from prohibited transaction treatment:⁷⁴

1. The provision of investment advice;
2. An investment transaction (i.e., a sale, acquisition, or holding of a security or other property) under the advice; and
3. The direct or indirect receipt of fees or other compensation in connection with the provision of the advice or an investment transaction under the advice.

Note 1: The prohibited transaction exemptions described above do not alter existing individual or class exemptions provided by statute or administrative action.

Note 2: The PPA also directs the Secretary of Labor, in consultation with the Secretary of Treasury, based on certain information to be solicited by the Secretary of Labor, to determine whether there is any computer model investment advice program that meets certain statutory requirements of the exemption and may be used with regard to IRAs (and perhaps HSAs).⁷⁵

The determination is to be made by December 31, 2007. If the Secretary of Labor determines that a program meets the provision’s requirements, the exemptions described above apply in connection with the use of the program as to beneficiaries of a plan that is subject to Code Section 4975 (e.g., a defined contribution plan, an IRA, an HSA, an Archer MSA, and a Coverdell Education Savings Account). If the Secretary of Labor determines that there is not such a program, the Secretary is directed to grant a class exemption from prohibited transaction treatment (as discussed below) for the provision of investment advice, the investment transactions under such advice, and the receipt of related fees by the investment adviser.

Note 3: In order for an HSA to be outside the scope of ERISA coverage, as discussed in Chapter 8, an employer, among other things, must not make or influence the investment decisions as to funds contributed to an HSA. Therefore, notwithstanding these PPA provisions regarding investment advice, an employer should avoid offering or arranging for such advice, as to an HSA, if it does not want the HSA to become subject to ERISA.⁷⁶

Eligible Investment Advice Arrangements

The exemption applies in connection with the provision of investment advice by a fiduciary adviser under an “eligible investment advice arrangement.” An eligible investment advice arrangement is an arrangement:

⁷³ P.L. 109-280, 120 Stat. 780.

⁷⁴ ERISA §§ 408(b)(14), 408(g), 4975(d)(17), 4975(f)(8), as amended by PPA § 601.

⁷⁵ PPA § 601; Compare DOL Advisory Opinion 2001-09A (Dec, 14, 2001) available at <http://www.dol.gov/ebsa/programs/ori/advisory2001/2001-09A.htm>.

⁷⁶ Field Assistance Bulletin 2004-01 (April 7, 2004); DOL Field Assistance Bulletin 2006-02 (October 27, 2006).

1. That meets certain requirements (discussed below), and
2. Which either:
 - a. Provides that any fees (including any commission or compensation) received by the fiduciary adviser for investment advice or as to an investment transaction involving plan assets do not vary depending on the basis of any investment option selected, or
 - b. Uses a computer model under an investment advice program as described below in connection with the provision of investment advice to a participant or beneficiary.

In the case of an eligible investment advice arrangement, the arrangement must be expressly authorized by a plan fiduciary other than the person offering the investment advice program, or any person providing investment options under the plan, including an affiliate of either person.

Investment Advice Program Using Computer Model

In general, if an eligible investment advice arrangement provides investment advice under a computer model, the model must satisfy all of the following requirements:

1. Applies generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time;
2. Uses relevant information about the participant or beneficiary;
3. Uses prescribed objective criteria to provide asset allocation portfolios comprised of investment options under the plan;
4. Operates in a manner that is not biased in favor of any investment options offered by the fiduciary adviser or related person; and
5. Takes into account all the investment options under the plan in specifying how a participant's or beneficiary's account should be invested without the inappropriate weighting of any investment option.

An "eligible investment expert" must certify, before the model is used and in accordance with rules prescribed by the Secretary of Labor, that the model meets these requirements. The certification must be renewed if there are material changes to the model as determined under regulations. For this purpose, an eligible investment expert is a person who meets requirements prescribed by the Secretary and who does not bear any material affiliation or contractual relationship with any investment adviser or related person.

Also, if a computer model is used, the only investment advice that may be provided under the arrangement is the advice generated by the computer model, and any investment transaction under the advice must occur solely at the direction of the participant or beneficiary. This requirement does not preclude the participant or beneficiary from requesting other investment advice, but only if the request has not been solicited by any person connected with carrying out the investment advice arrangement.

Audit Requirements

In the case of an eligible investment advice arrangement, an audit is required at the times and in the manner prescribed by the Secretary of Labor. Special audit requirements may apply to a qualified defined contribution plan as to an eligible investment advice arrangement (e.g., audit by a person unrelated to those offering an individual advice arrangement).

Notice Requirements

Before the initial provision of investment advice, the fiduciary adviser must provide written notice (which may be in electronic form) containing various information to the advice's recipient, including information relating to:

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1. The role of any related party in developing the investment advice program or selecting investment options under the plan;
2. Past performance and rates of return for each investment option offered under the plan;
3. Any fees or other compensation to be received by the fiduciary adviser or affiliate;
4. Any material affiliation or contractual relationship of the fiduciary adviser or affiliates in the security or other property involved in the investment transaction;
5. The manner and under what circumstances any participant or beneficiary information will be used or disclosed;
6. The types of services provided by the fiduciary adviser in connection with the provision of investment advice;
7. The adviser's status as a plan fiduciary in connection with providing advice; and
8. The ability of the advice's recipient to separately arrange for the provision of advice by another adviser that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property.

This information must be maintained in accurate form and must be provided to the investment advice's recipient, without charge, on an annual basis, on request, or in the case of any material change.

Any notification must be written in a clear and conspicuous manner, calculated to be understood by the average plan participant, and sufficiently accurate and comprehensive so as to reasonably apprise participants and beneficiaries of the required information. The Secretary of Labor is directed to issue a model form for the disclosure of fees and other compensation as required by the provision. The fiduciary adviser must maintain for at least six years any records necessary for determining whether the prohibited transaction exemption requirements were met. A prohibited transaction will not be considered to have occurred solely because records were lost or destroyed before the end of six years due to circumstances beyond the adviser's control.

Additional Requirements

In order for the exemption to apply, the following additional requirements must be satisfied:

1. The fiduciary adviser must provide disclosures applicable under securities laws;
2. An investment transaction must occur solely at the direction of the recipient of the advice;
3. Compensation received by the fiduciary adviser or affiliates in connection with an investment transaction must be reasonable; and
4. The terms of the investment transaction must be at least as favorable to the plan as an arm's length transaction would be.

Fiduciary Adviser

For purposes of the exemption, a "fiduciary adviser" is defined as a person who is a plan fiduciary by reason of the provision of investment advice to a participant or beneficiary and who also is:

- A registered investment adviser under the Investment Advisers Act of 1940 or under state laws;
- A bank, a similar financial institution supervised by the United States or a state, or a savings association (as defined under the Federal Deposit Insurance Act), but only if the advice is provided through a trust department that is subject to periodic examination and review by federal or state banking authorities;
- An insurance company qualified to do business under state law;
- A registered broker or dealer under the Securities Exchange Act of 1934;
- An affiliate of any of the preceding; or
- An employee, agent, or registered representative of any of the preceding who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of advice.

A person who develops the computer model or markets the investment advice program or computer model is treated as a person who is a plan fiduciary by reason of the provision of investment advice and is treated as a fiduciary adviser, except that the Secretary of Labor may prescribe rules under which only one fiduciary adviser may elect treatment as a plan fiduciary. The term “affiliate” means an affiliated person as defined under section 2(a)(3) of the Investment Company Act of 1940. The term “registered representative” means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 or a person described in section 202(a)(17) of the Investment Advisers Act of 1940.

Fiduciary Rules

Subject to certain requirements, an employer or other person who is a plan fiduciary, other than a fiduciary adviser, is not treated as failing to meet the fiduciary requirements of ERISA solely by reason of the provision of investment advice as permitted under this exemption,⁷⁷ or of contracting for or otherwise arranging for the provision of the advice. This rule applies if: (1) the advice is provided under an arrangement – between the employer or plan fiduciary and the fiduciary adviser – whereby the fiduciary adviser provides investment advice as permitted under the exemption; (2) the terms of the arrangement require compliance by the fiduciary adviser with the requirements of the exemption; and (3) the terms of the arrangement include a written acknowledgement by the fiduciary adviser that the fiduciary adviser is a plan fiduciary as to the provision of the advice.

Caution: The employer or a plan fiduciary retains responsibility under ERISA for the prudent selection and periodic review of a fiduciary adviser with whom the employer or plan fiduciary has arranged for the provision of investment advice, if ERISA applies. However, the employer or plan fiduciary does not have the duty to monitor the specific investment advice given by a fiduciary adviser. The exemption also provides that nothing in the ERISA fiduciary responsibility provisions is to be construed to preclude the use of plan assets to pay for reasonable expenses in providing investment advice.

Special HSA/IRA Determination

Under the exemption, the Secretary of Labor must determine, in consultation with the Secretary of Treasury, whether any computer model investment advice program that can be used by IRAs and HSAs meets certain statutory requirements of the exemption. Unless the Secretary of Labor determines that there is a computer model investment advice program that can be used by IRAs and HSAs, the exemption as to an eligible investment advice arrangement involving a computer model does not apply to IRAs and HSAs. If the Secretary of Labor determines that there is no such program, the Secretary is directed to grant a class exemption, from prohibited transaction treatment (as discussed above), for the provision of investment advice, investment transactions pursuant to such advice, and the receipt of related fees by the investment adviser, with respect to the beneficiaries of such IRAs or similar arrangements including HSA.

Any person may request the Secretary of Labor to make a determination as to any computer model investment advice program as to whether it can be used by IRAs and HSAs, and the Secretary must make such determination within 90 days of the request.

Effective Date

The investment adviser provisions are effective as to investment advice provided on or after January 1, 2007. The provision relating to the study by the Secretary of Labor is effective on the enactment date.

⁷⁷ ERISA § 408(b) and IRC § 4975(d)(17).

Transactions with Service Providers

The PPA offers relief in that a transaction between a plan and a party-in-interest, who is not a fiduciary, is not a prohibited transaction (i.e., sale, exchange, lease, loan, or use of plan assets) under ERISA Section 406 so long as the plan receives no less than or pays no more than adequate consideration for the transaction.⁷⁸

Note: A person designated by a named fiduciary to carry out fiduciary responsibilities (other than trustee responsibilities under the plan) is treated as a fiduciary. Accountants, attorneys, actuaries, insurance agents, and consultants who provide services to a plan generally are not considered fiduciaries unless they exercise discretionary authority or control over the plan management or administration of the plan assets, even if such activities are unauthorized.⁷⁹

Note: Because an HSA account owner may be the only individual who exercises discretionary authority or discretionary control as to management or disposition of its assets, the account owner may be the only fiduciary as to the HSA.

Other Issues

Pledging of Account

If an account owner pledges any portion of an HSA as security for a loan, the portion pledged is treated as a deemed distribution as of the first day of the taxable year and is subject to income tax and the 10% additional tax on HSA distributions that are not used for qualified medical expenses.⁸⁰ The prohibited transaction penalty tax does not apply to a deemed distribution.

Note: Any amount treated as distributed as the result of pledging the amount as security for a loan will not be treated as used to pay for qualified medical expenses. Therefore, the account owner must include the distribution in gross income and generally will be subject to the additional 10% tax on distributions not used for qualified medical expenses.⁸¹

Cash Incentives

It is possible for an insurer to offer a cash incentive to establish an HSA and an HDHP without violating the prohibited transaction rules. The DOL approved an insurer's program that awarded \$100 bonus payment to anyone who signs up for an HSA and an HDHP with the insurer. The DOL also approved a similar situation in which a bank that had a contractual relationship with an insurer offered a \$100 cash bonus if an individual established an HSA with the bank and an HDHP with the insurer. In both cases, (1) the individual was not required to make a contribution to receive the \$100 bonus payment, (2) the payment, which could not be

⁷⁸ IRC § 4975(d)(20); ERISA §§ 406(a)(1)(A), (B) and (D); 408(b)(17); See PPA § 611.

⁷⁹ ERISA § 3(21)(A); PWBA Interpretive Bulletin 75-5, Q&A D-1; DOL Reg. § 2509.75-5, Q&A D-1; *John Hancock Mut Life Ins Co v Harris Trust & Sav Bank*, 510 US 86 (1993); *Kaniewski v Equitable Life Assurance Soc'y*, No. 88-01296, 1993 WL 88200 (6th Cir Mar 26, 1993) (unpublished opinion); *Kyle Rys Inc v Pacific Admin Servs Inc*, 990 F2d 513 (9th Cir 1993) (third-party administrator); *Nieto v Ecker*, 845 F2d 868 (9th Cir 1988) (attorneys); *Olson v EF Hutton & Co*, 957 F2d 622 (8th Cir 1992); *Procacci v Drexel Burnham Lambert*, No. 89-0555 (ED Pa 1989); *Painters of Phila Dist Council No. 21 Welfare Fund v Price Waterhouse*, 879 F2d 1146 (3d Cir 1989)(accountants); *Pappas v Buck Consultants Inc*, 923 F2d 531 (7th Cir 1991) (actuaries); *Schloegel v Boswell*, 994 F2d 266 (7th Cir 1993)(insurance agent).

⁸⁰ IRC §§ 223(e)(2), 408(e)(4).

⁸¹ IRC § 223(f)(2); Notice 2004-2, Q&A 25, 2004-2 IRB 269.

diverted, was made directly into the individual's HSA, and (3) neither the HDHP premiums nor HSA account charges would vary (increase or decrease) as a result of the cash bonus payment. Thus, in those situations, the \$100 cash bonus payment program was not a prohibited transaction.⁸²

If the cash bonus payment were to be made to the individual (or other disqualified person), the payment would have constituted a prohibited transaction. Similarly, if the cash bonus payment was conditioned on the investment in products of the bank or insurer, the cash bonus program likely would constitute a prohibited transaction. The controlled group rules under Code Sections 414(b), (c), and (m) also would have to be considered in some situations in determining the identity of all disqualified persons.⁸³

The 10% Additional Tax

Unless an exception applies (discussed in the following section), all HSA distributions not used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or a dependent are subject to a 10% additional tax.⁸⁴

Caution: A distribution that does not violate the contribution limit may not be treated as a distribution of an excess amount. Individuals may not elect to treat a distribution as a correction of an excess contribution unless they violate their contribution limit.⁸⁵ Any distribution from the account that is not a correction of a true excess is subject to the additional 10% tax to the extent it is not used for qualified medical expenses, unless another exception applies.

Exceptions to the 10% Additional Tax

The four general exceptions to the 10% additional tax on distributions not used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or a dependent are as follows:

1. *Disability.* Distributions made after the account owner becomes disabled.⁸⁶
2. *Death.* Distributions made to the designated beneficiary(ies) upon the account owner's death.⁸⁷
3. *Age, currently 65.* Distributions made to an account owner after such individual becomes eligible for Medicare; that is, the age specified in Section 1811 of the Social Security Act (currently age 65).⁸⁸
4. *Rollovers and transfers.* Distributions from an HSA that later are rolled over to another HSA within 60 days after the day of receipt of the distribution or transferred directly from one HSA to another HSA (see Chapter 5).

Note: If an account owner timely withdraws earnings from an HSA due to having excess contributions and such amounts are not used for one of the exceptions above, the 10% additional tax does not appear to apply.⁸⁹ To be timely, earnings must be withdrawn in a correcting distribution before the filing due date. This issue may be addressed in future guidance. See Chapter 4.

Also, these additional exceptions avoid the 10% additional tax:

⁸² IRC § 4975(c)(2), 4975(e)(1)(E); DOL Advisory Opinion 2004-09A (Dec. 22, 2004).

⁸³ DOL Advisory Opinion 2004-09A (Dec. 22, 2004), footnotes 2 and 4.

⁸⁴ IRC § 223(f)(4)(A); Notice 2004-2, Q&A 25, 2004-2 IRB 269.

⁸⁵ Notice 2004-50, Q&A 35, 2004-33 IRB 196.

⁸⁶ IRC § 223(f)(4)(B).

⁸⁷ IRC § 223(f)(4)(B).

⁸⁸ IRC § 223(f)(4)(C).

⁸⁹ See Notice 2004-50, Q&A-34, 2004-33 IRB 196 (no suggestion of 10% additional tax).

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- A distribution made by a mistake of fact due to reasonable cause that is timely repaid into an HSA (see later discussion).
- An eligible rollover distribution that is deposited into another HSA within 60 days of the receipt of the distribution (see Chapter 5).⁹⁰
- A direct transfer (trustee-to-trustee) of an HSA account from one spouse to another spouse, or former spouse, under a divorce or separation instrument (see Chapter 5).⁹¹

Rollovers and transfers are discussed in Chapter 5.

Disabled Definition

An individual is disabled if all three of the following conditions are satisfied:⁹²

- The individual is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment;
- The disability is expected to result in death or to be of a long-continued and indefinite duration; and
- The individual furnishes proof of the disability in the form and manner required by the IRS.

Whether the impairment in a particular case constitutes a disability is determined with reference to all the facts in the case. The following are examples of impairments that ordinarily would be considered as preventing substantial gainful activity:

1. Cancer that is inoperable or progressive;
2. Loss of use of two limbs;
3. Certain progressive diseases that have resulted in the physical loss or atrophy of a limb, such as diabetes, multiple sclerosis, or Buerger's disease;
4. Diseases of the heart, lungs, or blood vessels that have resulted in major loss of heart or lung reserve as evidenced by X-ray, electrocardiogram, or other objective findings, so that, despite medical treatment, breathlessness, pain, or fatigue is produced on slight exertion, such as walking several blocks, using public transportation, or doing small chores;
5. Damage to the brain or a brain abnormality that has resulted in severe loss of judgment, intellect, orientation, or memory;
6. Mental diseases (for example, psychosis or severe psychoneurosis) requiring continued institutionalization or constant supervision of the individual;
7. Loss or diminution of vision to the extent that the affected individual has a central visual acuity of no better than 20/200 in the better eye after best correction, or has a limitation in the fields of vision such that the widest diameter of the visual fields subtends an angle no greater than 20 degrees;
8. Permanent and total loss of speech; and
9. Total deafness uncorrectable by a hearing aid.

The existence of one or more of the impairments described above (or of an impairment of greater severity) will not, however, in and of itself always permit a finding that an individual is disabled. Any impairment, whether of lesser or greater severity, must be evaluated in terms of whether it does in fact prevent the individual from engaging in the individual's customary or any comparable substantial gainful activity.⁹³

⁹⁰ IRC § 223(f)(2), 223(f)(5).

⁹¹ IRC § 223(f)(7).

⁹² IRC § 72(m)(7).

⁹³ Treas. Reg. § 1.72-17A(f)(2).

Substantial Gainful Activity

The term “substantial gainful activity” for purposes of the disability exception means an activity or any comparable activity in which an individual customarily engaged before the disability occurred.⁹⁴

In determining whether an individual’s impairment renders the individual unable to engage in any substantial gainful activity, primary consideration is given to the impairment’s nature and severity. Consideration also is given to other factors such as the individual’s education, training, and work experience. The substantial gainful activity is the activity, or a comparable one in which the individual customarily engaged before the disability occurred or before retirement if the individual was retired at the time the disability arose.⁹⁵

An impairment that is remediable does not constitute a disability. An individual will not be deemed disabled if, with reasonable effort and safety, the impairment can be diminished to the extent that it will not prevent the individual from engaging in the customary or any comparable substantial gainful activity.⁹⁶

Indefinite Duration

The term “indefinite duration” for purposes of the disability exception means that the individual is unable to reasonably anticipate that the disability will, in the foreseeable future, be so diminished as to no longer prevent any substantial gainful activity. For example, an individual who suffers a bone fracture that prevents the individual from working for an extended period of time will not be considered disabled, if recovery can be expected in the foreseeable future; however, if the fracture persistently fails to knit, the individual ordinarily would be considered disabled.⁹⁷

Returning Distributions Mistakenly Made

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 owner can repay the mistaken distribution no later than April 15 following the first year that the account owner knew or should have known the distribution was a mistake (provided the trustee allows this).⁹⁸

Reasonable Cause

In general, reasonable cause exists when there is “clear and convincing evidence” the account owner reasonably, but mistakenly, believed that an expense was a qualified medical expense and was reimbursed for that expense from the HSA.⁹⁹

No Obligation to Accept

A trustee or custodian is not obligated to accept a return of a mistaken distribution. If the trustee agrees to accept a return due to a mistake of fact, the trustee may rely upon the account owner’s representation that the contribution is a repayment of a mistake-of-fact distribution and not subject to the contribution limit.¹⁰⁰

⁹⁴ Treas. Reg. § 1.72-17A(f)(1).

⁹⁵ Treas. Reg. § 1.72-17A(f)(1).

⁹⁶ Treas. Reg. § 1.72-17A(f)(4).

⁹⁷ Treas. Reg. § 1.72-17A(f)(3); *Williams v. Comm.*, TC Summ. Op. 2004-57 (May 13, 2004); *Meyer v. Comm.*, T.C. Memo 2003-12 (Jan. 13, 2003).

⁹⁸ Notice 2004-50, Q&A 37, 2004-33 IRB 196.

⁹⁹ Notice 2004-50, Q&A 37, 2004-33 IRB 196.

¹⁰⁰ Notice 2004-50, Q&A 76, 2004-33 IRB 196.

Tax Treatment

A mistake-of-fact HSA distribution that is properly and timely re-deposited into an HSA is treated as follows:¹⁰¹

- The distribution is not included in gross income.
- The distribution is not subject to the 10% additional tax.
- The repayment is not subject to the 6% excise tax on excess contributions (see Chapter 4).

Death Distributions to Designated Beneficiaries

General rules upon the death of the HSA account owner depend upon the identity of the designated beneficiary, as follows.

Spouse Beneficiary

If the HSA account owner designated his or her spouse as the designated beneficiary, the surviving spouse automatically is treated as the new HSA account owner after the decedent account owner's death. This means that when the HSA account owner dies, if the surviving spouse is the designated beneficiary, the HSA automatically is assumed by the surviving spouse.¹⁰²

A surviving spouse who assumes ownership of an HSA is subject to income taxes only to the extent that HSA distributions are not used to pay for qualified medical expenses.¹⁰³

Nonspouse Beneficiary

If a nonspouse beneficiary (other than the estate) is designated as the beneficiary, the account ceases to be an HSA on the date of the decedent account owner's death, and the fair market value of the HSA account on the date of death is treated as taxable to the nonspouse beneficiary in the taxable year that included the date of death.¹⁰⁴

Practice Pointer →

A nonspouse designated beneficiary is entitled to the income in respect to a decedent deduction under Code Section 691.¹⁰⁵

Note: Earnings in the HSA account after the date of the decedent account owner's death must be included on the recipient's tax return because the account has ceased to be an HSA and has lost its tax-exempt status.

Estate Beneficiary

If the decedent account owner's estate is the designated beneficiary, the fair market value of the HSA on the date of death is includible on the decedent account owner's final return.

¹⁰¹ Notice 2004-50, Q&A 37, 2004-33 IRB 196.

¹⁰² IRC § 223(f)(8)(A).

¹⁰³ Notice 2004-2, Q&A 31, 2004-2 IRB 269.

¹⁰⁴ IRC § 223(f)(8)(B)(i)(I), 223(f)(8)(B)(i)(II); Notice 2004-2, Q&A 31, 2004-2 IRB 269.

¹⁰⁵ IRC §§ 223(f)(8)(B)(i), 691(c).

Exception

Distributions made to a designated beneficiary are not taxable to the extent that the decedent account owner incurred qualified medical expenses before death and the designated beneficiary pays such amounts within one year of the date of death.¹⁰⁶

Note: If the designated beneficiary is the estate, and the decedent account owner's gross income for the last taxable year is increased by the amount of the distribution, the estate taxes are reduced by such amount.¹⁰⁷

Federal Estate Tax

Generally, there is no specific exclusion for HSAs under the federal estate tax rules. Therefore, in the event of death, the HSA balance will be includible in the decedent account owner's gross estate for federal estate tax purposes. However, if the surviving spouse is the HSA beneficiary, the amount in the HSA may qualify for the marital deduction available under Code Section 2056.

Federal Gift Tax

The amount that a beneficiary receives from an HSA plan is not treated as a transfer of property for federal gift tax purposes.¹⁰⁸

Income Tax Withholding on HSA Distributions

Code Section 3405 does not apply because an HSA would not be considered a pension plan. Distributions used to pay for qualified medical expenses are not subject to income tax, so no withholding of federal income tax would apply.

However, in cases where the HSA distribution is not used for medical expenses, or the HSA account owner dies and the designated beneficiary either is a nonspouse or the decedent account owner's estate, the value of the distribution would become taxable.

Although certain distributions may be taxable, the payer of the HSA distribution is not required to withhold income taxes from the distribution. The account owner is responsible for determining the taxability or nontaxability of any distribution from an HSA.

¹⁰⁶ IRC § 223(f)(8)(B)(ii)(I).

¹⁰⁷ IRC § 223(f)(8)(B)(ii)(II).

¹⁰⁸ IRC §§ 2503(e)(1), 2503(e)(2)(A).

Chapter 7

Administration and Compliance

This chapter examines the administrative and compliance issues relating to trustees and custodians as to IRS reporting and participant information reporting. The chapter also discusses the sponsor's use of model documents for establishing Health Savings Accounts (HSAs) as well as restrictions on investments and distributions. Finally, the chapter addresses specific requirements for filing IRS forms.

HSA Documents

HSAs can be offered in the form of trusts or custodial accounts.¹ Whether an arrangement constitutes a trust or custodial arrangement is determined under state law. An HSA trust or custodial account must be created in the United States for the exclusive benefit of the account owner.

Trustee vs. Custodian

The differences between a “custodian” and a “trustee” are minor.

A trust is a legal entity under which assets actually are owned and held on behalf of a beneficiary. As the legal owner, a trustee has some level of discretionary fiduciary authority over the entity's assets. The trustee must exercise that authority in the best interests of the beneficiary (the account owner).

A custodial arrangement is similar to a trust, but the custodian simply holds the assets on behalf of their owner. Other than holding the assets and doing as the owner orders, the custodian has no fiduciary obligations to the owner.

HSA Model Forms

The IRS issued model forms that trustees and custodians can use to allow individuals to establish an HSA: model Form 5305-B, *Health Savings Trust Account*, and model Form 5305-C, *Health Savings Custodial Account*, in August 2004.²

The final versions of Forms 5305-B and 5305-C differ from their draft versions in only a few respects. The changes mainly clarified that:

- Individuals no longer are eligible to contribute to an HSA after they are enrolled in Medicare (as opposed to when an individual “is eligible for Medicare” or “reaches age 65”). Thus, otherwise eligible individuals who actually are not enrolled in Medicare Part A or Part B may contribute to an HSA until the month that they actually enroll in Medicare.
- Eligibility and contribution limits are determined monthly (although there is no actual monthly limit).
- An insurance company, not just a life insurance company, can be the HSA trustee or custodian.

¹ IRC § 223(d)(1), 223(d)(4)(E).

² Notice 2004-50, Q&A 62, 2004-33 IRB 196.

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- If the account owner's estate is the beneficiary, the account's fair market value as of the date of death is taxable on the account owner's final return. For other beneficiaries, the account's fair market value is taxable to that person in the taxable year that includes that date.

No Filing of Model Forms with the IRS

The IRS preapproved the HSA model forms. The forms are not to be filed with the IRS and should be kept with the account owner's permanent tax records.

The model forms are drafted to allow for the inclusion of additional provisions that the trustee or custodian and the account owner agree upon. Article XI (in both model forms) and any that follow it may add or incorporate additional provisions agreed to by the account owner and trustee or custodian.

Note: The model HSA forms likely will be modified for the new rules that allow a one-time transfer from a Flexible Spending Arrangement (FSA) and a one-time transfer from an Individual Retirement Arrangement (IRA) or Roth IRA which are transferred directly to fund an HSA (see Chapter 5).

Examples of Additional Provisions

The HSA model forms contain specific instructions that list numerous examples of provisions that may be added or incorporated into them. The sponsor may attach additional pages if necessary. The additional provisions, for example, may include:

- Definitions;
- Restrictions on rollover contributions from HSAs or Archer Medical Savings Accounts (Archer MSAs) (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period);
- Investment powers;
- Voting rights;
- Exculpatory provisions;
- Amendment and termination;
- Removal of trustee or custodian;
- Trustee or custodian's fees;
- State law requirements;
- Treatment of excess contributions;
- Distribution procedures (e.g., frequency or minimum dollar amount);
- Use of debit, credit, or stored-value cards;
- Return of mistaken distributions; and
- Descriptions of prohibited transactions.

Inconsistent Provisions

The model forms treat any provision added or incorporated as being "void" if it is inconsistent with Code Section 223 or IRS published guidance.³

Prototype Document Approval

The IRS, at the time of publication, has not released a procedure for approval of a prototype HSA trust or custodial account. The IRS did release draft forms in June 2004, "to allow HSA trustees and custodians to use

³ Form 5305-B, Art IX; Form 5305-C, Art IX.

some or all of the language from the draft forms in their own trust or custodial agreements.” Master and prototype (M&P) programs for HSA accounts likely will be announced shortly.

