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IRS Provides Additional Comprehensive HSA Guidance

The IRS issued Notice 2004-50 during the last week of July 2004. In January of 2004 the IRS had issued Notice 2004-2. Notice 2004-2 had provided certain basic information on HSAs in question-and-answer format. There were 41 questions covered in Notice 2004-2. Notice 2004-50 provides additional information in question-and-answer format. There are 88 questions covered in Notice 2004-50.

The IRS is being very proactive in giving HSA guidance. Much of their guidance is not totally new, but is an expanded discussion of what the Internal Revenue Code provides or what has been discussed in previous IRS announcements. However, some of the guidance is new.

Topic #1 — Establishing the HSA

The IRS has issued two model HSA plan agreement forms, a trust version and a custodial version.

As with IRAs, the IRS reminds readers that the law does not permit a "joint" HSA. Only one person may be an HSA account beneficiary.

As with IRAs, a person may establish more than one HSA and contribute to more than one HSA, but the same contribution limit applies with respect to the account beneficiary no matter how many HSAs a person has.

The HSA plan agreement may not restrict the ability of an account beneficiary to roll over or transfer funds from his or her HSA to another HSA. Note that this is a new rule with respect to transfers. With respect to IRAs, the IRS has said that the right to transfer is a contractual right and is not a statutory right. It is somewhat unclear whether or not the HSA custodian will be able to charge fees with respect to rollover distributions and transfers. We believe the HSA custodian could charge fees as long as such fees were not so large as to in effect take away the right to roll over or transfer HSA funds.

Topic #2 — Who is an eligible individual?

The IRS set forth eleven questions to expand on this subject.

1. The IRS states very clearly that an employee is eligible for an HSA even in the situation where the employer gives the employee the choice of going with a high deductible health plan or a low deductible health plan, and the employee elects the HDHP. That is, the employee could have chosen the plan with a low deductible, but did not.

2. The general rule was thought to be that an individual eligible for Medicare at age 65 is no longer eligible to contribute to an HSA. The IRS makes the following important distinction. Mere eligibility for Medicare does not make a person ineligible for HSA purposes. In order to be ineligible for an HSA, one must be both eligible and enrolled in Medicare. Therefore, a person who is age 65 or older who is presently not enrolled for Medicare benefits is still eligible to make an HSA contribution if he or she is covered under an HDHP. Once an individual applies for and starts receiving Medicare benefits, that person is then no longer an eligible individual and may not contribute to an HSA.

3. A person who is age 65 or older and who is not enrolled in Medicare is eligible to make the additional catch-up contribution for such year.

4. A person who is eligible to receive VA medical benefits, but who is not actually receiving such benefits during the preceding three months is an eligible individual for HSA purposes.

5. A person who is covered by an HDHP but who also receives health benefits under the TRICARE for active-duty and retired members of the uniformed services is not eligible to contribute to an HSA, because the annual deductible requirement will not be satisfied.

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6. A person who has insurance coverage for one or more specified diseases or illnesses and who is paid an insurance benefit from such insurance before the HDHP deductible has been met is still eligible to contribute to an HSA. The reason is that the law provides at a person covered by an HDHP may also be covered for any benefit provided by permitted insurance. Such insurance would include cancer, diabetes, asthma or congestive heart failure.

7. The IRS makes clear that an employee who is otherwise eligible for an HSA will not become ineligible solely because he or she holds a discount card that allows him or her to obtain discounts for health-care services and products at managed care market rates. The individual, of course, is required to pay the costs of the health care, after taking into account any discount, until the deductible of the HDHP is satisfied.

8. The IRS also makes clear that coverage under an employee assistance program (EAP), disease management program or wellness program does not constitute a health plan and therefore will not make the person ineligible to make an HSA contribution. These programs are not health plans for HSA purposes, as long as they do not provide significant benefits in the nature of medical care or treatment.

9. An employee who becomes covered by the HDHP during the middle of the month will not be able to contribute to his HSA until the first day of the month following the first day of the pay period when HDHP coverage begins.

10. Although an HSA custodian may not place restrictions on rolling or transferring out HSA funds, there is no requirement that an HSA custodian is required to accept a proposed rollover or transfer contribution of HSA funds.

Topic #3 — The Investment of HSA Contributions and Earnings

HSA funds are subject to the same rules governing how funds may be invested as apply to IRAs. Thus, many HSA vendors will have a custodial (savings and time deposits) plan agreement, a trust plan agreement and a custodial-self directed plan agreement.

