The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added Internal Revenue Code Sec. 223 to permit eligible individuals to establish health savings accounts (HSAs) for tax years beginning after 2003. In an effort to clarify what HSAs are, who can have them, how to establish them, and the basic rules for contributions and withdrawals, the Internal Revenue Service and the Department of the Treasury have issued various forms of guidance. The following "Quick Answers" reflect some of this guidance.

What is a health savings account?
A health savings account (HSA) is a tax-exempt trust or custodial account. Beginning in 2004, individuals participating in high deductible health plans (HDHPs) are allowed to make tax deductible contributions to an HSA to fund lifetime medical needs.

Who is eligible to establish an HSA?
An HSA is established for the benefit of an individual, is owned by that individual, is portable and can be funded by employer, employee and other contributions.

An individual is eligible to establish an HSA if, with respect to any month, he or she:

- is covered under a high deductible health plan (HDHP) on the first day of that month;
- is not also covered by any health plan that is not an HDHP (with certain exceptions discussed below);
- is not entitled to benefits under Medicare; and
- may not be claimed as a dependent on another person’s tax return.

An individual, who is otherwise an eligible individual, does not fail to be an eligible individual in the following situations:

- the individual is covered by an HRA, which, in addition to paying and reimbursing expenses for vision, dental and preventive care, pays and reimburses health plan premiums;
- the individual has family HDHP coverage with an imbedded individual deductible that is no less than the minimum family HDHP deductible;
- the individual 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;
- the individual has access to free health care or health care at charges below fair market value from an employer's on-site clinic if the clinic does not provide significant benefits in the nature of medical care; and
- the individual has family HDHP coverage that covers dependents, and the dependents have other, disqualifying, non-HDHP coverage.

In addition, an otherwise eligible individual covered by an HDHP also may be covered by a health plan that is not an HDHP as long as the deductible of the other coverage equals or exceeds the statutory minimum HDHP deductible.

An individual is not an eligible individual in the following situations:

- the individual is covered under a plan that pays for medical expenses incurred before the minimum HDHP deductible is satisfied and the coverage is not permitted insurance, disregarded coverage, or preventive care;
• an employee is covered by an HDHP and the employer pays or reimburses some or all of the employee's medical expenses incurred before the minimum HDHP is satisfied;
• an individual is enrolled in Medicare Part D or any other Medicare benefit; and
• an individual with family HDHP coverage is covered by a post-deductible HRA or post-deductible health FSA that reimburses the Internal Revenue Code Sec. 213(d) medical expenses of any covered individual before the minimum family HDHP deductible has been satisfied.

What if an individual participates in other health-related programs, beyond the HDHP?
In general, individuals who are covered by HDHPs are not eligible to participate in HSAs if they are also covered by another health plan that is not an HDHP. However, there are some exceptions:

Permitted insurance and permitted coverage. Individuals who are covered under an HDHP and an HSA also may have coverage for "permitted insurance" and other specified coverage ("permitted coverage"). "Permitted insurance" is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specific disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. "Permitted coverage" (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision or long-term care. Workers' compensation or other statutorily required benefits are exempted from the insurance contract requirement for permitted insurance. Cards for discounted medical services (such as prescription drug cards) may be used in conjunction with an HSA as long as the insured pays for the discounted services and those payments apply toward the high deductible.

Prescription drug riders. The IRS has ruled that an individual who is covered by both an HDHP that does not apply to prescription drugs and by a separate prescription drug plan (or rider) that provides benefits before the minimum annual HDHP deductible has been satisfied does not qualify and cannot make HSA contributions. The same result occurs if the prescription drug benefit is provided as a benefit under a health plan or as a benefit for the individual under a spouse's plan.

Other health-related programs. An individual will not lose his or her eligibility for an HSA solely because he or she is covered under an Employee Assistance Program (EAP), disease management program or wellness program if the program does not provide significant benefits in the nature of medical care or treatment. These types of programs are not considered to be health plans under Internal Revenue Code Sec. 223(c)(1). For example, an EAP that provides free or low-cost, short-term counseling to identify employee problems that may affect job performance does not provide significant benefits in the nature of medical care or treatment.

What is a high deductible health plan (HDHP)?

• 2020. For self-only coverage, an HDHP has an annual deductible of at least $1,400 and annual out-of-pocket expenses required to be paid (deductibles, copayments and other amounts, but not premiums) of not more than $6,900 (as indexed for 2020). For family coverage, an HDHP has an annual deductible of at least $2,800 and annual out-of-pocket expenses that do not exceed $13,800 (as indexed for 2020).

Note that, for family coverage, a plan is an HDHP only if, under the terms of the plan and without regard to which family member or members incur expenses, no amounts are payable from the HDHP until the family has incurred annual covered medical expenses above the minimum annual deductible.