Note: The 2004 draft forms were not intended to be used as stand-alone trust or custodial agreements until finalized.⁴

Establishment of HSA

Model Forms 5305-B and 5305-C each are considered established when the form is fully executed by both the account owner and the trustee or custodian. The form can be completed at any time during the taxable year. However, an HSA account cannot be effective before the effective date of the eligible individual’s High Deductible Health Plan (HDHP) coverage (see Chapter 2).

Identifying Number

The model HSA trust and custodial account require the use of the account owner’s Social Security number as the identifying number.

Documentation

The plan sponsor should provide a trust document or custodial agreement, a disclosure statement, and an adoption agreement for the account owner to complete and sign. Organizations that offer an HSA also may use certain administrative forms to facilitate such items as beneficiary designations, contributions, and distribution requests.

Investments

The following rules pertain to HSA investments:

- HSA funds may be invested in any investments approved for IRAs (for example, bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds).⁵
- HSAs may not invest in life insurance contracts or in collectibles (for example, any work of art, antique, metal, gem, stamp, coin, alcoholic beverage, or other tangible personal property specified in IRS guidance under Code Section 408(m)(3)).
- HSAs may invest in certain types of bullion or coins, as described in Code Section 408(m)(3).

Restrictions

The HSA trust or custodial agreement may restrict investments to certain types of permissible investments (for example, particular investment funds).⁶

Trustees and custodians also are subject to the rules against prohibited transactions. The same rules that apply to account beneficiaries apply to trustees and custodians (see Chapter 6).⁷

⁴ Treasury Press Release, Office of Public Affairs, June 25, 2004 (JS-1748).

⁵ Notice 2004-50, Q&A 65, 2004-33 IRB 196.

⁶ Notice 2004-50, Q&A 65, 2004-33 IRB 196.

⁷ Notice 2004-50, Q&A 68, 2004-33 IRB 196.

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The HSA trust or custodial agreement may not contain a provision that restricts HSA distributions only to pay or reimburse the account owner's qualified medical expenses.⁸

Commingling

Code Section 223(d)(1)(D) states that the HSA trust assets may not be commingled with other assets except in a common trust fund or common investment fund. Individual accounts maintained on behalf of HSA individual account beneficiaries may be held in a common trust fund or common investment fund.⁹ A "common trust fund" is defined in Treasury Regulation Section 1.408-2(b)(5)(ii). A "common investment fund" is defined in Code Section 584(a)(1).

Note: An Employer Identification Number (EIN) is required for a common trust fund created for HSAs.

Account Fees

An amount withdrawn from an HSA for administration and account maintenance fees (for example, flat administrative fees) will not be treated as a taxable distribution and will not be included in the account owner's gross income.¹⁰

Fees Withdrawn From HSA

If administration and account maintenance fees are withdrawn from the HSA, the withdrawn amount does not increase the HSA maximum annual contribution limit. For example, if the maximum annual contribution limit for self-only coverage is \$2,850 (the 2007 limit), and a \$25 administration fee is withdrawn from the HSA, the annual contribution limit still is \$2,850, not \$2,825.¹¹

Fees Paid Into HSA

Administration and account maintenance fees may be paid directly by the account owner or the employer and, if so, will not be considered contributions to the HSA. For example, an individual contributes to his HSA the maximum annual amount of \$2,850 for 2007. The account owner pays an annual administration fee of \$25 directly to the trustee. The individual's maximum annual contribution limit (\$2,850) is not affected by the payment of the administration fee.¹²

Trustees and Custodians

Any insurance company or any bank (including a similar financial institution as defined in Code Section 408(n)) can be an HSA trustee or custodian. Insured banks and credit unions automatically are qualified to handle HSAs. Any bank, credit union, or any other entity that currently meets the IRS standards for being a trustee or custodian for an IRA or an Archer MSA can be an HSA trustee or custodian.

Also, any other person already approved by the IRS to be a trustee or custodian of an IRA or an Archer MSA automatically is approved to be an HSA trustee or custodian. Other persons may request approval to be a

⁸ Notice 2004-50, Q&A 79, 2004-33 IRB 196.

⁹ IRC § 223(d)(1)(D).

¹⁰ Notice 2004-50, Q&A 69, 2004-33 IRB 196.

¹¹ Notice 2004-50, Q&A 70, 2004-33 IRB 196.

¹² Notice 2004-50, Q&A 71, 2004-33 IRB 196.

trustee or custodian in accordance with the procedures set forth in Treasury Regulation Section 1.408-2(e) (relating to IRA nonbank trustees).¹³

An individual will not qualify to be an HSA trustee or custodian if he or she would not satisfy many requirements to be a nonbank trustee or custodian (for example, continuity of existence).

Contribution Limits

The trustee or custodian may not accept annual contributions to any HSA that exceed the statutory maximum annual contribution and catch-up contribution limits (see Chapter 4), except in the case of rollover contributions or trustee-to-trustee transfers (see Chapter 5).¹⁴

All contributions must be in cash, other than rollover contributions or trustee-to-trustee transfers.¹⁵

The account owner is responsible for determining whether contributions to an HSA exceed the maximum annual contribution limit for a particular account owner.¹⁶

Excess Contributions

The account owner is 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.¹⁷

Information Reporting

The trustee or custodian is responsible for filing required information returns with the IRS (Form 5498-SA and Form 1099-SA).¹⁸

Age Determination

The trustee or custodian may rely on the account owner's representation regarding his or her date of birth.¹⁹

Return of Mistaken Distributions

The trustee or custodian does not have to permit account beneficiaries to return mistaken distributions to the HSA. However, if the HSA trust or custodial agreement allows the return of mistaken distributions (discussed in Chapter 6), the trustee or custodian may rely on the account owner's representation that the distribution, in fact, was a mistake.²⁰ The trustee or custodian is required to correct any filed Form 1099-SA with the IRS and account beneficiary which reflected the mistaken distributions because such repayments are not included in gross income, are not subject to the 10% additional tax, and the payment is not subject to the excise tax on

¹³ Notice 2004-50, Q&A 72, 2004-33 IRB 196.

¹⁴ Notice 2004-50, Q&A 73, 2004-33 IRB 196.

¹⁵ IRC § 223(d)(1)(A); Notice 2004-50, Q&A 73, 2004-33 IRB 196.

¹⁶ Notice 2004-50, Q&A 74, 2004-33 IRB 196.

¹⁷ Notice 2004-50, Q&A 74, 2004-33 IRB 196.

¹⁸ IRC § 223(h); Notice 2004-50, Q&A 74, 2004-33 IRB 196.

¹⁹ Notice 2004-50, Q&A 75, 2004-33 IRB 196.

²⁰ Notice 2004-50, Q&A 76, 2004-33 IRB 196.

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excess contributions. The trustee or custodian must correct Form 1099-SA as soon as it becomes aware of the error. It also should be noted that the repayment is not treated as a contribution on Form 5498-SA.

Accepting Rollovers and Transfers

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.²¹ Similarly, a *qualified HSA distribution* from a FSA and a *qualified HSA funding distribution* from an IRA which are transferred directly to fund an HSA are allowed, but trustees or custodians are not required to accept them.²² See Chapter 5.

Reasonable Restrictions

Trustees or custodians may place reasonable restrictions both on the frequency and the minimum amount of distributions from an HSA.²³

Where a trustee or custodian does not sponsor the HDHP, the trustee or custodian may require proof or certification that the account owner is an eligible individual.²⁴

Reports

The statute provides that two types of reports may be required in connection with an HSA.²⁵ Specifically, the Secretary of Treasury may require:

1. The HSA trustee to make such reports regarding such account to the Secretary and to the account owner as to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate.²⁶
2. Any person who provides an individual with an HDHP to make such reports to the Secretary and to the account owner as to such plan as the Secretary determines appropriate.²⁷

The reports required by the Secretary of Treasury are described below.²⁸

Failure to File Reports

Generally, if a trustee or an employer fails to file a required report (other than an information return or a payee statement), there is a \$50 penalty for each failure unless it is shown that such failure is due to reasonable cause.²⁹

²¹ Notice 2004-50, Q&A 78, 2004-33 IRB 196; Notice 2004-2, Q&A 23, 2004-2 IRB 269.

²² The qualified HSA distribution rules apply to distributions made after December 20, 2006. The qualified HSA funding distribution rules are effective for taxable years beginning after 2006. See Tax Relief and Health Care Act of 2006 (TRHCA) (P.L. 109-432), Sections 302(c)(1), 307(c).

²³ Notice 2004-50, Q&A 80, 2004-33 IRB 196.

²⁴ Notice 2004-2, Q&A 10, 2004-2 IRB 269.

²⁵ IRC § 223(h).

²⁶ IRC § 223(h)(1).

²⁷ IRC § 223(h)(2).

²⁸ IRC § 223(f).

²⁹ IRC §§ 223(h), 6693(a)(1), 6693(a)(2)(c), 6724(d)(1)(C)(i) (concerning information returns), 6724(d)(2)(W) (concerning payee statements).

Reporting HSA Contributions on Form 5498-SA

Purpose of Form 5498-SA

Form 5498-SA, *HSA, Archer MSA, or Medicare Advantage MSA Information*, is used to report contributions to HSAs, Archer MSAs, or Medicare Advantage MSAs (MA-MSAs). A separate Form 5498-SA must be filed for each account type.

Who Must File

The trustee or custodian must file Form 5498-SA with the IRS and provide a copy to each person for whom it maintained an HSA (or Archer MSA or MA-MSA) during the year.

Rollovers

The receipt of a rollover from an Archer MSA or an HSA to an HSA (and the receipt of a rollover from one Archer MSA to another Archer MSA) are reported in box 4.

Transfers

The trustee or custodian does not report a trustee-to-trustee transfer from an Archer MSA to an HSA or from one HSA to another HSA (or one Archer MSA or MA-MSA to another Archer MSA or MA-MSA). For reporting purposes, contributions and rollovers do not include these transfers. On the other hand, a qualified HSA distribution from an employer's FSA or an HRA is to be reported in box 4 on Form 5498-SA as a rollover contribution. A qualified HSA distribution also is reported by the employer in box 12 of Form W-2.

Beginning in 2007, a qualified funding distribution which is transferred from an IRA to an HSA will be treated as a contribution to the HSA by the trustee or custodian on Form 5498-SA. A qualified funding distribution is subject to the maximum annual contribution limit (\$2,850 for self-only coverage or \$5,650 for family coverage for 2007).

Total Distribution/No Contribution

Generally, if a total distribution was made from an HSA during the year and no contributions were made for that year, a Form 5498-SA is not required to be filed. Neither is a fair market value (FMV) statement required to be furnished to the account owner because the FMV on December 31 would be zero.

Due Dates

If required, the 2007 version of Form 5498-SA must be filed with the IRS by June 2, 2008.

If Form 5498-SA is required, a statement must be provided to the account owner (generally Copy B) by June 2, 2008. The trustee or custodian may, but is not required to, provide a statement of the December 31, 2007, FMV of the account owner's account by January 31, 2008.³⁰

Death of Owner

In the year that an HSA owner dies, Form 5498-SA generally is required to be filed and the trustee or custodian is required to provide a statement of the December 31 FMV of the decedent's account by the following May 31.

³⁰ See, Part C in the 2007 *General Instructions for Forms 1099, 1098, 5498, and W-2G*.

Note: If the beneficiary is the spouse, the spouse becomes the HSA account owner, and the spouse (if an eligible individual) may make contributions to the HSA. If the beneficiary is not the spouse or there is no named beneficiary, the account ceases to be an HSA, an Archer MSA, or a MA-MSA (see Chapters 5 and 6).

Completion of Boxes on Form 5498-SA

For 2007, the HSA distribution reporting codes for Form 5498-SA purposes are as follows:

- *Box 1:* This box is used to report Archer MSA contributions. Do not report HSA contributions in this box.
- *Box 2: Total Contributions Made in 2007.* Enter total HSA (or Archer MSA) contributions made in 2007, including contributions made in 2008 and designated for the prior year (2007).

Note: For contributions made between January 1 and April 15, the trustee or custodian should obtain the participant's designation of the year for which the contributions are made.

- *Box 3: Total HSA (or Archer MSA) Contributions Made in 2008 for 2007.* Enter total HSA made in 2008 for 2007. Do not include repayments of mistaken distributions. The trustee or custodian may have to file a corrected Form 1099-SA for mistaken contributions. A corrected Form 1099-SA must be filed with the IRS and a copy provided to the account owner as soon as the trustee or custodian becomes aware of the mistaken distribution.
- *Box 4: Rollover Contributions.* Enter any rollover contribution to an HSA (or Archer MSA) received during 2007. Do not report any direct trustee-to-trustee transfers. Also included are qualified HSA funding distributions (direct transfers of employer contributions) from a Health Care Flexible Spending Arrangement (FSA) or Health Reimbursement Arrangement (HSA) to fund an HSA. The amount on line 4 is not included in box 1, 2, or 3.

A rollover is where the account owner takes a distribution from one account and has a 60-day period to redeposit (roll over) into another account.

- *Box 5: Fair Market Value.* Enter the FMV of the HSA (or MSA) on December 31, 2007.
- *Box 6: Checkbox.* Check the "HSA" box.

Reporting HSA Distributions on Form 1099-SA

Purpose of Form 1099-SA

Form 1099-SA, Distributions From an HSA, Archer MSA, or Medicare Advantage MSA, is used to report distributions made from an HSA, an Archer MSA, or a MA-MSA. A separate return must be filed for each plan type. Form 1099-SA is not required to be filed if no distributions have been made from the account for a year.

All distributions from an HSA are required to be reported for the year during which a distribution takes place.

Who Must File

The trustee or custodian must file Form 1099-SA with the IRS and for each person for whom it maintained an HSA (or an Archer MSA or a MA-MSA) during the year if a distribution was made from the account. Rollovers and transfers from one HSA to another HSA are not treated as distributions for reporting purposes.

Also, the trustee or custodian may have to file a corrected Form 1099-SA for mistaken contributions. A corrected Form 1099-SA must be filed with the IRS and a copy provided to the account owner as soon as the trustee or custodian becomes aware of the mistaken distribution.

Recipients of Form 1099-SA

If a distribution was made, Form 1099-SA is required to be filed with the IRS, and the payer also must furnish a statement to recipients containing the information furnished to the IRS and, in some cases, additional information.

Due Dates

If Form 1099-SA is required to be filed with the IRS, Copy B of the form or a substitute statement must be provided to the account owner by January 31 following the year of the distribution.

If required to be filed, the 2007 version of Form 1099-SA must be filed with the IRS by February 28, 2008, or by March 31, 2008, if filed electronically. The electronic and magnetic media filing requirements for 2007 are contained in Revenue Procedure 2007-51 (2007-30 I.R.B. 143).

Substitute Statement

Generally, a substitute statement is any statement other than Copy B (and C, in some cases) of the official form. Substitute statements may be developed or purchased from a private printer. However, the substitutes must comply with the format and content requirements specified in IRS Publication 1179, *General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and W-2G (and 1042-S)*.

Treatment of Transfers

For reporting purposes, contributions and rollovers do not include direct transfers from an Archer MSA to an HSA or from one HSA to another HSA.

Completion of Form 1099-SA

The rules and coding for Form 1099-SA depend upon when the distribution is made (that is, whether in the year of death or in the year after the year of death). If the HSA account owner dies and the beneficiary is his or her spouse, the spouse becomes the account owner. If the named beneficiary is anyone other than the spouse, the account ceases to be an HSA on the date of the decedent account owner's death. If there is no named beneficiary, or the decedent account owner's estate becomes the beneficiary, the FMV of the HSA as of the date of death is required to be reported in box 4 of Form 1099-SA.

Note: The account owner is responsible for determining whether a distribution is used for qualified medical expenses and to determine any taxes or penalties due (see Chapter 6). For 2007, the numbered boxes on Form 1099-SA (2007) are completed as follows:

Box 1: Gross Distribution

This shows the amount distributed from the HSA for the year. Enter the gross amount of the distribution, including any earnings on excess contributions reported in box 2. The payer is not responsible for determining the taxable amount of a distribution. The distribution may have been paid directly to a medical service provider or the account owner. If the payment was made directly to a medical service provider, show the account owner as the recipient.

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Death. The gross distribution also is reported when a final distribution is made to the beneficiary in the year of the decedent account owner's death or in a year after the year of death. Do not report a negative amount in box 1.

Box 2: Earnings on Excess Contributions

Enter only the earnings attributable to an excess contribution made to an HSA or Archer MSA that was returned to the account owner by the due date of the account owner's tax return. This amount also is included in box 1. However, earnings on other distributions only are reported in box 1.

Note: In the case of a nonspouse beneficiary of a decedent account owner, any earnings on the account after the date of death, box 1 minus box 4 of Form 1099-SA, are taxable. In the case of an HSA, the amount included on the federal income tax return (other than an estate) is first reduced by any payments from the HSA made for the decedent's qualified medical expenses incurred before the decedent's death and paid within one year after the date of death.

Box 3: Distribution Code

Enter one of the following distribution codes. If more than one code applies to multiple distributions from the same account, separate Forms 1099-SA must be filed showing the proper code for that distribution.

- *Code 1, normal distributions.* Use Code 1 for normal distributions to the account owner and any direct payments to a medical service provider. Use this code if no other code applies.
- *Death.* If the final distribution is made to a surviving spouse beneficiary after the decedent account owner's year of death, use Code 1.
- *Code 2, excess contributions.* Use Code 2 for distributions of excess HSA contributions.
- *Code 3, disability.* Use Code 3 if distributions are made after the account owner was disabled (within the meaning of Code Section 72(m)(7)).
- *Code 4, death distribution (other than Code 6).* Use Code 4 for payments to a decedent's estate in the year of death. Also use Code 4 for payments to an estate after the year of death. Do not use with Code 6.

Note: If the estate is the beneficiary, enter the estate's name and taxpayer identification number (TIN) in place of the recipient's TIN on the form.

- *Code 5, prohibited transaction.* Use Code 5 for amounts treated as distributed if the HSA account loses its exemption from taxation when the account owner or the decedent account owner's beneficiary engages in a prohibited transaction.³¹
- *Pledge of account.* To the extent that HSA assets are pledged as security for a loan and treated as distributed, use Code 5.³²
- *Code 6, death distribution after year of death to a nonspouse beneficiary.* Use Code 6 for payments to a nonspouse beneficiary, other than an estate, after the year of death. Do not use with Code 4. See Codes 1 and 4.

Box 4: FMV on Date of Death

Enter the FMV of the account on the decedent account owner's date of death.

³¹ IRC § 223(e)(2).

³² IRC § 223(e)(2).

Note: If an HSA is inherited by a nonspouse beneficiary, the FMV on the date of death is reported on the beneficiary's tax return for the year in which the decedent account owner dies, even if the distribution is received in a later year.

If the HSA account owner dies and the beneficiary is the spouse, the spouse becomes the account owner. If the named beneficiary is anyone other than the spouse, the account ceases to be an HSA on the date of the decedent account owner's death. If there is no named beneficiary, or the person's estate becomes the beneficiary, the HSA's FMV as of the date of death is required to be reported in box 4 of Form 1099-SA.

Box 5: Checkbox

This shows the type of account that is being reported. Check the appropriate box (for example, HSA, Archer MSA, or MA-MSA).

Reporting Additional Taxes on Excess HSA Contributions on Form 5329

Purpose of Form 5329

Form 5329, *Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts*, is used by individuals to report additional taxes on many different types of retirement, education, and health arrangements. Part VII of Form 5329 addresses the tax on excess contributions to an HSA under Code Section 4973 (discussed later).

Who Must File Form 5329

An individual must file Form 5329 for 2007 if contributions as to 2007 exceed the maximum contribution limit.

Note: Form 5329 also is required to be filed if a tax is due from an excess contribution on line 17 (regarding traditional IRAs), line 25 (regarding Roth IRAs), line 33 (regarding Coverdell Education Savings Accounts (ESAs)), or line 41 (regarding Archer MSAs) of the prior year's (2007) Form 5329. However, excess contributions to an HSA for the prior year are addressed on Form 8889 (discussed later).

No Joint Filings of Form 5329

In the case of a joint return, if both spouses are required to file Form 5329, a separate form must be completed for each spouse. The combined tax is reported on Form 1040, line 60 (or Form 1040NR, line 55).

Amended return. If filing an amended 2007 Form 5329, check the box at the top of page 1 of the form. Do not use the 2007 Form 5329 to amend a return for any other year.

Due Date

Form 5329 is filed as an attachment to Form 1040 by the due date, including extensions, of Form 1040. If Form 1040 is not required to be filed, Form 5329 is completed and filed itself at the time and to the place that Form 1040 would be required to be filed.

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Note: Be sure to include the address information and the signature. Enclose, but do not attach, a check or money order payable to "United States Treasury" for any taxes due. For 2007 contributions, write the Social Security number and "2007 Form 5329" on the check.

Prior tax years. If filing Form 5329 for a prior year, use that year's version of the form. Unless there are other changes, the form can be filed by itself; otherwise file Form 5329 for that year with Form 1040X, *Amended U.S. Individual Income Tax Return*.

Completion of Part VII of Form 5329

If the contributions to an individual's HSA exceed the contribution limit and were not timely removed (see Chapter 6), Part VII must be completed, as follows:

Line 42. Enter the excess contributions from line 48 of the prior year (2006).

Line 43. Enter the difference between what could have been contributed to the HSA for 2007 (from Form 8889, line 10) and the amount that was contributed for 2007 (from Form 8889, line 2). Otherwise enter zero.

Note: Also enter on Form 8889, line 11, the smaller of line Form 5329, line 43, or the excess (if any) of Form 5329 lines 42 over line 44.

Line 44. Enter 2007 distributions from HSA (from Form 8889, line 14).

Line 45. Add lines 43 and 44.

Line 46. Prior year excess contributions (subtract line 45 from line 42, if zero or less, enter zero).

Line 47. Excess 2007 contributions. Enter the contributions made for 2007 (unless withdrawn) that exceed the contribution limit for 2007. The instructions for Form 8889 explain how to figure excess contributions. Some or all of the excess contributions for 2007 may be withdrawn, and they will not be treated as having been contributed if:

- The withdrawal is made by the due date, including extensions, of the 2007 return;
- No exclusion from income is claimed for the amount of the withdrawn contributions; and
- Any earnings on the withdrawn contributions also are withdrawn and included in gross income.

Line 48. Add lines 46 and 47.

Line 49. The 6% tax (or, if less, the HSA's FMV on December 31, 2007) is calculated and reported on line 49. The amount of tax also is entered on Form 1040, line 60 (or Form 1040NR, line 55). The December 31st balance includes contributions made in 2008 for 2007.

Extension for Timely Filers

If the tax return was timely filed without withdrawing the excess contributions, the withdrawal can be made no later than six months after the tax return's due date, excluding extensions. If applicable, file an amended return with "Filed pursuant to section 301.9100-2" written at the top. Report any related earnings for 2007 on the amended return and include an explanation of the withdrawal. Make any other necessary changes on the amended return (for example, if the contributions were reported as excess contributions on the original return, include an amended Form 5329 reflecting that the withdrawn contributions no longer are treated as having been contributed).

Reporting Excise Tax on Prohibited Transactions on Form 5330

Purpose of Form 5330

Form 5330, *Return on Excise Taxes Related to Employee Benefit Plans*, is used to report any tax on a prohibited transaction (see Chapter 6). Code Section 4975 generally imposes an excise tax on a disqualified person that engages in a prohibited transaction with an HSA (as well as other types of health, education, and retirement plans).

Note: If the account owner engages in a prohibited transaction as to an HSA, the account ceases to be an HSA, and the prohibited transaction tax does not apply. Other individuals who are disqualified individuals (for example, the employer), however, may have participated in the prohibited transaction and are required to file Form 5330.

Caution: An HSA may be subject to the excise tax on prohibited transactions under Code Section 4975 (see Chapters 2 and 8).³³

Due Date

If a prohibited transaction is subject to the prohibited transaction excise tax, Form 5330 is required to be filed by the last day of the seventh month after the end of the taxable year of the employer or other person who must file the return.

Completion of Form 5330

When a disqualified person participates in a prohibited transaction involving an HSA (other than his or her own account that ceases to be an HSA), he or she must complete Part IV, Tax on Prohibited Transactions, and Part V, *Schedule of Other Participating Disqualified Persons and Description of Correction*, of Form 5330. If all prohibited transactions have not been corrected by the end of the taxable year, an explanation must be attached that indicates when each correction has been or will be made.

The tax determined in Part IV (line 25c) is then entered on line 6a of the form on page 1. The total tax due is shown on line 13c. “Form 5330, Section(s) 4975, [enter applicable Code sections]” should be shown on the payment along with the taxpayer’s name and taxpayer identification number.

Reporting HSA Contributions and Distributions on Form 8889

Purpose of Form 8889

The purpose of Form 8889, Health Savings Accounts (HSAs), is to:

- Report HSA contributions (including those made on the HSA owner’s behalf and employer contributions);
- Calculate the HSA deduction; and
- Report distributions from HSAs.

³³ IRC § 4975. See, IRC § 4975(d), 4975(f)(6)(B)(ii), and 4975(f)(6)(B)(iii) for specific exemptions to prohibited transactions. See also, IRC § 4975(c)(2) for certain other transactions or classes of transactions that may be exempt.

Who Must File Form 8889

The HSA account owner must file the 2007 version of Form 8889 with the IRS as an attachment to Form 1040 by the account owner if either of the following apply:

- Contributions were made to the HSA, including contributions made on the account owner's behalf and by the account owner's employer in 2007.
- The account owner received distributions from his or her HSA in 2007.

Also, if a beneficiary (including an estate) acquired an interest in an HSA because of the death of the account owner, Form 8886 must be filed.

Practice Pointer →

Forms 1040EZ or 1040A are designed to be filed without attachments, so a taxpayer (who otherwise is qualified to use either form) would be unable to report contributions and distributions if filing Form 1040EZ or 1040A. Form 8889 must be attached to Form 1040.

Filing Upon Death of Owner

If the decedent account owner's surviving spouse is the designated beneficiary, the HSA is treated as if the surviving spouse were the account owner. The surviving spouse completes Form 8889 as though the HSA belonged to him or her.

If the designated beneficiary is not the decedent account owner's surviving spouse, or there is no designated beneficiary, the account ceases to be an HSA as of the date of death. The beneficiary completes Form 8889 as follows:

- Enter "Death of HSA account beneficiary" across the top of Form 8889.
- Enter the name(s) and the Social Security number shown on the account owner's tax return in the spaces provided at the top of the form and skip Part I, regarding contributions and deductions.
- On line 14a, enter the HSA's FMV as of the date of death.
- On line 15, for a beneficiary other than the estate, enter qualified medical expenses incurred by the account beneficiary before the date of death that are paid within one year after the date of death.
- Complete the rest of Part II.

If the decedent account owner's estate is the beneficiary, the value of the HSA's value as of the date of death is included on the decedent account owner's final income tax return. Complete Form 8889 as described above, except Part I should be completed if applicable.

<p><i>Note:</i> The distribution is not subject to the additional 10% tax. Report any earnings on the account after the date of death as income on the beneficiary's tax return.</p>
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Reporting Contributions and Deductions

Part I of Form 8889 is used to figure the HSA deduction, any excess contributions made (including those made on the account owner's behalf), and any excess contributions made by an employer.

The amount that may be deducted for HSA contributions is limited by the applicable portion of the HDHP's annual deductible (line 3) reduced by any contributions to the taxpayer's Archer MSAs (line 4) and any employer contributions (line 9).

If the account owner is age 55 or older at the end of 2007, he or she can increase the contribution limit by up to \$800 (the 2007 catch-up contribution limit; line 3 or line 7 depending on the type of coverage and marital status).

An individual can make deductible contributions to an HSA even if his or her employer made contributions.

Complete as instructed lines 1 through 13 on the form. However, if married filing jointly, and each spouse has a separate HSA and an HDHP with family coverage, complete a separate Form 8889 for each spouse using the rules described in Chapter 4. Combine the amounts on line 13 of both Forms 8889 and enter this amount on Form 1040, line 25 (or Form 1040NR, line 25) (for 2007). Be sure to attach both Forms 8889 to the tax return.

If an individual does not have the same coverage on the first day of every month during 2007, or was age 55 or older at the end of 2007, work through the chart (see Chapter 4; also in the Form 8889 instructions) for each month of 2007. Enter the result on the worksheet next to the corresponding month. If eligibility and coverage did not change from one month to the next, enter the same number that was entered for the previous month. This may limit the amount permitted to be deducted.

Employer contributions include any amount that an employer contributes to an HSA. These contributions should be shown in box 12 of Form W-2 with Code W. If an employer made excess contributions, the excess may have to be reported as income. The excess employer contributions are the excess, if any, of the employer's contribution over the taxpayer's limitation shown on line 8 of Form 8889. If the excess was not included in income on Form W-2, it is to be reported as "Other income" on Form 1040 (unless corrected, see Chapter 4).