As with IRAs, HSAs may be held in a common trust fund or common investment fund.

Otherwise, HSA assets are prohibited from being commingled with other assets.

Topic #4 — Monitoring Contributions.

The HSA custodian will have a limited duty to monitor the amount of the contributions made on behalf of an account beneficiary. The HSA custodian will be required to determine if a person is eligible for a catch-up contribution. The HSA custodian is able to rely on the account beneficiary's representation as to his or her date of birth. For those account beneficiaries who are not entitled to the additional catch-up contribution, the maximum contribution for such individuals is $5,150 (for 2004) or the current maximum limit for a family HDHP. For those account beneficiaries who are entitled to the additional catch-up contribution, the maximum contribution for such individuals is $5,650 (for 2004).

The IRS reemphasizes that an HSA custodian is not responsible to determine whether contributions to an HSA exceed the maximum annual contribution for a particular account beneficiary. This is the responsibility of the account beneficiary. And it is the responsibility of the account beneficiary to notify the HSA custodian that he or she has made an excess contribution and request it (along with the net earnings) be distributed to him or her. This notice does not discuss what duty, if any, the HSA custodian has to assist with the calculation of the related income. We believe the IRS would want the HSA custodian to assist. The HSA custodian could certainly charge a fee for such assistance.

The HSA custodian is required to accept contributions as long as they are equal to or less than the $5,150 or the $5,650 limits.

As discussed later, it is permissible for any person and an employer to make a contribution to a person's HSA. CWF will write its plan agreements to permit a person other than the account beneficiary and the employer to make a contribution only if the account beneficiary consents in writing.

Topic # 5 — Monitoring Distributions

The HSA plan agreement cannot be written to restrict an HSA distribution to pay or reimburse only the qualified medical expenses of the account beneficiary, his or her spouse, or any dependent. Under the law, the HSA account beneficiary must have the discretion to withdraw and use his or her HSA funds for any reason.

The HSA custodian, however, is permitted to place reasonable restrictions on both the frequency and the amount of distributions from an HSA. It would be permissible for the HSA custodian to prohibit distributions of less than $40 or allow only 2 distributions per month. The IRS sees these restrictions as contract matters. However, an unreasonable restriction might lead to the result that the purported HSA would fail to qualify as an HSA.

Once the HSA funds have been contributed to an account beneficiary's HSA, these contributions solely belong to the account beneficiary. The IRS apparently has adopted the position that there is no authority for an employer to recoup from an employee's HSA any portion of a contribution previously made to an employee's HSA, regardless of the reason for the incorrect contribution. Suffice it to say the law is very unsettled in this area — the ability to correct for mistaken contributions and the ability of a creditor to reach assets within an HSA.

Topic #6 — Governmental and Account Beneficiary Reporting Duties

The HSA custodian will be responsible to prepare any required reporting forms. The reporting form for contributions (annual and rollover) will be the Form 5498-SA, and the form to report distributions will be the Form 1099-SA.

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Code section 223 contains a provision that there will be prohibition transaction rules similar to those that apply to IRAs.

When a prohibited transaction occurs with respect to an IRA and an IRA accountholder, the IRA is considered distributed to the IRA accountholder as of the first day of the year. It will be included in his or her income and subject to the 10% additional tax, if applicable. The rule for HSAs will be very similar. A distribution is deemed to have occurred and it will be treated as not used to pay qualified medical expenses. The distribution will be included in the account beneficiary's income and subject to the 10% additional tax, if applicable.

The IRS did not state the result when a prohibited transaction occurs with respect to an HSA because the HSA Custodian causes the prohibited transaction. Presumably, rules very similar to the rules which apply to IRA situations would apply.

Topic #7 — Charging Fees for HSA Services

The IRS devoted three questions/answers to the topic of fees. Based on the IRS discussion, we conclude that the IRS is going to apply their IRA fee rules to HSAs. The Notice expressly discusses administration and account maintenance fees. The Notice contains no discussion of transactional types of fees.

If the HSA custodian withdraws administration and account maintenance fees from the HSA, the account beneficiary does not have to include such distributions in income and pay income tax (and penalty). Since such fees are taken from the HSA, there is no deemed or actual distribution made to the account beneficiary. The HSA contribution limit is not affected by the assessment of the fee. An account beneficiary who had a maximum contribution limit for the year of $ 1,000 is not able to contribute to $1,025 because a $25 fee was assessed.

