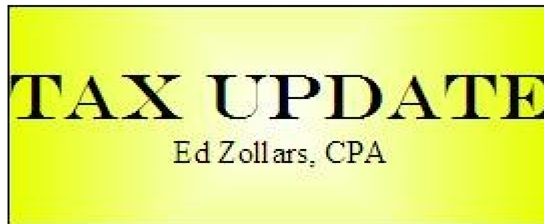

IRS Updates HSA Guidance
June 30,2008

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Notice 2008-59 Updates IRS HSA Guidance

The IRS has given us additional guidance on various issues related to Health Savings Accounts, providing us with some additional options for planning with HSAs, especially when attempting to use HSAs with Flexible Savings Accounts (FSA) or Health Reimbursement Accounts (HRA). Some of the new options are interesting, and some simply clarify issues that hadn't been totally clear before.

The IRS divides the guidance into issues affecting who is an eligible individual, high deductible health plans, contributions to HSAs, distributions from HSAs, prohibited transaction issues, establishment of an HSA, and one issue regarding administration.

Eligible Individual Guidance

The notice starts out by describing issues that affect whether an individual is an eligible individual for HSA purposes. An “eligible individual” is defined in the notice as:

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

Various issues that might impact meeting this definition are dealt with in 11 questions and answers.

HRA Reimbursement of Health and Accident Plan

The first question deals an individual who is covered by an HRA that provides for reimbursement of premiums for a health and accident plan, in addition to vision, dental and preventive care (allowed coverages). The IRS answers that this arrangement would not cause an individual to cease to be an eligible individual for HSA purposes, and points us to the guidance in Notice 2002-45 and Revenue Ruling 2002-41 for general guidance on HRAs.

The IRS gives the following example of such a structure that would not cause an individual to cease to be an eligible individual for HSA purposes:

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

Obviously the insurance provided has to meet the requirements of being a high deductible health plan (HDHP in HSA acronym-speak), but the mere fact that the employer offers the coverage via an HRA does not create disqualified coverage. As is true of many of these provisions, there's nothing terribly surprising here—but it is meant to remind those involved in the design of employee benefit plans of these options, or to give and explicit "OK" for such structures.

Plans to Pay for Expenses Prior to Meeting HDHP Deductible

The IRS reminds us in Question 2 that there are limits on what can be offered, since the whole point of an HSA is to encourage individuals to "negotiate" for medical fees, and if the employee is given a plan that pays for expenses incurred prior to meeting the

deductible under the HDHP and is not permitted insurance under §223(c)(3), that will end the person's eligibility for HSA purposes. We need to insure that only the specifically allowed “extra” coverages are allowed, as the IRS points out in its example with Question 2.

> Example. Individual B is covered by an HDHP. In addition, Individual B is covered by a "mini-med" plan that provides the following benefits: a fixed amount per day of hospitalization; a fixed amount per office visit with a physician; a fixed amount per out-patient treatment at a hospital; a fixed amount per ambulance use; and coverage for expenses relating to the treatment of a specified list of diseases.
>
> Although the fixed amount per day of hospitalization benefit and specified disease benefit are allowed in addition to the HDHP as permitted insurance, the other benefits are not disregarded coverage or preventive care and, thus, Individual B is not an eligible individual who can contribute to an HSA.

Employee benefit specialists looking to design plans that will allow employees to make use of HSAs need to be aware of the types of coverages that are allowed, and those that are not.

Question 3 also addresses this, but points out a planning opportunity in plan design. While an employer cannot reimburse expenses below the minimum HDHP deductible for the type of HSA involved (individual or family coverage), the IRS does bless an expense reimbursement arrangement that pays for expenses above the minimum allowed HDHP deductible and the amount of the actual deductible for the HDHP insurance policy. In essence, the IRS allows “combining” the HRA and the insurance policy, and just insure that the two combined require that at least the minimum deductible be incurred.

The IRS gives us examples of what won't work first.

> Example 1. For 2008, an HDHP with self-only coverage has an annual deductible of $2,500. The employee pays the first $250 of covered medical expenses below the deductible. The employer reimburses the next $1,350 of covered medical expenses below the deductible. The employee is responsible for the last $900 of covered medical expenses below the deductible. The $1,350 of medical expenses paid or reimbursed by the employer is not a contribution to an HSA and not disregarded coverage or preventive care.
>
> An employee covered by this type of plan is not an eligible individual under § 223(c)(1) because the employee has disqualifying coverage from a plan that is not an HDHP.