For non-calendar year plans, the minimum annual deductible amount and the maximum out-of-pocket expense limit may be based on the limits that were in effect on January 1 of the year in which the plan year falls.

An employer may offer employees a choice between several health plans, including HDHPs and health plans with a low deductible, without hurting an employee's eligibility for an HSA. In determining whether a person is an eligible individual, the actual health coverage chosen is controlling and not what the individual could have chosen.
State high-risk pool health plans may qualify as an HDHP if the plans do not pay benefits before the high deductible is reached.

**Coverage period.** An eligible individual must have HDHP coverage as of the first day of the month. Thus, an individual with employer-provided HDHP coverage on a payroll-by-payroll basis becomes an eligible individual on the first day of the month on or after the first day of the pay period when HDHP coverage begins (18).

**Plan designs.** HDHPs may impose reasonable annual and/or lifetime limits on different plan benefits after the plan deductible is met, as long as "significant other benefits" remain available under the plan in addition to the restricted benefits. Expenses incurred due to reasonable restrictions, including penalties for not following plan rules, are not considered out-of-pocket expenses counted toward the maximum. Usual, customary, and reasonable benefits reimbursement is considered a "reasonable" benefits restriction; thus, the insured's expenses exceeding that amount are not included in determining the out-of-pocket maximum (20).

**Can an HDHP provide preventive care benefits before the annual deductible is met?**

Generally, an HDHP may not provide benefits for any year until the deductible is satisfied. However, there is a safe harbor for preventive care. An HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible (22). Preventive care includes, but is not limited to:

- 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; and
- Screening services.

Preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition (24). But a preventive care service or screening that also includes the treatment of a related condition during the procedure qualifies as preventive care. For example, removal of polyps during a diagnostic colonoscopy is preventive care (26). Also, a health plan will not fail to qualify as an HDHP merely because it provides without a deductible preventive health services required under Public Health Services Act Sec. 2713 (28).

**Chronic conditions.** In July 2019, the Treasury Department and the IRS, in consultation with the HHS, determined that certain medical care services received and items purchased, including prescription drugs, for certain chronic conditions should be classified as preventive care for someone with that chronic condition. Accordingly, the IRS expanded the list of preventive care benefits that may be provided by an HDHP to include certain care for chronic conditions (30). Some examples of the additional preventive care services and items for chronic conditions that may be treated as preventive care are:

- ACE inhibitors for congestive heart failure, diabetes, and/or coronary artery disease;
- Beta-blockers for congestive heart failure and/or coronary artery disease;
- Insulin and other glucose lowering agents for diabetes;
- Selective serotonin reuptake inhibitors for depression; and
- Statins for heart disease and/or diabetes.

**Coronavirus testing.** A health plan that otherwise satisfies the requirements to be an HDHP under Internal Revenue Code Sec. 223(c)(2)(A) will not fail to be an HDHP merely because it provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible, according to a notice issued by the IRS (32). As a result, an individual may use an HDHP for testing for and treatment of coronavirus before meeting the deductible without jeopardizing eligibility. The IRS
also noted that as in the past, any vaccination costs continue to count as preventive care and can be paid for by an HDHP.

**Do drugs or medications qualify as preventive care?**

Drugs or medications 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 (in other words, the person does not have symptoms). For example, the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease qualifies as preventive care. Such medications also are considered preventive care when taken to prevent the reoccurrence of a disease from which a person has recovered.

Drugs or medications used as part of procedures providing preventive care services (such as obesity-related weight-loss and tobacco cessation programs) also are preventive care. Note that drugs or medications used to treat an existing illness, injury or condition are not considered preventive care.

Also, as reported above, prescription drugs used for treating certain chronic conditions are considered preventive care.

**How are HDHP deductible issues handled?**

An employer who switches from a non-HDHP to an HDHP in the middle of the year can provide a credit against the HDHP deductible for unreimbursed expenses that employees incurred during the previous health plan’s short plan year. This could be a significant consideration for employers that might not otherwise want to switch their employees, during mid-year, to an HDHP.

When an individual switches from a family HDHP to a self-only HDHP, 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.

If a health plan imposes a separate or higher deductible for specific benefits, amounts paid to satisfy the separate or higher deductible are not treated as out-of-pocket expenses as long as significant other benefits remain available under the plan. A health plan that restricts benefits to expenses for hospitalization or inpatient care is not an HDHP.

In determining when the HDHP deductible is satisfied for purposes of a post-deductible HRA or post-deductible health FSA, only medical expenses described in Internal Revenue Code Sec. 213(d) and covered by the HDHP may be taken into account.

**Who can contribute to an HSA?**

HSA contributions on behalf of an eligible individual may be made by any person, not just the employer or family members, and by state governments for individuals covered in the state's high-risk pools.