An HSA account beneficiary or an employer may choose to pay the administration and account maintenance fee directly to the HSA custodian. The individual's maximum contribution amount is not affected (i.e. it is not reduced) by the payment of the administration fee.

The IRS rule for transactional fees for IRAs is that neither the individual nor the employer may pay such fees. If they do, such payments are considered to be contributions and must count against the maximum contribution limit.

Topic #8 — What health plans qualify as an HDHP and what plans don't?

An individual is eligible to have contributions made to his or her HSA only if he or she is covered by an HDHP. The IRS has furnished additional guidance on the rules to be applied to determine if a plan qualifies to be an HDHP.

A health plan will be an HDHP if it meets two requirements: (1) a minimum deductible limit and (2) a maximum amount which can be expended on out of pocket expenses. Certain limits apply to health plans with self-only coverage and certain limits apply to family coverage.

In this day and age of networked plans, many plans negotiate discounted prices for health care services. The IRS states there is no violation of the annual deductible requirement even though covered individuals receive benefits at the discounted prices, regardless of whether they have satisfied the plan's deductible.

There will be some employers who decide to switch from a non-HDHP to an HDHP during the middle of a year. It is clear that the minimum annual deductible requirement must still be met. However, is it permissible, for HSA purposes, for an HDHP to provide a credit towards the annual deductible for expenses incurred (and not reimbursed) under the previous plan's short plan year? The IRS rules such a credit is permissible. Such a credit is also permissible if the situation is where an employer switches from an HDHP to another HDHP.

There will also be some eligible employees who change from having self-only HDHP coverage to family HDHP coverage during the year. The IRS also states that the individual (and any other person covered under the family coverage) does not fail to be covered by an HDHP because the family coverage credits the individual's expenses (for purposes of determining if the annual deductibles for family coverage has been met) incurred while he or she had the self-only coverage. For example, an eligible individual has self-only coverage from January I through March 31, marries, and from April I through December 31 has family coverage under an HDHP. The unreimbursed expenses incurred from January I to March 31 may be used to satisfy the family deductible limit. Note that the individual's permissible contribution amount would be determined as follows: 3/12 of the self-only deductible plus 9/12 of the family deductible).

There are also some health plans that allow the deductible to be met over a period longer than 12 months. It would not be "right" to allow a plan which has a fifteen month deductible period to have the same deductible amount as when the period is twelve months. The deductible for self-only coverage is $1,000. This $1,000 must be adjusted as follows: multiply 12 by the number of months to arrive at $15,000 and then divide by 12. The result is $1,250. As long as the plan has a deductible of $1,250 or greater, the plan qualifies as an HDHP for HSA purposes. If the plan qualifies as an HDHP, the maximum annual HSA contribution will be the lesser of: (1) divide the plan's deductible by the number of months allowed to satisfy the deductible and multiply the result by 12; or (2) the applicable statutory limit of $2,600 or $5,150.

Preventive Care. The law contains a major exception to the minimum annual deductible requirement. An HDHP may provide benefits for preventive care which are not subject to the minimum deductible requirement. That is, the health plan may pay the cost of preventive care and not require the insured to meet a deductible requirement. Presumably, many health insurance companies will start writing HDHP polices which authorize an expanded amount of preventive care. The IRS is being quite aggressive as to what qualifies as preventive care. These changes could lead to some revolutionary changes in the medical industry.

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In Notice 2004-23, the IRS had stated the general rule is that preventive care generally does not include any service or benefit intended to treat an existing illness or injury or condition. Many times, however, an individual will go in for a preventive care or screening care and then the doctor will perform a treatment immediately. This immediate treatment may also not be subject to the deductible rule. The IRS states the new rule as - "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 also falls within the safe harbor for preventive care." The IRS gave as an example, the removal of polyps during a diagnostic colonoscopy would also qualify as preventive care.

The IRS also ruled that there will be situations when drugs or medications will come within the safe-harbor for preventive care services. The taking of drugs or medications will qualify as preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered. For example, the taking of many heart drugs will qualify as preventive care. In addition, obesity weight-loss and tobacco cessation programs are also preventive care. Note, the preventive care exception will not apply if the benefit being paid by the HDHP is intended to treat an existing illness or other condition.

Family Coverage. The IRS also felt it desirable to illustrate the term "family coverage," as some people are having a hard time understanding that there is no requirement that all family members covered by an HDHP be eligible for an HSA. There is no requirement that both a husband and wife be eligible to make an HSA contribution. Only one of them needs to be eligible.