Contrast this with the second example the IRS gives us, where the employee ends up not being disqualified:

> Example 2. For 2008, an HDHP with self-only coverage has an annual deductible of $4,500. The employee pays the first $1,100 of covered medical expenses below the deductible. The employer reimburses the next $3,400 of covered medical expenses below the deductible. The $3,400 of medical expenses paid or reimbursed by the employer is not a contribution to an HSA and not disregarded coverage or preventive care.
>
> An employee covered by this type of plan is an eligible individual under § 223(c)(1) because the employee is responsible for the minimum annual deductible under § 223(c)(2)(A).

Thus an employer can design a plan to try and take advantage of reductions in insurance cost by having deductibles in excess of the HDHP minimum, but address employee concerns about being potentially liable for such higher deductibles. As well, if the employer is making contributions to the employee's HSAs, the employer can contribute the minimum deductible and only be “on the hook” for additional amounts if an employee actually incurs expenses in excess of that minimum.

This may open up an opportunity if the reduction in premium is significant enough, and the employer is willing to take on the risk of covering that shortfall in order to attempt to gain back the benefit of the reduced premium without having to deal with employee concerns about exposure to additional medical expenses.

Family Coverage Deductible Options

The IRS mentions another similar option for plan design—per Question 4(a), it would be allowable for a HDHP policy that provides for family coverage with a higher than the minimum combined deductible, but provides that benefits will still be paid if a single individual incurs more than the amount of expenses equal to the minimum family deductible required under the law, although the policy itself provides for a higher combined deductible.

This allows for a variant of a policy in which, hopefully, the cost would be lower than for a plan that was at the very minimum HDHP family coverage deductible, but which would still kick in that level if a single member of the family incurred expenses in excess of the lower minimum family HDHP deductible.

Post Deductible FSAs and HRAs

The IRS in Question 4(b) also notes that it is permissible for an FSA or HRA to provide reimbursement of medical expenses once an individual has cleared the minimum deductible for family coverage. The IRS covers the issues of both Questions 4(a) and (b) in the following example:

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

Mere Eligibility for Medicare Part D

The IRS indicates in Question 5 that mere eligibility for coverage under Medicare would not disqualify a person, but also notes that a person is not eligible for any month in which the person is both eligible to receive Medicare benefits and actually is enrolled to receive benefits under Medicare, and points us to the guidance in Q&A 2 and 3 of Notice 2004-50 for additional guidance regarding the impact of Medicare Parts A and B. Question 6 makes clear that Medicare Part D counts for disqualification purposes, and that a person who enrolls in any Medicare program loses his eligibility for HSA purposes.

Non-HDHP Coverage

In Question 7 the IRS holds that an individual can have non-HDHP coverage so long as the individual has qualified HDHP coverage and the other coverage does not have its benefits start until after the minimum HDHP deductible has been exceeded. The second policy does not have to meet the other requirements for an HDHP plan, offering up options to "supplement" the HDHP coverage with another policy.

The IRS offers the following example of such a policy:

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

Post-Deductible FSA or HRA Reimbursements of Other Member of Family Expenses

Question 8 notes that if a post-deductible FSA or HRA covering both the employee and the employee's dependents reimburses the medical expenses of a spouse or dependent of an employee prior to incurring the minimum family HDHP deductible, the individual will not be an eligible employee for HSA purposes. That's true even if the individual is only claiming single coverage—the employer's tax advantaged payment of expenses for the

dependents is still prohibited.

> Example 1. Employee C has family HDHP coverage. Employee C's spouse and children (but not Employee C) are also covered by non-HDHP family coverage provided by the spouse's employer. Employee C and Employee C's spouse and children are also covered by a post-deductible health FSA. The health FSA pays for unreimbursed medical expenses of the spouse and child without regard to the satisfaction of the deductible of the family HDHP.
>
> Because the health FSA covering Employee C reimburses medical expenses before the minimum family HDHP deductible is satisfied, Employee C is not an eligible individual.