The allowable HSA deduction (taking into account employer contributions that were excluded from income) is shown on line 13 of Form 8889.

Practice Pointer →

If line 2 (actual contributions) is more than line 13 (deductible contributions), the individual made an excess contribution. See the prior discussion of Form 5329 and methods of correction to avoid the 6% tax on excess contributions.

Deemed Distributions

The following situations resulting in deemed distributions from an HSA are reported in the following manner:

1. *The owner participated in a prohibited transaction as to an HSA at any time in 2007.* The account ceases to be an HSA as of January 1, 2007, and the fair market value (FMV) of all assets in the account of January 1, 2007 must be included on line 14a.
2. *Any portion of an HSA was used as security for a loan at any time in 2007.* The FMV of the assets used as security for the loan must be included as income on Form 1040, line 21. On the dotted line next to line 21, enter "HSA" and the amount.

Distribution Reporting—Part II of Form 8889

If a distribution is made from an HSA, Part II, HSA Distributions, of Form 8889 must be completed. Complete Part II as follows:

- *Line 14a.* Enter the total distributions received in 2007 from all HSAs. These amounts should be shown in box 1 of Form 1099-SA.

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- *Line 14b.* Include any distributions received in 2007 that qualified as rollover contributions to another HSA. Also include any excess contributions (and the earnings on those excess contributions) included on line 12a that were withdrawn by the due date, including extensions, of the return.
- *Line 15.* In general, include distributions from all HSAs in 2007 that were used for the qualified medical expenses of the account owner and his or her spouse or dependents that were incurred on or after the first day of the first month that the HSA account owner became an eligible individual.

Caution: No deduction may be claimed on Schedule A (Form 1040) for any amount included on line 15.

Additional 10% Tax

Lines 17a and 17b. HSA distributions included in income (line 14) are subject to an additional 10% tax unless an exception applies (see Chapter 6).

If any of the following exceptions apply to any of the distributions included on line 16, check the box on line 17a. Enter on line 17b only 10% of any amount included on line 16 that does not meet any of the exceptions:

1. Disability.
2. Death.
3. Age (currently 65 or older).
4. Rollovers and transfers.

See Chapter 6 for a more detailed discussion of these exceptions.

The additional 10% tax does not apply to distributions made after the account owner dies, becomes disabled, or turns age 65.

Note: It also would appear that the 10% additional tax would not apply to earnings that must be distributed in connection with the correction of an excess contribution. The earnings are reported in box 2 of Form 1099-SA. Although included in gross income, the earnings are not reported on Form 8889, and therefore are not included in the amount subject to the 10% additional penalty shown on line 16.

Reporting Employer Contributions on Form W-2

All employer contributions to an HSA, whether or not made through a cafeteria plan, must be reported in box 12 of Form W-2, using code W. Generally, employer contributions to an employee's HSA are not subject to income, Social Security/Medicare, or Railroad Retirement taxes and reporting these amounts in box 12 will not affect amounts otherwise reported in boxes 1, 3, and 5 of Form W-2. The account owner must enter the amount shown as an HSA contribution in box 12 of Form W-2 on line 9 of the Form 8889.

Pre-tax contributions of employees made through a cafeteria plan also should be reported by the employer on Form W-2 in box 12 (but not in boxes 1, 3, and 5). Pre-tax salary reduction contributions are treated as employer contributions for Code purposes. It makes sense to report these contributions in box 12 of the Form W-2, because when an employee is completing Form 8889 these contributions then will be designated as amounts that are not deductible. This applies regardless of whether the contributions are (1) made from employee contributions deducted under a cafeteria plan election or (2) made by the employer outside of Code Section 125 under the comparability requirements.

Chapter 8

Beyond the Internal Revenue Code: Other Federal and State Laws That Affect Health Savings Accounts

Although most Health Savings Account (HSA) requirements are set forth in the Internal Revenue Code (Code) and IRS guidance, other federal laws that could affect HSAs are the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules. Also, certain state laws may affect HSA administration or may influence whether a High Deductible Health Plan (HDHP) can be offered in a particular state. Finally, because an HSA is an investment vehicle, federal laws that regulate securities also may apply. This chapter begins by examining both the U.S. Department of Labor (DOL) guidance that sets the parameters regarding ERISA plan status and the consequences of that status. The chapter then discusses the effect that state law may have on HSAs and accompanying HDHPs. Finally, the chapter covers the potential effect on HSAs of other federal laws, including securities laws.

DOL Guidance Regarding the Application of ERISA to HSAs

Field Assistance Bulletin (FABs) 2004-01 and 2006-2

In April 2004, the DOL issued guidance that should allow most HSAs to be outside the scope of ERISA, as long as specific requirements are satisfied. The guidance was issued in the form of two Field Assistance Bulletins, FABs 2004-01 and 2006-02, which provide that, although an HDHP sponsored by an employer will be considered an ERISA plan, the HSA itself generally will not be considered an ERISA plan—even if the employer makes contributions to the HSA and selects only one HSA provider to which it forwards employer and employee contributions—as long as the employer does not do any of the following:¹

1. Require employees to establish an HSA (for example, employees voluntarily must agree to make contributions);
2. Limit the ability of participants to roll funds over to another HSA, if allowed by the Code;
3. Impose conditions on the use of HSA funds (for example, stating that HSA distributions only may be used for medical expenses);
4. Make or influence the investment decisions as to funds contributed to an HSA;
5. Represent that the HSA is an employee welfare benefit plan established and maintained by the employer; and
6. Receive any payment or compensation in connection with an HSA.

¹ 29 C.F.R. Reg. §2510.3-1(j); see also 29 C.F.R. Reg. §§2509.99-1 and 2510.3-2 for similar rules relating to payroll deduction IRAs.

Note: A DOL Field Assistance Bulletin (FAB) is guidance that the DOL issues to its enforcement staff to follow in conducting an audit. Although the guidance is not binding directly on employers like a statute or administrative regulation,² a court likely would defer to the DOL position taken in a FAB because FABs are considered views of the agency responsible for interpreting and issuing guidance as to ERISA.³

Later DOL guidance, issued as FAB 2006-02 and discussed below, clarifies that an HSA may be exempt from ERISA by either complying with: (1) the terms of the group insurance safe harbor, which prohibits employer contributions and employer endorsement, or (2) DOL guidance pertaining to HSAs (i.e., FAB 2004-01 and FAB 2006-02), which allows employer contributions and employer endorsement.

Group Insurance Safe Harbor

Under the group insurance safe harbor rules, ERISA Title I relating to the protection of employee benefit rights does not apply to any group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:⁴

1. No contributions are made by an employer or employee organization;
2. Participation in the program is completely voluntary for employees or members;
3. The sole functions of the employer or employee organization as to the program are, without endorsing the program (discussed below), to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check offs, and to remit them to the insurer; and
4. The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check offs.

What It Means for an Employer to "Establish and Maintain" an ERISA Plan under the Group Insurance Safe Harbor

DOL guidance and case law involving the group insurance safe harbor under DOL Regulation Section 2510.3-1(j) illustrates certain actions that could lead to a determination that the employer has established and maintained a group insurance arrangement, causing the arrangement to be outside the safe harbor and subject to ERISA. This guidance is helpful in determining what actions potentially may cause the HSA to be subject to ERISA if an employer is relying upon this test to support its position that the HSA is not subject to ERISA. These actions include the following:⁵

1. Use of employer's name on HSA communication and promotional materials without a disclaimer indicating that the employer is not the HSA sponsor and does not endorse it;
2. A statement by the employer on HSA documents indicating that ERISA applies;

² See *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

³ See *In re: WorldCom, Inc.*, 2005 WL 221263 (S.D.N.Y. Feb. 1, 2005), in which the Court relied heavily on a DOL Field Assistance Bulletin in ruling that Merrill Lynch had no liability as a directed trustee in connection with losses suffered by the WorldCom 401(k) plan resulting from its holdings in WorldCom stock.

⁴ See DOL Adv. Opn. 94-26A (July 11, 1994); DOL Adv. Opn. 80-21A (April 17, 1980); DOL Adv. Opn. 75-06 (November 3, 1975); *Nicholas v. Standard Ins. Co.*, 29 EBC 1570 (6th Cir. 2002); *Adams v. Unum Life Insurance Company of America*, 200 F. Supp. 2d 796 (N.D. OH 2002).

⁵ See DOL Adv. Opn. 94-26A (July 11, 1994); DOL Adv. Opn. 80-21A (April 17, 1980); DOL Adv. Opn. 75-06 (November 3, 1975); *Nicholas v. Standard Ins. Co.*, 29 EBC 1570 (6th Cir. 2002); *Adams v. Unum Life Insurance Company of America*, 200 F. Supp. 2d 796 (N.D. OH 2002).

Beyond the Internal Revenue Code: Other Federal and Health Savings Accounts

3. Listing the employer as the HSA plan administrator and agent for legal service of process in the Summary Plan Description (SPD); and
4. Giving the employer sole authority to cancel the HSA arrangement.

The following examples illustrate the types of actions that the employer may take or should avoid, to increase the likelihood that the HSA will not be considered an ERISA plan if the employer is relying on the group insurance safe harbor as to the HSA:

Example 8-1

Employer A, wishing to make an HSA available to employees who participate in the HDHP that it sponsors, contacts potential HSA trustees, and selects one to provide trust services to its employees. Employer A signs a contract with the HSA trustee that identifies the specific services that the HSA trustee will provide to its employees, including accepting pre-tax salary reduction contributions from its payroll system. Employer A also signs a trust agreement with the HSA trustee on behalf of all employees (employees do not execute their own individual trust agreements with the HSA trustee). Employer A distributes enrollment materials bearing only its logo to employees with instructions that they may establish an HSA by completing and returning such materials to Employer A during the open enrollment period. Employer A distributes an HSA SPD bearing only its logo to each employee who enrolls in the HSA option. The SPD indicates that Employer A is the HSA plan administrator, and that all questions about the HSA should be directed to Employer A. Under this fact pattern, it would appear that the employer has represented that it is establishing and maintaining the HSA. Thus, the HSA likely would be subject to ERISA.

Example 8-2

Same facts as *Example 8-1*, except that Employer B:

- Does not sign a trust agreement with the HSA trustee. Rather, Employer B specifies in the contract with the HSA trustee that the trustee must execute separate trust agreements with each of Employer B's employees who decide to enroll in the HSA;
- Distributes enrollment materials that clearly identify the HSA trustee and indicate that the employer merely is facilitating HSA enrollment, but is not the HSA sponsor. The materials advise employees that all questions about the HSA's operation should be directed to the HSA trustee. The materials provide the HSA trustee's contact name and phone number.
- Distributes an SPD briefly describing the HSA, which also clearly identifies the HSA trustee, states that Employer B is not the HSA plan administrator, and states that the HSA is not intended to be subject to ERISA.

Under this fact pattern, it would not appear that Employer B has represented that it is establishing and maintaining the HSA. Thus, in the absence of other circumstances prohibited in the DOL FAB 2006-02, the HSA likely would not be subject to ERISA.

Field Assistance Bulletin (FAB) 2006-02

On October 27, 2006, the DOL issued FAB 2006-02, addressing frequently asked questions that it has received concerning the application of ERISA to HSAs since the release of FAB 2004-01 in April 2004. The guidance is helpful to employers because it identifies several ways in which an employer can assist employees with setting up an HSA without causing the HSA to become subject to ERISA. Particularly significant is that the DOL has clarified that the prohibition on employer "endorsement" that applies under other DOL safe harbor guidance relating to group or group-type insurance does not apply to an HSA as long as the employer satisfies the specific requirements of FAB 2004-01.

FAB 2006-02 clarifies that an employer can take the following actions and still satisfy the above requirements of FAB 2004-01, allowing employee HSAs to be outside the scope of ERISA:

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- *Open an account for employees and make contributions on behalf of employees.* The DOL states that this would not violate the “voluntary” requirement of FAB 2004-01, as long as employees could decide whether or not to make salary reduction contributions, and could move funds to a different HSA provider.
- *Select an HSA provider that also offers some or all of the investment options made available to employees in the employer-sponsored 401(k) plan.* The DOL states that this would not violate the prohibition against making investment decisions as long as there are reasonable investment options available and employees are not limited in moving their funds to another HSA. However, the DOL states that the selection of a single HSA provider that offers a single investment option would not afford employees a reasonable choice of investment options. Given this guidance, it is not clear whether an HSA provider could require an account owner to accumulate a threshold HSA account balance before offering additional investment options and still satisfy the “reasonable choice of investment options” requirement.
- *Pay HSA fees that the employees otherwise would have to pay.* The DOL states that because employers are allowed to contribute to an HSA without causing it to be subject to ERISA, employers should be able to pay fees as well.
- *Limit the HSA providers that an employer allows to market their HSA products in the workplace or select a single HSA provider to which it will forward contributions.* The DOL also provided this information in FAB 2004-01. This guidance makes clear that such actions will not be considered prohibited “endorsement” by the employer.
- *Allow employees to contribute to HSAs through the employer's cafeteria plan.* DOL states that the FICA and FUTA tax savings that an employer achieves by allowing employees to make HSA contributions through the employer's cafeteria plan should not be viewed as violating the prohibition in FAB 2004-01 that an employer not pay or receive compensation in connection with an HSA.
- *An HSA provider may offer to its own employees an HSA product that it offers to the public without the employee HSAs being considered ERISA plans.* The DOL states that offering HSA products that the employer offers to the public in the regular course of business would not mean that an HSA provider has established or is maintaining the HSA as an employer.

What It Means for an Employer to “Establish and Maintain” an ERISA Plan under the HSA Safe Harbor of FABs 2004-01 and 2006-02

It appears that FAB 2004-01 is more flexible than the group insurance safe harbor as to “endorsement” and that the HSA safe harbor may be met if: (1) the establishment of the HSA is voluntary, and (2) the employer is “neutral” with regard to the HSA's establishment. FAB 2006-02 appears to define “neutrality” as only prohibiting employers from:

- Limiting the ability of participants to roll funds over to another HSA, if allowed by the Code;
- Imposing conditions on the use of HSA funds (e.g., stating that HSA distributions may only be used for medical expenses);
- Making or influencing the investment decisions as to funds contributed to an HSA;
- Representing that the HSAs are an employee welfare benefit plan established and maintained by the employer; and
- Receiving any payment or compensation in connection with an HSA.

As such, the FAB may permit other actions by employers that could have constituted “endorsement” under the group insurer regulation, as described below.

Permissible Actions

Under the new standard the DOL articulated in FAB 2006-02, an employer should be able to take the following actions as to the HSA without representing that the HSAs are an employee welfare benefit plan established and maintained by the employer:

- Distribute materials prepared by the HSA vendor, including providing cover letters;
- Allow the HSA vendor directly to send HSA materials to employees;
- Use materials describing the HSA that contain both the employer's and HSA vendor's logos and names (co-branding);
- Put the HSA vendor's information on the employer's website. (However, a cautious approach would be for the employer to include a statement to the effect that HSA participation is voluntary, the employer's HSA involvement is limited, and that the HSA is not part of an employer-maintained ERISA-covered plan); and
- Make some positive statements about the HSA, such as explaining how the HSA works, how the HSA relates to the HDHP, the advantages and benefits of enrolling in an HSA, the prudence of savings for medical expenses, and a statement to the effect that "it is advisable to enroll and contribute to the HSA if you enroll in the HDHP option offered under the Plan."

Impermissible Actions

The employer should avoid taking the following actions as to the HSA in order to reduce the likelihood that it could be viewed as representing that the HSAs are an employee welfare benefit plan established and maintained by the employer:

- Making statements that are very promotional and biased in favor of HSAs; and
- Stating that either the HSA is an ERISA plan or part of the employer's ERISA plan.

Use of Debit Card with HSA

A debit, credit, or stored-value card may be used with an HSA to receive distributions for qualified medical expenses. However, it is not clear what, if any, impact the use of a debit card will have on the ERISA status of an HSA. For example, if an employer makes arrangements with an HSA trustee to offer an HSA with a debit card to employees, but the employer chooses a restricted debit card that can only be used for medical expenses, it is possible that DOL could take the position that the employer has impermissibly restricted the use of the HSA by limiting the debit card to use for medical expenses.

Although the DOL has not issued any direct guidance on this point, as long as an HSA account holder has the ability to make withdrawals from the HSA in some reasonable manner (e.g., a checkbook or withdrawal request form), it would appear that a debit card accompanying the HSA could be limited to use for medical expenses without violating the prohibition in the FABs against imposing conditions on the use of HSA funds. Also, this should not violate the IRS prohibition that the use of the HSA not be limited to medical expenses.⁶ It should be noted, however, that the answer may differ if the employer customizes the debit card to suit its particular needs. For example, if an employer requested that the HSA trustee offer a debit card that only could be used in a certain store or to purchase a particular product, the employer may be found to have imposed conditions on the use of HSA funds, resulting in impermissible employer involvement and ERISA status. To the extent possible, to avoid ERISA status, the employer should seek an "off the shelf" HSA with debit card to offer to employees.

⁶ See Notice 2004-50, Q&A 79, 2004-33 IRB 196.

Note: Regulation E, a federal banking regulation issued by the Board of Governors of the Federal Reserve System, which is designed to limit the liability of consumers engaged in electronics fund transfers, does not apply to an HSA. The Federal Reserve System has stated that “cards used solely for health related expenses—such as cards linked to flexible spending accounts, health savings accounts, or health reimbursement arrangements—are not governed by the regulation, whether funded by the employer or employee.”⁷ When a credit card is used, as opposed to a debit card, other issues may arise, such as Truth-in-Lending Act (Regulation Z) requirements.⁸

Investment Options

DOL FAB 2006-02 indicates that an employer may not make or influence the investment decisions as to funds contributed to an HSA without causing the HSA to be subject to ERISA. However, the guidance also provides that an employer can select a single HSA trustee to which it forwards salary reduction contributions. This raises the question of whether, by selecting an HSA trustee, the employer also has restricted investment options because any given trustee only will offer a particular set of investment options.

By choosing one particular HSA provider over another, to a certain extent, an employer is limiting an employee's HSA investment options. However, as long as the employer does not request that the HSA provider change its standard offerings, the mere act of selecting a single HSA trustee, even one with limited investment options, should not be viewed by the DOL as a violation of the prohibition against making or selecting investment options.

Note: The Pension Protection Act of 2006 (PPA)⁹ added a new category of prohibited transaction exemption under ERISA and the Code in connection with the provision of personalized investment advice through an “eligible investment advice arrangement” to HSA account owners who direct the investment of their accounts under the plan (discussed more fully in Chapter 6).

Practice Pointer →

No matter which HSA provider the employer selects, the employee may establish a second HSA with any trustee or custodian and transfer or roll over amounts from the employer HSA into the second HSA (see Chapter 5).

Paying Provider Fees

DOL FAB 2006-02 specifically states that the employer should be permitted to pay any fee that the HSA provider imposes on HSA account owners for services that the provider performs in connection with establishing and maintaining the contribution deduction process itself without causing the HSA to be subject to ERISA. The FAB provides that an employer is permitted to make contributions to an HSA without causing the HSA to be subject to ERISA and, therefore, administrative fees also should not cause the HSA to be subject to ERISA. Similarly, the employer also should be permitted to assume the internal costs (e.g., for overhead, bookkeeping, and so on) of implementing and maintaining the contribution deduction program without causing the HSA to be subject to ERISA.¹⁰

Also, these fees should be excludible from the employees' gross income and not counted as wages for FICA and FUTA purposes. Although there is no authority directly on point, this is generally how administrative fees are treated as to Individual Retirement Arrangements (IRAs) and employer-sponsored group health

⁷ 12 CFR Part 205, 71 Fed. Reg. 51437 (Aug. 30, 2006). Copy available at <http://edocket.access.gpo.gov/2006/pdf/-7223.pdf>.

⁸ 12 CFR 226.

⁹ P.L. 109-280 (H.R. 4).

¹⁰ See 29 CFR 2509.99-1(c)(2) relating to payroll deduction IRAs.

arrangements, and the tax treatment of HSA administrative fees should be analogous. In the IRA context, the IRS has ruled that expenses charged by an insurance company under an annuity contract, including a flat annual charge per participant account, could be paid directly to the employer and still be excludible from the employees' income and wages for FICA and FUTA purposes.¹¹ Similarly, for health plans subject to Code Section 106(a), it generally is accepted that the employer's payment of administrative fees associated with such coverage should be excludible from the employee's income (even though not technically a "health benefit"). For example, fees that an employer pays to a health insurer that are part of the insurance premium are not required to be segregated from the premium and imputed as taxable income.

Employees of Service Providers

The DOL specifically stated in FAB 2006-02 that offering HSA products that the employer offers to the public in the regular course of business would not mean that an HSA provider has established or is maintaining the HSA as an employer. This position is consistent with DOL guidance for IRA providers. In the IRA guidance, the DOL indicated that a financial institution may select itself to be the exclusive provider for payroll deduction IRAs offered to its own employees without creating an ERISA-covered IRA.¹²

Practice Pointer →

Because an employer is permitted to make contributions to the HSAs of employees, it would seem that an employer who is in the business of providing HSAs could waive administrative fees normally charged to the public for its own employees without causing the HSA to be subject to ERISA. However, the DOL has not issued guidance on this issue.

Single Option HDHP and HSA

An employer can offer the HDHP and HSA as a single option without making the HSA subject to ERISA. As long as an employee is not required to make salary reduction contributions to the HSA, the DOL should not view as violating the rule that HSA participation must be voluntary. If the other DOL FAB 2004-01 requirements are satisfied, HDHP/HSA options should not be viewed as subject to ERISA.¹³

Contribution Caps

If the employer imposes restrictions on the amount that an employee is permitted to contribute to the HSA linked to the employer's HDHP, the contribution cap could be viewed as impermissible employer involvement under DOL FAB 2004-01, causing the HSA to be subject to ERISA. Code Section 223 itself already contains contribution limits, and the DOL easily could take the position that an employer who restricts an employee from fully funding a particular HSA up to this limit has imposed restrictions that cause the HSA to be an ERISA-covered plan. The DOL has not commented on this issue, however.

Consequences of Being outside the Scope of ERISA

The issue of whether ERISA applies is significant because a plan sponsor must satisfy certain obligations only when the plan is subject to ERISA. For example, if the HSA is not subject to ERISA, there is no obligation as to the HSA to file a Form 5500 (ERISA Section 103), provide an SPD (ERISA Section 102), adopt a claims procedure (ERISA Section 503), offer Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage (ERISA Part 6), or comply with HIPAA portability or nondiscrimination rules (ERISA Part 7). Also, the fiduciary responsibility requirements of ERISA Part 4 will not apply. Similarly, ERISA Section 502 and the legal actions available under ERISA Part 5 will not apply. If an employer or insurer is sued in connection with

¹¹ See, e.g., PLRs 7948017, 7951122.

¹² 29 CFR 2509.99-1(g).

¹³ FAB 2004-1 (Apr. 7, 2004).

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an HSA, state law rather than ERISA will control because ERISA preemption (ERISA Section 514) would not apply. Please note that the Code Section 4975 prohibited transaction rules will continue to apply, as described below.

Legal Obligations If HSA Is Subject to ERISA

Although there is no DOL guidance on legal obligations if the HSA is subject to ERISA, presumably the employer would have to treat the HSA as it would any other group health plan that is subject to ERISA. This would include complying with applicable Form 5500 filing requirements, maintaining a plan document, and providing an SPD to participants. Also, as described below, the employer would have to determine how, if at all, to comply with the federal mandates that apply to group health plans including COBRA rules, HIPAA portability/nondiscrimination rules, and claims procedure requirements for group health plans, notwithstanding that, from a practical standpoint, these rules may not make sense in the HSA context. Finally, the ERISA fiduciary rules would apply and, if an employer or insurer were sued in connection with an HSA, ERISA rather than state law generally would control because of ERISA preemption.

Application of COBRA If HSA Is Subject to ERISA

IRS Notice 2004-2, Q&A-35 (2004-2 IRB 269), provides that HSAs are not subject to COBRA continuation coverage under Code Section 4980B. This position is based on language in Code Section 106(d), which cross-references Code Section 106(b)(5) (providing that a contribution by an employer to an Archer Medical Savings Account (Archer MSA) is not subject to the COBRA rules under Code Section 4980B). However, both the Congress and the IRS left open the question of whether HSAs are subject to COBRA continuation coverage under ERISA Part 6. The DOL has not addressed this issue, and it is possible that if the DOL considers an HSA sponsored by an employer to be a “group health plan” under ERISA Part 6, an employer would have to satisfy all applicable COBRA notice and disclosure requirements, including providing a COBRA General Notice within 90 days of enrollment in the HSA.

However, the IRS and the DOL jointly administer COBRA, with the IRS responsible for interpreting the substantive rules and the DOL responsible for interpreting the notice and disclosure rules.¹⁴ It therefore is unlikely that the DOL unilaterally would enforce a COBRA obligation where the IRS has stated in its guidance that COBRA does not apply for Code purposes. Further, because the HSA account must be nonforfeitable to satisfy Code Section 223 requirements (see Chapters 2 and 3), an HSA account owner therefore should never lose HSA coverage. Thus, there generally would not be a qualifying event with respect to an HSA for COBRA purposes.¹⁵

HIPAA Portability and Nondiscrimination Rules If HSA Is Subject to ERISA

If an HSA is subject to ERISA, it is possible that an employer would be required to distribute a HIPAA certificate of creditable coverage and comply with the HIPAA nondiscrimination rules.

The DOL has not addressed this issue, but if the DOL considers an HSA sponsored by an employer to be a “group health plan” for purposes of ERISA Part 7, an employer technically would be required to comply with the HIPAA portability and nondiscrimination rules, including providing a HIPAA certificate of creditable coverage upon request, and not discriminating between HSA account owners on the basis of a health factor (but see the note at the end of this section).

ERISA Section 733(a) provides that the term “group health plan” means an employee welfare benefit plan that provides medical care to employees or their dependents (as defined under the plan terms) directly or through

¹⁴ See Treas. Reg. § 54.4980B-1 through 10; see 29 CFR 2590.606.

¹⁵ See ERISA § 603.

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insurance, reimbursement, or otherwise. The term “medical care” for this purpose means amounts paid for (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (2) amounts paid for transportation primarily for and essential to medical care referred to in (1); and (3) amounts paid for insurance covering medical care referred to in (1) and (2).

Because an HSA primarily is designed to provide funds for medical care, the HIPAA portability and nondiscrimination rules technically will apply to an HSA, requiring an employer with two or more active employees (ERISA Section 732(a)) enrolled in an HSA to comply with the HIPAA portability and nondiscrimination requirements of Part 7 of ERISA. These rules, among other things, would require an employer to issue a certificate of creditable coverage as to the HSA upon request of the HSA account owner to comply with ERISA Section 701(e)(1)(A) and 29 CFR 2590.701-5(a)(2)(iii). Although a certificate of coverage also is required upon loss of coverage, as noted above, an HSA account owner generally will not lose HSA coverage. Also, the HIPAA nondiscrimination rules described in ERISA Section 702 and 29 CFR 2590.702 would prohibit an employer who sponsors a group health plan from discriminating on the basis of any health factor. These rules could be relevant in the HSA context if, for example, the employer wished to contribute an additional amount to the HSAs of employees who were willing to participate in a wellness program for which the DOL sets forth specific requirements.¹⁶

Note: The final HIPAA portability regulations note in the preamble that, as a practical matter, the rules pertaining to preexisting conditions and special enrollment generally will not apply to HSAs.¹⁷

DOL Claims Procedure Rules if HSA Is Subject to ERISA

If an HSA is subject to ERISA, it is possible that an employer would be required to comply with the DOL claims procedure rules that apply to group health plans. The DOL has not addressed this issue, but if the DOL considers an HSA sponsored by an employer to be a welfare plan for purposes of ERISA generally, an employer would be required to implement a claims procedure that satisfies certain requirements.¹⁸ Presumably, that claims procedure would have to comply with the requirements applicable to group health plans. ERISA Section 3(1) defines an ERISA welfare benefit plan as any plan, fund, or program established or maintained by an employer, an employee organization, or both, for the purpose of providing benefits for its participants or their beneficiaries that include medical, surgical, hospital care or benefits, or benefits in the event of sickness. Because an HSA primarily is designed to provide funds for medical care, in the absence of further DOL guidance, it appears that the claims procedure rules would apply. These rules, for example, would require an employer to provide a notice of adverse determination and appeal rights within a certain timeframe when an employee requests a withdrawal from an HSA with insufficient funds in it.