"Family coverage" means any coverage other than self-only coverage. Since self-only coverage is only for one individual who is eligible for an HSA, then a plan with family coverage is a plan covering one person who is eligible for an HSA and at least one other person. This other person need not be eligible for an HSA. Example # 1. An employer provides an HDHP to a woman and her family. Her family includes her husband and her three children. Her husband is not eligible for an HSA because he is covered by a non-HDHP at his work. It is still permissible for him to be covered by the HDHP, but he is still ineligible for an HSA because of his other coverage. Example #2. Assume the same facts as example # 1, but the husband is excluded from coverage under his wife's plan. The plan covering the wife is still an HDHP and the woman is eligible for an HSA. Example #3. A family HDHP exists if it covers a person eligible for an HSA and one child.

The IRS makes clear that it is possible for a state high-risk health insurance plan to qualify as an HDHP. Such pool must, however, comply with the rule to not pay benefits below the applicable annual deductible limit.

Lifetime Limits. It is fairly common that health insurance plans contain a lifetime limit on benefits. In order to qualify as an HDHP, the health plan must meet an annual minimum deductible requirement, but there is an overall annual limit on out-of-pocket expenses. A literal reading of code section 423 would mean a health policy could not contain a lifetime limit on benefits and still qualify as an HDHP, because if the individual was required to pay any expense above the maximum limit, then there would be situations where the limit of the annual out-of-pocket expenses would be exceeded. Somewhat surprisingly, the IRS has ruled that an HDHP may impose a reasonable lifetime limit on benefits. The IRS does this by stating that amounts paid by the individual above the lifetime limit will not be treated as out-of-pocket expenses. An attempt to use this special rule as a way to circumvent the maximum out-of-pocket limit will be found to be unreasonable, and the plan will fail to be an HDHP. The IRS furnished this example. A health plan pays 100% of covered expenses once the annual deducible has been met, but only up to a lifetime limit of $1,000,000. The lifetime limit of $1,000,000 is reasonable, and, therefore, this health plan will qualify as an HDHP, since any amount the individual would expend to cover expenses in excess of $1,000,000 is not considered to be an out of pocket expense.

The IRS also discussed what amounts are aggregated to determine if the $5,000 or $10,000 out-of-pocket limit requirement is met. The IRS stated the following five clarifications.

The first new rule is — only covered benefits need to be aggregated. The IRS states that a health plan may be designed with reasonable benefit restrictions (including exclusions) limiting the covered benefits. A restriction is reasonable only if significant other benefits remain available under the plan, in addition to the benefits subject to the restriction or exclusion. Set forth below are two IRS examples. Example #1 illustrates a health plan with a reasonable lifetime limit, some reasonable exclusions and some reasonable restrictions, so that the plan still qualifies as an HDHP. Example #2 illustrates a health plan with an unreasonable restriction so the plan will not comply with the annual out-of-pocket limit requirement.

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

Example (2). A plan provides self-only coverage with a $2,000 deductible. The plan imposes a lifetime limit on reimbursements for covered benefits of $1 million. For

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expenses for covered benefits incurred above the deductible, the plan reimburses 80 percent of the UCR costs. The plan includes no express limit on out-of-pocket expenses. This plan does not qualify as an HDHP because it does not have a limit on out-of-pocket expenses.

The second new rule applies to expenses in excess of UCR. Some health plan policies have been written to limit covered benefits to those that are usual, customary and reasonable (UCR). The expenses in excess of UCR are not covered. If such expenses must be included in the out-of-pocket calculation, then the plan will not qualify as an HDHP. The IRS states that such a restriction is reasonable and such expenses are not to be included in determining the maximum out-of-pocket expenses.

There are many health plans without an express limit on out-of-pocket expenses. The IRS makes clear that such plans will generally not qualify as an HDHP. However, the absence of an express out-of-pocket limit does not automatically mean the health plan does not qualify. If the health plan is so written that, in actuality, the out-of-pocket maximum limit will not be exceeded, then it does not matter that there is not an express out of pocket limit. We have rewritten the IRS' examples.

Example # 1. A plan without an express out-of-pocket limitation provides self-only coverage with a $2,000 deductible, and it pays 100% of the covered benefits in excess of $2,000. By paying 100% of covered expenses in excess of $2,000, the annual out-of-pocket limit ($5,000) will automatically be met, therefore the plan is an HDHP.

