



Health Savings Accounts: Overview of Rules for 2011

Janemarie Mulvey
Specialist in Aging and Income Security

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Summary

Health Savings Accounts (HSAs) are one way people can pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a tax-advantaged basis. HSAs can be established and funded by eligible individuals when they have a qualifying high-deductible health plan and no other health plan, with some exceptions. For 2011, the deductible for self-only coverage must be at least \$1,200 (with an annual out-of-pocket limit not exceeding \$5,950); the deductible for family coverage must be at least \$2,400 (with an annual out-of-pocket limit not exceeding \$11,900).

The annual HSA contribution limit in 2011 for individuals with self-only coverage is \$3,050; for family coverage, it is \$6,150. Individuals who are at least 55 years of age but not yet enrolled in Medicare may contribute an additional \$1,000.

The tax advantages of HSAs can be significant for some people: contributions are deductible (or excluded from income that is taxable if made by employers), withdrawals are not taxed if used for medical expenses, and account earnings are tax-exempt. Unused balances may accumulate without limit.

HSAs and the accompanying high-deductible health plans are one form of what some call “consumer-driven health plans.” One objective of these plans is to encourage individuals and families to set money aside for their health care expenses. Another is to give them a financial incentive for spending health care dollars prudently. Still another goal is to give them the means to pay for health care services of their own choosing, without constraint by insurers or employers. Since HSAs are still relatively new (they have been authorized for less than six years), the extent to which they will further these objectives is not yet known with any assurance, notwithstanding some early data.

This report is limited to a summary of the principal rules governing HSAs, covering such matters as eligibility, qualifying health insurance, contributions, and withdrawals. The major changes to HSAs in 2011 were a result of provisions in the Patient Protection and Affordable Care Act (PPACA). These include changes to the definition of qualified expenses and increases to the penalty for distributions for non-qualified expenses. These are discussed in greater detail in this report.

This report will be updated as the rules change, either by legislation or regulatory action.

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Introduction

Health Savings Accounts (HSAs) are one way people can pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a tax-advantaged basis. HSAs can be established and funded by eligible individuals when they have a qualifying high-deductible health plan (HDHP, i.e., high-deductible insurance) with a deductible in 2011 of at least \$1,200 for self-only coverage and \$2,400 for family coverage. Qualifying HDHPs must also limit out-of-pocket expenses for covered benefits to certain amounts. With some exceptions, eligible individuals cannot have other health insurance coverage.

HSA tax advantages can be significant for some people: contributions are deductible (or excluded from income that is taxable if made by employers), withdrawals are not taxed if used for medical expenses, and account earnings are tax-exempt. Unused balances may accumulate without limit.

HSAs were first authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). However, other tax-advantaged accounts for health care expenses have existed for some time. Flexible Spending Accounts (FSAs), which many employees can use, began spreading in the 1980s once the Internal Revenue Service (IRS) established clear guidelines. Archer Medical Savings Accounts (MSAs), a precursor of HSAs, became available for a limited number of people starting in 1997. Health Reimbursement Accounts (HRAs), made available by some employers, were approved for tax-exempt status in 2002. For an overview of the similarities and differences of these accounts, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Carol Rapaport. Also see Internal Revenue Service publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*.

When coupled with high-deductible health plans, these accounts are part of what some call “consumer-driven health plans.” One objective of these plans is to encourage individuals and families to set money aside for their health care expenses. Another is to give them a financial incentive for spending health care dollars prudently. Still another goal is to give them the means to pay for health care services of their own choosing, without constraint by insurers or employers.

Since HSAs are still relatively new, the extent to which they will further these objectives is not yet known with any assurance, notwithstanding some early data. However, many individuals and employers are interested in HSAs, and additional information about them is emerging continually.

This report provides a summary of the principal rules governing HSAs, covering such matters as eligibility, qualifying health insurance, contributions, and withdrawals. It will be updated as the rules change, either by legislation or regulatory action.

HSA Rules

Rules governing HSAs are laid out primarily in Section 223 of the Internal Revenue Code and guidance issued by the Department of the Treasury and the Internal Revenue Service (IRS).¹

¹ As of March, 2009, most of the official guidance was available at <http://www.treas.gov/offices/public-affairs/hsa/technical-guidance/>.

Section 223 of the Code was enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, Section 1201(a)).² The section has been amended three times: first by the Gulf Opportunity Zone Act of 2005 (P.L. 109-135, Section 404(c)); second by the Tax Relief and Health Care Act of 2006 (P.L. 109-432); and finally by the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148).