The claims procedures, if required by DOL, will not apply in many circumstances. IRS Notice 2004-2, Q&A-29 and 30 (2004-2 IRB 269), provides that an HSA account owner is not required to submit receipts for medical expenses to trustees, custodians, or employers. Rather, a self-substantiation rule is in place, and an HSA account owner is responsible for determining on his or her own whether an item is a medical expense. Thus, there will be few circumstances in which the employee makes a “claim” with the employer for HSA funds. However, as noted above, if an employee attempts to withdraw amounts from an HSA with insufficient funds, which would presumably require the employer to provide a notice of adverse determination and appeal rights. Also, for urgent care claims and pre-service claims, the DOL claims procedures require that claimants be apprised of the HSA plan’s benefit determination, whether the determination is adverse or a complete grant, in accordance with the timeframes generally applicable to urgent care and pre-service claims.¹⁹ These notices

¹⁶ See ERISA § 702(b)(2)(B); 29 CFR 2590.702(c)(3).

¹⁷ 69 FR 78720, 78734 (December 30, 2004) (29 CFR Part 2590, 26 C.F.R. Parts 54 and 602 and 45 CFR Parts 144 and 146).

¹⁸ See ERISA § 503 and 29 CFR 2560.503-1.

¹⁹ See 29 CFR 2560.503-1(f)(2)(i) and (iii).

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must contain sufficient information to fully apprise the claimant of the HSA plan's decision to approve the requested benefits. Accordingly, it appears that there may be situations in which an employer technically is required to provide a notice of approval when an employee withdraws an amount from his or her HSA. However, this rule will be difficult to administer in practice, given the fact that the employer may not know the reason that an employee requests an HSA distribution.

Fiduciary Standards If HSA Is Subject to ERISA

If an HSA is subject to ERISA, the following fiduciary standards, set forth in ERISA Part 4, would have to be satisfied:

- *Written plan document.* The HSA written plan document would have to describe the funding policy, procedure for allocation of responsibilities under the plan, procedure for amending the plan, and basis on which payments are made to and from the plan. A fiduciary must follow the written plan document.²⁰
- *Trust or custodial account.* HSA plan assets would be required to be held in trust or custodial account.²¹ This also would be a requirement for purposes of Code Section 223 (see Chapter 7).

⚠ Caution: Although there is an IRA exception to the ERISA Section 403 trust requirement in ERISA Section 403(b)(3)(B) which permits plan assets for ERISA-covered IRAs to be held in custodial accounts, this rule does not, on its face, extend to HSAs.

Practice Pointer →

If an HSA is subject to ERISA but an entity that normally would act as trustee (e.g., a bank) wishes to limit liability, the employer could be the trustee and the bank could continue in a custodial role. Alternatively, the bank could be a directed trustee, which would limit its liability more than if it were a regular trustee (but the liability would be greater than if the bank was a custodian). See discussion below.

- *Prudent investor standard.* The “prudent investor” standard of care requires a fiduciary to discharge his or her duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent investor acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.²² The HSA's fiduciary would have to comply with this standard. Although ERISA Section 404(c) is available to protect fiduciaries who oversee participant-directed pension plans, this section would not apply to HSAs. Thus, the fiduciary could be exposed to liability for loss on participant-directed investments in an HSA.
- *Diversification.* The duty to diversify plan investments would require an HSA fiduciary to diversify the investments of the HSA so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.²³
- *Exclusive benefit rule.* The exclusive benefit rule requires that plan money must be spent only on benefits or expenses of plan administration.²⁴ The exclusive benefit rule would prohibit a fiduciary from using HSA assets for any purpose other than to benefit the account owner or to pay HSA expenses.

²⁰ ERISA § 402.

²¹ ERISA § 403.

²² ERISA § 404(a)(1)(B).

²³ ERISA § 404(a)(1)(C).

²⁴ ERISA § 404(a)(1)(A).

Comparison: HSA Trustee versus HSA Custodian

A trustee has fiduciary responsibilities and potential liabilities that a custodian does not have. A custodian simply holds the assets on behalf of the owner of the assets. Other than holding the assets and doing as the owner orders, the custodian has no fiduciary obligations to the owner. A trustee may have custody of the assets, but a trustee also is a fiduciary under ERISA (and common law as well). This means that a trustee's duties to take care of the assets may extend beyond what the trustee has agreed to do under contract. The trustee's duties include following the terms of the written plan document, adhering to a "prudent man" standard of care in discharging fiduciary duties, diversifying plan investments to minimize the risk of large losses if prudent to do so, and limiting the use of plan assets for any purpose other than to benefit the beneficiary or to pay plan expenses. Also, the trustee could be found to have a duty to disclose certain relevant information to beneficiaries under principles of common law. This duty generally would not apply to the custodian. The trustee is subject to liability for failure to satisfy any of these duties.

The custodian and trustee do not have to be the same entity. So, for example, if an HSA is subject to ERISA (e.g., because of a high level of employer involvement), it would be possible to designate the bank as the HSA custodian and some other party, such as the employer, as the HSA trustee. Alternatively, a trustee can contract to be a "directed trustee." In this regard, ERISA Section 403(a) specifically recognizes that where a plan expressly provides that the trustee is subject to the direction of a named fiduciary who is not a trustee (e.g., an HSA account owner), the trustee will have limited authority or discretion. This limited authority or discretion, in turn, limits the trustee's fiduciary liabilities (although a directed trustee still would have more fiduciary liability than a custodian).²⁵

Consequences under ERISA of Fiduciary Violation

The potential consequences that result from a fiduciary violation of ERISA are as follows:

- The fiduciary personally is liable to make good any losses suffered by the ERISA-covered plan on account of the fiduciary's violation and to restore to the plan any profits that the fiduciary made by use of plan assets in violation of his or her fiduciary duties.²⁶
- The DOL, plan participants and beneficiaries, and other fiduciaries can sue and, if they win, can be awarded attorneys fees and court costs in addition to the cost of making up losses and restoring any improper profits.²⁷
- In any DOL-involved action or settlement, the DOL must assess a penalty of 20% of the "applicable recovery amount" in a case of a breach of fiduciary duty or co-fiduciary liability. The DOL may waive or reduce the penalty only if it concludes that (1) the fiduciary acted reasonably and in good faith, or (2) the fiduciary could not be expected to make the plan whole without severe hardship unless a waiver is granted.²⁸
- A court can order the fiduciary removed from his or her position as a fiduciary, can enjoin further breaches by the fiduciary or other party-in-interest, and provide other equitable relief.²⁹
- In the case of a criminal, willful violation of the ERISA Part I, an individual may be subject to fines of up to \$100,000 and imprisonment for up to 10 years, while a corporation may be subject to fines of up to \$500,000.³⁰

²⁵ DOL FAB 2004-03 (Dec. 17, 2004).

²⁶ ERISA §§ 409, 502(a)(2).

²⁷ ERISA § 502(g)(3).

²⁸ ERISA § 502(l).

²⁹ ERISA § 501(a)(5) and (8).

³⁰ ERISA § 501.

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In the case of a prohibited transaction by a party-in-interest (the same as a “disqualified person”), the IRS may assess a penalty of 15% of the “amount involved” (defined under Code Section 4975(f)(4)) in each transaction for each year, or part thereof, during which the prohibited transaction continues. If the transaction is not corrected within the taxable period, the penalty may be in an amount of not more than 100% of the amount involved.³¹

Fiduciary Standards That Apply If an HSA Is Not Subject to ERISA

If an HSA is not subject to ERISA, state law fiduciary trust requirements (which may be similar to the ERISA requirements described above) will apply. The following is an illustration of such requirements under Minnesota and Connecticut law.

Trust document. A trustee is required to administer the trust in accordance with the terms of its underlying trust documents. This particularly is relevant as to investment strategy and the allocation of receipts to and disbursements from the trust. To the extent that the trust documents are silent, state law may impose different duties on the trustee.³²

Best judgment/prudent investor rules. A trustee must invest the trust assets with reasonable care and must diversify the trust assets unless contrary to the purposes of the trust.³³

Loyalty. A trustee must administer the trust solely in the interest of the trust's beneficiaries.³⁴

Records. The trustee must maintain adequate records supporting all transactions with the trust and the records must be made reasonably available to the trust beneficiaries. The trustee also must separately account for each beneficiary under the trust.³⁵

DOL Guidance on HSAs and the Prohibited Transaction Rules

In December 2004, the DOL issued Advisory Opinion 2004-09A involving the application of the prohibited transaction rules to HSAs. Specifically, the Advisory Opinion held that an incentive payment deposited by an HSA trustee to an account owner would not violate the prohibited transaction rules of Code Section 4975 or ERISA Section 406 (see Chapter 7). FAB 2006-02 also clarifies the following issues as to the application of the prohibited transaction rules to HSAs under Code section 4975:

- HSA providers may offer cash incentives that are put directly into accounts, without violating the prohibited transaction rules.
- An employer promptly must transmit account owners' contributions to the HSA provider, otherwise fiduciary and prohibited transaction issues could be raised for the employer.
- An employer who selects an HSA vendor may not receive a discount on another product from the HSA vendor.
- Certain ERISA prohibited transaction class exemptions that apply to IRA owners do not apply to HSA account owners.

³¹ IRC § 4975.

³² E.g., Minn. Trust Companies § 48A.07 (where no written instruction, bank or trust company must use best judgment in selection of authorized securities and is responsible for the validity, regularity, quality and value of them at the time made, and for their safekeeping); Conn. Principal and Income Act § 45a-542b; § 45a-542c (if unable to comply with written terms of trust, a trustee shall consider all factors relevant to the trust and its beneficiaries, including the needs for liquidity, regularity of income and preservation and appreciation of capital).

³³ Minn. Trust Companies § 48A.07; Conn. Uniform Prudent Investor Act § 45a-541b.

³⁴ Minn. Uniform Custodial Trust Act § 529.06; Conn. Uniform Prudent Investor Act § 45-541e.

³⁵ Minn. Uniform Custodial Trust Act §§ 529.05, 529.06.

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- An HSA account owner may direct the payment of HSA funds to a credit line vendor to reimburse the vendor for HSA expenses paid with a credit card, but certain other transactions involving a line of credit associated with an HSA could raise prohibited transaction issues.

Note: The prohibited transaction rules are under both the Internal Revenue Code (Code Section 4975) and ERISA (ERISA Section 406). Even if an HSA is not subject to ERISA, the prohibited transaction rules of Code Section 4975 will apply.³⁶

HSAs and HIPAA Privacy

The Centers for Medicare and Medicaid Services (CMS) has not yet issued any guidance on whether an HSA is subject to the HIPAA privacy regulations. However, the regulations apply to a health plan, which is broadly defined to include “any other individual or group plan, or combination of individual or group plans, which provides or pays for the cost of medical care.”³⁷ It would seem that this definition would be broad enough to encompass an HSA arrangement, whether provided by the employer or individually, because it is an arrangement primarily intended to pay for medical care. Whether an HSA is subject to ERISA is not relevant to this determination. As a practical matter, health information may not actually be used or disclosed because HSA account owners do not have to submit receipts for medical care in order to obtain reimbursement. Accordingly, there may be little need for safeguards. Nevertheless, the privacy notice and business associate requirements technically may apply.

Practice Pointer →

The fact that someone is a plan participant can be considered protected health information. Accordingly, the HSA (for example, trustee/administrator) would need to be careful not to disclose a list of participants for purposes other than administering the plan (for example, it could not sell or provide a list of participants for marketing purposes). The trustee or administrator should consider providing a privacy notice when the person enrolls in the HSA, including language explaining that the HSA funds used for medical expenses are self-substantiated, so generally there would not be any access to health information. However, to the extent there is access to health information, the notice would apply. As to an HSA sponsored by an employer, the employer should enter into a business associate contract with the administrator or trustee.

HSAs and HIPAA Electronic Standards Regulations

It also is possible that the HIPAA electronic standards regulations will apply to HSAs, depending upon how the payments from the HSA are structured. The regulations require that a “covered entity” that conducts certain transactions electronically with another “covered entity” must conduct those transactions under standards set by the Secretary of Health and Human Services.³⁸ Also, if any party requests that a health plan conduct one of the listed transactions as a “standard transaction,” the health plan must do so.³⁹

A “covered entity” is defined as a health plan, provider, or clearinghouse. For example, if a provider submits a claim to a health plan electronically, the claim must be submitted and received using the standard transactions. When the health plan sends a payment to the provider electronically, this transmission also must be conducted in accordance with the standard transactions. The regulations do not apply to a transmission involving a

³⁶ IRC § 4975(e)(1)(E).

³⁷ 45 CFR 160.103.

³⁸ 45 CFR 162.923(a).

³⁹ 45 CFR 162.925(a).

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noncovered entity, including an individual. So, if an individual submits a claim to a plan, and the plan sends payment to the individual, these transmissions would fall outside the regulations because they would not be between two covered entities.

If the HSA is considered a “health plan” for HIPAA purposes, as previously described, the HIPAA Electronic Standard regulations may apply. Note that the CMS have not issued guidance on this question. However, if this is the case and if the party submitting the request for payment and receiving the payment is the individual, the transmission would not involve two covered entities and would be outside the regulations. The CMS addressed a similar fact pattern in a Q&A discussing the use of a debit card under an FSA or HRA and stated that this transmission would be between an individual and a plan, so would be outside of the regulations.⁴⁰

However, if the HSA is considered a “health plan” for HIPAA purposes and the HSA is structured so a provider can directly submit claims to, and receive payment from, the HSA, and these transmissions are conducted electronically, the CMS may consider these transmissions to be covered under the Electronic Standards Regulations. Note that the regulations also state that any party may request a health plan to conduct a transaction as a standard transaction. So, if an individual or other party did request an HSA to receive claims or make payments using the standard transactions, the HSA would have to do so. However, this seems very unlikely.

Medicare Part D

Certificates of Creditable Coverage

An HSA is not a plan for which an employer must issue a certificate of creditable coverage for purposes of Medicare Part D. The CMS issued final regulations⁴¹ implementing the new Voluntary Medicare Part D prescription drug benefit that took effect in January 2006 under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Under the final regulations,⁴² all group health plan sponsors that offer prescription drug coverage are required to provide a notice to all Medicare-eligible participants that states whether prescription drug coverage under its plan is “creditable” when compared to the prescription drug coverage under Medicare Part D. The CMS believes that this information will help participants decide whether to enroll in Part D. Also, a participant who has a certificate of creditable coverage has the ability to stay in the employer-sponsored health plan and enroll in Medicare Part D at a later date without incurring a late enrollment penalty. Coverage is considered “creditable” if its actuarial value equals or exceeds the value of Medicare Part D coverage. As to HSAs, however, CMS later issued guidance on account-based plans which indicates that HSAs are not retiree plans for purposes of the creditable coverage rules due to the fact that no contributions can be made to HSAs once the retiree becomes entitled to Medicare.⁴³

Practice Pointer →

Even though an employer is not required to provide a notice of creditable coverage as to the HSA, such notice still will be required for Medicare-eligible individuals participating in the HDHP.

⁴⁰ See <http://questions.cms.hhs.gov>, Answer ID 2352 (search on “FSA”).

⁴¹ 42 CFR Part 423.

⁴² 42 CFR § 423.56.

⁴³ The guidance is available at: <http://www.cms.hhs.gov/EmployerRetireeDrugSubsid/downloads/AccountbasedPlansGuidanceRev1.pdf>.

Employer Subsidy under Medicare Part D

An HSA is not a plan for which an employer may apply for the employer subsidy under Medicare Part D. Beginning in 2006, employer and union sponsors of qualified retiree prescription drug plans have the ability to receive tax-free retiree drug subsidy payments for a portion of their plan's prescription drug costs. For each qualifying covered retiree, the sponsor is eligible to receive payments of 28% of the allowable drug costs attributable to gross prescription drug costs between the cost threshold (\$265 in 2007) and the cost limit (\$5,350 in 2007).

HSAs and State Laws

State Mandated Benefits

A state could have laws that regulate insured HDHPs. These laws, for example, may require certain benefits to be covered under an HDHP without regard to whether the deductible is satisfied. Unless a state's mandated benefits satisfy the definition of "preventive care" for federal purposes, this would cause the HDHP to fail to satisfy the Code Section 223 requirements (see Chapter 2). This would mean that an individual in a state with those laws could not contribute to an HSA. Other state laws may require that an insurer or Health Maintenance Organization (HMO) must comply with limits on deductibles, which could similarly conflict with federal requirements. (See Appendix C following this chapter for a list of states with mandates that could cause an HDHP to fail to satisfy applicable requirements.)

The IRS addressed the fact that, in certain states, it is not possible to issue an HDHP that satisfies both state and federal requirements by issuing relief for months before January 1, 2006, as to state requirements in effect on January 1, 2004.⁴⁴ This guidance states that during this time period, an HDHP will not be considered to violate federal requirements if the sole reason it does not comply with the requirements is because it is complying with state benefit mandates. However, after January 1, 2006, individuals who are covered by calendar-year insured HDHPs or HMOs subject to state laws that conflict with Code Section 223 requirements will not be considered "eligible individuals" who are able to contribute to HSAs.

In Notice 2005-83,⁴⁵ the IRS extended the expiration date of the transition guidance provided in Notice 2004-43 for non-calendar year HDHPs to the earlier of: (1) the health plan's next renewal date or (2) December 31, 2006. The reason for this extension is that generally a health plan may not reduce existing benefits before its renewal date. Thus, even though a state may amend its laws before January 1, 2006, to authorize HDHPs that comply with Code Section 223(c)(2), non-calendar year plans still may fail to qualify as HDHPs after January 1, 2006, because existing benefits cannot be changed until the next renewal date. Accordingly, the IRS concluded in Notice 2005-83 that additional transitional relief is appropriate for non-calendar year health plans. Under this relief, for any coverage period of 12 months or less beginning before January 1, 2006, a health plan will be treated as an HDHP that otherwise qualifies as an HDHP as defined in Code Section 223(c)(2), except that it complied on its most recent renewal date before January 1, 2006, with state-mandated requirements (in effect on January 1, 2004) to provide certain benefits without regard to a deductible or with a deductible below the minimum annual deductible specified in Code Section 223(c)(2).

Example 8-3

A state amends its laws to authorize HDHPs, effective November 1, 2005. A health plan with a renewal date of July 1, 2005, is required to retain the state-mandated low-deductible coverage for the plan year July 1, 2005, through June 30, 2006 because under state law the benefits can only be modified on the renewal date. Under the transition relief provided in Notice 2005-83, the health plan is to be treated as an HDHP until the renewal

⁴⁴ Notice 2004-43, 2004-27 IRB 10.

⁴⁵ I.R.S. Notice 2005-83, 2005-49 I.R.B. 1075.

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date of the policy, when it can be amended to comply with federal requirements (i.e., for the months of January through June, 2006).

Hawaiian Exception

An employer generally cannot make the same HDHP/HSA available to its employees in Hawaii as is available in other states. Hawaii has a unique exception from the ERISA preemption provision that allows the state to regulate directly the terms of ERISA health plans, including self-funded plans.⁴⁶ Hawaii's Prepaid Health Care Act (PHCA) requires employers to provide health benefits to Hawaii-based employees who are employed at least 20 hours per week for 4 consecutive weeks.⁴⁷ Also, the PHCA sets forth various requirements concerning plan benefits and cost-sharing.⁴⁸ Accordingly, an HDHP offered by an employer in Hawaii, whether self-insured or insured, must satisfy the PHCA requirements.

An employer in Hawaii essentially has three options in deciding how to satisfy the PHCA's benefit requirements:

1. The employer may buy health insurance coverage that has already been pre-approved by the Hawaii Department of Labor and Industrial Relations (DLIR);
2. The employer may seek DLIR approval for a health insurance policy that it has not yet approved; or
3. The employer may seek DLIR approval for self-funded plan coverage.

At present, there are not yet any pre-approved HDHP/HSA products available on the Hawaii insurance market. An employer offering a plan that has not been pre-approved by the DLIR must submit an application to the state and request approval. It appears, based on informal DLIR comments, that in order to view the HDHP as satisfying the requirements of the PHCA, the DLIR may require significant employer HSA contributions to ensure that most of the high deductible is covered by the employer rather than the employee.

New Jersey Considerations

New Jersey enacted A4543⁴⁹ to make it possible for insurers and HMOs to offer HDHPs that satisfy federal requirements in that state. New Jersey requires that insurers and HMOs for groups with greater than 50 persons provide coverage below the deductible to children to pay for lead poisoning screening, medical evaluation, and necessary medical follow-up and treatment for lead-poisoned children. This caused a problem for HDHPs, because the rule under Code Section 223 is that the only benefits that can be provided below the deductible are those that satisfy the definition of "preventive care" (see Chapter 2). Because New Jersey requires treatment, which would not be preventive care, it would not have been possible to offer an insured or HMO member an HDHP in New Jersey without statutory change (the IRS did have limited transition guidance in place under Notice 2004-43, but that only covered months before January 1, 2006, for calendar-year plans). This law creates an exception to this rule for HDHPs that are intended to be used with an HSA. Under the exception, a deductible for lead poisoning benefits can be imposed under the HDHP, unless such services satisfy the definition of "preventive care" under federal law.

State Tax Consequences

Even if an HSA satisfies applicable federal requirements, a participant will not have necessarily the same favorable tax consequences under state law as under federal law. Although most states follow the federal tax law as to determination of taxable income, some states do not provide tax benefits for HSA participation.

⁴⁶ ERISA § 514(b)(5).

⁴⁷ Haw. Rev. Stat. §§ 393-3(8), 393-4, 393-11.

⁴⁸ Haw. Rev. Stat., ch. 393.

⁴⁹ P.L. 2005 Chpt. 248 (December 21, 2005).

Beyond the Internal Revenue Code: Other Federal and Health Savings Accounts

There are currently four states in which the state tax consequences of HSA participation differ from the federal tax consequences (for example, where HSA employer contributions that are excludible for federal tax purposes are required to be included in income, where interest earned on the HSA is taxed, or where the deduction for state tax purposes is not available). These are: Alabama, California, New Jersey, and Wisconsin. Also, it is possible that in certain states, the Tax Relief and Health Care Act of 2006 (TRHCA) provisions that apply to HSAs (e.g., increased contribution limits) do not apply for purposes of state tax law. See Appendix C for a complete list of states and tax consequences.

Alabama

Currently, Alabama does not conform to Code Section 223 and therefore it appears that Alabama does not afford the favorable tax treatment for individuals under the section for state individual income tax purposes. Therefore, employer HSA contributions are not excludible from income for state income tax purposes, unless made through a cafeteria plan as described below. Also, it appears that earnings on these contributions will be subject to state income tax. It is unclear whether distributions are taxable as such distribution amounts already have been taxed under state law when contributed. Interestingly, Alabama has not amended its tax forms and instructions to inform HSA participants of their obligation to report this income, so it is unclear whether Alabama intends to enforce the taxation of HSAs for state income tax purposes.

Alabama, however, conforms to Code Section 125. Therefore, HSA contributions that are made through a cafeteria plan are free from state income tax. It appears, however, that earnings will continue to be subject to state income tax.

California's Assembly Bill 115 (A.B. 115)

California's Assembly Bill 115 (Stat. 2005, Ch. 691 (Oct. 17, 2005)) conforms California income tax law to federal tax law as of April 15, 2005, but specifically excludes HSAs. Under A.B. 115, HSA contributions may not be made on a pre-tax basis, no deduction is available for after-tax contributions, and earnings are taxed.

New Jersey

Currently, New Jersey does not conform to Code Section 223. As a result, New Jersey does not exclude HSA contributions by employers or by employees through an employer's cafeteria plan from an individual's income. Also, it appears that earnings on these contributions will be subject to state income tax. It is unclear whether distributions are taxable as such distribution amounts already have been taxed under state law. Similar to Alabama, it does not appear that New Jersey individual income tax forms or instructions inform HSA participants of their obligation to report these amounts as income.

Wisconsin

In general, Wisconsin law conforms to the Internal Revenue Code as of December 31, 2002. As a result, Wisconsin has not conformed to the tax treatment of HSAs, and therefore Wisconsin does not exclude HSA contributions by employers or by employees through an employer's cafeteria plan from an individual's income. Also, earnings on HSA amounts are taxable. HSA distributions, however, may be included in the computation of the Wisconsin itemized deduction credit (See Instructions for Schedule I <http://www.revenue.wi.gov/forms/2007/07i-128.pdf>).

The Wisconsin state legislature passed legislation conforming to the federal tax treatment of HSAs in 2004 and more recently in 2006. However, the Wisconsin governor vetoed these measures.

Pennsylvania –Favorable Tax Treatment for HSA Contributions

Pennsylvania's The Health Savings Account Act (S.B. 300), enacted into law on July 6, 2006, exempts contributions to an HSA from the 3.07% state personal income tax. Before S.B. 300 was enacted, Pennsylvania

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exempted interest income earned by an HSA and distributions used to pay for eligible medical or dental expenses from state personal income tax, but did not exclude HSA contributions by employers or by employees through an employer's cafeteria plan from an individual's income. Now, HSA contributions by employers and by employees through an employer's cafeteria plan are excludible from an individual's income for state income tax purposes. Similarly, earnings on these amounts are tax-free.

Davis-Bacon Act

Employer contributions to an HSA most likely count as fringe benefits under the Davis-Bacon Act of 1931. The Act requires contractors and subcontractors working on federally-funded construction projects in excess of \$2,000 to pay their laborers and mechanics a wage that is not less than the prevailing wage for similarly situated employees in the locality.⁵⁰ Included in the "prevailing wage" are two components: (1) basic hourly wages, and (2) fringe benefits. Although the basic hourly wages must be paid in cash, fringe benefit obligations may be satisfied by paying fringe benefits in cash as additional wages, contributing payments to a bona fide plan, or both.⁵¹

Employer contributions to HSAs are likely to count as fringe benefits under the Act because HSAs are designed to pay for medical expenses, which are a benefit listed under the Act. Also, HSAs are funded and nonforfeitable, and therefore appear to satisfy the funded plans requirements under 29 C.F.R. Section 5.26. Although the HSA funds could be used for non-medical purposes if an account owner is willing to incur income tax and a 10% additional tax, a contractor is permitted to substitute cash for the fringe benefits. Accordingly, it is likely that the DOL would consider employer contributions to an HSA to satisfy the fringe benefits requirements under the Act.

USA Patriot Act

The Customer Identification Procedures of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (USA PATRIOT Act) apply to HSAs for which a bank is trustee or custodian. Title III of the USA PATRIOT Act, "International Money Laundering Abatement and Anti-terrorist Financing Act of 2001," adds several new provisions to the Bank Secrecy Act of 1970 (BSA),⁵² designed to facilitate the prevention, detection, and prosecution of international money laundering and the financing of terrorism.⁵³

Section 326 of the USA PATRIOT Act adds new subsection (1) to 31 U.S.C. 5318 of the BSA, which directs the Secretary of Treasury to draft regulations establishing minimum standards that shall apply in connection with the opening of an account at a financial institution regarding the customer's identity. The regulation under 31 CFR Section 103.121 entitled "Customer Identification Programs for banks, savings associations, credit unions, and certain non-Federally regulated banks" (CIP regulation) sets forth minimum information that a bank must obtain from a customer before opening an account.

These rules generally require that a bank implement a written Customer Identification Program appropriate for its size and type of business that includes obtaining the name, date of birth, address, and taxpayer identification number of a customer before opening an account. After obtaining this information, the bank must verify the customer's identity within a reasonable time after the account is opened. This can be done, for example, by reviewing a customer's unexpired government-issued identification such as a driver's license or passport. If the

⁵⁰ 40 U.S.C. §§ 3141 to 3144, 3146 and 3147.

⁵¹ See 40 U.S.C. § 1341; 29 C.F.R. § 5.31.

⁵² BSA, 31 U.S.C. 5311 *et seq.*

⁵³ USA Patriot Act (P.L. 107-56).

bank cannot form a reasonable belief that it knows the true identity of a customer, the bank must follow procedures that it has adopted describing when the bank should not open an account, when a customer may use an account while the bank attempts to verify the customer's identity, when the bank should close an account (after attempts to verify a customer's identity have failed) and when the bank should file a Suspicious Activity Report in accordance with applicable law and regulation. The CIP regulation also contains rules requiring that the bank keep records of identifying information about a customer, including any document that was relied on to verify the customer's identity. These records must be retained for five years after the date that the account is closed. Finally, the bank must adopt procedures for determining whether the customer appears on any list of known or suspected terrorists or terrorist organizations issued by any federal government agency. Bank customers also must be given notice that the bank is requesting information to verify their identities. A sample notice is provided in the regulation for this purpose.

HSAs and Securities Law

In addition to being regulated by the IRS, the DOL, and Health and Human Services, it is possible that an HSA also will be subject to regulation by the Securities and Exchange Commission (SEC). However, as of this writing, the SEC has not issued any guidance on this issue. The threshold question is whether HSAs are "securities." If HSAs are securities, persons in the business of selling HSAs would have to register as brokers or dealers. Also, if HSAs are securities, it is likely that interests in HSAs would have to be registered as securities under the Securities Act of 1933, and the HSA issuer may have to register as an investment company under the Investment Company Act of 1940.