Contributions to an HSA must be made in cash. Payments for the HDHP and contributions to the HSA can be made through a cafeteria plan.

**What if an individual's spouse has nonqualifying family coverage?**

An individual who otherwise qualifies as an eligible individual under the HSA rules remains eligible to make HSA contributions even if his or her spouse has nonqualifying family coverage, provided the spouse’s coverage does not cover the individual. The maximum amount the eligible individual may contribute to an HSA in such a situation is based on whether the individual has self-only or family HDHP coverage.

An eligible individual with family HDHP coverage that covers a spouse or dependent children who also have non-HDHP coverage, Medicare, or Medicaid may contribute the statutory maximum for family coverage.

The maximum annual HSA contribution limit for a married couple if one spouse has family HDHP coverage and the other spouse has self-only HDHP coverage is the statutory maximum for family coverage. The contribution limit is divided between the spouses by agreement. Likewise, the maximum HSA contribution limit for a married
couple where both spouses have family HDHP coverage is the statutory maximum. This rule applies regardless of whether each spouse's family coverage covers the other spouse.

**When can contributions be made to an HSA?**

Contributions for the taxable year can be made in one or more payments at any time prior to the time prescribed by law (without extensions) for filing the 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 is generally April 15 following the year for which the contributions are made. Although the annual contribution is determined monthly, the maximum contribution may be made on the first day of the year.

**How much can be contributed to an HSA?**

The maximum annual HSA contribution is an indexed statutory amount, and is no longer limited to the deductible amount under an HDHP (\[44\]). The Secretary of Treasury will publish cost-of-living adjustments to the HSA contribution limits for each year no later than June 1 of the preceding calendar year.

- **2020.** For 2020, the maximum aggregate annual contribution that can be made to an HSA is $3,550 for self-only coverage and $7,100 for family coverage (\[46\]).

**Full annual contribution for part-year coverage.** Individuals who become covered under an HDHP in a month other than January can still make the full deductible HSA contribution for the year (\[48\]). For example, 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 of the taxable year for purposes of computing the annual amount that may be contributed to the HSA. The eligible individual is also treated as enrolled in the same HDHP coverage (self-only or family coverage) as he or she has on the first day of the last month on the year (\[50\]). The full contribution rule applies without regard to whether the individual:

- was an eligible individual for the entire year;
- had HDHP coverage for the entire year; or
- had disqualifying non-HDHP coverage for part of the year.

For these individuals, the maximum HSA contribution for the year is the greater of (\[52\]):

- **Sum of the monthly contribution limits.**— the sum of the contribution limits determined separately for each month, based on eligibility and health plan coverage on the first day of the month. For this purpose, the monthly limit is of the indexed amount for self-only or family coverage. Any catch-up contribution is also computed on a monthly basis.
- **Full contribution.**— the maximum annual HSA contribution based on the individual's HDHP coverage (self-only or family) on the first day of the last month of the individual's taxable year, plus catch-up contributions, if applicable.

**Testing period.** For the full contribution rule, a testing period applies to individuals who are eligible individuals on the first day of the last month of the taxable year. The testing period begins on the first day of the last month of the taxable year and ends on the following 12th month following that month. For a calendar year taxpayer, the testing period is from December 1 of the current year to December 31 of the following year.

If an individual makes contributions under the full contribution rule and does not remain eligible during the testing period, the contributions attributable to the months preceding the months in which the individual was an eligible individual, which could not have been made but for the rule, are includible in gross income. A 10-percent additional tax also applies to the amount includible

The amount that is included in the individual's gross income is computed by subtracting the sum of the monthly contribution limits that the individual would otherwise have been entitled to from the amount actually contributed. It is not necessary to distribute this amount from the HSA, and there may be additional adverse consequences from such a distribution.
To remain an eligible individual during the testing period, an individual is not required to keep the same level of HDHP coverage during the testing period. Thus, changing from family HDHP coverage to single HDHP coverage during the testing period does not result in inclusion of amounts in gross income or an additional 10-percent tax.

An exception applies if the employee ceases to be eligible due to death or disability (¶541).

Neither employers nor trustees are responsible for reporting whether an individual remains an eligible individual during the testing period.

**Excise tax on excess contributions.** An amount included in gross income because an individual failed to remain an eligible individual during the testing period is not an excess contribution, and the 6-percent excise tax under Internal Revenue Code Sec. 4973 does not apply to this amount. For this reason, the amount cannot be withdrawn under the excess contribution rules (¶56).