Example #2. A plan without an express out-of-pocket limitation provides self-only coverage with a $2,000 deductible; there is a lifetime limit of $1,000,000, and, with respect to plan expenses in excess of $2,000, the plan reimburses 80% of UCR costs and requires the individual to pay the other 20%. Since it does not limit the out-of-pocket expenses to $5,000 the health plan fails to be an HDHP.

Example #3. The same facts as example #2, except once the individual's co-payments reach $3,000, then the plan pays 100% of UCR costs, until $1,000,000 is reached. Since the $5,000, limit is satisfied even though there is not an express out-of-pocket limit, the plan will be an HDHP because the out-of-pocket limit is satisfied in actual practice.

The third new rule is concerned with the treatment of certain penalties. There are many health plans which impose a flat dollar penalty if a person fails to obtain a pre-certification for a specific provider or for certain medical procedures. The IRS states such penalties are not an out-of-pocket expense and therefore are not to be counted for purposes of $5,000/$10,000 limits. This is true even if the penalty is not a flat dollar amount, but is determined by use of a formula. Some plans provide an individual who fails to obtain a pre-certification (or uses a provider outside of the network) will be required to pay a 20% co-payment whereas the co-payment would have been 10% if the pre-certification had been obtained. The additional amount paid by the individual (20% - 10% x cost) will not need to be considered for purposes of the $5,000/$10,000 limits.

The fourth new rule deals with how to treat cumulative embedded deductibles under family coverage for purposes of the out-of-pocket limit requirement. The IRS makes clear that a plan, in order to qualify as an HDHP, must limit the out-of-pocket expenses paid by the covered individuals. These limits may either be express or as a result of plan design. Again, we have rewritten the two examples furnished by the IRS.

Example #1. A plan without an express out-of-pocket limitation provides family coverage with a $2,000 deductible for each family member. The plan pays 100% of the covered benefits in excess of $2,000. As long as there are only five family members, the health plan qualifies as an HDHP, since, by plan design, the out-of-pocket expenses for five or fewer family members will comply with the $10,000 requirement. However, the health plan will not qualify as an HDHP if there are more than five family members covered, because the plan, in that situation, does not impose the $10,000 out-of-pocket limit.

Example #2. If the plan in example #I stated it would reimburse all expenses above $10,000 as determined in the aggregate, then the $10,000 limit requirement for out-of-pocket expenses would be met.

The fifth clarification is that in determining whether or not the plan complies with the out-of-pocket limit, the amount paid for premiums is not included. The amounts to be included are: the deductible, co-payments and other amounts. As previously discussed, one does not count towards the out-of-pocket limit any amounts incurred for non-covered benefits, amounts in excess of UCR and financial penalties. Although a plan need not take co-payments into account in determining if the deductible limit is met, the plan must take co-payments into account for purposes of the out-of-pocket limit. The following example illustrates this clarification.

Example #1. A plan provides self-only coverage with a $1,000 deductible. The plan pays 100% of UCR for covered benefits. In addition, the plan pays for preventive care as follows: there is a $20 co-payment for each screening and then the plan pays the rest The plan does not count these $20 co-payments for purposes of satisfying the $1,000 deductible. The plan must count these $20 co-payments for purposes of determining the out-of-pocket limit.

Topic #9 — Additional Guidance on Contributions

The IRS also chooses to expand who is eligible to make contributions to an eligible individual. The IRS now states that "any person," in addition to an employer, may make HSA contributions. It does not appear that nonperson legal entities may make contributions unless they would be doing so in their role of being an employer.

However, the IRS also states that a state government is eligible to make an HSA contribution to eligible individuals insured under the state's comprehensive health insurance programs for high risk individuals.

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Topic #10 — Contributions for Family HDHP Coverage

It is clear the IRS has received many questions about calculating the contribution limits for eligible individuals with family coverage.

Such family coverage many times has embedded individual deductibles and an umbrella deductible. The maximum annual HSA contribution limit for 2004 for an individual with family coverage is the lesser of: (1) the statutory limit of $5,150 for 2004, (2) the umbrella deductible; or (3) the embedded individual deductible multiplied by the number of family members covered by the plan. An umbrella deductible is when the plan sets forth a maximum amount of expenses the family could incur before any benefits will be paid. The embedded individual deductible is when the plan provides payments for covered medical expenses if any member of the family incurs expenses in excess of the minimum annual deductible (i.e. $2,000).