It appears that to the IRS the key "taint" is the fact that FSA is providing coverage to the eligible individual—and, as such, any coverage provided to his family will still need to meet the HSA rules even if they are not themselves eligible individuals. The IRS notes in its second example

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

As you note, we see a pattern here—the IRS is "OKing" kicking in benefits to plug a hole between the HDHP's policy's actual deductible and the minimum that would have been required, but attempting to "fill in" below that level kills eligibility.

Veterans Administration Coverage

VA coverage is addressed in Question 9, and provides that so long as an individual only receives medical care that is disregarded coverage or preventative care from the VA, they would remain an eligible individual. The full discussion is reproduced below:

> Q-9. Is an individual an eligible individual if he or she is eligible for medical benefits through the Department of Veterans Affairs (VA) but only receives medical care that is disregarded coverage or preventive care from the VA and is otherwise an eligible individual?
>
> A-9. Yes. Although an individual actually receiving medical benefits from the VA at any time in the previous three months is generally not an eligible individual, this rule does not apply if the medical benefits consist solely of disregarded coverage or preventive care.

Employer Provided Free or Low Cost Clinics

If an employee takes advantage of an employer's free health clinic, or one provided by the employer that provides care at below market value, the individual will still be eligible if

the "the clinic does not provide significant benefits in the nature of medical care (in addition to disregarded coverage or preventive care)" per Question 10. The IRS gives the following example of such a program:

> Example 1. A manufacturing plant operates an on-site clinic that provides the following free health care for employees: (1) physicals and immunizations; (2) injecting antigens provided by employees (e.g., performing allergy injections); (3) a variety of aspirin and other nonprescription pain relievers; and (4) treatment for injuries caused by accidents at the plant.
>
> The clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

However, there are limits to this exception as noted in the next example the IRS offers:

> Example 2. A hospital permits its employees to receive care at its facilities for all of their medical needs. For employees without health insurance, the hospital provides medical care at no charge. For employees who have health insurance, the hospital waives all deductibles and co-pays.
>
> Because the hospital provides significant care in the nature of medical services, the hospital's employees are not eligible individuals under § 223(c)(1)(A).

Dependents Disqualifying Coverage

Question 11 deals with a case where an employee has a family HDHP insurance policy, but the dependents have disqualifying coverage. This question provides that the employee is still an eligible individual, and Question 16 indicates that the person may contribute the statutory maximum for family coverage to the plan—the only limitation is that if the spouse has nonqualifying coverage, none of the HSA contribution can be allocated to the spouse.

High Deductible Health Plan Guidance

The next section of the ruling discusses issues related to high deductible health plans (HDHPs) and Health Savings Accounts.

Switching from Family to Self-Only HDHP Coverage

Question 12 deals with how to allocate the expenses incurred prior to the change from family to self-only HDHP coverage in the year of change, and generally allows that the expense may be allocated in some reasonable method to the deductible for the self-only coverage. As well, the notice counsels about meeting the requirements under the COBRA rules as well if COBRA applies. The Q&A provides:

> Q-12. If an individual switches from a family HDHP to a self-only HDHP, does the individual fail to be an eligible individual during the period of self-only coverage merely because the self-only HDHP, for the purpose of satisfying the self-only deductible, takes into account expenses incurred while the individual had family HDHP coverage?
>
> A-12. A self-only HDHP may use any reasonable method to allocate the covered expenses incurred during the period of family coverage for the purpose of satisfying the deductible for self-only coverage. For example, subject to state law requirements, the plan may allocate to the self-only deductible only the expenses incurred by that individual. Alternatively, the plan may allocate the expenses incurred during family HDHP coverage on a per-capita basis according to the number of persons covered by the family HDHP. If the family deductible was satisfied before the change to self-only coverage, the plan may also treat the individual as having satisfied the self-only deductible for that plan year. In all cases, each expense must be allocated on a reasonable and consistent basis and, except in the case of COBRA continuation coverage, each expense may be allocated to only one individual, and the plan year must be 12 months. For individuals switching from self-only HDHP coverage to family HDHP coverage, see Notice 2004-50, Q&A-23. If COBRA continuation coverage is required to be made available, the HDHP must comply with the requirements of Q&A-2 of § 54.4980B-5 for those individuals receiving COBRA continuation coverage.