**HSA distribution not used for qualified medical expenses.** An HSA distribution not used for qualified medical expenses is included in gross income and is subject to an additional 20-percent tax under Internal Revenue Code Sec. 223(f)(4) (with certain exceptions), regardless of whether the amount contributed to the HSA under the full contribution limit is included in the account beneficiary’s income and subject to the additional tax under Internal Revenue Code Sec. 223(b)(8)(B)(i) (¶58).

**Are “catch-up contributions” allowed?**

Yes, an increase in the annual HSA contribution limits (i.e., a catch-up contribution) is permitted for individuals who have reached age 55 by the end of the tax year. Eligible individuals (including covered spouses) may contribute an additional $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter.

Catch-up contributions apply pro rata, based on the number of months of the year a taxpayer is considered an eligible individual, as well as the number of months of the year the taxpayer is age 55 or over.

**What are the general rules regarding employer contributions?**

IRS guidance indicates that (¶60):

- employer contributions to employees’ HSAs made between January 1 and the date for filing the employees’ returns, without extensions, may be allocated to the prior year;
- an employer may recoup amounts contributed to the account of an employee who was never an eligible individual;
- an employer may recoup amounts contributed to an employee’s HSA that exceed the maximum annual contribution allowed in Internal Revenue Code Sec. 223(b);
- an employer cannot recoup amounts contributed to the HSA of an employee who ceases to be an eligible individual during a year; and
- employer contributions to the HSA of an employee’s spouse (who is not an employee of this employer) are not excluded from the employee’s gross income and wages.

**On what basis may employers make contributions to HSAs?**

Employer contributions to HSAs must be made on a comparable basis on behalf of all comparable participating employees in a similar high deductible plan. Comparable participating employees must be in the same category of employees (current full-time employees, current part-time employees, and former employees) and have the same category of HDHP coverage (self-only or family). Family HDHP coverage can be further subdivided into: (1) self plus one; (2) self plus two; and (3) self plus three or more. The comparability rules apply separately to each of the categories of employees. If an employer contributes to the HSA of any employee in a category of employees, the employer must make comparable contribution to the HSAs of all comparable participating employees within that category. As a result, the comparability rules apply to a category of employees only if an employer contributes to the HSA of any employee within the category. For example, full-time eligible employees with self-only HDHP coverage and part-time eligible employees with self-only HDHP coverage are separate...
categories of employees, and different amounts can be contributed to the HSA for each of these categories (\[62\]).

For comparable contribution purposes, nonhighly compensated employees and highly compensated employees are not treated as comparable participating employees. Thus, employers are allowed to make larger HSA contributions for nonhighly compensated employees than for highly compensated employees (\[64\]).

Employer contributions to the HSAs of nonhighly compensated employees may be larger than employer contributions to the HSAs of highly compensated employees with comparable coverage during a period. Conversely, employer contributions to the HSAs of highly compensated employees may not exceed employer contributions to the HSAs of nonhighly compensated employees with comparable coverage during a period (\[66\]).

The comparability rules still apply with respect to contributions to the HSAs of all nonhighly compensated employees who are comparable participating employees (eligible individuals who are in the same category of employees with the same category of high deductible plan (HDHP) coverage). Employers must make comparable contributions to the HSA of each nonhighly compensated employee who is a comparable participating employee during the calendar year. Similarly, the comparability rules still apply with respect to contributions to the HSAs of all highly compensated employees who are comparable participating employees.

Contributions are considered to be "comparable" if they are the same percentage of the deductible amount or are the same dollar amount. The comparability rule does not apply to amounts transferred from an employee's health account, health FSA or Archer MSA, or to contributions made through a cafeteria plan. If the comparable contributions requirement is not met, a 35-percent excise tax must be paid by the employer on the amount of the actual contributions made but all or part of this tax can be waived if due to reasonable cause and not willful neglect (\[68\]). All companies under common control are treated as a single employer for purposes of the comparability rule.

An employer's match of an employee's HSA contribution does not necessarily satisfy the comparability rule, nor does an age-based contribution or contributions based on participation in health assessments, disease management, or wellness programs (\[70\]).

The comparability rules do not apply to HSA contributions that an employer makes through a cafeteria plan. However, Internal Revenue Code Sec. 125 nondiscrimination rules apply to HSA contributions (including matching contributions) made through a cafeteria plan (\[72\]).

**HSAs not established by year end.** With regard to employees who have not established an HSA by December 31, or who may have established an HSA but not notified the employer of that fact, employers can comply with the comparability rules for a calendar year by meeting a notice requirement and a contribution requirement (\[74\]). The employer must provide written notice to all such employees by January 15 of the following calendar year that each eligible employee who, by the last day of February, both establishes an HSA and notifies the employer that he or she has established the HSA, will receive a comparable contribution to the HSA. The notice may be delivered electronically, and sample language for preparing the notice is included in the regulations. For each eligible employee who does this, the employer must make comparable contributions to the HSA by April 15 (taking into account each month that the employee was a comparable participating employee) plus reasonable interest.