Example # 1. In 2004, H and W, a married couple, have HDHP coverage for themselves and their two dependent children. The HDHP will pay benefits to each and every family member who has covered expenses in excess of $2,000. However, if no family member has expenses in excess of $2,000, then the plan will not pay any benefits until their combined expenses exceed $5,000. The 2004 maximum contribution for H and W is $5,000, since that is the lesser of $5,150, $5,000 and $8,000 (4 x $2,000). H and W are to split the $5,000 equally, unless they agree to a different division.

Example #2. The facts are the same as Example #I except only H and W are covered under the plan. The 2004 maximum contribution for H and W is $4,000, since that is the lesser of $5,150, $5,000 and $4,000 (2 x $2,000). H and W are to split the $4,000 equally, unless they agree to a different division.

In many situations, there will be family coverage and one of the family members may be an ineligible individual. For example, this will happen most often when one spouse is covered only by the HDHP, as are the children, but the other spouse is covered by the HDHP and also a health plan which is not an HDHP. This means that the spouse who is eligible will wish to make 100% of the permissible contribution to his or her own HSA, because the other spouse's contribution must be zero. The maximum annual HSA contribution for a married couple with family HDHP coverage is the lesser of. (1) the statutory limit for 2004 of $5,150; or (2) the lowest annual deductible of the HDHPs, if there is more than one such plan. We at CWF perceive that some people think that in this situation it is unfair if the couple still gets the full contribution limit. It is not, however, because generally the family HDHP does cover one or more family members other than the spouse. However, there is no requirement that the family plan cover a family member in addition to a spouse. See example #I below.

Example # 1. In 2004, H and W, a married couple, have an HDHP with family coverage.

Neither qualifies for a catch-up contribution. The plan has a $5,000 deductible. H is an eligible individual who has no other health insurance. W is not an eligible individual, as she also has a health plan with self-only coverage with a $200 deductible. H may contribute $5,000 to an HSA, since W is ineligible to make a contribution.

Example #2. The same facts as Example #1 except W has self-only HDHP coverage with a $2,000 deductible. Both H and W are now eligible individuals. H and W are treated only as having family coverage. The self-only policy is ignored. Their combined contribution limit is $5,000, and it is to be split equally unless they agree on a different division.

Example #3. The same facts as Example #1 except W is covered under another family HDP with a deductible of $3,000 rather than the self-only coverage. Both H and W are now eligible individuals. H and W are treated as having family coverage with the lowest deductible ($3,000). Their combined contribution limit is $3,000 and it is to be split equally unless they agree on a different division.

Example #4. In 2004, H and W are a married couple. Neither qualifies for a catch-up contribution. H has family coverage with a $5,000 deductible under his employer's HDHP. W has family coverage with a $500 deductible under her employer's non-HDHP. Neither is an eligible individual and neither may contribute to an HSA.

Example #5. In 2004, H and W, a married couple, have an HDHP with family coverage. Neither qualifies for a catch-up contribution. The plan has a $5,000 deductible. H is an eligible individual who has no other health insurance. W is not an eligible individual, as she also is enrolled in Medicare. H may contribute $5,000 to an HSA, since W is ineligible to make a contribution.

Example #6. Mary, age 48, has a daughter, Roberta, age 18. Mary elects to have family coverage under her employer's HDHP. There is a $5,000 deductible. Mary does not qualify for catch-up contributions. Roberta also has non-HDHP coverage at her place of work, as the plan's deductible is only $200. Mary is entitled to contribute a maximum of $5,000 to her HSA. Roberta is ineligible to contribute to an HSA for two reasons — she is covered by a non-HDHP and she is a dependent.

The IRS furnished an example to illustrate the rule that a married couple splits the contribution to which they are entitled while they are married. The couple is not entitled to split HSA contributions made prior to their marriage. Mark and Rita marry on March 16, 2004. Mark had self-only HDHP coverage with a deductible of $1,200 for the period of January 1, 2004, through March 31, 2004. Mark and Rita have family HDHP coverage with a deductible of $2,400 from April 1, 2004, to December 31, 2004. Neither is eligible to make any catch-up contributions. Both Mark and Rita are eligible individuals. Mark is entitled to make a $300 HSA contribution for the first three months when he was not married. The contribution limit which applies to the period of marriage is $1,800 (9/12 x $2,400).

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They are to divide the $1,800 equally unless they agree to a different division.