The IRS goes on to give four examples in this case to show the application of this holding:

> Example 1. Employer D offers its employees a calendar year health plan otherwise qualifying as an HDHP. Employee E and E's spouse are covered by Employer D's family coverage HDHP with a $6,000 deductible. Employee E incurs $2,500 in covered expenses; Employee E's spouse incurs $2,000 in covered expenses. On July 1, Employee E and Employee E's spouse each change to self-only HDHP coverage with a $3,000 deductible and Employee E's spouse is no longer covered under the plan.
>
> Example 2. The same facts as Example 1, except that Employee E's spouse is entitled to elect, and elects, COBRA continuation coverage under the HDHP. In this case, the HDHP must comply with the requirements of Q&A-2 of § 54.4980B-5.
>
> Example 3. The same facts as Example 2, except that the amounts incurred by Employee E and Employee E's spouse are reversed: Employee E incurred $2,000 of medical expenses and Employee E's spouse incurred $2,500.

> If the HDHP credits Employee E's spouse with $2,250 toward the satisfaction of the deductible, this would not satisfy the requirements of Q&A-2 of § 54.4980B-5. Employee E's spouse must be credited with at least $2,500 toward the satisfaction of the deductible to comply with the requirements of Q&A-2 of § 54.4980B-5.
>
> Example 4. Employer F offers its employees a calendar year health plan, otherwise qualifying as an HDHP. As of January 1, 2008, Employee G, and Employee G's spouse and child are covered by Employer F's family coverage HDHP with a $6,000 deductible. From January 1 through September 30, 2008, Employee G incurs $2,500 in covered expenses; Employee G's spouse incurs $500 in covered expenses, and Employee G's child incurs $3,000 in covered expenses. Employee G and spouse are divorced, effective October 1, 2008. On that date, Employee G changes to self-only HDHP coverage with a $3,000 deductible and the child and ex-spouse elect COBRA continuation coverage in Employer F's family HDHP coverage.
>
> The plan may (1) credit Employee G's individual deductible with $2,500 and reduce the expenses allocated to the child and ex-spouse in family coverage by $2,500; or (2) credit Employee G's self-only deductible with $2,000 and reduce the expenses allocated to the child and ex-spouse by $2,000 (allocating one-third of the $6,000 in expenses to Employee G's individual deductible and two-thirds of the $6,000 in expenses to the former spouse and child remaining in family coverage). Coverage of the child and former spouse is COBRA continuation coverage. However, if the pro rata allocation of expenses of the family to the child and former spouse were less than the actual expenses incurred by the child and former spouse, then allocation of only the ratable share of the family expenses would not comply with the requirements of Q&A-2 of § 54.4980B-5; (3) credit Employee G with no expenses and continue to credit the child and ex-spouse with all expenses incurred under family coverage; or (4) treat Employee G as having satisfied the $3,000 individual deductible while treating the former spouse and child as having satisfied the $6,000 family deductible.

Separate or Higher Deductible for Specific Benefits

Question 13 holds that an HDHP can require a separate or higher deductible for specific benefits and not violate the “out of pocket” limitations if significant other benefits are available under the HDHP.

The IRS gives the following example:

> Example. In 2008, a self-only health plan with a $3,000 deductible imposes a

> lifetime limit of $1,000,000 on reimbursements for covered benefits. The plan pays 100 percent of covered expenses after the $3,000 deductible is satisfied. Although the plan provides benefits for substance abuse treatment, the substance abuse treatment benefits are subject to a separate $5,000 deductible, and these benefits are limited to $10,000, after the separate deductible is satisfied.
>
> The plan is an HDHP and no expense incurred by a covered individual other than the $3,000 general deductible is treated as an out-of-pocket expense under § 223(c)(2)(A).

However, the IRS notes there is a limit to how restrictive a plan can be in providing benefits and remain an HDHP, and covers that limit in question 14. The IRS indicates that a plan providing coverage limited to hospitalization or in-patient care would not offer significant other benefits aside from those subject to exclusion, thus causing payments made after satisfying the general deductible as being out of pocket expenses under §223(c)(2)(A).