**Acceleration of employer contributions.** An employer may accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses exceeding the employer's cumulative HSA contributions at that time (\[76\]). If an employer accelerates contributions for this reason, these contributions must be available on an equal and uniform basis to all eligible employees throughout the calendar year and employers must establish reasonable uniform methods and requirements for acceleration of contributions and the determination of medical expenses. An employer is not required to contribute reasonable interest on either accelerated or non-accelerated HSA contributions. 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 prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year.

**Maximum HSA contribution for mid-year eligible employees.** For employer contributions made for calendar years beginning on or after January 1, 2010, an employer can contribute up to the maximum annual contribution amount for the calendar year (based on the employees' HDHP coverage) to the HSAs of all employees who are eligible individuals during the last month of the taxable year, including employees who become eligible individuals after January 1 of the calendar year and eligible individuals who are hired after January 1 of the calendar year ("mid-year eligible individuals"). An employer who makes the maximum calendar year HSA contribution, or who contributes more than a pro-rata amount, on behalf of employees who are mid-year eligible individuals will not fail to satisfy comparability merely because some employees will have received more contributions on a monthly basis than employees who worked the entire calendar year (78).

Employers are not required to make these greater than pro-rata contributions and instead may prorate contributions based on the number of months that an individual was both employed by the employer and an eligible individual. However, if an employer contributes more than the monthly pro-rata amount for the calendar year to a mid-year eligible employee's HSA, the employer must then contribute, on an equal and uniform basis, a greater than pro-rata amount to the HSAs of all comparable participating employees who are mid-year eligible individuals.

Likewise, if the employer contributes the maximum annual contribution amount for the calendar year to any mid-year eligible employee's HSA, the employer must contribute that same amount to the HSAs of all comparable participating employees who are mid-year eligible individuals.

**How are contributions treated for tax purposes?**

Contributions made by an eligible individual to an HSA are deductible by the eligible individual in determining adjusted gross income. Contributions made by a family member on behalf of an eligible individual to an HSA are deductible by the eligible individual in computing adjusted gross income. The contributions are deductible whether or not the eligible individual itemizes deductions. However, the individual cannot also deduct the contributions as medical expense deductions under Internal Revenue Code Sec. 213.

An individual who may be claimed as a dependent on another person's tax return is not an eligible individual and may not deduct contributions to an HSA.

Employer contributions to an eligible employee's HSA are treated as employer-provided coverage for medical expenses under an accident or health plan and are excludable from the employee's gross income. The employer contributions 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. Contributions to an employee's HSA through a cafeteria plan are treated as employer contributions. The employee cannot deduct employer contributions on his or her federal income tax return as HSA contributions or as medical expense deductions under Internal Revenue Code Sec. 213.

Contributions by an individual are not deductible to the extent they exceed contribution limits, and contributions by employers are included in the employee's gross income to the extend they exceed the limits. In addition, an excise tax of 6 percent is imposed on the account beneficiary for excess contributions (80).

**Can funds be rolled over from an IRA to an HSA?**

For taxable years beginning after December 31, 2006, eligible individuals may make a one-time contribution to an HSA of amounts distributed from an IRA (qualified funding distribution). The contribution must be made in a direct trustee-to-trustee transfer. Amounts distributed from an IRA are not includible in income to the extent that the distribution would otherwise be includible in income. In addition, such distributions are not subject to the 10-percent additional tax on early distributions (82).
A qualified HSA funding distribution may be made from a traditional IRA or a Roth IRA, but not from an ongoing SIMPLE IRA or an ongoing SEP IRA (84).

For calendar years beginning on or after January 1, 2010, if an employer offers qualified HSA distributions to any employee who is an eligible individual covered under any HDHP, the employer must offer them to all employees who are eligible individuals covered under any HDHP (85). However, an employer that offers qualified HSA distributions only to employees who are eligible individuals under the employer's HDHP would not be required to offer them to employees who are eligible individuals but not covered under the employer's HDHP.

**One-time transfer.** Only one distribution and contribution may be made during the lifetime of the individual. However, if a distribution and contribution are made during a month in which an individual has self-only coverage as of the first day of the month, an additional distribution and contribution may be made during a subsequent month within the taxable year in which the individual has family coverage. Both distributions count against the individual's maximum HSA contribution for that taxable year.

**Multiple IRAs.** If an individual wants to use amounts in multiple IRAs to make a qualified HSA funding distribution, the individual must first make an IRA-to-IRA transfer of the amounts to be distributed into a single IRA, and then make the one-time qualified HSA funding distribution from that (88).