Topic #11 — HSA and HRA Coverage

The general rule is that an individual who is covered by an HDHP and also a post-deductible health reimbursement arrangement (HRA) is ineligible to contribute to an HSA. In Rev. Rul. 2004-45 the IRS discussed the possibility that the HRA might be so written that the HRA does not pay or reimburse any medical expense before the HDHP deductible has been satisfied. The IRS clarifies two things. First, it is possible that the HDHP and the HRA may have different deductibles. In this situation, the contributions to the HSA are limited to the lower of the deductibles. Secondly, although separate expenses may be used to satisfy the two deductibles, no benefits may be paid by either the HDHP or the HRA until the minimum deductible under the HDHP has been satisfied.

Topic #12 — Rollovers and Transfers

This notice states that an account beneficiary may make only one rollover contribution to an HSA during a one-year period. Hopefully, the IRS will give additional guidance, since the IRA rules are apparently not being applied to HSAs. The IRS had expanded the IRA rules to allow one rollover per year per IRA plan agreement. It does not appear that this expansion applies to HSAs. The rollover discussion in Notice 2004-50 states that an HSA account beneficiary will be able to make one rollover "contribution" per 12-month period. Code section 223 states that the HSA rollover rules are to be very similar to the IRA rules. For a long time, the IRA rule has been that an individual is allowed to roll over only one "distribution" per 12-month period. It is permissible to make multiple contributions, as long as there has only been one distribution. These explanations are not the same. Under the HSA explanation, it would be permissible to receive multiple distributions and combine them into one rollover contribution. This is impossible under the IRA rule. We suggest following the IRA rules until the IRS provides additional guidance.

The notice does not expressly state that HSA transfers are authorized, but it is certainly implied. The IRS states there are no limits to the number of transfers allowed during a year.

This notice states that the HSA plan agreement may not restrict the ability of an account beneficiary to roll over or transfer funds from his or her HSA to another HSA. Note that this is a new rule with respect to transfers. With respect to IRAs, the IRS has said that the right to transfer is a contractual right and is not a statutory right. It is somewhat unclear whether or not the HSA custodian will be able to charge fees with respect to rollover distributions and transfers. We believe the HSA could charge fees as long as such fees were not so large as to in effect take away the right to roll over or transfer HSA funds.

Although an HSA custodian may not place restrictions on rolling or transferring out HSA funds, there is no requirement that an HSA custodian is required to accept a proposed rollover or transfer contribution of HSA funds.

This notice does not expressly answer the question of whether MSA funds may be transferred to an HSA. It could be argued this notice infers that they could be. The more conservative approach for an HSA custodian would be to require the transactions be performed as rollovers rather than as transfers, until the IRS states expressly that funds may be transferred from an MSA to an HSA.

Topic #13 — Excess Contributions

The IRS issued two additional items of guidance with respect to excess HSA contributions. As with IRAs, there is a requirement to withdraw the related income. Not surprisingly, the IRS states that the rules for computing related net income for excess contributions apply to HSAs.

The IRA rules also allow a contributor to treat a contribution as an excess contribution even though the contribution is not technically an excess contribution. This is a special IRA situation which arose when it became possible to make nondeductible IRA contributions. Such a rule does not apply to HSA contributions, since all HSA contributions are fully deductible. Therefore, it was not surprising that the IRS states that an individual who has made an excess HSA contribution may not withdraw it as an excess. He or she will have to apply the standard taxation rules for HSAs. Since the distribution will be used for non-qualifying health reasons, the distribution will need to be included in income and may well be subject to the 10% additional tax.

Topic #14 — Distributions

An account beneficiary is allowed to withdraw funds from his HSA and use such funds to pay the qualified medical expenses of himself, his spouse and other dependents. These will be tax-free distributions for him. This is true even if, at the time of distribution, his spouse or dependents are covered by a non-HDHP. However, this would not be the case if such distributions were used for expenses already reimbursed by another HDHP or a non-HDHP. This would also be true even if his wife has her own HSA. Either spouse has the option of taking withdrawals from their HSA to pay either of their medical expenses. Both HSAs may not reimburse the same medical expenses.

The IRS states a very important new rule for distributions. There is no deadline by which an individual must reimburse himself or herself for medical expenses which he or she chooses to pay. An account beneficiary may defer to later taxable years distributions from the HSA to pay or reimburse qualified medical expenses incurred in the current year as long as the expenses were incurred after the HSA was established. Similarly, a distribution in the current year can be used to pay or reimburse expenses incurred in any prior year, as long as the expenses were incurred after the HSA was established. For example, an account beneficiary could pay from her checking account a qualifying medical expense in 2004 and then reimburse herself in 2015.