The IRS gives the following example:

> Example. In 2008, a self-only health plan with a $2,000 deductible includes a $3,000,000 lifetime limit on covered benefits. Generally, the plan only provides benefits for medical services provided while a covered individual is admitted to a hospital as an overnight patient or provided at a "same day" surgery facility. A same day surgery facility does not include a hospital emergency room, a trauma center, a physician's office or a clinic. Covered medical services for individuals admitted to a hospital or same day surgery facility include room accommodations, miscellaneous medical services and supplies necessary for treatment, primary surgery, pathology charges and the administration of anesthesia while at the hospital or center, and charges by the primary attending physician for one visit per day while at the hospital. In addition, the plan provides: an organ transplant benefit, a hospice care benefit, and home health care visits. The home health care benefit is subject to a 60 visit per year limit, and must be in connection with the hospitalization. The plan also pays for certain preventive care screening and ambulance service. The plan pays for no visits to physician's offices nor any other out-patient care other than those noted above. The maximum dollar amount that the covered individual pays for covered benefits under the plan for 2008 is $5,500.
>
> The restriction of benefits to medical services provided while the covered individual is admitted to a hospital or at a same day surgery facility is not reasonable because significant other benefits do not remain available under the plan after application of the restriction. Any expenses incurred by a covered individual for outpatient care or visits to physician's offices are treated as out-of-

> pocket expenses under § 223(c)(2)(A). Because the plan maximum for amounts paid by a covered individual does not restrict payments for those out-of-pocket expenses, the plan fails to qualify as an HDHP.

Expenses for Post-Deductible HRAs and FSAs

Question 15 holds that the only expenses that can be counted in determining if an HDHP deductible has been exceeded and payments can be made from a post-deductible HRA and FSA are those that are described in §213(d) and are covered by the HDHP policy. If an expense is not covered by the HDHP policy (the question uses the example of chiropractic care that was not covered under the policy), that cannot be counted for qualifying for payment under the post-deductible HRA and FSA.

The IRS gives the following example:

> Example. In 2008, an individual, spouse and child have family HDHP coverage with a $2,500 deductible. The HDHP does not provide benefits for vision or dental care. They are also covered by a combination limited purpose/post-deductible HRA that pays or reimburses § 213(d) medical expenses incurred by each family member after the family incurs $2,500 in covered medical expenses, and pays or reimburses vision and dental expenses before and after the HDHP deductible is satisfied. On February 15, 2008, the family incurs $2,500 in vision and dental expenses that are reimbursed by the HRA. On March 17, 2008, the family then incurs $400 in expenses covered by the HDHP (but for the deductible). The family must incur an additional $2,100 in covered medical expenses before the HDHP deductible is satisfied.
>
> The HRA may not reimburse the family for the $400 of expenses because the family had not incurred $2,500 in covered expenses when the $400 was incurred.

Contribution Issues

Issues related to contributions are covered in the next section of the notice. As we've already discussed Question 16's answer earlier when dealing with spouses that have non-HDHP coverage when the employee has family coverage, we'll start with Question 17.

One Spouse with Self-Only and One with Family Coverage

The IRS deals with the combination of one spouse having self-only HDHP coverage and the other spouse has family HDHP coverage. In this case, the IRS holds that the overall maximum contribution is the family coverage maximum contribution. The contribution can be divided between the spouses as they agree.

The IRS gives the following example:

> Example. For 2008, H and W are married. Both are 40 years old. H and W are otherwise eligible individuals. H has self-only HDHP coverage. W has an HDHP with family coverage for W and their two children.
>
> The combined contribution limit for H and W is $5,800, which is the § 223(b)(2)(B) statutory contribution limit for 2008. H and W divide the $5,800 contribution limit between them by agreement.

Both Spouses with Family Coverage

What if both spouses have a family coverage HDHP policy—the answer is the same as the last one according to Question 18's answer. Again the IRS gives us an example:

> Example. In 2008, H, who is 37, and W, who is 32, are married with two dependent children. H has HDHP family coverage for H and their two children with an annual deductible of $3,000. W has HDHP family coverage for W and their two children with a deductible of $3,500.
>
> The combined contribution limit for H and W is $5,800, the maximum annual contribution limit. H and W divide the $5,800 contribution limit between them by agreement.

Losing Eligibility During the Year

Question 19 reminds us of the rules for years in which we cease to remain eligible for an HSA—contributions can still be made for the months for which we were eligible, and contributions can be made through the extended due date for the year in which the contribution is made.

> Example. J has a self-only HDHP, and is an eligible individual for the first four months of 2008. J has until April 15, 2009 (the date for filing the 2008 return, without extensions) to contribute 4/12 x $2,900 ($967) to an HSA.

Rollovers When No Longer HSA Eligible

Question 20 makes it clear that an individual who is no longer eligible to make an HSA contribution can still roll over his HSA to another HSA account.