**Maximum funding distribution amount.** A qualified HSA funding distribution must be less than or equal to the IRA or Roth IRA account owner's maximum HSA contribution. The maximum annual HSA contribution is based on the individual's:

1. age as of the end of the taxable year (for catch-up contributions); and
2. type of HDHP coverage (self-only or family) at the time of the distribution.

**Testing period.** If a qualified HSA funding distribution is made from an individual's IRA to an HSA and the individual remains an eligible individual during the entire testing period, the amount of the distribution is excluded from the individual's gross income and the 10-percent additional tax does not apply. The testing period begins with the month in which the distribution is contributed to the HSA and ends on the last day of the month one year later. Each qualified HSA funding distribution has a separate testing period. For testing period purposes, an eligible individual who changes from family HDHP coverage to self-only coverage during the testing period remains an eligible individual (90).

Note that there is no interaction between the testing period rules in Internal Revenue Code Sec. 223(b)(8) (regarding full contributions) and the rules under Internal Revenue Code Sec. 408(d)(9) (regarding qualified funding distributions). The testing period rules pertaining to full contributions do not apply to amounts contributed to an HSA through a qualified funding distribution.

**Can funds be rolled over from a health FSA or HRA to an HSA?**

Yes, certain amounts could be distributed from a health flexible spending account (FSA) or health reimbursement arrangement (HRA) and contributed through a direct transfer to an HSA ("qualified HSA distribution") without violating the otherwise applicable requirements. The amount could not exceed the lesser of the balance in the health FSA or HRA as of September 21, 2006, or the balance as of the date of the distribution (92).

Only one qualified HSA distribution with respect to each health FSA or HRA of an individual was allowed. Contributions had to be made directly to the HSA before January 1, 2012. If an employer made available to any employee the ability to make contributions to an HSA from distributions from a health FSA or HRA, all employees who were covered under an HDHP of the employer had to be allowed to make such distributions and contributions.

If an individual who made a qualified HSA distribution from an FSA or HRA did not remain an eligible individual during the testing period, the amount of the contribution was includible in the individual's gross income. The testing period was the period beginning with the month in which the qualified HSA distribution was contributed.
to the HSA and ending on the last day of the 12th month following such month. A 10-percent additional tax also applied. An exception applied if the employee ceased to be an eligible individual by reason of death or disability.

The IRS issued guidance on rollovers from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs) to health savings accounts (HSAs) ([94]). For certain amounts in a health FSA or HRA to be rolled over into an HSA and for the rollover to receive favorable tax treatment, employers had to amend their health FSAs or HRAs and employees had to elect a rollover by the end of the plan year. In addition, employers had to transfer the balance amount to an HSA within two and a half months after the end of the plan year.

**Interaction between FSA grace period rules and HSA eligibility.** For taxable years beginning after December 31, 2006, coverage under a health FSA during the period immediately following the end of a plan year during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified expenses (i.e., the grace period) is disregarded coverage. Such coverage is disregarded if ([96]):

1. the balance in the health FSA at the end of the plan year is zero; or
2. the individual is making a qualified HSA distribution in an amount equal to the remaining balance in the health FSA at the end of the plan year.

**How are HSA distributions treated?**

Amounts distributed from an HSA in order to pay qualified medical expenses are not includible in the beneficiary's income. "Qualified expenses" are those that are defined in Internal Revenue Code Sec. 213(d) for itemized deductions for medical care. IRS guidance indicates that the following are qualified medical expenses for HSA purposes ([98]):

- Medicare Part D premiums if the account beneficiary has attained age 65;
- premiums for continuation coverage required under federal law for the spouse or dependent of an account beneficiary;
- premiums for health coverage for a spouse or dependent during a period when the spouse or dependent is receiving unemployment compensation under any federal or state law; and
- Internal Revenue Code Sec. 213(d) medical expenses incurred by an account beneficiary's child who is claimed as a dependent by the account beneficiary's former spouse.

Distributions from HSAs generally cannot be made for expenses for insurance premiums except for (1) long-term care insurance, (2) health insurance during any federally required continuation coverage period, and (3) premiums for health coverage while a person is receiving unemployment compensation under state or federal law ([100]).

Although Internal Revenue Code Sec. 125 cafeteria plans may not include long-term care insurance benefits, HSA funds contributed through an Internal Revenue Code Sec. 125 salary reduction plan may be used to pay for long-term care insurance premiums. However, the amount of long-term care premiums that the HSA may fund is limited to the adjusted amounts under Internal Revenue Code Sec. 213(d)(10) ([102]).

An HSA holder may pay for his or her spouse's or dependent's qualified medical expenses, regardless of whether that spouse or dependent is an eligible individual. However, these expenses cannot be reimbursed more than once ([104]).