The federal securities laws define the term "security" as including an "investment contract" (for example, Securities Exchange Act of 1934 Section 3(10)). Therefore, an HSA will be a security if it qualifies as an investment contract. An investment contract involves a contract, transaction, or scheme whereby (1) a person invests his or her money (2) in a common enterprise, (3) with an expectation of profit, and (4) solely from the efforts of a promoter or other third party.⁵⁴

Individual Retirement Arrangements and Securities Law

Because HSAs have many of the same features as IRAs, and because Code Section 223 refers to IRA rules as to certain issues (for example, identity of trustee), SEC guidance regarding IRAs may be helpful in determining the status of HSAs under federal securities laws. The SEC has taken the position that most IRAs are "investment contracts."⁵⁵ However, the SEC also has opined that certain types of IRAs do not involve separate securities. These include:

- IRAs involving direct investment by an individual in an exempt security (such as government-issued securities or certain securities issued by a bank);
- IRAs involving direct investment by an individual in an underlying investment that is not a security (such as a traditional fixed annuity); and
- IRAs funded solely by mutual fund shares registered under the Securities Act of 1933.
- If the SEC were to take a similar position as to HSAs, most HSAs would not be required to be registered.

⁵⁴ *SEC v. W.J. Howey Co.*, 328 U.S. 293 (1946).

⁵⁵ See SEC Release 33-6188, 1980 WL 2942, *13 (Feb. 1, 1980) ("Release No. 6188").

Use of Electronic Media

The Treasury and the IRS has issued final regulations regarding the use of electronic media to provide notices to employee benefit plan participants and beneficiaries and to transmit elections or consents from participants and beneficiaries to employee benefit plans. The standards set forth in these proposed regulations would apply to any “notice, election, or similar communication” made to or by an HSA account owner.⁵⁶

⁵⁶ Treas. Reg. § 1.401(a)-21 (effective for notices provided, and participant elections made, on or after January 1, 2007).

Appendix A

Annual Health Savings Accounts Limitations

The maximum HSA contribution limits generally apply to an eligible individual with an HDHP and an HSA for the entire taxable year (see chapters 3 and 4). However, an exception is provided for an individual who becomes HSA-eligible after the beginning of a taxable year who does not establish an HDHP as of the beginning of such year, generally, January 1st (see chapter 4). In general, for tax years beginning after 2006, an individual who becomes covered under a HDHP in a month other than January may be permitted to make the full HSA contribution for the year. An individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual during every month during the taxable year for purposes of computing the amount that may be contributed to the HSA for the year. As a result, such individual is allowed to make contributions for months before the individual was enrolled in an HDHP.

If an individual makes contributions under the exception and does not remain an eligible individual during the testing period, the amount of the contributions attributable to months preceding the month in which the individual was an eligible individual which could not have been made but for the provision is includible in gross income. A 10% additional tax also applies to the amount includible. An exception applies if the employee ceases to be an eligible individual by reason of death or disability. For taxable years beginning in 2007, the HSA maximum annual contribution limit for an eligible individual with self-only coverage is \$2,850 and \$5,650 for family coverage. For taxable years beginning before 2007, the annual contribution amount could not exceed annual deductible under the HDHP. The repeal of the annual plan deductible limit is effective for taxable years beginning after 2006. For taxable years beginning in 2008, the HSA maximum annual contribution limit for an eligible individual with self-only coverage is \$2,900 and \$5,800 for family coverage.

	2008		2007		2006		2005		2004		Base Amount ¹	
	Self-Only	Family	Self-Only	Family	Self-Only	Family	Self-Only	Family	Self-Only	Family	Self-Only	Family
HSA Maximum Annual	\$2,900	\$5,800	\$2,850	\$5,650	\$2,700	\$5,450	\$2,650 ²	\$5,250 ²	\$2,600 ²	\$5,150 ²	\$2,250	\$4,500
HSA Catch-Up Contributions (age 55 by end of year)	\$900		\$800		\$700		\$600		\$500		n/a	
HDHP Minimum Annual Deductible³	\$1,100	\$2,200	\$1,100	\$2,200	\$1,050	\$2,100	\$1,000	\$2,000	\$1,000	\$2,000	\$1,000	\$2,000
HDHP Maximum Out-of-Pocket⁴	\$5,600	\$11,200	\$5,500	\$11,000	\$5,250	\$10,500	\$5,100	\$10,200	\$5,000	\$10,000	\$5,000	\$10,000

¹ These are the base amounts upon which the limits for 2004 and subsequent years are computed. How annual limits are computed and adjusted for inflation (based on the Consumer Price Index (CPI)) is more fully discussed in chapter 3.

² But not more than the annual plan deductible under the HDHP associated with the HSA (for taxable years beginning before 2007). IRC §223(b)(2)(A)-(B). The contribution limit does not apply to rollovers or transfers from an Archer MSA, FSA, HRA or an HSA into an HSA.

³ To be a HDHP, the plan deductible may not be less than the indexed limit. IRC §223(c)(2)(A)(i). See chapter 3.

⁴ To be a HDHP, the sum of the annual deductible and other out-of-pocket expenses may not exceed the indexed amount. IRC §223(c)(2)(A)(ii). See chapter 3.

Appendix B

Groom Comparison HSAs, FSAs, HRAs

Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
<p>General Description</p> <ul style="list-style-type: none"> • Trust or custodial account used to accumulate funds on a tax-preferred basis to pay for certain medical expenses under Code Section 213(d), as described below. • Available to individuals covered by a high deductible health plan and no other health plan that is not a high deductible health plan, except for certain “permitted” insurance or coverage. • Contributions may be made by an employer, eligible individual, or both. Contributions may also be made by any other individual (and would be deductible by the account holder). • An HSA may be offered through a cafeteria plan. 	<ul style="list-style-type: none"> • Employer-sponsored benefit program under which employees receive reimbursement for certain medical expenses under Code Section 213(d), as described below. • Generally offered as part of an employer’s cafeteria plan, but not in conjunction with any other insurance policy. • Contributions typically made by employees through salary reduction. 	<ul style="list-style-type: none"> • Employer-sponsored benefit program under which employees may receive reimbursement for medical expenses under Code Section 213(d), as described below. • May be offered in conjunction with a high deductible or other type of health plan, but this is not required. • Contributions must be solely from the employer.

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	Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
Expenses Eligible for Tax-Free Reimbursement	<ul style="list-style-type: none"> • Amounts distributed for medical expenses (generally defined under IRC § 213(d))¹ incurred by the account holder and the account holder's spouse or dependents (as defined in IRC § 152, without regard to gross income limitations under IRC § 152(d)(1)(B)) are excludable from income, except for amounts distributed to pay health insurance premiums. • However, distributions for expenses of the following types of health insurance premiums are excludable from income: (i) retiree health insurance premiums (other than Medicare supplemental policies) for individuals who have reached Medicare eligibility, (ii) premiums for COBRA coverage, (iii) premiums for a qualified long-term care insurance contract, or (iv) premiums for a health plan during a period in which an individual is receiving unemployment compensation. 	<ul style="list-style-type: none"> • Amounts may be distributed to reimburse an employee for medical expenses (generally defined under IRC § 213(d)) incurred by the employee and the employee's spouse or dependents, except for: (i) expenses for any type of health insurance premiums and, (ii) expenses for long-term care services. 	<ul style="list-style-type: none"> • Amounts may be distributed to reimburse an employee for medical expenses (generally defined under IRC § 213(d)) incurred by the employee and the employee's spouse or dependents, except for expenses for qualified long-term care services. (Note that premiums for qualified long-term care insurance are reimbursable.)

¹ Code Section 213(d) provides that the term "medical care" means amounts paid (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (B) for transportation primarily for and essential to medical care referred to in subparagraph (A); (C) for qualified long-term care services (as defined in IRC § 7702B(c)); or (D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract (as defined in IRC § 7702B(b)).

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	Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
Distributions For Non-Medical Expenses	<ul style="list-style-type: none"> • Distributions that are not used for medical expenses are includible in income and subject to a 10 percent additional tax. • The 10 percent additional tax does not apply to amounts distributed in the event of death, disability, or after an individual reaches Medicare eligibility. • If amounts that would otherwise be taxable HSA distributions are rolled over into another HSA within 60 days, there is no tax consequence associated with the distribution (so long as there has been no other such rollovers in the last 12 months). 	<ul style="list-style-type: none"> • Distributions may not be made for non-medical expenses. 	<ul style="list-style-type: none"> • Distributions may not be made for non-medical expenses.
Eligibility	<p>An individual (or spouse) who is covered by a high deductible health plan and no other non-high deductible health plan that provides benefits covered under the high deductible plan, unless the non-high deductible health plan provides coverage for accidents, disability, dental care, vision care, long-term care or other types of “permitted insurance,” as defined below.</p> <p>For 2007, a high deductible health plan is a health plan that has an annual deductible of not less than \$1,100 for self-only coverage, and \$2,200 for family coverage, with a cap on out-of-pocket expenses (including the deductible) of \$5,500 self and \$11,000 family (all indexed for inflation in \$50 increments), with the following exceptions related to preventive care and out-of-network expenses.</p>	<ul style="list-style-type: none"> • An employee who satisfies the eligibility criteria of the employer and who has made an election under the employer’s cafeteria plan. 	<ul style="list-style-type: none"> • An employee who satisfies the eligibility criteria of the employer.

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Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
<ul style="list-style-type: none"> For 2008, a high deductible health plan is a health plan that has an annual deductible of not less than \$1,100 for self-only coverage, and \$2,200 for family coverage, with a cap on out-of-pocket expenses (including the deductible) of \$5,600 self and \$11,200 family (as indexed), with the following exceptions related to preventive care and out-of-network expenses. 		
<ul style="list-style-type: none"> Preventive Care: a plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care. 		
<ul style="list-style-type: none"> Network plans: a plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitations. In addition, such plan's annual deductible for services provided outside of the network is not taken into account in determining the annual contribution limit. 		
<ul style="list-style-type: none"> "Permitted Insurance" is defined as: (A) insurance if substantially all of the coverage provided under such insurance relates to (i) liabilities incurred under workers' compensation laws, (ii) tort liabilities, (iii) liabilities relating to ownership or use of property, or (iv) such other similar liabilities as the Secretary may specify by regulations, (B) insurance for a specified disease or illness, and (C) insurance paying a fixed amount per day (or other period) of hospitalization. 		

	Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
Funding/ Tax Aspects	<p>Individuals who are entitled to benefits under Medicare are not eligible to make contributions.</p> <ul style="list-style-type: none"> • Account is funded. Earnings grow tax-free. • Contributions may be made either by the employer or the employee, or both, and may be made through a cafeteria plan. • Subject to certain limits, employer contributions are excludable from gross income, and contributions by an eligible individual are deductible in computing adjusted gross income. Contributions are not subject to employment taxes. • Rollovers are permitted from both MSAs and other HSAs, but not from FSAs or HRAs. Beginning December 20, 2006, FSAs and HRAs may be rolled over to an HSA by direct transfer if the requirements of Notice 2007-22 are satisfied. Beginning in 2007, a one-time transfer from an IRA to an HSA (subject to the maximum annual contribution limit) is permitted. 	<ul style="list-style-type: none"> • Account is generally not funded. Rather, reimbursements are paid from the employer's general assets. • Contributions are typically made by employees through salary reduction, are excludable from income, and are not subject to employment taxes. • There is no statutory limit to the amount of contributions that may be made; any limits are by plan design. 	<ul style="list-style-type: none"> • Account is generally not funded. Rather, reimbursements are paid from the employer's general assets.
Contribution Limits	<ul style="list-style-type: none"> • Maximum contributions (generally computed on a monthly basis based on the individual's health coverage) are \$2,850 (in the case of self-only coverage) or \$5,650 (in the case of family coverage) for 2007; indexed in \$50 increments thereafter. 	<ul style="list-style-type: none"> • There are no contribution limits. 	<ul style="list-style-type: none"> • There are no contribution limits.

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Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
<ul style="list-style-type: none"> • Maximum contribution amounts are decreased by the aggregate amount, if any, paid into an Archer Medical Savings Account (MSA) or another HSA. • The maximum contribution amount is increased for individuals who are age 55 or older (again computed on a monthly basis). These individuals may contribute an additional \$800 in 2007, increasing by \$100 increments each year until the limit reaches \$1,000 in 2009. 	<ul style="list-style-type: none"> • Nondiscrimination rules prohibit discrimination in favor of highly compensated individuals with respect to eligibility or benefits. (Code Sec. 105(h)). 	<ul style="list-style-type: none"> • Nondiscrimination rules prohibit discrimination in favor of highly compensated individuals with respect to eligibility or benefits. (Code Sec. 105(h)).
<p>Nondiscrimination Rules</p> <ul style="list-style-type: none"> • Nondiscrimination rules require an employer who makes contributions into an HSA for any employee to make comparable contributions to HSAs of all comparable participating employees. Failure to do so subjects the employer to an excise tax. 	<ul style="list-style-type: none"> • Also may be subject to cafeteria plan non-discrimination rules. 	<ul style="list-style-type: none"> • Amounts not used for medical expenses by the end of the year are subject to a "use it or lose it" rule that prevents carryover to future years.
<p>Carryover of Funds</p> <ul style="list-style-type: none"> • Amounts not used for medical expenses by the end of the year may be carried over to future years, and are non-forfeitable. 	<ul style="list-style-type: none"> • Amounts not used for medical expenses by the end of the year are subject to a "use it or lose it" rule that prevents carryover to future years. 	<ul style="list-style-type: none"> • Amounts not used for medical expenses by the end of the year may be carried over to future years. Limits may be imposed by plan design.

	Health Savings Account (HSA)	Flexible Spending Arrangement (FSA)	Health Reimbursement Arrangement (HRA)
Death of Account Holder	<ul style="list-style-type: none"> • If the surviving spouse is the designated beneficiary of the account, the HSA will be treated as if the spouse is the account holder. • If any person other than the surviving spouse is the designated beneficiary, the HSA will cease to be an HSA as of the date of death, and an amount equal to the fair market value of the assets in the account on such date will be includible in the gross income of that person or, in the absence of a designated beneficiary, in the account holder's estate. 	<ul style="list-style-type: none"> • The only amounts that may be distributed upon the employee's death are reimbursements for medical expenses incurred by the employee or by the employee's spouse or eligible dependents prior to the date of the employee's death. 	<ul style="list-style-type: none"> • Upon the account holder's death, the account may continue to be used by a spouse or eligible dependents for reimbursement of medical expenses. • When there is no longer a spouse or eligible dependents, the account must be forfeited.
	<ul style="list-style-type: none"> • A deduction is permitted for qualified medical expenses incurred by the decedent before death if paid within one year of death. 		

Appendix C

State Conformity to Federal Income Tax Treatment of HSAs

Recent Changes to the HSA Rules and State Conformity to the Federal Tax Treatment of HSAs¹

What Are the Recent Changes That Were Made to the HSA Rules?

In one of its final legislative acts, the 109th Congress approved several significant Health Savings Account ("HSA") provisions as part of the Tax Relief and Health Care Act of 2006 (the "Act"). On December 20, 2006, the President signed the Act into law. The following changes, which are generally effective for taxable years beginning after December 31, 2006, are intended to make HSAs more attractive.

Modifies the limit on contributions to HSAs, so that it is not limited to the annual deductible of the high deductible health plan ("HDHP"); instead, contributions would be limited only by indexed dollar amount (\$2,850 self-only; \$5,650 family for 2007).

Requires the Secretary of Treasury to announce the cost-of-living adjustments applicable to HSAs by June 1 of each year. This change is effective for tax years beginning after 2007.

Allows individuals who become covered by a HDHP after January to contribute up to the full annual limit, even if they were only eligible individuals for a portion of the taxable year.

Permits an individual to transfer the balance remaining in his or her FSA or HRA account as of September 21, 2006 (or, if less, the balance on the date of the transfer) to an HSA. The transfer must be made before January 1, 2012.

Allows coverage under a health FSA during the "2-1/2 Month Grace Period" to be disregarded for eligible individuals who have a zero balance in their HSA at the end of the previous calendar year.

Allows employers to make contributions to HSAs on behalf of non-highly compensated employees in higher amounts (or higher percentages of deductibles) than to highly compensated employees without violating the comparable contribution rules.

Allows individuals to make a one-time distribution to rollover amounts from an IRA to an HSA, subject to the HSA contribution limit.

¹ This chart was prepared by Christopher E. Condeluci for clients and friends of the Groom Law Group Chartered. Please contact Chris or Christine L. Keller at 202-857-0620 with any questions regarding the federal and state tax treatment of HSAs. Reprinted with permission.

Do States Conform to the Federal Tax Treatment of HSAs, Along with the Recent Changes to the HSA Rules?

In general, a majority of States conform their state income tax laws to the federal income tax rules set forth under the Internal Revenue Code of 1986, as amended (the "Code"). A number of these States incorporate the Code by reference, conforming to any and all amendments made to the Code. Other States conform to the Code as of a specified date. In this instance, a State will generally not conform to amendments made to the Code after this specified date. Only until the respective State legislature updates the date of conformity with the Code under the State's statute will the State conform to recent changes made to the federal tax laws. As a practical matter, however, unless a State amends its tax forms and instructions requiring taxpayers to, for example, "add back" HSA contributions that are otherwise deductible or excludible under federal law, it is unlikely that the State will pursue the collection of tax on these unreported amounts (see, e.g., North Carolina).

The following chart indicates whether a particular State conforms to the Code, and the date upon which conformity is enumerated in the State's statute (if any). A State's conformity with the Code will indicate whether the State conforms to the recent changes to the HSA rules articulated above.

State Conformity to Federal Income Tax Treatment of HSAs Adviser's

State/District	Conforms to Federal Tax Treatment of HSAs	Conforms to Tax Relief and Health Care Act of 2006	Comments Relating to the State's Conformity with the Internal Revenue Code of 1986, as amended and HSAs
Alabama	Generally No.	No.	Alabama income tax is not based on the Internal Revenue Code of 1986, as amended. In general, Alabama "gross income" includes gains, profits and income derived from, among other things, salaries, wages, or compensation for personal services of whatever kind unless specifically exempt by law. Ala. Code § 40-18-14(1). There is no specific exemption for HSA contributions (including employer HSA contributions, individual HSA contributions, or earnings on HSA amounts). However, Alabama's Code includes an explicit exemption for contributions to a cafeteria plan that are otherwise excludable for federal income tax purposes under Code section 125. Ala. Code § 40-18-14(3)(k). Therefore, HSA contributions that are made through a cafeteria plan should be free from Alabama state income tax.
Arizona	Yes.	No.	Arizona adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Ariz. Rev. Stat. Ann. §§ 43-102.A.1, 43-1001. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Arizona conforms to the Internal Revenue Code as of January 1, 2006. Ariz. Rev. Stat. Ann. § 43-105.A. Therefore, it appears that, as a technical matter, Arizona would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Arkansas	Yes.	No.	In general, HSAs are exempt from taxation for Arkansas state tax purposes. Ark. Code Ann. § 26-51-453(a). Arkansas also excludes from "gross income" employer HSA contributions (which presumably includes contributions under a cafeteria plan). Ark. Code Ann. § 26-51-404(a), (b)(26). It appears, however, that Arkansas conforms to Code section 223 as of January 1, 2005. Therefore, it appears that, as a technical matter, Arkansas would not conform to the changes made under the Act until conformity with Code section 223 is updated.
California	No.	No.	Although California conforms to the Internal Revenue Code as of January 1, 2005 (See Cal. Rev. & Tax Code §§ 23051.5(a), 17024.5(a)), California specifically does not conform to Code sections 223 or 106(d) for personal income tax purposes (See Cal. Rev. & Tax Code §§ 17215.4 and 17131.4). As a result, California does not exclude employer HSA contributions and HSA contributions made by employees through an employer's cafeteria plan from an individual's income. California requires a taxpayer to "add back" HSA contributions that were deducted on his or her federal tax return (See 2005 Instructions for Schedule CA (540)). Also, earnings on HSA amounts are taxable.
Colorado	Yes.	Yes.	Colorado conforms to the Internal Revenue Code of 1986, as amended from time to time. Colo. Rev. Stat. § 32-22-103(11). Colorado also permits insurance carriers authorized to conduct business in the state to offer a high deductible health plan that may be offered in conjunction with an HSA. Colo. Rev. Stat. § 10-16-129. Therefore, it appears that Colorado conforms to the federal tax treatment of HSAs, and conforms to the amendments made by the Act.
Connecticut	Yes.	Yes.	Connecticut adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Connecticut conforms to the Internal Revenue Code of 1986, as amended from time to time. Conn. Gen. Stat. § 12-701(a)(2), (a)(16). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Connecticut conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Delaware	Yes.	Yes.	Delaware adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Delaware conforms to the Internal Revenue Code, as amended from time to time. Del. Code Ann. 30, §§ 1105, 1101. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Delaware conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
District of Columbia	Yes.	Yes.	DC adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and DC conforms to the Internal Revenue Code of 1986, as amended from time to time. D.C. Code §§ 47-1803.02(b)(1), 47-1801.04(28A). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that DC conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.

Guide to Health Savings Accounts

State/District	Conforms to Federal Tax Treatment of HSAs	Conforms to Tax Relief and Health Care Act of 2006	Comments Relating to the State's Conformity with the Internal Revenue Code of 1986, as amended and HSAs
Georgia	Yes.	No.	Georgia adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Ga. Code Ann. § 48-7-27(a). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Georgia conforms to the Internal Revenue Code as of January 1, 2006. Ga. Code Ann. § 48-2-2(14). Therefore, it appears that, as a technical matter, Georgia would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Hawaii	Yes.	No.	Hawaii adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Haw. Rev. Stat. § 235-2.3. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Hawaii conforms to the Internal Revenue Code as of December 31, 2005. Haw. Rev. Stat. § 235-2.3(a). Therefore, it appears that, as a technical matter, Hawaii would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Idaho	Yes.	Yes.	Idaho adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Idaho Code Ann. § 63-3011B, C. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. The Idaho legislature recently updated the State's conformity to the Internal Revenue Code to January 1, 2007. Idaho Code Ann. § 63-3004(a), as amended by H.B. 16 (signed by Governor 2/14/07). Therefore, Idaho conforms to the federal tax treatment of HSAs and to the changes made under the Act.
Illinois	Yes.	Yes.	Illinois adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Illinois conforms to the Internal Revenue Code of 1986, as amended from time to time. 35 Ill. Comp. Stat. 5/203(a)(1), 5/102. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Illinois conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Indiana	Yes.	No.	Indiana adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Ind. Code § 6-3-1-3.5. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Indiana conforms to the Internal Revenue Code as of January 1, 2006. Ind. Code § 6-3-1-11. Therefore, it appears that, as a technical matter, Indiana would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Iowa	Yes.	No.	In general, Iowa adjusted gross income is federal adjusted gross income (with certain additions and subtractions) and contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. Iowa Code § 422.7. However, Iowa conforms to the Internal Revenue Code as of January 1, 2006. Iowa Code § 422.3(5). Therefore, it appears that, as a technical matter, Iowa would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Kansas	Yes.	Yes.	Kansas adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Kansas conforms to the Internal Revenue Code of 1986, as amended from time to time. Kan. Stat. An. §§ 79-32, 117, 79-32, 109(a). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Kansas conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Kentucky	Yes.	No.	Kentucky adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Ky. Rev. Stat. Ann. § 141.010(10). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Kentucky conforms to the Internal Revenue Code as of December 31, 2004. Ky. Rev. Stat. Ann. § 141.010(3). Therefore, it appears that, as a technical matter, Kentucky would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Louisiana	Yes.	Yes.	Louisiana adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Louisiana conforms to the Internal Revenue Code of 1986, as amended from time to time. La. Rev. Stat. Ann. §§ 47:293(1), 47:290A. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Louisiana conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.

State Conformity to Federal Income Tax Treatment of HSAs Adviser's

State/District	Conforms to Federal Tax Treatment of HSAs	Conforms to Tax Relief and Health Care Act of 2006	Comments Relating to the State's Conformity with the Internal Revenue Code of 1986, as amended and HSAs
Maine	Yes.	No.	Maine adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Me. Rev. Stat. Ann. § 36, § 5121. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount (prior to January 1, 2006, HSA contributions were required to be "added back" to income). However, Maine conforms to the Internal Revenue Code as of December 31, 2005. Me. Rev. Stat. Ann. § 36, § 1111-A). Therefore, it appears that, as a technical matter, Maine would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Maryland	Yes.	Yes.	Maryland adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Md. Code Ann., Tax-Gen. § 10-203. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. Although Maryland does not generally adopt the Internal Revenue Code, the Maryland Comptroller is required to apply the administrative and judicial interpretations of the federal income tax law to the administration of the Maryland income tax law. Md. Code Ann., Tax-Gen. § 10-107. As a result, it appears that Maryland conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Massachusetts	Yes.	No.	Massachusetts adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Mass. Gen. Laws 62, § 1(d). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Massachusetts conforms to the Internal Revenue Code as of January 1, 2005. Mass. Gen. Laws 62, § 1(c). Therefore, it appears that, as a technical matter, Massachusetts would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Michigan	Yes.	Yes.	Michigan adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Michigan conforms to the Internal Revenue Code as of January 1, 1996 or, at the option of the taxpayer, in effect for the tax year. Mich. Comp. Laws §§ 206.30, 206.12(3). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that, at the election of the taxpayer, Michigan conforms to the federal tax treatment of HSAs and to the changes made under the Act.
Minnesota	Yes.	No.	Minnesota adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Minn. Stat. § 290.01(19), (19a), (19b). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, for the 2007 tax year, Minnesota conforms to the Internal Revenue Code as of May 18, 2006. Minn. Stat. § 290.01(31). Therefore, it appears that, as a technical matter, Minnesota would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Mississippi	Yes.	Yes.	Mississippi income tax is not based on the Internal Revenue Code of 1986, as amended, but it has provisions that either parallel many of the federal provisions or directly incorporate specific provisions or federal treatment. For example, Mississippi generally defines "gross income" as federal W-2 wages. Miss. Code Ann. § 27-7-13, 27-7-15(1). However, gross income does not include HSA contributions (presumably made by an employer or through a cafeteria plan) and earnings thereon. Miss. Code Ann. § 27-7-15(4)(aa). Mississippi also allows a deduction for HSA contributions made on an after-tax basis. Miss. Code Ann. §§ 83-62-1 through 83-62-1. As a result, it appears that Mississippi conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Missouri	Yes.	Yes.	Missouri adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Missouri conforms to the Internal Revenue Code of 1986, as amended from time to time. Mo. Rev. Stat. §§ 143.111, 143.121, 143.091. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Missouri conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Montana	Yes.	Yes.	Montana adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Montana conforms to the Internal Revenue Code, as amended from time to time. Mont. Code Ann. §§ 15-30-111, 15-30-101(13). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Montana conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.

Guide to Health Savings Accounts

State/District	Conforms to Federal Tax Treatment of HSAs	Conforms to Tax Relief and Health Care Act of 2006	Comments Relating to the State's Conformity with the Internal Revenue Code of 1986, as amended and HSAs
Nebraska	Yes.	Yes.	Nebraska adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Neb. Rev. Stat. § 77-2715(2). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. The Nebraska legislature recently updated the State's conformity to the Internal Revenue Code to February 15, 2007. Neb. Rev. Stat. § 49-801.01, as amended by L.B. 315 (signed by Governor 2/15/07). Therefore, Nebraska conforms to the federal tax treatment of HSAs and to the changes made under the Act.
New Jersey	No.	No.	New Jersey income tax is not based on the Internal Revenue Code of 1986, as amended. In general, New Jersey "gross income" means all income that the taxpayer received in the form of money, goods, property, and services unless specifically exempt by law. See Instructions, 2005 NJ-1040, New Jersey Income Tax Return. There is no specific exemption for HSA contributions (including employer HSA contributions, individual HSA contributions, or earnings on HSA amounts). Also, New Jersey generally does not conform to Code section 125, which means that amounts received under "salary reduction plans" (i.e., cafeteria plans or flexible spending arrangements) that give employees the option to receive salary or to use a portion of that salary to purchase medical or insurance coverage would be considered taxable income. See New Jersey Division of Taxation Technical Bulletin, TB-39(R), March 3, 2003. As a result, it appears that employee HSA contributions made through a cafeteria plan are taxable.
New Mexico	Yes.	Yes.	New Mexico adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and New Mexico conforms to the Internal Revenue Code of 1986, as amended from time to time. N.M. Stat. §§ 7-2-2A, 7-2-2J. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that New Mexico conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
New York	Yes.	Yes.	New York adjusted gross income is federal adjusted gross income (with certain additions and subtractions). N.Y. Tax Law § 612(a). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount (special rules apply to New York State Employees). As a result, it appears that New York conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
North Carolina	Yes.	Yes.	North Carolina conforms to the Internal Revenue Code as of January 1, 2006. N.C. Gen. Stat. § 105-228.90(b)(1b). However, the North Carolina Department of Revenue has announced that because of the difficulty of identifying changes made to the federal income tax laws after January 1, 2006, and the likelihood that the North Carolina General Assembly will update the State's conformity to the Internal Revenue Code, the Department will follow the federal changes enacted after January 1, 2006 administratively and process income tax returns as if the State conformed to these changes. Consequently, North Carolina has not modified its income tax forms to account for differences that might arise as a result of North Carolina's current conformity date. See http://www.dormc.com/fed_legislation_notice06.html
North Dakota	Yes.	Yes.	North Dakota adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and North Dakota conforms to the Internal Revenue Code of 1986, as amended from time to time. N.D. Cent. Code § 57-38-01.5. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that North Dakota conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Ohio	Yes.	No.	Ohio adjusted gross income is federal adjusted gross income. Ohio Rev. Code Ann. § 5747.01(A). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Ohio conforms to the Internal Revenue Code as of March 30, 2006. Ohio Rev. Code Ann. § 5701.11. Therefore, it appears that, as a technical matter, Ohio would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Oklahoma	Yes.	Yes.	Oklahoma adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Oklahoma conforms to the Internal Revenue Code of 1986, as amended from time to time. Okla. Stat. 68, § 2353(11), (13), (2). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Oklahoma conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.