HSAAs are affected by other rules as well. For example, whether an expenditure is a qualified medical expense is governed by Section 213(d) of the Internal Revenue Code and IRS guidance on it; aside from exceptions pertaining to the purchase of health insurance, Section 223 does not change these rules.

The summaries of the principal HSA rules that follow do not provide all details or cite supporting documentation. Further information might be obtained by referring to the statutory provisions cited above, to IRS and other government publications, or to a growing body of secondary analyses.

What is an HSA?

An HSA is a tax-exempt trust or custodial account established for paying qualified medical expenses of the account beneficiary. Accounts may be established with banks and insurance companies or with other entities approved by the IRS to hold Individual Retirement Accounts (IRAs) or MSAs. In addition, other entities may request approval to be an HSA trustee or custodian.

Insurance companies that offer qualified high-deductible health plans (HDHPs) often also establish HSAs for the policyholders. However, there is no federal requirement that HSAs be established by the entity that provides the health plan.

Individuals interested in establishing an HSA must locate an entity that accepts the accounts; they cannot simply deem an ordinary savings account to be an HSA.

Who May Have an HSA?

Individuals are eligible to establish and contribute to an HSA if they have a qualifying HDHP and no disqualifying coverage, as discussed under the next two headings. Whether someone has a qualifying HDHP is determined as of the first of each month; thus, a person might be eligible to contribute to an HSA in some months but not others.³ For example, if someone first enrolled in an HDHP on September 15, their HSA eligibility period would begin on October 1 of that year.

Individuals cannot be enrolled in Medicare (a form of disqualifying coverage), which generally occurs at age 65.⁴ They cannot have received Veterans Administration medical benefits (another

² Sections 1201(b) through 1201(i) amend a number of other Code provisions that affect the tax treatment of HSAs, contributions to accounts, and other related matters. Some of the rules summarized in this report are governed by these provisions rather than Section 223.

³ Individuals should be able to find out from their insurer whether their HDHP is qualifying coverage. They need not apply to the IRS or other government agency for a determination.

⁴ Individuals remain eligible to establish and contribute to HSAs after becoming *eligible* for Medicare, provided they do not enroll in either Part A or Part B.

form of disqualifying coverage) within the past three months, other than benefits for preventive care or from disregarded coverage (for the latter, see exceptions to disqualifying coverage in the section on “What Is Disqualifying Coverage?,” below). On the other hand, individuals can be eligible even if they have access to free or reduced price health services at an on-site employer clinic, provided the clinic does not offer significant benefits.

Individuals are not eligible if they may be claimed as a dependent on another person’s tax return. Tax dependency is determined on a yearly basis; this might not be known until the end of the year.

Individuals may keep their HSAs once they become ineligible. Thus, individuals do not lose their HSA (or the right to access it) by turning age 65 or by obtaining insurance with a low deductible. However, they could not make contributions until they become eligible once again.

Individual members of a family may have their own HSAs, provided they each meet the eligibility rules just described. They can also be covered through the HSA of someone else in the family; for example, a husband may use his HSA to pay expenses of his spouse whether or not she has qualifying coverage and whether or not she has her own HSA. The husband might use his HSA to pay the spouse’s expenses even if she has disqualifying coverage. Individuals may have more than one HSA account.

What Is a Qualifying Health Plan?

A health plan must meet several tests to be qualified: it must have a deductible above a certain minimum level, and it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level. These two tests are described immediately below.

In addition, a qualifying health plan must provide general coverage: substantially all of its coverage cannot be through what the statute calls “permitted insurance” (e.g., coverage for only a particular disease) or certain other coverage (e.g., vision care). This rule prevents individuals from making HSA contributions when the only insurance they have is high-deductible coverage for a narrow class of benefits. (More details on permitted insurance and these other forms of coverage are provided under the heading “What Is Disqualifying Coverage?”.)

Minimum Deductible

For self-only coverage, the annual deductible in 2011 must be at least \$1,200; for family coverage, it must be at least \$2,400. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.⁵

Only usual, customary, and reasonable charges for covered benefits are taken into account in determining whether deductibles are met. Premiums are not included in meeting the deductible, though copayments may be at the option of the HDHP.

⁵ This and other HSA inflation adjustments are based upon the Consumer Price Index for all urban consumers published by the U.S. Department of Labor. Sec. 304 of P.L. 109-432 provides that the measurement period for HSA inflation adjustments is the 12-month period ending on March 31 of the prior year.

The minimum deductible requirement does not apply to preventive care. The exception is established in the statutory language, which does not define the term. However, IRS regulations provide that preventive care includes but is not limited to periodic health evaluations (including tests and diagnostic procedures ordered in connection with routine examinations), routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services. Drugs and medications can be included when taken by a person who has developed risk factors for a disease, or to prevent its recurrence. In general, preventive care does not include services or benefits intended to treat existing illnesses, injuries, or conditions; an exception is allowed when the treatment is incidental to the preventive care service and it would be unreasonable or impracticable to perform another service.