Once a person becomes eligible for Medicare, HSA distributions can be made tax-free for health insurance premiums for Medicare (other than Medigap premiums) as well as the employee share of premiums for employer-sponsored retiree health insurance ([106]).
Distributions that are not used to pay for qualified medical expenses are subject to income tax and a 10 percent penalty tax unless made after death, disability, or after the person reaches the age of Medicare eligibility (i.e., age 65) (108).

Distributions mistakenly made from an HSA (such as for an expense that was thought to be a qualified medical expense but turned out not to be) can be repaid to the HSA if the repayment is made by April 15 of the following year (110).

There is no time limit as to how long an HSA holder can wait to have medical expenses repaid from the account. However, they need to retain their records in case they need to confirm the eligibility of their expenses (112).

**Can HSA holders perform rollovers of their account balances?**

Yes, the rules governing rollovers of HSA balances are similar to those for IRAs. However, an HSA beneficiary may make only one rollover contribution to the HSA during a one-year period, and rollovers from one HSA to another must be done within 60 days of the payment receipt or distribution. This restriction does not apply to rollovers from one HSA trustee to another.

An HSA that is funded by amounts rolled over or transferred from another HSA (or an Archer MSA) is established as of the date the prior account was established (114).

**Are HSAs subject to ERISA requirements?**

No, HSAs established in connection with employment-based group health plans generally do not constitute "employee welfare benefit plans" for purposes of Title I of ERISA. This is because HSAs are personal health savings vehicles rather than a form of group health insurance. Private-sector employer-sponsored HDHPs, on the other hand, are group health plans subject to ERISA's reporting, disclosure, fiduciary responsibility and other requirements (116).

An employer can make contributions to the HSA of an eligible individual without being considered to have established or maintained the HSA as an ERISA-covered plan, provided that the employer's involvement with the HSA is limited. This means that the employer does not:

- limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Internal Revenue Code;
- impose conditions on utilization of HSA funds beyond those permitted under the Internal Revenue Code;
- make or influence the investment decisions with respect to funds contributed to an HSA;
- represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or
- receive any payment or compensation in connection with an HSA.

While HSAs are generally not covered by ERISA, they are subject to the prohibited transaction provisions of Internal Revenue Code Sec. 4975.

**Are HSAs subject to COBRA requirements?**

IRS guidance indicates that HSAs are not subject to COBRA continuation coverage (118).

**Are HSAs subject to HIPAA requirements?**

EBSA and HHS guidance indicates that HSAs are not subject to the HIPAA portability requirements under ERISA or the Public Health Services Act. The guidance also notes that HDHPs are subject to such requirements (120).

**How do HSAs compare to MSAs?**

HSAs are similar to medical savings accounts (MSAs). However, MSA eligibility has been restricted to employees of small businesses and self-employed individuals. HSAs are open to everyone with a high
deductible health insurance plan (HDHP). The annual deductible for an HDHP must be at least $1,400 as indexed for 2020 for individual coverage, and at least $2,800 as indexed for 2020 for family coverage (122).

How do HSAs compare to health FSAs?
Many of the restrictions that apply to health FSAs do not apply to HSAs. For example, HSAs, unlike FSAs, are not subject to the "use it or lose it" rule. Similarly, HSAs are not subject to the FSA rule requiring that the maximum annual amount be available at all times or to the 12-month period of coverage rule. For more information about flexible spending accounts, begin at ¶13,604.

How do HSAs interact with health FSAs and health reimbursement arrangements (HRAs)?
There are several ways that individuals may have access to benefits from FSAs and HRAs and remain eligible to contribute to an HSA (124).

Eligible individuals (who must be covered by a HDHP) may continue to contribute to an HSA while also covered by the following types of employer-provided plans that reimburse employee medical expenses:

- Limited purpose FSAs and HRAs that restrict reimbursements to certain permitted benefits such as vision, dental, or preventive care benefits.
- Suspended HRAs where the employee has elected to forgo health reimbursements for the coverage period.
- Post-deductible FSAs or HRAs that only provide reimbursements after the minimum annual deductible has been satisfied.
- Retirement HRAs that only provide reimbursements after an employee retires.

Individuals with coverage by an FSA and an HRA, as well as an HSA, may reimburse expenses through the FSA or HRA prior to taking distributions from the HSA, as long as the individual does not seek multiple tax-favored reimbursements from the same expense.

What are some actions employers, custodians and trustees are permitted (and prohibited) to take?
Trustees and custodians of HSAs are allowed to take certain actions and are prohibited from others.

Trustees and custodians are allowed to (126):

- refuse to accept rollovers;
- place reasonable limits on the frequency or minimum amounts of distributions; and
- refuse to accept repayments of "mistaken distributions" from the HSA.