State Conformity to Federal Income Tax Treatment of HSAs Adviser's

State/District	Conforms to Federal Tax Treatment of HSAs	Conforms to Tax Relief and Health Care Act of 2006	Comments Relating to the State's Conformity with the Internal Revenue Code of 1986, as amended and HSAs
Oregon	Yes.	No.	Oregon adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Or. Rev. Stat. §§ 316.048, 316.022(6). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Oregon conforms to the Internal Revenue Code as of December 31, 2004. Or. Rev. Stat. § 314.011(2). Therefore, it appears that, as a technical matter, Oregon would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Pennsylvania	Yes.	Yes.	Pennsylvania taxable income is not derived from federal taxable income and must be determined independently. See 72 Pa. Stat. Ann. § 7303(a)(1). Beginning in 2006, Pennsylvania conforms to Code section 223. Therefore, Pennsylvania conforms to the federal income tax treatment of HSAs (See PI Tax Bulletin 2006-6), and as a result, it appears that Pennsylvania conforms to the changes made under the Act.
Rhode Island	Yes.	Yes.	Rhode Island adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Rhode Island conforms to the Internal Revenue Code of 1954, as amended. R.I. Gen. Laws §§ 44-30-12, 44-30-6. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Rhode Island conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
South Carolina	Yes.	No.	South Carolina adjusted gross income is federal adjusted gross income. S.C. Code Ann. § 12-6-560. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, South Carolina conforms to the Internal Revenue Code as of December 31, 2005. S.C. Code Ann. § 12-6-40. Therefore, it appears that, as a technical matter, South Carolina would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Utah	Yes.	Yes.	In general, Utah adjusted gross income is federal adjusted gross income (with certain additions and subtractions), and Utah conforms to the Internal Revenue Code of 1986, as amended from time to time. Utah Code Ann. § 59-10-103(1)(a), (y). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. As a result, it appears that Utah conforms to the federal tax treatment of HSAs, and conforms to the changes made under the Act.
Vermont	Yes.	No.	Vermont adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Vt. Stat. Ann. § 58.1-581(21). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Vermont conforms to the Internal Revenue Code as of January 1, 2005. Vt. Stat. Ann. § 58.1-5824. Therefore, it appears that, as a technical matter, Vermont would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Virginia	Yes.	No.	Virginia adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Va. Code Ann. § 58.1-322.A. In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, Virginia conforms to the Internal Revenue Code as of December 31, 2005. Va. Code Ann. § 58.1-301.B. Therefore, it appears that, as a technical matter, Virginia would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
West Virginia	Yes.	No.	West Virginia adjusted gross income is federal adjusted gross income (with certain additions and subtractions). W. Va. Code § 11-21-12(a). In general, contributions to an HSA (made by the individual, employer, or through a cafeteria plan) are not required to be "added back" to the federal adjusted gross income amount. However, West Virginia conforms to the Internal Revenue Code as of December 31, 2006. W. Va. Code § 11-21-9(a). Therefore, it appears that, as a technical matter, West Virginia would not conform to the changes made under the Act until conformity with the Internal Revenue Code is updated.
Wisconsin	No.	No.	Wisconsin adjusted gross income is federal adjusted gross income (with certain additions and subtractions). Wis. Stat. § 71.01(4), (13). Wisconsin conforms to the Internal Revenue Code as of December 31, 2004. However, Wisconsin does not conform to Code section 223. Wis. Stat. § 71.01(6)(f). Therefore, Wisconsin does not conform to the federal tax treatment of HSAs. See Wisconsin Tax Bulletin No. 150, January 2007; Wisconsin Tax Bulletin No. 145, November 2005.

The following States do not have personal income tax:

Alaska, Florida, New Hampshire, South Dakota, Tennessee, Texas, Washington, and Wyoming

Appendix D

Administrative Forms

ADDITIONAL CONTRIBUTION/DEPOSIT TO EXISTING HSA

GENERAL INFORMATION

Organization: _____
Participant: _____ SSN: _____ Account No: _____
Residence Address: _____

DEPOSIT INFORMATION

Type of Deposit (Check one): **Amount of this Deposit: \$** _____

- HSA regular contribution (including spousal) for Tax Year: _____
- Mistake of Fact Reimbursement
- Rollover from another HSA or Archer MSA.
- Transfer from another HSA or Archer MSA
- One-Time Transfer from an FSA or HRA (treated as a rollover)
- One-Time Transfer from an IRA (treated as a regular HSA contribution)

Transfer received from: _____

Investment(s) Requested:

- Regular Savings: \$ _____ Certificate: \$ _____ Term _____ Rate _____ %
Maturity Date: _____
- Other: \$ _____ Please specify: _____

Add to existing investment Account No.: _____

Deposit Date: _____ Total Deposit Amount: \$ _____

Deposit accepted by (initials): _____

Authorization

I authorize and direct the Trustee/Custodian to place this contribution in my HSA. I acknowledge that I am solely responsible for determining my eligibility to make HSA contributions and that I will not make annual contributions in excess of my maximum allowable amount. If this is a rollover contribution, I certify that this deposit is being made within 60 days of my receipt of the HSA distribution that I am depositing and that this amount is eligible to be rolled over. I understand that contributions to my HSA except Mistake of Fact Reimbursements and certain direct transfers will be reported to the Internal Revenue Service.

Participant's Signature: _____ Date: _____

HSA DISTRIBUTION REQUEST

GENERAL INFORMATION

Organization: _____ Account Number: _____

Participant: _____ SSN: _____ Birth Date: _____

Residence Address: _____ Phone: _____

For death distributions, complete the following. Beneficiary's Name: _____

SSN: _____ Relationship: _____ Birth Date: _____

Residence Address: _____ Phone: _____

DISTRIBUTION REASON

- 1. Distribution used to pay or reimburse for qualified medical expenses
- 2. Distribution *not* used to pay or reimburse for qualified medical expenses and no other exception applies
- 3. Distribution after becoming eligible for Medicare (age 65)
- 4. Permanent Disability (if you are disabled within the meaning of section 72(m)(7) of the Internal Revenue Code)
- 5. Death (If you are a Designated Beneficiary of this account and can furnish a certified copy of the Death Certificate)
- 6. Removal of Excess plus earnings before tax filing deadline: Excess amount: \$ _____ Earnings: \$ _____
Earnings on excess contributions are taxed in the year of distribution.
- 7. Transfer (including Transfer Incident To Divorce, Legal Separation, or to a Surviving Spouse). Payable to: _____
- 8. Other (specify reason not listed above): _____

FINANCIAL INFORMATION

I instruct the Custodian or Trustee to distribute from the above account. Choose either 1 or 2:

- 1. The entire account balance.
- 2. Partial distribution

Payment Instructions:

Issue check to Participant/Beneficiary

Distribute funds to Account #: _____

In-kind. _____ Shares; Name of Security: _____

Other: _____

	Amount Requested	\$ _____
	Administrative Fees (including CD penalty)	(-) _____
	<input type="checkbox"/> Check this box if fees and/or CD penalty paid from remaining HSA assets.	
	Amount Withdrawn (reported to IRS)	\$ _____
	Federal Income Tax Withheld	(-) _____
	State Income Tax Withheld	(-) _____
	Net Amount Paid to Recipient or Transferred to another Organization:	\$ _____

METHOD OF PAYMENT

Until I give written instructions to the contrary, I direct the Custodian or Trustee to distribute the amount requested as follows:

1. Date payment(s) to commence(s): _____
2. Distribution(s) to be made: one time monthly quarterly semi-annually annually other _____
3. Make payments(s) to me directly account # _____ other: _____

SIGNATURES

I certify that I am the proper party to receive payment(s) from this HSA, and that all information provided by me is true and accurate. I understand that although HSAs are not subject to withholding, I am still liable for the payment of Federal income tax on the taxable amount of any distribution. I understand that any amounts withdrawn that are not used to pay or reimburse for qualified medical expenses may be subject to income taxes and penalties. I also understand that I may be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax are not adequate. I certify that no tax advice has been given to me by the Custodian or Trustee, that distributions are reported to the IRS, and that all decisions regarding this withdrawal are my own. The Account Beneficiary is solely responsible for determining the taxability or non-taxability of any distribution from this HSA. I expressly assume the responsibility for any adverse consequences which may arise from this withdrawal and I agree that the Custodian or Trustee shall in no way be responsible for those consequences.

Participant's or Beneficiary's Signature: _____ Date: _____

HSA BENEFICIARY DESIGNATION OR CHANGE FORM

GENERAL INFORMATION

Organization: _____ Account No.: _____
 Participant: _____ SSN: _____ Birth Date: _____
 Address: _____ Phone No: _____

DESIGNATION OF BENEFICIARY(IES)

I hereby revoke any prior beneficiary designation made by me and designate the individuals named below as my Primary and Contingent Beneficiaries of this HSA. If the Primary or Contingent Beneficiary box is not checked for a beneficiary, the beneficiary will be deemed to be a Primary Beneficiary.

In the event of my death, the balance in the account shall be paid to the Primary Beneficiaries who survive me in equal shares (or in the specified shares, if indicated). If none of the Primary Beneficiaries survive me, the balance in the account shall be paid to the Contingent Beneficiaries who survive me in equal shares (or in the specified shares, if indicated). If any Primary or Contingent Beneficiary does not survive me, such beneficiary's interest and the interest of such beneficiary's heirs shall terminate completely, and the share for any remaining Primary or Contingent Beneficiary shall be increased on a pro rata basis.

Primary	Contingent	Name: _____	SSN: _____	Birth Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Address: _____ Relationship: _____ Share: _____ %		
Primary	Contingent	Name: _____	SSN: _____	Birth Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Address: _____ Relationship: _____ Share: _____ %		
Primary	Contingent	Name: _____	SSN: _____	Birth Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Address: _____ Relationship: _____ Share: _____ %		
Primary	Contingent	Name: _____	SSN: _____	Birth Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Address: _____ Relationship: _____ Share: _____ %		
Primary	Contingent	Name: _____	SSN: _____	Birth Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Address: _____ Relationship: _____ Share: _____ %		

If I named a Beneficiary that is a Trust, I understand I must complete the Trust Beneficiary Certification Form.

PARTICIPANT'S SIGNATURE

I understand that I may change or add beneficiaries at any time by completing and delivering the proper form to the Custodian or Trustee.

Signature of Participant: _____ Date: _____

CONSENT OF SPOUSE

I consent to the above Beneficiary Designation.

Signature of Spouse: _____ Date: _____

(Note: Consent of the Participant's Spouse may be required in a community property or marital property state to effectively designate a beneficiary other than or in addition to the Participant's Spouse.)

Disclaimer For Community and Marital Property States: The Participant's Spouse may have a property interest in the account and the right to dispose of the interest by will. Therefore, the Trustee or Custodian disclaims any warranty as to the effectiveness of the Participant's beneficiary designation or as to the ownership of the account after the death of the Participant's Spouse. For additional information, please consult your legal advisor.

ACCEPTANCE

The Custodian/Trustee acknowledges and accepts receipt of this HSA Beneficiary Designation or Change Form.

Authorized Signature of Custodian/Trustee: _____ Date Accepted: _____

HSA TRUST BENEFICIARY CERTIFICATION FORM**GENERAL INFORMATION**

Organization: _____ Account No: _____

Participant: _____ SSN: _____

If the Account Owner is deceased, the following must be completed:

Name of Trustee(s) of Trust: _____ Trust EIN: _____

Date of Death: _____

TRUST BENEFICIARY(IES)

I certify that I am either the Participant or the Trustee of the Trust and I have either:

- Provided the Trustee/Custodian with a copy of the Trust; or
 Listed below the beneficiary(ies) of the Trust.

Primary Contingent Name: _____ SSN: _____ Birth Date: _____

 Address: _____ Relationship: _____ Share: _____ %

Conditions on entitlement: _____

Primary Contingent Name: _____ SSN: _____ Birth Date: _____

 Address: _____ Relationship: _____ Share: _____ %

Conditions on entitlement: _____

Primary Contingent Name: _____ SSN: _____ Birth Date: _____

 Address: _____ Relationship: _____ Share: _____ %

Conditions on entitlement: _____

SIGNATURES

I understand if the Trust instrument is amended at any time in the future I must, within a reasonable time, provide a copy of such amendment or a corrected certification form to the Trustee/Custodian. I also agree to provide a copy of the trust instrument to the Trustee/Custodian upon demand; and upon the death of the Participant, provide a final list of all beneficiary(ies) or an actual copy of the Trust no later than October 31st of the year following the year of the participant's death.

Signature: _____ Date: _____

Signature of: Participant Trustee of Trust
(check one)**ACCEPTANCE**

The Trustee/Custodian acknowledges and accepts receipt of this Trust Beneficiary Certification Form.

Signature: _____ Date Accepted: _____

HSA to HSA ROLLOVER CONTRIBUTION DOCUMENTATION

HSA PARTICIPANT INFORMATION

Participant's Name: _____ Account _____ No: _____

Residence Address: _____

SSN: _____ Birth Date: _____ Home Phone #: _____ Bus. Phone #: _____

Form of Rollover/Direct Rollover: In Cash \$ _____ In Kind (Specify): _____

ROLLOVER FROM ANOTHER HSA OR AN ARCHER MSA

I certify that the following statements are true and correct.

1. This rollover contribution is being made within 60 days after my receipt of funds from another HSA or an Archer MSA, in which I was either the participant or surviving spouse beneficiary.
2. During the 12-month period prior to my receipt of the distribution being rolled over, I have not received a distribution from the same HSA which was subsequently rolled over to another HSA, and the distribution being rolled over has not been part of a distribution from another HSA that was subsequently rolled over.

SIGNATURE OF HSA PARTICIPANT

The undersigned hereby irrevocably elects to treat this contribution as a rollover contribution. I understand that this will not be a valid HSA rollover unless the statements above are true and correct. I understand that rollover contributions are reported to the IRS. I hereby release the Trustee/Custodian from any claim for damages on account of the failure of this transaction to qualify as a valid rollover.

Date: _____ Signature of Participant: _____

HSA TO HSA TRANSFER DOCUMENTATION

GENERAL INFORMATION

Present _____ Custodian _____ or _____ Trustee: _____

Participant: _____ SSN: _____ Account No: _____

Residence Address: _____ Phone: _____

TRANSFER INSTRUCTIONS

Directly transfer all or part of my HSA or Archer MSA with your organization in the manner indicated below.

1. Please make a check payable as follows:

_____, as the Custodian Trustee
 Name of Accepting Organization

Or to _____ HSA.
 Participant's Name and Account Number

2. Transfer the assets in the manner prescribed below:

Asset Description	Quantity In HSA	Quantity To Be Transferred	Liquidate Immediately	Transfer At Maturity	Transfer In Kind
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This transfer will (Check one) completely partially close my HSA. I am aware that penalties may be incurred if time deposits are liquidated prior to their maturity date.

3. Delivery instructions - Mail check to:

4. If DTC eligible, DTC #: _____

SIGNATURES

The transfer amount should should not be placed in a separate HSA. New HSA Account Number: _____

Participant's Signature: _____ Date: _____

Accepting Organization: Our organization agrees to serve as the new Custodian or Trustee for the HSA account of the above-named individual, and as Custodian or Trustee, we agree to accept the assets being transferred.

New Custodian or Trustee: _____ EIN #: _____

Address: _____

Authorized Signature for Accepting Organization: _____ Date: _____

ONE-TIME SPECIAL TRANSFER TO AN HSA

Organization: _____ Account Number: _____
Participant: _____ SSN: _____ Birth Date: _____
Residence Address: _____ Phone: _____

ONE-TIME TRANSFER FROM AN FSA OR HRA

- The undersigned hereby elects a one-time transfer from an FSA or HRA to an HSA and certifies that the following statements are true and correct.
 1. This one-time transfer from an FSA and HRA qualifies as a Qualified HSA Distribution.
 2. I have not previously completed a Qualified HSA Distribution from an FSA or HRA.
 3. I understand that this Qualified HSA Distribution is treated as a rollover contribution and will not reduce my regular HSA contribution limit for the year.
 4. The maximum amount eligible to be transferred does not exceed the lesser of (a) the balance in the FSA or HRA on September 21, 2006; or (2) the balance in the FSA or HRA on the date of the transfer.
 5. This one-time transfer is being completed on or before December 31, 2011.
- The undersigned acknowledges and understands the following information:
 1. The amount transferred from the FSA or HRA to the HSA must be made directly by the employer to the trustee or custodian of the HSA.
 2. If the undersigned HSA-eligible individual ceases to be an HSA-individual at any time during the testing period, the amount transferred will be taxed and subject to an additional 10% income tax for the year the undersigned ceases to be HSA-eligible. This taxation does not apply if the individual becomes disabled or dies. For this purpose, the testing period begins with the month in which the Qualified HSA Distribution is transferred to the HSA and ends on the last day of the 12th month following such month.
 3. The amount transferred is not deductible as an HSA contribution made by the individual.

ONE-TIME TRANSFER FROM AN IRA

- The undersigned hereby elects a one-time transfer from an IRA to an HSA and certifies that the following statements are true and correct.
 1. The one-time transfer from an IRA to an HSA qualifies as a Qualified HSA Funding Distribution.
 2. I have not previously completed a Qualified HSA Funding Distribution from an IRA to an HSA.
 3. I understand that this Qualified HSA Funding Distribution is treated as a regular HSA contribution and I certify that the amount of this transfer does not exceed the current year's HSA contribution limit.
 4. I certify that this Qualified HSA Funding Distribution is not being made from a SEP IRA or SIMPLE IRA.
- The undersigned acknowledges and understands the following information:
 1. The amount transferred from the IRA to the HSA must be made directly by the trustee or custodian of the IRA to the trustee or custodian of the HSA.
 2. If the undersigned HSA-eligible individual ceases to be an HSA-individual at any time during the testing period, the amount transferred will be taxed and subject to an additional 10% income tax for the year the undersigned ceases to be HSA-eligible. This taxation does not apply if the individual becomes disabled or dies. For this purpose, the testing period begins with the month in which the Qualified HSA Funding Distribution is transferred to the HSA and ends on the last day of the 12th month following such month.
 3. The amount transferred is not deductible as an HSA contribution made by the individual because the amount transferred from the IRA is not considered a taxable distribution.

TRANSFER INSTRUCTIONS

1. Make check payable to _____ as the Trustee Custodian for:
(Name of Accepting Organization) _____ HSA.
(Participant's Name and Account Number)
2. Amount to be transferred: \$ _____ in cash in kind (specify: _____)
3. Delivery instructions – Mail check to: _____
4. If DTC eligible, DTC #: _____

SIGNATURES AND ACCEPTANCE

I certify that the above information is correct and that I qualify for either the Qualified HSA Distribution or Qualified HSA Funding Distribution as described above. I certify that no tax advice has been given to me by the Trustee or Custodian and that all decisions regarding this transaction are my own. I expressly assume the responsibility for any adverse tax consequences that may arise from this transaction or the failure to remain an HSA-eligible individual throughout the testing period applicable to these transfers and I agree that the Trustee or Custodian shall in no way be responsible for those consequences. The Trustee or Custodian has recommended that I consult with my own tax advisor or the IRS regarding this transfer.

Signature of Participant _____ Date _____

Accepting Organization: Our organization agrees to serve as the Trustee or Custodian for the HSA of the above-named eligible individual, and as Trustee or Custodian, we agree to accept the assets being transferred.

Trustee or Custodian: _____

Address: _____

Contact Name: _____ Phone: _____

Authorized Signature for Accepting Organization: _____ Date _____

Appendix E

IRS Forms

Adviser's Guide to Health Savings Accounts

CORRECTED (if checked)

TRUSTEE'S/PAYER'S name, street address, city, state, and ZIP code		OMB No. 1545-1517		Distributions From an HSA, Archer MSA, or Medicare Advantage MSA Copy B For Recipient This information is being furnished to the Internal Revenue Service.
		2007		
		Form 1099-SA		
PAYER'S federal identification number	RECIPIENT'S identification number	1 Gross distribution \$	2 Earnings on excess cont. \$	
RECIPIENT'S name		3 Distribution code	4 FMV on date of death \$	
Street address (including apt. no.)		5 HSA <input type="checkbox"/>		
City, state, and ZIP code		Archer MSA <input type="checkbox"/>		
Account number (see instructions)		MA MSA <input type="checkbox"/>		

Form **1099-SA**

(keep for your records)

Department of the Treasury - Internal Revenue Service

Instructions for Recipient

Distributions from a health savings account (HSA), Archer MSA, or Medicare Advantage (MA) MSA are reported to you on Form 1099-SA. File Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, or Form 8889, Health Savings Accounts (HSAs), with your Form 1040 to report a distribution from these accounts even if the distribution is not taxable. The payer is not required to compute the taxable amount of any distribution.

An HSA or Archer MSA distribution is not taxable if you used it to pay qualified medical expenses of the account holder and family or you rolled it over. An HSA may be rolled over to another HSA; an Archer MSA may be rolled over to another Archer MSA or an HSA. An MA MSA is not taxable if you used it to pay qualified medical expenses of the account holder only. If you did not use the distribution from an HSA, Archer MSA, or MA MSA to pay for qualified medical expenses, or in the case of an HSA or Archer MSA, you did not roll it over, you must include the distribution in your income (see Form 8889 or Form 8853). Also, you may owe a penalty.

For more information, see the separate instructions for Form 8853 and Form 8889. Also see Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans.

Spouse beneficiary. If you inherited an Archer MSA or MA MSA because of the death of your spouse, special rules apply. See Instructions for Form 8853. If you inherited an HSA because of the death of your spouse, see the Instructions for Form 8889.

Estate beneficiary. If the HSA, Archer MSA, or MA MSA account holder dies and the estate is the beneficiary, the fair market value (FMV) of the account on the date of death is includible in the account holder's gross income. Report the amount on the account holder's final income tax return.

Nonspouse beneficiary. If you inherited the HSA, Archer MSA, or MA MSA from someone who was not your spouse, you must report as income on your tax

return the FMV of the account as of the date of death. Report the FMV on your tax return for the year the account owner died even if you received the distribution from the account in a later year. See the Instructions for Form 8853 or Form 8889. Any earnings on the account after the date of death (box 1 minus box 4 of Form 1099-SA) are taxable. In the case of an HSA, the amount included on your tax return (other than an estate) is first reduced by any payments from the HSA made for the decedent's qualified medical expenses incurred before the decedent's death and paid within one year after the date of death.

Account number. May show an account or other unique number the payer assigned to distinguish your account.

Box 1. Shows the amount received this year. The amount may have been a direct payment to the medical service provider or distributed to you.

Box 2. Shows the earnings on any excess contributions you withdrew from an HSA or Archer MSA by the due date of your income tax return. If you withdrew the excess, plus any earnings, by the due date of your income tax return, you must include the earnings in your income in the year you received the distribution even if you used it to pay qualified medical expenses. This amount is included in box 1. An excise tax of 6% for each taxable year is imposed on you for excess individual and employer contributions that remain in the account. See Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts.

Box 3. These codes identify the distribution you received: 1—Normal distribution; 2—Excess contributions; 3—Disability; 4—Death distribution other than code 6; 5—Prohibited transaction; 6—Death distribution after year of death to a nonspouse beneficiary.

Box 4. If the account holder died, shows the FMV of the account on the date of death.

Box 5. Shows the type of account that is reported on this Form 1099-SA.

Adviser's Guide to Health Savings Accounts

Instructions for Trustees/Payers

General and specific form instructions are provided as separate products. The products you should use to complete Form 1099-SA are the 2007 General Instructions for Forms 1099, 1098, 5498, and W-2G and the 2007 Instructions for Forms 1099-SA and 5498-SA. A chart in the general instructions gives a quick guide to which form must be filed to report a particular payment. To order these instructions and additional forms, visit the IRS website at www.irs.gov or call 1-800-TAX-FORM (1-800-829-3676).

Caution: *Because paper forms are scanned during processing, you cannot file Forms 1096, 1098, 1099, or 5498 that you download and print from the IRS website.*

Due dates. Furnish Copy B of this form to the recipient by January 31, 2008.

File Copy A of this form with the IRS by February 28, 2008. If you file electronically, the due date is March 31, 2008. To file electronically, you must have software that generates a file according to the specifications in Pub. 1220, Specifications for Filing Forms 1098, 1099, 5498, and W-2G Electronically or Magnetically. IRS does not provide a fill-in form option.

Need help? If you have questions about reporting on Form 1099-SA, call the information reporting customer service site toll free at 1-866-455-7438 or 304-263-8700 (not toll free). For TTY/TDD equipment, call 304-267-3367 (not toll free). The hours of operation are Monday through Friday from 8:30 a.m. to 4:30 p.m., Eastern time. The service site can also be reached by email at mccirp@irs.gov.

Form **5329**

**Additional Taxes on Qualified Plans
(Including IRAs) and Other Tax-Favored Accounts**

OMB No. 1545-0074

2007

Attachment
Sequence No. **29**

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 1040 or Form 1040NR.

▶ See separate instructions.

Name of individual subject to additional tax. If married filing jointly, see instructions. Your social security number

**Fill in Your Address Only
If You Are Filing This
Form by Itself and Not
With Your Tax Return**

Home address (number and street), or P.O. box if mail is not delivered to your home Apt. no.
City, town or post office, state, and ZIP code If this is an amended
return, check here

If you **only** owe the additional 10% tax on early distributions, you may be able to report this tax directly on Form 1040, line 60, or Form 1040NR, line 55, without filing Form 5329. See the instructions for Form 1040, line 60, or for Form 1040NR, line 55.

Part I Additional Tax on Early Distributions

Complete this part if you took a taxable distribution, before you reached age 59½, from a qualified retirement plan (including an IRA) or modified endowment contract (unless you are reporting this tax directly on Form 1040 or Form 1040NR—see above). You may also have to complete this part to indicate that you qualify for an exception to the additional tax on early distributions or for certain Roth IRA distributions (see instructions).

1	Early distributions included in income. For Roth IRA distributions, see instructions	1		
2	Early distributions included on line 1 that are not subject to the additional tax (see instructions). Enter the appropriate exception number from the instructions: _____	2		
3	Amount subject to additional tax. Subtract line 2 from line 1	3		
4	Additional tax. Enter 10% (.10) of line 3. Include this amount on Form 1040, line 60, or Form 1040NR, line 55	4		
Caution: If any part of the amount on line 3 was a distribution from a SIMPLE IRA, you may have to include 25% of that amount on line 4 instead of 10% (see instructions).				

Part II Additional Tax on Certain Distributions From Education Accounts

Complete this part if you included an amount in income, on Form 1040 or Form 1040NR, line 21, from a Coverdell education savings account (ESA) or a qualified tuition program (QTP).

5	Distributions included in income from Coverdell ESAs and QTPs	5		
6	Distributions included on line 5 that are not subject to the additional tax (see instructions)	6		
7	Amount subject to additional tax. Subtract line 6 from line 5	7		
8	Additional tax. Enter 10% (.10) of line 7. Include this amount on Form 1040, line 60, or Form 1040NR, line 55	8		

Part III Additional Tax on Excess Contributions to Traditional IRAs

Complete this part if you contributed more to your traditional IRAs for 2007 than is allowable or you had an amount on line 17 of your 2006 Form 5329.

9	Enter your excess contributions from line 16 of your 2006 Form 5329 (see instructions). If zero, go to line 15	9		
10	If your traditional IRA contributions for 2007 are less than your maximum allowable contribution, see instructions. Otherwise, enter -0-	10		
11	2007 traditional IRA distributions included in income (see instructions)	11		
12	2007 distributions of prior year excess contributions (see instructions)	12		
13	Add lines 10, 11, and 12	13		
14	Prior year excess contributions. Subtract line 13 from line 9. If zero or less, enter -0-	14		
15	Excess contributions for 2007 (see instructions)	15		
16	Total excess contributions. Add lines 14 and 15	16		
17	Additional tax. Enter 6% (.06) of the smaller of line 16 or the value of your traditional IRAs on December 31, 2007 (including 2007 contributions made in 2008). Include this amount on Form 1040, line 60, or Form 1040NR, line 55	17		

Part IV Additional Tax on Excess Contributions to Roth IRAs

Complete this part if you contributed more to your Roth IRAs for 2007 than is allowable or you had an amount on line 25 of your 2006 Form 5329.