Prescription drugs are not exempt from the minimum deductible, whether they are treated like other benefits in the high-deductible insurance plan or have different deductibles and copayment requirements. Prescription or other discount cards do not disqualify individuals from meeting the minimum deductible requirement. Similarly, individuals are not disqualified by coverage under an employee assistance program, disease management program, or wellness program, provided the program does not provide significant benefits in the nature of medical care or treatment.

Out-of-Pocket Limit

For self-only coverage, the annual limit on out-of-pocket expenditures for covered benefits must not exceed \$5,950 in 2011. For family policies, the limit must not exceed \$11,900. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.

These limits should not be interpreted as ceilings on all out-of-pocket expenditures for health care. Premiums for the HDHP and other insurance would be extra, as would payments for benefits not covered by insurance. Even for covered benefits, the limits would apply only to payments for usual, customary, and reasonable charges. On the other hand, both deductibles and copayments must be taken into account in determining whether the limits are exceeded.

The out-of-pocket limit rule does not preclude HDHPs from imposing reasonable lifetime limits (for example, \$1 million) on plan benefits.

What Is Disqualifying Coverage?

While covered by a qualifying HDHP, individuals generally must not have other coverage that is not high deductible and that provides coverage for any benefit under their high-deductible plan. For example, individuals with a qualifying HDHP are not eligible to establish or contribute to an HSA if they are also covered under a spouse's low deductible policy for the same benefits. (If the spouse's policy were high deductible, the individual could contribute to his or her own HSA.)

However, eligible individuals may have "permitted insurance," which is insurance under which substantially all coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property (such as automobile insurance); insurance for a specified disease or illness; or insurance that pays a fixed amount per day or other period of hospitalization. In addition, eligible individuals may have coverage (through insurance or otherwise) for accidents, disability, vision care, dental care, or long-term care. As mentioned

above, the permitted insurance and other coverage described here do not provide the general form of coverage to be considered a qualifying health plan for purposes of HSA eligibility.⁶

Eligible individuals may also have Flexible Spending Accounts and Health Reimbursement Accounts, provided these accounts are for limited purposes (for example, dental services or preventive care), provide reimbursement for services covered by the HDHP only after the qualifying deductible is met, or are used in retirement. However, coverage under any Flexible Spending Account is allowed during the account's 2½-month grace period after the end of the year (leeway, which employers may allow), provided the balance in the account is zero or is transferred to the HSA.

Who May Contribute to an HSA?

Contributions to HSAs may be made by eligible individuals, as well as by other individuals or entities on their behalf. Thus, individuals may contribute to accounts of eligible family members, and employers may contribute to accounts of eligible employees. Contributions can also be made by state governments.

Contributions by one individual or entity do not preclude contributions by others, provided that the total of all contributions (aside from those classified as rollover contributions) does not exceed annual contribution limits.

Contributors cannot restrict how HSA funds are to be used. For example, employers may not limit HSAs just to certain medical expenses (let alone just to medical expenses alone), even for funds they contribute. Account owners always can make withdrawals for any purpose, though nonqualified withdrawals are subject to taxation, as discussed below.

When and How May Contributions Be Made to an HSA?

Contributions to HSAs may be made at any time during a calendar year and until the filing date (without extensions) for federal income tax returns, normally April 15 of the following year. Thus, contributions could occur over a 15½ month time span (e.g., from January 1, 2011, through April 15, 2012), provided they do not exceed the allowable annual limit described below.

HSA contributions may be made through cafeteria plan salary reduction agreements, that is, benefit arrangements established by employers under which employees accept lower take-home pay in exchange for the difference being deposited in their account.⁷ The IRS has determined that salary reduction agreements must allow employees to stop or increase or decrease their HSA contributions throughout the year as long as the changes are effective prospectively; however, employers may place restrictions on these elections if they apply to all employees. The IRS has also determined that these agreements allow employers to contribute amounts to cover medical expenses that exceed employees' current HSA balances (subject to maximum amounts the

⁶ In private letter ruling PLR 200704010 (January 26, 2007), the IRS provided guidance on how broad "permitted insurance" and "other coverage" can be without being deemed disqualifying coverage. While private letter rulings are not precedent, they are often useful indicators of the tax analysis the IRS applies to a particular issue.

⁷ Health care flexible spending accounts generally are also funded through salary reduction agreements; however, they have a number of restrictions that do not apply to HSAs.

employees had elected to contribute), provided the employees repay the accelerated contributions before the end of the year.