Employer Contributions After January 1

Question 21 indicates that an employer that makes a contribution to an employee's account after January 1 but before the unextended due date of the employee's return can designate that payment as being allocable to the prior year. But if an employer does so,

the employer must notify the HSA trustee or custodian of the designation and must also notify the employee of the designation. However, such a payment is reported with Code W in box 12 of the W-2 of the employee for the year in which the contribution is actually paid, not the year it is designated as applying to.

The example, reproduced below, has additional information about how the employee reports on his/her return.

> Example. In January 2009, Employer K contributes $500 to each employee's HSA and notifies the HSA trustee (and provides a statement to the employees) that the contributions are for 2008. Subsequently, in 2009, Employer K contributes $250 to each employee's HSA on March 31, June 30, September 30 and December 31. For each employee whose HSA received these contributions, Employer K reports a total contribution of $1,500 in box 12 with code W on the Form W-2 for 2009.
>
> In completing the Form 8889 for 2008, to compute Employer K's contributions, the employees add the $500 to any employer contributions reported in box 12, code W on the 2008 Form W-2. In completing the Form 8889 for 2009, the employees subtract the $500 from the box 12 code W amount on the 2009 Form W-2 and add to the remaining $1,000 any contributions for 2009 made by Employer K between January 1, 2009 and his or her filing date without extensions. See Instructions to Form 8889.

Catch Up Contributions

Question 22 clarifies that if both husband and wife are eligible to make catch up contributions, the catch up contributions for each spouse must be made to that spouse's HSA.

Employer Contribution for Ineligible Employee

Question 23 holds that an employee may recoup amounts that the employer deposited in error to an HSA for an employee who was not eligible. The employer can request that the financial institution return the funds to employer. However if the employer does not recover the funds by the end of the calendar year, the amounts paid must be included as gross income and wages on the W-2 for the employee for that year.

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

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

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

Employer Overcontributions

Question 23 indicates that if an employer, in error, contributes more than the annual limit to an employee's HSA account, the employer can optionally recover that amount from the financial institution or, if the funds aren't recovered, include the amount in the employee's W-2 wages. However, the answer reiterates that if the employer contributed less than the maximum annual contribution allowed under §223(b), then no amounts may be recovered from the account by the employer.

Employee Ceases to Be an Eligible Individual

Question 24 gives an answer that might be surprising, given the last two answers. The IRS holds that if an employee was an eligible individual but ceases to be eligible during the year in question, the employer cannot recover the payments the employer made after the individual ceased to be an eligible individual. This appears to be a limitation to simplify administration for HSA trustees or custodians, since they would only have to refund to the employer the amount in excess of the maximum annual contribution or the entire amount for the year—not a partial amount that is less than the annual maximum.

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

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

Employer Contribution to HSA of Employee's Spouse

Question 26 notes that exclusion from wages for contributions by an employee is restricted solely to contributions for the employee. A contribution for the employee's spouse must be included in the employee's wages.

Distributions

The IRS next moves on to issues related to distributions from HSAs.

Use of Debit Cards

Question 27 clarifies that debits cards can be used to access funds in an HSA if that debit card restricts payments and reimbursements to medical care. As well, the funds must also be available via other means—that is, the debit card cannot be the sole method available to access funds by purchasing care with the card. Such other access can be via online transfers, withdraws at ATMs, or check writing. Employers, if they are involved, must notify employees of the availability of the other methods of access.

Designation for NonOwner to Withdraw Funds from HSA

The IRS holds in question 28 that individuals other than the owner of the HSA may be authorized to withdraw funds, but if the funds are not used to pay medical expenses for the account beneficiary, the beneficiary's spouse or dependents the amounts are subject to tax. As well, the IRS cautions that there are prohibited transaction rules applicable to HSAs discussed later in the notice.

Medicare Part D Premium Payments

In Question 29 the IRS holds for an individual that has attained age 65 that Medicare Part D payments are qualified medical expenses that are eligible for tax free payments from the HSA.

Spouse's Medicare Premiums

If the beneficiary has not attained age 65, the IRS holds in question 30 that the payment of the individual's spouse's Medicare premiums are not qualified medical expenses for HSA reimbursement/payment purposes.