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Comprehensive HSA Guidance, Continued from page 7

The IRS furnished the following example. It has been modified somewhat. Karla, an eligible individual, contributes $1,000 to an HSA in 2004, on January 1, 2004. On December 1, 2004, she incurs medical expenses of $1,500. At that time the balance of the HSA was only $1,025. On January 3, 2005, she contributes another $1,000, bringing the balance to $2,025. In June of 2005, she withdraws $1,500 to reimburse herself. This distribution will be excludable from her income. There is the requirement that the medical expense be incurred after the HSA is established. Note that she is able to reimburse herself the $1,500 (at a later time) even though her HSA's balance was not sufficiently large to cover that expense at the time the medical expense was incurred.

In order to exclude an HSA distribution from income, the account beneficiary must keep tax records sufficient to show that the distributions were exclusively used to pay or reimburse qualified medical expenses, that the qualified medical expenses have not been previously paid or reimbursed from another source, and that the medical expenses have not been taken as an itemized deduction in any prior year.

The IRS has issued a major new rule. It deals with the ability of the account beneficiary to correct for an HSA distribution which was received because of a mistake of fact due to a reasonable cause. There must be clear and convincing evidence that amounts were distributed from an HSA because of a mistake of fact due to reasonable cause. The IRS gives the following example. The account beneficiary reasonably, but mistakenly, believed that an expense was a qualified medical expense and was reimbursed for that expense from the HSA. The account beneficiary will be able to repay or re-contribute such distribution as long as it takes place no later than April 15 following the first year the account beneficiary knew or should have known the distribution was a mistake. If so corrected, then the distribution need not be included in income, is not subject to the special 10% tax and is not subject to the 6% excess contributions tax.

Note that the HSA custodian is not required to allow an account beneficiary to return a mistaken distribution. The HSA custodian has an option whether it will or won't accept the return of a mistaken distribution. The IRS states that the plan agreement should be written to authorize the return of mistaken distributions. The HSA custodian then could rely on the account beneficiary's representation that the distribution was, in fact, a mistake. It is not clear what options the account beneficiary has if the HSA will not accept the return of a mistaken distribution. It may be that the account beneficiary would just keep asking HSA custodians until he finds one that will accept the return of a mistaken distribution.

Topic #15 — Long-term Care Insurance

Additional guidance was needed because different Code sections provided different rules about long-term care insurance. Code section 223 provides that a distribution from an HSA to pay qualified long-term care insurance will be tax free because it qualifies as a qualified medical expense. Code section 125(f) provides that the term "qualified benefit" for section 125 purposes shall not include any product which is advertised, marketed or offered as long-term care insurance. Code section 106(c) provides that employer-provided coverage for long-term care services provided through a flexible spending or similar arrangement are included in the employee's gross income. Code section 213 provides that amounts paid for qualified long-term care services are medical care. The IRS had previously ruled that an employee may pay either his health insurance premium for an HDHP or make a contribution to his HSA by salary reduction through a section 125 plan.

The IRS has determined that an account beneficiary may pay qualified long-term care insurance premiums with distributions from an HSA (and such are qualified medical expenses) even though the contributions had been made by salary reduction through a section 125 plan because section 125(f) is inapplicable, because it is the HSA and not the long-term care insurance that is offered under the cafeteria plan. However, a limit applies to this tax-free income treatment. Code section 213(d)(10) sets forth limits that will also apply to the distributions from HSAs.

The IRS has also determined that Code section 106(c) does not apply to these distributions, since the distributions are coming from an HSA, which is a special personal health savings vehicle used to pay for qualified medical expenses.

Topic #16 — Paying for Insurance After Age 65

Code section 223 sets forth the general rule that the purchase of health insurance is not a qualified medical expense. However, Code section 223 contains express authority allowing the payment for coverage for health insurance once an account beneficiary has attained age 65. It does not matter if such insurance comes from insured or self-insured plans. The IRS gives an example that the key to the exception is the age requirement. The account beneficiary must be age 65. Payments for premiums on account of a serious illness or being disabled will not receive the tax-free treatment.

Code section 223 also states that the payment of premiums for Medicare part A and part B will qualify for tax-free treatment. Some recipients of social security benefit payments have their Medicare premiums deducted from such payments. These individuals will be entitled to withdraw funds from their HSA and be reimbursed.

Topic #17 — HSAs and Cafeteria Plans

The September 2004, Pension Digest, will contain an article on cafeteria plans and HSAs.