18	Enter your excess contributions from line 24 of your 2006 Form 5329 (see instructions). If zero, go to line 23	18		
19	If your Roth IRA contributions for 2007 are less than your maximum allowable contribution, see instructions. Otherwise, enter -0-	19		
20	2007 distributions from your Roth IRAs (see instructions)	20		
21	Add lines 19 and 20	21		
22	Prior year excess contributions. Subtract line 21 from line 18. If zero or less, enter -0-	22		
23	Excess contributions for 2007 (see instructions)	23		
24	Total excess contributions. Add lines 22 and 23	24		
25	Additional tax. Enter 6% (.06) of the smaller of line 24 or the value of your Roth IRAs on December 31, 2007 (including 2007 contributions made in 2008). Include this amount on Form 1040, line 60, or Form 1040NR, line 55	25		

Part V Additional Tax on Excess Contributions to Coverdell ESAs

Complete this part if the contributions to your Coverdell ESAs for 2007 were more than is allowable or you had an amount on line 33 of your 2006 Form 5329.

26	Enter the excess contributions from line 32 of your 2006 Form 5329 (see instructions). If zero, go to line 31			26	
27	If the contributions to your Coverdell ESAs for 2007 were less than the maximum allowable contribution, see instructions. Otherwise, enter -0-	27			
28	2007 distributions from your Coverdell ESAs (see instructions)	28			
29	Add lines 27 and 28			29	
30	Prior year excess contributions. Subtract line 29 from line 26. If zero or less, enter -0-			30	
31	Excess contributions for 2007 (see instructions)			31	
32	Total excess contributions. Add lines 30 and 31			32	
33	Additional tax. Enter 6% (.06) of the smaller of line 32 or the value of your Coverdell ESAs on December 31, 2007 (including 2007 contributions made in 2008). Include this amount on Form 1040, line 60, or Form 1040NR, line 55			33	

Part VI Additional Tax on Excess Contributions to Archer MSAs

Complete this part if you or your employer contributed more to your Archer MSAs for 2007 than is allowable or you had an amount on line 41 of your 2006 Form 5329.

34	Enter the excess contributions from line 40 of your 2006 Form 5329 (see instructions). If zero, go to line 39			34	
35	If the contributions to your Archer MSAs for 2007 are less than the maximum allowable contribution, see instructions. Otherwise, enter -0-	35			
36	2007 distributions from your Archer MSAs from Form 8853, line 10	36			
37	Add lines 35 and 36			37	
38	Prior year excess contributions. Subtract line 37 from line 34. If zero or less, enter -0-			38	
39	Excess contributions for 2007 (see instructions)			39	
40	Total excess contributions. Add lines 38 and 39			40	
41	Additional tax. Enter 6% (.06) of the smaller of line 40 or the value of your Archer MSAs on December 31, 2007 (including 2007 contributions made in 2008). Include this amount on Form 1040, line 60, or Form 1040NR, line 55			41	

Part VII Additional Tax on Excess Contributions to Health Savings Accounts (HSAs)

Complete this part if you, someone on your behalf, or your employer contributed more to your HSAs for 2007 than is allowable or you had an amount on line 49 of your 2006 Form 5329.

42	Enter the excess contributions from line 48 of your 2006 Form 5329. If zero, go to line 47			42	
43	If the contributions to your HSAs for 2007 are less than the maximum allowable contribution, see instructions. Otherwise, enter -0-	43			
44	2007 distributions from your HSAs from Form 8889, line 16	44			
45	Add lines 43 and 44			45	
46	Prior year excess contributions. Subtract line 45 from line 42. If zero or less, enter -0-			46	
47	Excess contributions for 2007 (see instructions)			47	
48	Total excess contributions. Add lines 46 and 47			48	
49	Additional tax. Enter 6% (.06) of the smaller of line 48 or the value of your HSAs on December 31, 2007 (including 2007 contributions made in 2008). Include this amount on Form 1040, line 60, or Form 1040NR, line 55			49	

Part VIII Additional Tax on Excess Accumulation in Qualified Retirement Plans (Including IRAs)

Complete this part if you did not receive the minimum required distribution from your qualified retirement plan.

50	Minimum required distribution for 2007 (see instructions)			50	
51	Amount actually distributed to you in 2007			51	
52	Subtract line 51 from line 50. If zero or less, enter -0-			52	
53	Additional tax. Enter 50% (.50) of line 52. Include this amount on Form 1040, line 60, or Form 1040NR, line 55			53	

Signature. Complete **only** if you are filing this form by itself and not with your tax return.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Please Sign Here	Your signature		Date	
	Preparer's signature		Date	Check if self-employed <input type="checkbox"/>
Paid Preparer's Use Only	Firm's name (or yours if self-employed), address, and ZIP code		EIN	Preparer's SSN or PTIN
			Phone no. ()	

Form **5330**
(Rev. March 2007)
Department of the Treasury
Internal Revenue Service

**Return of Excise Taxes
Related to Employee Benefit Plans**

(Under sections 4965, 4971, 4972, 4973(a)(3), 4975, 4976, 4977, 4978, 4978A, 4979, 4979A, 4980, and 4980F of the Internal Revenue Code)

OMB No. 1545-0575

Filer tax year beginning _____, and ending _____

A Name of filer (see page 3 of the instructions)

Number, street, and room or suite no. (If a P.O. box, see page 3 of the instructions)

City or town, state, and ZIP code

C Name and address of plan sponsor

D Name of plan

B Filer's identifying number (see instructions)

Employer identification number (EIN)

Social security number (SSN)

E Plan sponsor's EIN

F Plan year ending

G Plan number

H Check here if this is an amended return

Part I Summary of Taxes Due		FOR IRS USE ONLY		
1	Section 4972 tax on nondeductible contributions to qualified plans (from line 14)	161	1	
2	Section 4973(a)(3) tax on excess contributions to section 403(b)(7)(A) custodial accounts (from line 24)	164	2	
3	Section 4976 tax on disqualified benefits for funded welfare plans (see instructions)	200	3	
4a	Section 4978 and 4978A tax on certain ESOP dispositions (see instructions)	209	4a	
b	The tax on line 4a is a result of the application of: <input type="checkbox"/> Sec. 664(g) <input type="checkbox"/> Sec. 1042 <input type="checkbox"/> Sec. 4978A		4b	
5a	Section 4979A tax on certain prohibited allocations of qualified ESOP securities (see instructions)	203	5a	
b	Section 4965 tax on prohibited tax shelter transactions	237	5b	
6a	Section 4975(a) tax on prohibited transactions (from line 25c)	159	6a	
b	Section 4975(b) tax on failure to correct prohibited transactions (see Part IV instructions)	224	6b	
7a	Section 4971(a) tax on failure to meet minimum funding standards (see instructions)	163	7a	
b	Section 4971(b) tax on failure to correct minimum funding standards (see Part VI instructions)	225	7b	
8	Section 4977 tax on excess fringe benefits (from line 30d)	201	8	
9	Section 4979 tax on excess contributions to certain plans (see instructions)	205	9	
10	Section 4980 tax on reversion of qualified plan assets to an employer (from line 34)	204	10	
11	Section 4980F tax on failure to provide notice of significant reduction in future accruals (from line 41)	228	11	
12a	Section 4971(f)(1) tax on failure to pay liquidity shortfall (from line 45)	226	12a	
b	Section 4971(f)(2) additional tax on failure to correct liquidity shortfall (see Part XI instructions)	227	12b	
13a	Total tax. Add lines 1 through 12b (see page 5 of the instructions)		13a	
b	Enter amount of tax paid with Form 5558 or any other tax paid prior to filing this return		13b	
c	Total tax due. Subtract line 13b from line 13a. Attach check or money order payable to "United States Treasury." Write your name, identifying number, plan number, and "Form 5330, Section(s) _____" on your payment		13c	

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature

Telephone number

Date

Paid Preparer's Use Only

Preparer's signature

Date

Firm's name (or yours if self-employed) and address

For Privacy Act and Paperwork Reduction Act Notice, see page 11 of the instructions. Cat. No. 11870M Form **5330** (Rev. 3-2007)

DUE DATE: The taxes listed on this page are due by the last day of the 7th month after the end of the tax year of the filer.

Part II Tax on Nondeductible Employer Contributions to Qualified Plans (Section 4972)

14a Total contributions for your tax year to your qualified (under section 401(a), 403(a), or 408(k), or 408(p)) plan	
b Amount allowable as a deduction under section 404	
c Subtract line 14b from line 14a	
d Enter amount of any prior year nondeductible contributions made for years beginning after 12/31/86	
e Amount of any prior year nondeductible contributions for years beginning after 12/31/86 returned to you in this tax year or any prior tax year	
f Subtract line 14e from line 14d	
g Amount of line 14f carried forward and deductible in this tax year	
h Subtract line 14g from line 14f	
i Tentative taxable excess contributions. Add lines 14c and 14h	
j Nondeductible section 4972(c)(6) or (7) contributions exempt from excise tax	
k Taxable excess contributions. Subtract line 14j from line 14i	
l Multiply line 14k by 10%. Enter here and on line 1 ▶	

Part III Tax on Excess Contributions to Section 403(b)(7)(A) Custodial Accounts (Section 4973(a)(3))

15 Total amount contributed for current year less rollovers (see page 6 of the instructions)	
16 Amount excludable from gross income under section 403(b) (see page 6 of the instructions)	
17 Current year excess contributions. Subtract line 16 from line 15; but not less than zero	
18 Prior year excess contributions not previously eliminated. If zero, go to line 22a	
19 Contribution credit. If line 16 is more than line 15, enter the excess; otherwise, enter -0-	
20 Total of all prior years' distributions out of the account included in your gross income under section 72(e) and not previously used to reduce excess contributions	
21 Adjusted prior years' excess contributions. Subtract the total of lines 19 and 20 from line 18	
22a Taxable excess contributions. Add lines 17 and 21	
b Multiply line 22a by 6%	
23a Enter the value of your account as of the last day of the year	
b Multiply line 23a by 6%	
24 Excess contributions tax. Enter the lesser of line 22b or line 23b. Enter here and on line 2 ▶	

DUE DATE: Section 4975 taxes are due by the last day of the 7th month after the end of the tax year of the filer.

Part IV Tax on Prohibited Transactions (Section 4975)(see instructions)

25a Is the excise tax a result of a prohibited transaction that was (check one or more):
 discrete other than discrete (a lease or a loan)

b Complete the table below to disclose the prohibited transactions and figure the initial tax (see instructions).

(a) Transaction number	(b) Date of transaction (see page 7 of the instructions)	(c) Description of prohibited transaction	(d) Amount involved in prohibited transaction (see page 7 of the instructions)	(e) Initial tax on prohibited transaction (multiply each transaction in column (c) by the appropriate rate (see page 7 of the instructions))
(i)				
(ii)				
(iii)				
(iv)				
(v)				
(vi)				
(vii)				
(viii)				
(ix)				
(x)				

25c Add amounts in column (e). Enter here and on line 6a ▶

26 Have you corrected **all** of the prohibited transactions that you are reporting on this return? (See page 8 of the instructions) Yes No
If "Yes," complete Part V of this form. If "No," complete Part V of this form and see page 8 of the instructions.

Part V Schedule of Other Participating Disqualified Persons and Description of Correction (see instructions)

27 Complete the schedule of other participating disqualified persons and description of correction (see instructions)

(a) Item no. from Part IV	(b) Name and address of disqualified person	(c) EIN or SSN	(d) Date of correction	(e) Description of correction

DUE DATE: See **When To File** on page 2 of the instructions for taxes due under sections 4971, 4977, 4979, 4980, 4971(f), and 4980F.

Part VI Tax on Failure To Meet Minimum Funding Standards (Section 4971(a) and 4971(b))

28 Accumulated funding deficiency in the plan's minimum funding standard account (see page 9 of the instructions)	
29 Multiply line 28 by tax rate (see instructions on page 9 for applicable tax rates). Enter here and on line 7a ▶	

Part VII Tax on Excess Fringe Benefits (Section 4977)

30a Did you make an election to be taxed under section 4977? <input type="checkbox"/> Yes <input type="checkbox"/> No b If "Yes," enter the calendar year in which the excess fringe benefits were paid ▶ _____ c If line 30a is "Yes," enter the excess fringe benefits on this line (see page 9 of the instructions) d Enter 30% of line 30c on this line and on line 8 ▶	
--	--

Part VIII Tax on Excess Contributions to Certain Plans (Section 4979)

31a Enter the amount of any excess contributions under a cash or deferred arrangement that is part of a plan qualified under section 401(a), 403(a), 403(b), 408(k), 501(c)(18) or excess aggregate contributions described in section 401(m)	
b Multiply line 31a by 10%. Enter here and on line 9 ▶	

Part IX Tax on Reversion of Qualified Plan Assets to an Employer (Section 4980) (See page 10 of instructions)

32 Date reversion occurred ▶ month ____ day ____ year ____	
33a Employer reversion amount _____ b Excise tax rate _____ %	
34 Multiply line 33a by line 33b and enter the amount here and on line 10 ▶	
35 Explain below why you qualify for a rate other than 50%:	

Part X Tax on Failure to Provide Notice of Significant Reduction in Future Accruals (Section 4980F)

36 Enter the number of applicable individuals who were not provided ERISA section 204(h) notice ▶	
37 Enter the effective date of the amendment ▶	
38 Enter the number of days in the noncompliance period ▶	
39 Enter the total number of failures to provide ERISA section 204(h) notice (see page 11 of the instructions) ▶	
40 Provide a brief description of the failure, and of the correction made, if any	
41 Multiply line 39 by \$100. Enter here and on line 11	

Part XI Tax on Failure to Pay Liquidity Shortfall (Section 4971(f)(1))

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
42 Amount of shortfall					
43 Shortfall paid by the due date					
44 Net shortfall amount					
45 Multiply line 44 (total column) by 10% (5% for multiemployer plans). Enter here and on line 12a ▶					

Adviser's Guide to Health Savings Accounts

CORRECTED (if checked)

TRUSTEE'S name, street address, city, state, and ZIP code		1 Employee or self-employed person's Archer MSA contributions made in 2007 and 2008 for 2007 \$	OMB No. 1545-1518 2007 Form 5498-SA	HSA, Archer MSA, or Medicare Advantage MSA Information Copy B For Participant The information in boxes 1 through 6 is being furnished to the Internal Revenue Service.
TRUSTEE'S federal identification number	PARTICIPANT'S social security number	2 Total contributions made in 2007 \$	3 Total HSA or Archer MSA contributions made in 2008 for 2007 \$	
PARTICIPANT'S name		4 Rollover contributions \$	5 Fair market value of HSA, Archer MSA, or MA MSA \$	
Street address (including apt. no.)		6 HSA <input type="checkbox"/> Archer MSA <input type="checkbox"/> MA MSA <input type="checkbox"/>		
City, state, and ZIP code				
Account number (see instructions)				

Form **5498-SA**

(keep for your records)

Department of the Treasury - Internal Revenue Service

Instructions for Participant

What's new. See boxes 2 and 4 for qualified HSA funding distributions added by the Tax Relief and Health Care Act of 2006. Box 2 includes trustee-to-trustee transfers from an IRA to an HSA. Box 4 includes direct transfers from an HRA or an FSA to an HSA.

This information is submitted to the Internal Revenue Service by the trustee of your health savings account (HSA), Archer MSA, or Medicare Advantage MSA (MA MSA).

Generally, contributions you make to your HSA or Archer MSA are deductible. However, employer contributions to your HSA are not deductible. If your employer makes a contribution to one of your Archer MSAs, you cannot contribute to any Archer MSA for that year. If you made a contribution to your Archer MSA when your employer has contributed, you cannot deduct your contribution, and you will have an excess contribution. If your spouse's employer makes a contribution to your spouse's Archer MSA, you cannot make a contribution to your Archer MSA if your spouse is covered under a high deductible health plan that also covers you.

Contributions that the Social Security Administration makes to your MA MSA are not includible in your gross income nor are they deductible. Neither you nor your employer can make contributions to your MA MSA.

See Form 8853, Archer MSAs and Long-Term Care Insurance Contracts, and its instructions or Form 8889, Health Savings Accounts (HSAs) and its instructions. Any employer contributions made to an Archer MSA are shown on your Form W-2 in box 12 (code R); employer contributions made to HSAs are shown in box 12 (code W).

For more information, see Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans.

Account number. May show an account or other unique number the trustee assigned to distinguish your account.

Box 1. Shows employee or self-employed person's Archer MSA contributions made to your Archer MSA in 2007 and through April 15, 2008, for 2007. You may be able to deduct this amount on your 2007 Form 1040. See the Form 1040 instructions.

Note. The information in boxes 2 and 3 is provided by the trustee for IRS use only.

Box 2. Shows the total employer and employee/self-employed contributions made in 2007 to your HSA or Archer MSA. This includes qualified distributions (trustee-to-trustee transfers) from an IRA to fund an HSA. The trustee of your MA MSA is not required to, but may, show contributions to your MA MSA.

Box 3. Shows the total HSA or Archer MSA contributions made in 2008 for 2007.

Box 4. Shows any rollover contribution you made to this Archer MSA in 2007 after a distribution from another Archer MSA or shows any rollover to this HSA from another HSA or Archer MSA. Also included are qualified HSA funding distributions (direct transfers of employer contributions) from a health flexible spending arrangement (FSA) or health reimbursement arrangement (HRA) to fund an HSA. See Form 8853 or Form 8889 and their instructions for information about how to report distributions and rollovers. This amount is not included in box 1, 2, or 3.

Box 5. Shows the fair market value of your HSA, Archer MSA, or MA MSA at the end of 2007.

Box 6. Shows the type of account that is reported on this Form 5498-SA.

Other information. The trustee of your HSA, Archer MSA, or MA MSA may provide other information about your account on this form.

Note. Do not attach Form 5498-SA to your income tax return. Instead, keep it for your records.

Instructions for Trustees

General and specific form instructions are provided as separate products. The products you should use to complete Form 5498-SA are the 2007 General Instructions for Forms 1099, 1098, 5498, and W-2G and the 2007 Instructions for Forms 1099-SA and 5498-SA. A chart in the general instructions gives a quick guide to which form must be filed to report a particular payment. To order these instructions and additional forms, visit the IRS website at www.irs.gov or call 1-800-TAX-FORM (1-800-829-3676).

Caution: *Because paper forms are scanned during processing, you cannot file Forms 1096, 1098, 1099, or 5498 that you download and print from the IRS website.*

Due dates. Furnish Copy B of this form to the participant by June 2, 2008.

File Copy A of this form with the IRS by June 2, 2008. To file electronically, you must have software that generates a file according to the specifications in Pub. 1220, Specifications for Filing Forms 1098, 1099, 5498, and W-2G Electronically or Magnetically. IRS does not provide a fill-in form option.

Need help? If you have questions about reporting on Form 5498-SA, call the information reporting customer service site toll free at 1-866-455-7438 or 304-263-8700 (not toll free). For TTY/TDD equipment, call 304-267-3367 (not toll free). The hours of operation are Monday through Friday from 8:30 a.m. to 4:30 p.m., Eastern time. The service site can also be reached by email at mccirp@irs.gov.

2007

Department of the Treasury
Internal Revenue Service

Instructions for Form 8889

Health Savings Accounts (HSAs)

Section references are to the Internal Revenue Code unless otherwise noted.

General Instructions

What's New

Contribution limit. Contributions to your health savings account (HSA) are no longer limited to your annual health plan deductible. For 2007, your annual contribution and deduction limit is \$2,850 if you have a high deductible health plan with self-only coverage, or \$5,650 if you have family coverage. If you are age 55 or older at the end of 2007, your additional contribution amount is \$800.

Part-year coverage. If you are an eligible individual on the first day of the last month of your tax year, you are considered an eligible individual for the entire tax year for purposes of determining the amount that can be contributed to your HSA. If you fail to remain an eligible individual during the testing period, you will have to include certain amounts in income and are subject to a 10% additional tax on that amount.

Qualified HSA distribution. You may be able to make a qualified HSA distribution from your health flexible spending arrangement or health reimbursement arrangement to your HSA. If you fail to remain an eligible individual during the testing period, you will have to include the distribution in income and are subject to a 10% additional tax on that distribution.

Qualified HSA funding distribution. You can make a qualified HSA funding distribution from your individual retirement arrangement to your HSA. If you fail to remain an eligible individual during the testing period, you will have to include the distribution in income and are subject to a 10% additional tax on that distribution.

Purpose of Form

Use Form 8889 to:

- Report health savings account (HSA) contributions (including those made on your behalf and employer contributions),
- Figure your HSA deduction,
- Report distributions from HSAs, and

- Figure amounts you must include in income and additional tax you may owe if you fail to be an eligible individual.

Additional information. See Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans, for more details on HSAs.

Who Must File

You must file Form 8889 if any of the following applies.

- You (or someone on your behalf, including your employer) made contributions for 2007 to your HSA.
- You received HSA distributions in 2007.
- You must include certain amounts in income because you failed to be an eligible individual during the testing period.
- You acquired an interest in an HSA because of the death of the account beneficiary. See *Death of Account Beneficiary* on page 2.

Definitions

Eligible Individual

To be eligible to have contributions made to your HSA, you must be covered under a high deductible health plan (HDHP) and have no other health coverage except permitted coverage. If you are an eligible individual, anyone can contribute to your HSA. However, you cannot be enrolled in Medicare or be claimed as a dependent on another person's tax return. You must be, or be considered, an eligible individual on the first day of a month to take an HSA deduction for that month (see *Last-month rule* next).

Last-month rule. If you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered to be an eligible individual for the entire year.

Testing period. You must remain an eligible individual during the testing period. The testing period begins with the last month of your tax year and ends on the last day of the 12th month following that month (for example, December 1, 2007 – December 31, 2008). If you fail to remain an eligible individual during this period, other than because of death or becoming

disabled, you will have to include in income the total contributions made that would not have been made except for the last-month rule. You include this amount in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. (See *Part III*.)

Account Beneficiary

The account beneficiary is the individual on whose behalf the HSA was established.

HSA

Generally, an HSA is a health savings account set up exclusively for paying the qualified medical expenses of the account beneficiary or the account beneficiary's spouse or dependents.

Distributions From an HSA

Distributions from an HSA used exclusively to pay qualified medical expenses of the account beneficiary, spouse, or dependents are excludable from gross income. (See the line 15 instructions for information on medical expenses of dependents not claimed on your return.) You can receive distributions from an HSA even if you are not currently eligible to have contributions made to the HSA. However, any part of a distribution not used to pay qualified medical expenses is includable in gross income and is subject to an additional 10% tax unless an exception applies.

Qualified Medical Expenses

Generally, qualified medical expenses for HSA purposes are unreimbursed medical expenses that could otherwise be deducted on Schedule A (Form 1040). See the Instructions for Schedule A and Pub. 502, Medical and Dental Expenses (Including the Health Coverage Tax Credit). However, you cannot treat insurance premiums as qualified medical expenses unless the premiums are for:

- Long-term care (LTC) insurance,
- Health care continuation coverage (such as coverage under COBRA),
- Health care coverage while receiving unemployment compensation under federal or state law, or
- Medicare and other health care coverage if you were 65 or older (other

Cat. No. 37971Y

Adviser's Guide to Health Savings Accounts

than premiums for a Medicare supplemental policy, such as Medigap).

High Deductible Health Plan

An HDHP is a health plan that meets the following requirements.

	Self-only coverage	Family coverage
Minimum annual deductible	\$1,100	\$2,200
Maximum annual out-of-pocket expenses*	\$5,500	\$11,000

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses (such as copayments and other amounts, but not premiums) for services within the network should be used to figure whether the limit is reached.

An HDHP can provide preventive care and certain other benefits with no deductible or a deductible below the minimum annual deductible. For more details, see Pub. 969. An HDHP does not include a plan if substantially all of the coverage is for accidents, disability, dental care, vision care, or long-term care. An HDHP also cannot be insurance that you are permitted to have in addition to an HDHP. See *Other Health Coverage* next.

Other Health Coverage

If you have an HSA, you (and your spouse, if you have family coverage) generally cannot have any health coverage other than an HDHP. But your spouse can have health coverage other than an HDHP if you are not covered by that plan. If you have a health flexible spending arrangement or health reimbursement arrangement, see Pub. 969.

Exceptions. You can have additional insurance that provides benefits only for:

- Liabilities under workers' compensation laws, tort liabilities, or liabilities arising from the ownership or use of property,
- A specific disease or illness, or
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (either through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

For information on prescription drug plans, see Pub. 969.

Disabled

An individual generally is considered disabled if he or she is unable to engage in any substantial gainful activity due to a physical or mental

impairment which can be expected to result in death or to continue indefinitely.

Death of Account Beneficiary

If the account beneficiary's surviving spouse is the designated beneficiary, the HSA is treated as if the surviving spouse were the account beneficiary. The surviving spouse completes Form 8889 as though the HSA belonged to him or her.

If the designated beneficiary is not the account beneficiary's surviving spouse, or there is no designated beneficiary, the account ceases to be an HSA as of the date of death. The beneficiary completes Form 8889 as follows.

- Enter "Death of HSA account beneficiary" across the top of Form 8889.
- Enter the name(s) shown on your tax return and your SSN in the spaces provided at the top of the form and skip Part I.
- On line 14a, enter the fair market value of the HSA as of the date of death.
- On line 15, for a beneficiary other than the estate, enter qualified medical expenses incurred by the account beneficiary before the date of death that you paid within 1 year after the date of death.
- Complete the rest of Part II.

If the account beneficiary's estate is the beneficiary, the value of the HSA as of the date of death is included on the account beneficiary's final income tax return. Complete Form 8889 as described above, except you should complete Part I, if applicable.

The distribution is not subject to the additional 10% tax. Report any earnings on the account after the date of death as income on your tax return.

Deemed Distributions From HSAs

The following situations result in deemed distributions from your HSA.

- You engaged in any transaction prohibited by section 4975 with respect to any of your HSAs, at any time in 2007. Your account ceases to be an HSA as of January 1, 2007, and you must include the fair market value of all assets in the account as of January 1, 2007, on line 14a.
- You used any portion of any of your HSAs as security for a loan at any time in 2007. You must include the fair market value of the assets used as security for the loan as income on line 21 of Form 1040 or Form 1040NR.

Any deemed distribution will not be treated as used to pay qualified medical

expenses. Generally, these distributions are subject to the additional 10% tax.

Rollovers

A rollover is a tax-free distribution (withdrawal) of assets from one HSA or Archer MSA that is reinvested in another HSA. Generally, you must complete the rollover within 60 days after you received the distribution. You can make only one rollover contribution to an HSA during a 1-year period. See Pub. 590, Individual Retirement Arrangements (IRAs), for more details and additional requirements regarding rollovers.

Note. If you instruct the trustee of your HSA to transfer funds directly to the trustee of another HSA, the transfer is not considered a rollover. There is no limit on the number of these transfers. Do not include the amount transferred in income, deduct it as a contribution, or include it as a distribution on line 14a.

Qualified HSA distribution. This is a distribution from a health flexible spending arrangement (FSA) or health reimbursement arrangement (HRA) that is contributed by your employer directly to your HSA. This is a one-time distribution from any of these arrangements. The distribution is treated as a rollover contribution to the HSA and is subject to the testing period rules shown below. See *Pub. 969* for more information.

Testing period. You must remain an eligible individual during the testing period. The testing period begins with the month in which the qualified HSA distribution is contributed to the HSA and ends on the last day of the 12th month following that month. For example, if the distribution is contributed on June 12, 2007, the testing period ends on June 30, 2008. If you fail to remain an eligible individual during this period, other than because of death or becoming disabled, you will have to include the qualified HSA distribution in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. (See *Part III*.)

Specific Instructions

Name and social security number (SSN). Enter your name(s) as shown on your tax return and the SSN of the HSA beneficiary. If married filing jointly and both you and your spouse have HSAs, complete a separate Form 8889 for each of you.

Part I—HSA Contributions and Deductions

Use Part I to figure:

- Your HSA deduction,
- Any excess contributions you made (or those made on your behalf), and
- Any excess contributions made by an employer (see *Excess Employer Contributions* beginning on page 5).

Figuring Your HSA Deduction

The maximum amount that can be contributed to your HSA depends on the type of HDHP coverage you have. If you have self-only coverage, your maximum contribution is \$2,850. If you have family coverage, your maximum contribution is \$5,650.

Note. If you are age 55 or older at the end of 2007, you can make an additional contribution of \$800.

Your maximum contribution is reduced by any employer contributions to your HSA, any contributions made to your Archer MSA, and any qualified HSA funding distributions.