Payment of Continuation Coverage

Although the payment of medical insurance premiums are generally not qualified medical expenses for HSA purposes, the IRS notes in question 31 that the payment of continuation coverage for the spouse or dependent of a beneficiary of an HSA are an exception to the general rule pursuant to IRC §223(d)(2)(C)(i).

Insurance for Unemployed Spouse or Dependent

Question 32 outlines another insurance exception—HSA funds can be used tax free to pay for coverage under a health plan during the period of receipt of unemployment benefits for the beneficiary's spouse or dependents pursuant to IRC §223(d)(2)(C)(iii).

Divorced Parent Rule

A beneficiary can use HSA tax free to pay for the medical care of his/her child who is claimed as a dependent by the taxpayer's former spouse. In question 33 the IRS refers us to IRC §§152(e) and 213(d)(5).

Prohibited Transactions

The IRS continues on, discussing prohibited transactions applicable to HSAs.

Borrowing from the Beneficiary's HSA

Borrowing from your HSA is a prohibited transaction under IRC §4975, Question 34 points out that an HSA is defined as a plan subject to §4975 by §4975(e)(1)(E), and the HSA beneficiary is defined as a disqualified person in §4975(e)(2), thus making a loan to the beneficiary a prohibited transaction under §4975(c)(1)(B).

Trustee Lends Money to an HSA

Question 35 points out that a trustee loaning money to the HSA is also a prohibited transaction under §4975(c)(1)(B). The IRS provides examples of what types of lending from the trustee are and aren't allowable.

> Example 1. Bank X is the trustee of an HSA. Bank X extends a line of credit to the HSA. The line of credit is a prohibited transaction under § 4975.
>
> Example 2. Bank Y is the trustee of an HSA. The account beneficiary accesses the funds in the HSA through a debit card. In addition, Bank Y extends a line of credit to the account beneficiary, which is not secured by the account beneficiary's HSA, and amounts in the HSA cannot be used to repay the line of credit.
> The line of credit is not a prohibited transaction.

Pledging HSA as Security for a Loan

Pledging your HSA as security for a loan also is a prohibited transaction, as is pointed out by Question 36. The IRS gives the following example:

> Example. Individual P is an account beneficiary of an HSA. Bank Z is the trustee

> of the HSA. Bank Z extends to Individual P a line of credit secured by the HSA. The pledge securing the line of credit is a prohibited transaction under § 4975.

Consequences of HSA Prohibited Transaction

Question 37 points out that normally the consequences of an HSA entering into a prohibited transaction are rather nasty—disqualification of the HSA as of the first day of the year in which the prohibited transaction takes place. However, if the beneficiary is not the person engaging in the prohibited transaction, the answer notes:

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

Establishing an HSA

The date of establishment of an HSA is dealt with in a series of questions and answers in the next section of the notice.

General Rule for Establishment of Initial HSA

The general rule is that we look to state law for the date of establishment of an HSA trust to determine when an HSA is established, per question 38. The IRS holds:

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

Question 39 clarifies that there's not an option to pick another date to treat as the date the HSA was established, but that different rules will apply in the case of rollovers, or if a previous HSA was established.

Date of Establishment if Rollover

If funds in an HSA were rolled over or transferred from an Archer MSA or another HSA, question 40 holds that the new HSA will “inherit” the date the prior account was established. However, qualified HSA distributions under § 106(e) or qualified HSA funding distributions under § 408(d)(9) do not affect the establishment date for an HSA.

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

Previous HSA Established

If the beneficiary had a previously established HSA that had a greater than zero balance anytime in the 18 months before the new HSA is established, the new HSA will inherit the establishment date of the pre-existing HSA, per the guidance in question 41.

The IRS provides the following detailed examples:

> Example 1. An account beneficiary established an HSA on March 1, 2007. On June 15, 2007, he withdrew all the funds from the HSA, resulting in a zero balance. On November 21, 2008, he established a second HSA.
> Because the second HSA was established within 18 months of June 15, 2007, the second HSA is deemed to be established on March 1, 2007.
>
> Example 2. The same facts as Example 1, except that the account beneficiary establishes a third HSA on January 1, 2009. On that date, the second HSA has a balance greater than zero.
>
> The third HSA is deemed to be established on March 1, 2007.

Administration

The notice closes with one bit of guidance related to maintenance and administration fees withdrawn from the HSA by the trustee. The IRS provides:

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