Trustees and custodians may not:

- accept more than the annual HSA limit from an account (but they are not obligated to make further determinations on whether the account holder may exceed annual limits);
- restrict a party's right to roll over amounts;
- limit distributions to qualified medical expenses; and
- ignore the account beneficiary's age (but they can rely on the person's own representation as to his or her age) (128).

Trustees, custodians and employers are not required to determine whether HSA distributions are used for qualified medical expenses. Individuals who establish HSAs make that determination and should maintain records of their medical expenses sufficient to show that the distributions have been made exclusively for qualified medical expenses (130).

What are some rules governing account administration?
HSAs may use the same investments as IRAs, but HSA funds may not be invested in life insurance contracts or collectibles. The HSA trust or custodial agreement may restrict investments.
Administrative fees paid out of an HSA are not treated as taxable distributions, nor do they raise the annual maximum contribution allowed. However, administrative fees paid directly by an employer or an account beneficiary do not count against the annual contribution limit.

Spouses cannot have joint HSAs but individuals can have as many HSAs as they want (as long as they don't exceed annual limits).

Prohibited transaction rules similar to those for IRAs also apply to HSA beneficiaries, trustees, and custodians (132).

**Can an HSA be administered through a debit card?**

An HSA may be administered through a debit card that restricts payments and reimbursements to health care if the funds in the HSA are otherwise readily available, such as through online transfers, withdrawals from automatic teller machines or check writing. The guidance notes that employers must notify employees that other access to funds is available (134).

**How soon must an employer deposit HSA contributions withheld from employee pay?**

Amounts withheld from participant wages must be deposited on the earliest date on which they can be reasonably segregated from the employer's general assets (136). For plans with fewer than 100 participants, a safe harbor provides that amounts deposited with the plan not later than the seventh business day following the day on which they are received by the employer, or would otherwise have been payable in cash, are deemed to meet the criteria (138).

While HSAs are generally not ERISA-covered plans (due to limited employer involvement), they are subject to the prohibited transaction provisions of Internal Revenue Code Sec. 4975. Under Internal Revenue Code Sec. 4975(c)(1)(D), prohibited transactions include the "transfer to, or use by or for the benefit of, a disqualified person of the income or assets of a plan." As a result, employers that fail to transmit participants' HSA contributions promptly may violate the prohibited transaction provisions (140). If an HSA is covered by ERISA (due to more than limited employer involvement), the maximum time period applicable to welfare benefit plans would apply (see ¶12,726 for more information).

**What reporting and filing requirements do employers have?**

Employer contributions to an HSA must be reported on the employee’s Form W-2. In addition, information reporting for HSAs will be similar to information reporting for Archer MSAs.

Employers must report qualified HSA distributions as rollover contributions to the HSA trustee, and the HSA trustee must report the qualified HSA distribution as a rollover contribution on Form 5498-SA (142).

For forms due on or after January 1, 2010, persons who are liable for the excise tax under Internal Revenue Code Sec. 4980G (noncomparable contributions) are required to file a return on Form 8928, *Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code*. The return is due on or before the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made. The excise tax must be paid at the same time prescribed for filing of the excise tax return (144).

**Footnotes**


HR Compliance Library, ¶14,470, Health savings accounts

22 Internal Revenue Code Sec. 223(c)(2)(C).
48 Internal Revenue Code Sec. 223(b)(8)(A), as added by the Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
54 Internal Revenue Code Sec. 223(b)(8)(B), as added by the Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
62 IRS Reg. §54.4980G-3, Q&A-5.
64 Internal Revenue Code Sec. 4980G(d), as added by the Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
66 IRS Reg. §54.4980G-6.
68 Internal Revenue Code Sec. 4980G(b).
70 IRS Reg. 54.4980G-4, Q&A-8 through Q&A-11.
72 IRS Reg. §54.4980G-5, Q&A-1 and Q&A-2.
74 IRS Reg. §54.4980G-4, Q&A-14.
HR Compliance Library, ¶14,470, Health savings accounts

76 IRS Reg. §54.4980G-4, Q&A-15.
78 IRS Reg. §54.4980G-4, A-2(h).
82 Internal Revenue Code Sec. 408(d)(9), as added by Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
86 IRS Reg. §54.4980G-7.
92 Internal Revenue Code Sec. 106(e), as added by Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
96 Internal Revenue Code Sec. 223(c)(1)(B)(iii), as added by Tax Relief and Health Care Act of 2006 (P.L. 109-432, 120 Stat 2922), signed by the president on December 20, 2006.
100 Internal Revenue Code Sec. 223(d)(2)(C).
106 Internal Revenue Code Sec. 223(b)(7) and (d)(2)(C)(iv).
108 Internal Revenue Code Sec. 223(f)(4).
120 Preamble to final regulations, 69 FR 78719, December 30, 2004.

144 IRS Reg. §54.4980G-1, Q&A-5.