You can make deductible contributions to your HSA even if your employer made contributions. However, if you (or someone on your behalf) made contributions in addition to any employer contributions and qualified HSA funding distributions, you may have to pay an additional tax. See *Excess Contributions You Make* on page 5.

You cannot deduct any contributions for any month in which you were enrolled in Medicare. Also, you cannot deduct contributions if you can be claimed as a dependent on someone else's 2007 tax return.

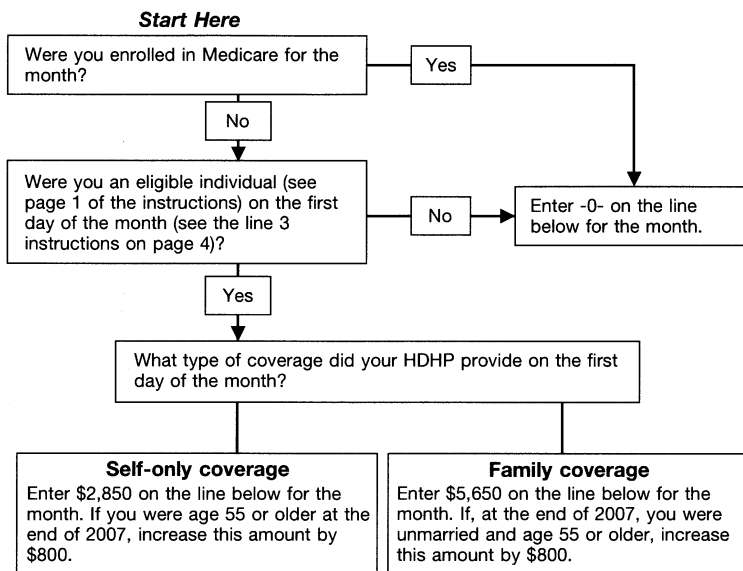
How To Complete Part I

Complete lines 1 through 13 as instructed on the form. However, if you, and your spouse if filing jointly, are both eligible individuals and either of you have an HDHP with family coverage, you both are treated as having only the family coverage plan. Disregard any plans with self-only coverage.

Complete a separate Form 8889 for each spouse. Combine the amounts on line 13 of both Forms 8889 and enter this amount on Form 1040, line 25; or Form 1040NR, line 25. Be sure to attach both Forms 8889 to your tax return.

Line 3 Limitation Chart and Worksheet

Go through this chart for each month of 2007.
See the instructions for line 3 on page 4.
(Keep for your records)



Month in 2007	Amount from chart above
January	_____
February	_____
March	_____
April	_____
May	_____
June	_____
July	_____
August	_____
September	_____
October	_____
November	_____
December	_____
Total for all months	_____
Limitation. Divide the total by 12. Enter here and on line 3.	_____

Line 1

If you were covered, or considered covered, by a self-only HDHP and a family HDHP at different times during the year, check the box for the plan that was in effect for a longer period. If you were covered by both a self-only HDHP and a family HDHP at the same time, you are treated as having family coverage during that period. If, on the first day of the last month of your tax year, December 1 for most taxpayers, you had family coverage, check the "family" box.

Line 2

Include on line 2 only those amounts you, or others on your behalf, contributed to your HSA. Include those contributions made from January 1, 2008, through April 15, 2008, that were for 2007. Do not include employer contributions (see line 9) or amounts rolled over from another HSA or Archer MSA, or a qualified HSA distribution. See *Rollovers* on page 2. Also, do not include any qualified HSA funding distributions (see line 10). Contributions to an employee's account through a cafeteria plan are treated as employer contributions and are not included on line 2.

Line 3

When figuring the amount to enter on line 3, apply the following rules.

1. Use the family coverage amount if you or your spouse had an HDHP with family coverage. Disregard any plan with self-only coverage.
2. If the last-month rule (see page 1) applies, you are considered an eligible individual for the entire year. You are treated as having the same HDHP coverage for the entire year as you had on the first day of the last month of your tax year.
3. If you were, or were considered, an eligible individual for the entire year and you did not change your type of coverage, enter \$2,850 for a self-only HDHP or \$5,650 for a family HDHP on line 3. (See (6) below.)
4. If you were, or were considered, an eligible individual for the entire year and you changed your type of coverage during the year, enter on line 3 (see (6) below) the greater of:
 - a. The limitation shown on the last line of the *Line 3 Limitation Chart and Worksheet* on page 3, or
 - b. The maximum amount that can be contributed based on the type of HDHP coverage you had on the first day of the last month of your tax year.

TIP If you had family coverage on the first day of the last month, you do not need to use the worksheet; enter \$5,650 on line 3.

5. If you were not an eligible individual on the first day of the last month of your tax year, use the *Line 3 Limitation Chart and Worksheet* on page 3 to determine the amount to enter on line 3. (See (6) below.)

6. If, at the end of 2007, you were unmarried and age 55 or older, you can increase the amount determined in (3) or (4) by \$800 (the additional contribution amount). For (5), the additional contribution amount is taken into account for each month you are an eligible individual.

Note. If you are married, the additional contribution amount is figured on line 7 and is not included on line 3.

See *Pub. 969* for more information.

TIP If you must complete the line 3 worksheet, and your eligibility and coverage did not change from one month to the next, enter the same number you entered for the previous month.

Line 6

Spouses who have separate HSAs and had family coverage under an HDHP at any time during 2007, use the following rules to figure the amount on line 6.

- If you are treated as having family coverage for each month, divide the amount on line 5 equally between you and your spouse, unless you both agree on a different allocation (such as allocating nothing to one spouse). Enter your allocable share on line 6.

Example. In 2007, you are an eligible individual and have self-only HDHP coverage. In March you marry and as of April 1 you have family HDHP coverage. Neither you nor your spouse qualify for the additional contribution amount. Your spouse has a separate HSA and is an eligible individual from April 1 to December 31, 2007. Because you and your spouse are considered to have family coverage on December 1, your contribution limit is \$5,650 (the family coverage maximum). You and your spouse can divide this amount in any allocation to which you agree (such as allocating nothing to one spouse).

- If you are not treated as having family coverage for each month, use the following steps to determine the amount to enter on line 6.

Step 1. Refigure the contribution limit that would have been entered on line 5 if you had entered on line 3 the total of the worksheet amounts only for the months you were treated as having family coverage. When refiguring line 5, use the same amount you previously entered on line 4.

Step 2. Divide the refigured contribution limit from *Step 1* equally

between you and your spouse, unless you both agree on a different allocation (such as allocating nothing to one spouse).

Step 3. Subtract the part of the contribution limit allocated to your spouse in *Step 2* from the amount determined in *Step 1*.

Step 4. Determine any other contribution limits that apply for the tax year and add that amount to the result in *Step 3*. Enter the total on line 6.

Example. In 2007, you are an eligible individual and have family HDHP coverage. In March you divorce and change your coverage as of April 1 to self-only. Neither you nor your spouse qualify for the additional contribution amount. Your spouse continued to have family HDHP coverage and was an eligible individual for the entire year. The contribution limit for the 3 months you both were considered to have family coverage is \$1,412.50 ($\$5,650 \times 3 \div 12$). You and your spouse divide the family coverage contribution equally. Your contribution limit for 9 months of self-only coverage is \$2,137.50 ($\$2,850 \times 9 \div 12$). This amount is not divided between you and your spouse.

Because you are covered under a self-only policy on December 1, you will show \$2,850 on line 6 (the greater of either (a) \$2,843.75 ($\$1,412.50$ family coverage + $\$2,137.50$ self-only coverage – $\$706.25$ spousal allocation) or (b) the maximum amount that can be contributed (\$2,850 for self-only coverage)). Your ex-spouse would show \$5,650 on line 6 (the greater of either (a) \$4,943.75 ($\$1,412.50$ family coverage for the 3 months prior to the divorce + $\$4,237.50$ family coverage maintained after the divorce – $\$706.25$ spousal allocation) or (b) the maximum amount that can be contributed (\$5,650 for family coverage)).

Line 7

Additional Contribution Amount

If, at the end of 2007, you were age 55 or older and married, use the Additional Contribution Amount Worksheet on page 5 if both of the following apply.

1. You or your spouse had family coverage under an HDHP and were, or were considered to be, an eligible individual on the first day of the month.
2. You were not enrolled in Medicare for the month.

Enter the result on line 7.

TIP If items (1) and (2) apply to all months during 2007, enter \$800 on line 7.

Additional Contribution Amount Worksheet

1. \$ 800 × number of months eligible _____
2. Divide line 1 by 12. Enter here and on line 7 _____

Example. At the end of 2007, you were age 55 and married. You had family coverage under an HDHP from January 1 through June 30, 2007 (6 months). You were not enrolled in Medicare in 2007. You would enter an additional contribution amount of \$400 on line 7 ($\$800 \times 6 \div 12$).

Line 9

Employer Contributions

Employer contributions (including contributions through a cafeteria plan) include any amount an employer contributes to any HSA for you for 2007. These contributions should be shown in box 12 of Form W-2 with code W. If either of the following apply, complete the Employer Contribution Worksheet below.

- Employer contributions for 2006 are included in the amount reported in box 12 of Form W-2 with code W.
- Employer contributions for 2007 are made in 2008.

If your employer made excess contributions, you may have to report the excess as income. See *Excess Employer Contributions* on this page.

Line 10

Enter on line 10 any qualified HSA funding distribution. This is a distribution from your IRA, other than a SEP IRA or SIMPLE IRA, to your HSA in a direct trustee-to-trustee transfer. This distribution is not included in your income, is not deductible, and reduces the amount that can be contributed to your HSA.

The maximum amount that can be excluded from income is based on your HDHP coverage (self-only or family). You can make only one qualified HSA funding distribution during your lifetime. However, if you make the distribution during a month when you have self-only HDHP coverage, you can make another qualified HSA funding

distribution in a later month in that tax year if you change to family HDHP coverage.

A qualified HSA funding distribution made during your tax year reduces the amount that can be contributed from other sources (including employer contributions) to your HSA. See the discussions under *Line 13* for the treatment of excess contributions.

See *Pub. 969* for more information.

Testing period. You must remain an eligible individual during the testing period. The testing period begins with the month in which the qualified HSA funding distribution is contributed to the HSA and ends on the last day of the 12th month following that month. For example, if the distribution is contributed on June 12, 2007, the testing period ends on June 30, 2008. If you fail to remain an eligible individual during this period, other than because of death or becoming disabled, you will have to include the qualified HSA funding distribution in income in the year in which you fail to be an eligible individual. This amount is also subject to a 10% additional tax. (See *Part III*.)

Line 13

If you or someone on your behalf (or your employer) contributed more to your HSA than is allowable, you may have to pay an additional tax on the excess contributions. Figure the excess contributions using the instructions below. See Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts, to figure the additional tax.

Excess Contributions You Make

To figure your excess contributions (including those made on your behalf), subtract your deductible contributions (line 13) from your actual contributions (line 2). However, you can withdraw some or all of your excess contributions for 2007 and they will be treated as if they had not been contributed if:

- You make the withdrawal by the due date, including extensions, of your 2007 tax return (but see the *Note* below),
- You do not claim a deduction for the amount of the withdrawn contributions, and

- You also withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.


Excess Employer Contributions

Excess employer contributions are the excess, if any, of your employer's contributions over your limitation on line 8. If you made a qualified HSA funding distribution (line 10) during the tax year, reduce your limitation (line 8) by that distribution before you determine whether you have excess employer contributions. If the excess was not included in income on Form W-2, you must report it as "Other income" on your tax return. However, you can withdraw some or all of the excess employer contributions for 2007 and they will be treated as if they had not been contributed if:

- You make the withdrawal by the due date, including extensions, of your 2007 tax return (but see the *Note* below),
- You do not claim an exclusion from income for the amount of the withdrawn contributions, and
- You also withdraw any income earned on the withdrawn contributions and include the earnings in "Other income" on your tax return for the year you withdraw the contributions and earnings.

Note. If you timely filed your return without withdrawing the excess contributions, you can still make the withdrawal no later than 6 months after the due date of your tax return, excluding extensions. If you do, file an amended return with "Filed pursuant to section 301.9100-2" written at the top. Include an explanation of the withdrawal. Make all necessary changes on the amended return (for example, if you reported the contributions as excess contributions on your original return, include an amended Form 5329 reflecting that the withdrawn contributions are no longer treated as having been contributed).

Employer Contribution Worksheet

Keep for Your Records 

1. Enter the employer contributions reported in box 12 of Form W-2, with code W	1. _____
2. Enter employer contributions made in 2007 for tax year 2006	2. _____
3. Subtract line 2 from line 1	3. _____
4. Enter employer contributions made in 2008 for tax year 2007	4. _____
5. Employer contributions for 2007. Add lines 3 and 4. Enter here and on Form 8889, line 9	5. _____

Part II—HSA Distributions


Line 14a

Enter the total distributions you received in 2007 from all HSAs. These amounts should be shown in box 1 of Form 1099-SA.

Line 14b


Include on line 14b any distributions you received in 2007 that qualified as a rollover contribution to another HSA. See *Rollovers* on page 2. Also include any excess contributions (and the earnings on those excess contributions) included on line 14a that were withdrawn by the due date, including extensions, of your return. See the instructions for line 13 on page 5.

Line 15

 Only include on line 15 distributions from your HSA that were used to pay or reimburse you for qualified medical expenses (see page 1) you incurred after the HSA was established. Do not include the distribution of an excess contribution taken out after the due date, including extensions, of your return even if used for qualified medical expenses.

In general, include on line 15 distributions from all HSAs in 2007 that were used for the qualified medical expenses (see page 1) of:

1. Yourself and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
 - a. The person filed a joint return.
 - b. The person had gross income of \$3,400 or more.
 - c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's return.

 You cannot take a deduction on Schedule A (Form 1040) for any amount you include on line 15.

Lines 17a and 17b

Additional 10% Tax

HSA distributions included in income (line 16) are subject to an additional

10% tax unless one of the following exceptions apply.

Exceptions to the Additional 10% Tax

The additional 10% tax does not apply to distributions made after the account beneficiary—

- Dies,
- Becomes disabled (see page 2), or
- Turns age 65.

If any of the exceptions apply to any of the distributions included on line 16, check the box on line 17a. Enter on line 17b only 10% (.10) of any amount included on line 16 that does not meet any of the exceptions.

Example 1. You turned age 63 in 2007 and received a distribution from an HSA that is included in income. Do not check the box on line 17a because you (the account beneficiary) did not meet the age exception for the distribution. Enter 10% of the amount from line 16 on line 17b.

Example 2. You turned age 65 in 2007. You received distributions that are included in income both before and after you turned age 65. Check the box on line 17a because the additional 10% tax does not apply to the distributions made after the date you turned age 65. However, the additional 10% tax does apply to the distributions made on or before the date you turned age 65. Enter on line 17b, 10% of the amount of these distributions included in line 16.

Part III—Income and Additional Tax for Failure to Maintain HDHP Coverage

Use Part III to figure any income and additional tax that must be reported on Form 1040 or Form 1040NR for failure to be an eligible individual during the testing period for:

- A qualified HSA distribution (see page 2),
- Part-year coverage (see *Last-month rule* on page 1), and
- A qualified HSA funding distribution (see page 5).

See the discussions on the pages indicated to determine the testing

period for each of these items. Include the amount in income in the year in which you fail to be an eligible individual.

Line 18

Enter the total of any qualified HSA distribution.

Line 19

You can use the *Line 3 Limitation Chart and Worksheet* in the Instructions for Form 8889 for the year the contribution was made to determine the contribution you could have made if the last-month rule did not apply. Enter the excess of the amount contributed over the redetermined amount on line 13.

Line 20

Enter the total of any qualified HSA funding distribution.

Paperwork Reduction Act Notice.

We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to give us the information. We need it to ensure that you are complying with these laws and to allow us to figure and collect the right amount of tax.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For the estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

22222		a Employee's social security number		OMB No. 1545-0008			
b Employer identification number (EIN)			1 Wages, tips, other compensation	2 Federal income tax withheld			
c Employer's name, address, and ZIP code			3 Social security wages	4 Social security tax withheld			
			5 Medicare wages and tips	6 Medicare tax withheld			
			7 Social security tips	8 Allocated tips			
d Control number			9 Advance EIC payment	10 Dependent care benefits			
e Employee's first name and initial		Last name	Suff.	11 Nonqualified plans			
				13 Statutory employee <input type="checkbox"/>	Retirement plan <input type="checkbox"/>	Third-party sick pay <input type="checkbox"/>	12a
				14 Other			12b
f Employee's address and ZIP code						12c	
						12d	
15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name	

Form **W-2** Wage and Tax Statement
 Copy 1—For State, City, or Local Tax Department

2007

Department of the Treasury—Internal Revenue Service

Adviser's Guide to Health Savings Accounts

Notice to Employee

Refund. Even if you do not have to file a tax return, you should file to get a refund if box 2 shows federal income tax withheld or if you can take the earned income credit.

Earned income credit (EIC). You must file a tax return if any amount is shown in box 9.

You may be able to take the EIC for 2007 if (a) you do not have a qualifying child and you earned less than \$12,590 (\$14,590 if married filing jointly), (b) you have one qualifying child and you earned less than \$33,241 (\$35,241 if married filing jointly), or (c) you have more than one qualifying child and you earned less than \$37,783 (\$39,783 if married filing jointly). You and any qualifying children must have valid social security numbers (SSNs). You cannot take the EIC if your investment income is more than \$2,900. **Any EIC that is more than your tax liability is refunded to you, but only if you file a tax return.** If you have at least one qualifying child, you may get as much as \$1,712 of the EIC in advance by completing Form W-5, Earned Income Credit Advance Payment Certificate, and giving it to your employer.

Clergy and religious workers. If you are not subject to social security and Medicare taxes, see Publication 517, Social Security and Other Information for Members of the Clergy and Religious Workers.

Corrections. If your name, SSN, or address is incorrect, correct Copies B, C, and 2 and ask your employer to correct your employment record. Be sure to ask the employer to file Form W-2c, Corrected Wage and Tax Statement, with the Social Security Administration (SSA) to correct any name, SSN, or money amount error reported to the SSA on Form W-2. If your name and SSN are correct but are not the same as shown on your social security card, you should ask for a new card at any SSA office or call 1-800-772-1213.

Credit for excess taxes. If you had more than one employer in 2007 and more than \$6,045.00 in social security and/or Tier I railroad retirement (RRTA) taxes were withheld, you may be able to claim a credit for the excess against your federal income tax. If you had more than one railroad employer and more than \$3,194.40 in Tier II RRTA tax was withheld, you also may be able to claim a credit. See your Form 1040 or Form 1040A instructions and Publication 505, Tax Withholding and Estimated Tax.

(Also see *Instructions for Employee* on the back of Copy C.)

Instructions for Employee (Also see *Notice to Employee*, on the back of Copy B.)

Box 1. Enter this amount on the wages line of your tax return.

Box 2. Enter this amount on the federal income tax withheld line of your tax return.

Box 8. This amount is **not** included in boxes 1, 3, 5, or 7. For information on how to report tips on your tax return, see your Form 1040 instructions.

Box 9. Enter this amount on the advance earned income credit payments line of your Form 1040 or Form 1040A.

Box 10. This amount is the total dependent care benefits that your employer paid to you or incurred on your behalf (including amounts from a section 125 (cafeteria) plan). Any amount over \$5,000 is also included in box 1. You **must** complete Schedule 2 (Form 1040A) or Form 2441, Child and Dependent Care Expenses, to compute any taxable and nontaxable amounts.

Box 11. This amount is (a) reported in box 1 if it is a distribution made to you from a nonqualified deferred compensation or nongovernmental section 457(b) plan or (b) included in box 3 and/or 5 if it is a prior year deferral under a nonqualified or section 457(b) plan that became taxable for social security and Medicare taxes this year because there is no longer a substantial risk of forfeiture of your right to the deferred amount.

Box 12. The following list explains the codes shown in box 12. You may need this information to complete your tax return. Elective deferrals (codes D, E, F, and S) and designated Roth contributions (codes AA and BB) under all plans are generally limited to a total of \$15,500 (\$10,500 if you only have SIMPLE plans; \$18,500 for section 403(b) plans if you qualify

for the 15-year rule explained in Pub. 571). Deferrals under code G are limited to \$15,500. Deferrals under code H are limited to \$7,000.

However, if you were at least age 50 in 2007, your employer may have allowed an additional deferral of up to \$5,000 (\$2,500 for section 401(k)(11) and 408(p) SIMPLE plans). This additional deferral amount is not subject to the overall limit on elective deferrals. For code G, the limit on elective deferrals may be higher for the last three years before you reach retirement age. Contact your plan administrator for more information. Amounts in excess of the overall elective deferral limit must be included in income. See the "Wages, Salaries, Tips, etc." line instructions for Form 1040.

Note. If a year follows code D, E, F, G, H, or S, you made a make-up pension contribution for a prior year(s) when you were in military service. To figure whether you made excess deferrals, consider these amounts for the year shown, not the current year. If no year is shown, the contributions are for the current year.

A—Uncollected social security or RRTA tax on tips. Include this tax on Form 1040. See "Total Tax" in the Form 1040 instructions.

B—Uncollected Medicare tax on tips. Include this tax on Form 1040. See "Total Tax" in the Form 1040 instructions.

C—Taxable cost of group-term life insurance over \$50,000 (included in boxes 1, 3 (up to social security wage base), and 5)

D—Elective deferrals to a section 401(k) cash or deferred arrangement. Also includes deferrals under a SIMPLE retirement account that is part of a section 401(k) arrangement.

E—Elective deferrals under a section 403(b) salary reduction agreement

(continued on back of Copy 2)

Adviser's Guide to Health Savings Accounts

Instructions for Employee *(continued from back of Copy C)*

F—Elective deferrals under a section 408(k)(6) salary reduction SEP

G—Elective deferrals and employer contributions (including nonelective deferrals) to a section 457(b) deferred compensation plan

H—Elective deferrals to a section 501(c)(18)(D) tax-exempt organization plan. See "Adjusted Gross Income" in the Form 1040 instructions for how to deduct.

J—Nontaxable sick pay (information only, not included in boxes 1, 3, or 5)

K—20% excise tax on excess golden parachute payments. See "Total Tax" in the Form 1040 instructions.

L—Substantiated employee business expense reimbursements (nontaxable)

M—Uncollected social security or RRTA tax on taxable cost of group-term life insurance over \$50,000 (former employees only). See "Total Tax" in the Form 1040 instructions.

N—Uncollected Medicare tax on taxable cost of group-term life insurance over \$50,000 (former employees only). See "Total Tax" in the Form 1040 instructions.

P—Excludable moving expense reimbursements paid directly to employee (not included in boxes 1, 3, or 5)

Q—Nontaxable combat pay. See the instructions for Form 1040 or Form 1040A for details on reporting this amount.

R—Employer contributions to your Archer MSA. Report on Form 8853, Archer MSAs and Long-Term Care Insurance Contracts.

S—Employee salary reduction contributions under a section 408(p) SIMPLE (not included in box 1)

T—Adoption benefits (not included in box 1). You **must** complete Form 8839, Qualified Adoption Expenses, to compute any taxable and nontaxable amounts.

V—Income from exercise of nonstatutory stock option(s) (included in boxes 1, 3 (up to social security wage base), and 5)

W—Employer contributions to your Health Savings Account. Report on Form 8889, Health Savings Accounts (HSAs).

Y—Deferrals under a section 409A nonqualified deferred compensation plan.

Z—Income under section 409A on a nonqualified deferred compensation plan. This amount is also included in box 1. It is subject to an additional 20% tax plus interest. See "Total Tax" in the Form 1040 instructions.

AA—Designated Roth contributions under a section 401(k) plan.

BB—Designated Roth contributions under a section 403(b) plan.

Box 13. If the "Retirement plan" box is checked, special limits may apply to the amount of traditional IRA contributions that you may deduct.

Note. Keep **Copy C** of Form W-2 for at least 3 years after the due date for filing your income tax return. However, to help **protect your social security benefits**, keep Copy C until you begin receiving social security benefits, just in case there is a question about your work record and/or earnings in a particular year. Review the information shown on your annual (for workers over 25) Social Security Statement.

HSA Glossary

Account beneficiary – The individual on whose behalf the HSA was established. The IRS model HSA forms use the term “account owner” to refer to the account beneficiary.

ACB – See **Adjusted Closing Balance**.

Adjusted Closing Balance – The fair market value of the HSA at the end of the computation period plus the amount of any distributions or transfers made from the HSA during the computation period.

Adjusted Opening Balance – The fair market value of the HSA at the beginning of the computation period plus the amount of any contributions or transfers made to the HSA during the computation period..

AOB – See **Adjusted Opening Balance**.

Computation period – The period beginning immediately before the time that the contribution being returned was made to the HSA and ending immediately before the removal of the contribution.

Custodial arrangement – The custodian holds the assets on behalf of the owner of the assets. The custodian has no fiduciary obligations to the owner other than holding the assets and doing as the owner order.

Dependent – A qualifying child or a qualifying relative.

Disabled – An individual is disabled if all three of these conditions are satisfied: (1) the individual is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment, (2) the disability is expected to result in death or to be of a long-continued and indefinite duration, and (3) the individual furnishes proof of the disability in the form and manner required by the IRS.

Disqualified person – Refers to a fiduciary, a person providing services to a plan, an employer any of whose employees are covered by a plan, among others.

Divorce or Separation Instrument – A decree of divorce or separate maintenance or a written instrument incident to such a decree; a written separation agreement; or a decree requiring a spouse to make payments for the support or maintenance of the other spouse.

Eligible individual – Any individual who, with respect to any month, is covered under a high deductible health plan as of the first day of such month, is not covered under certain under health plans, is not enrolled in Medicare, and cannot be claimed as a dependent on another person’s tax return.

Excess contribution – When contributions to all of an individual’s HSAs exceed the maximum amount that may be deducted under Code Section 223(a) and excluded from gross income under Code Section 106(d) in a taxable year, collectively.

Family coverage – Any coverage under an HDHP that is not self-only coverage.

Form 1099-SA – The form used by the payer to report distributions made from the HSA.

Form 5329 – The form used to report additional taxes on excess contributions to an HSA.

Form 5330 – The form used to report any tax on a prohibited transaction.

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Form 5498-SA – The form used by the trustee or custodian to report contributions to the HSA.

Form 8889 – The form used to report contributions to an HSA and distributions from an HSA.

HDHP – See **High Deductible Health Plan**.

Health Savings Account – A trust or custodial account created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account owner.

High deductible health plan – Generally, a health plan that satisfies certain requirements as to minimum annual deductibles and maximum annual out-of-pocket expense.

HSA – See **Health Savings Account**.

Indefinite duration – The individual is unable to reasonably anticipate that the disability will, in the foreseeable future, be so diminished as to no longer prevent any substantial gainful activity.

Medical care – Amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Also includes transportation that is primarily for and essential to medical care. The term generally does not include cosmetic surgery.

Medical discount cards – Discount cards that entitle the holder to obtain discounts for services or products at managed care market rates

Medicine and drugs – Includes only items that are legally procured and generally accepted as falling within the category of medicine and drugs.

Network plan – A plan that generally provides more favorable benefits for services provided by its network of providers than for services provided outside of the network.

Out-of-pocket expenses – Includes the plan's annual deductible, copayments, and any coinsurance payments required by the plan, but not premiums for covered benefits.

Permitted insurance – Types of insurance coverage that are disregarded in determining if an individual is an eligible individual, including insurance for a specified disease or illness.

Prohibited transaction – Includes any direct or indirect sale, exchange, or lease of any property between a plan and a disqualified person, among other things.

Qualified medical expenses – Those expenses incurred by the account owner, his or her spouse, and dependents that generally would qualify for the medical and dental expenses deduction under Code Section 213(a).

Qualifying child – A daughter, son, stepchild, sibling, or stepsibling (or descendent of any of these) who has the same principal place of abode as the taxpayer for more than one half of the taxable year and who (other than in the case of total disability) has not yet attained a specified age.

Qualifying relative – A person who satisfies these four requirements: (1) is not a qualifying child of the taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which the taxable year begins, (2) bears a relationship to the taxpayer, (3) receives more than half of his or her support from the taxpayer for the calendar year in which the taxable year begins, and (4) does not have gross income for the year in excess of the Code Section 151(d) dependency exemption amount.

Reasonable benefit restrictions – Benefit restrictions are reasonable only if significant other benefits remain available under the plan in addition to the benefits subject to the restriction or exclusion.

Self-only coverage – Coverage under an HDHP of only one eligible individual.

Substantial gainful activity – An activity or any comparable activity in which an individual customarily engaged before the occurrence of the disability.

TRICARE – The U.S. Military Health System’s health care program for active duty military, active duty service families, retirees and their families, survivors, and other beneficiaries as well as Reservists and National Guardsmen on active duty.

Trust – A legal entity under which assets are actually owned and held on behalf of a beneficiary. A trustee has some level of discretionary fiduciary authority over the assets of the fund.

Umbrella deductible – The stated maximum amount of expenses that a family could incur before receiving benefits under the HDHP.