Individuals may make one-time contributions to their HSAs from their traditional or Roth individual retirement accounts (IRAs), subject to the annual contribution limits described below, and limited, one-time rollovers from balances in each of their Flexible Spending Accounts and Health Reimbursement Accounts, which are not subject to those limits.⁸

Contributions to HSAs must be made in cash; contributions of property are not allowed.

How Much May Be Contributed to an HSA?

Two types of contributions may be made to HSAs, regular and catch-up. Both have annual limits that are calculated on a monthly basis: for each month during the year when individuals are eligible, they may contribute (or have others contribute on their behalf) up to one-twelfth of the applicable annual limit.⁹ For example, an individual who is eligible for January through July could contribute seven-twelfths of the annual limit for that year. However, individuals who are eligible during the last month of the year are treated as if they were eligible for the entire year, thus allowing them to contribute up to the annual limit.¹⁰

Contributions need not actually occur monthly; one contribution can be made for the entire year, provided it does not exceed the sum of the allowable monthly limits.

Regular Contributions

The annual contribution limit in 2011 for self-only coverage is \$3,050. The annual limit for family coverage is \$6,150. The limits will be adjusted for inflation (rounded to the nearest \$50) in future years.

In the case of a married couple, if one spouse has family insurance coverage both will be treated as if they have only that coverage; the monthly contribution limit will be divided equally between them unless they agree on a different division.

Catch-Up Contributions

These contributions may be made by individuals who are at least 55 years of age but not yet enrolled in Medicare. In 2011, they may contribute an additional \$1,000. This amount is not indexed for inflation.

⁸ Individuals who make additions to their HSAs under these circumstances must maintain their HSA eligibility for the following year (except in cases of disability or death); otherwise, the additions are included in gross income in determining federal income taxes and also are subject to a 20% penalty tax.

⁹ The applicable annual limits apply to total contributions to the HSA from all sources (e.g., from individuals and employers), not counting rollover contributions. As discussed in the text, applicable limits are reduced by the amount of any contributions individuals make to their Medical Savings Accounts the same year.

¹⁰ Individuals who make additional contributions under this rule must maintain their HSA eligibility for the following year (except in cases of disability or death); otherwise, the additional contributions are included in gross income in determining federal income taxes and also are subject to a 20% penalty tax.

Rollovers

Account owners may rollover balances from one HSA to another without being restricted by the annual contribution limits or affecting new contributions. If the owner withdraws funds and deposits them in another account, only one rollover is allowed each year. Deposits must be made within 60 days in order for the transfer to be considered a rollover. If instead an HSA trustee transfers funds to another, there is no limit on the number of rollovers allowed each year. HSA trustees are not obligated to accept either owner or trustee rollovers.

One-time, limited rollovers are also allowed of termination balances in Flexible Spending Accounts and Health Reimbursement Accounts. The rollovers must be made by employer transfers.

Interaction with Medical Savings Accounts

The annual limitations just described are reduced by the amount of any contribution individuals make to their MSAs in the same year. (MSAs are precursors to HSAs that were authorized under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. Eligibility was limited to people who either were self-employed or were employees covered by a high-deductible insurance plan established by employers with 50 or fewer workers.)

Individuals are permitted to rollover MSA balances to their Health Savings Accounts.

Excess Contributions

Contributions exceeding annual limits might occur for a number of reasons, including failure of employees to take account of employer contributions, early deposits that incorrectly anticipated continuing eligibility, and mathematical errors.

If an excess contribution and any earnings on it are withdrawn by the filing date (without extensions) for the federal income tax return for the year, the individual will not be subject to a penalty. Otherwise, the excess contribution will be subject to a 6% excise tax each year until it is withdrawn.

Comparability Requirement

Employers are not required to contribute to employees' HSAs, but if they do the contributions must be comparable.¹¹ Generally, contributions must be the same dollar amount or the same percentage of the HDHP annual deductible, adjusted to reflect the proportion of the year the employees have worked. Varying employer *matching* contributions (which might differ by how much an employee puts in) satisfy the comparability requirement only if employee contributions are made through a cafeteria plan.¹² If employers allow some employees to transfer Flexible

¹¹ The comparability requirement is in Section 4980G of the Internal Revenue Code, which references rules for MSAs in Section 4980E. The IRS issued final regulations for comparability on July 31, 2006 (71 *Federal Register* 43056) and April 17, 2008 (73 *Federal Register* 20794). Failure to comply subjects the employer to an excise tax.

¹² Cafeteria plans allow employees to choose among certain nontaxable benefits (or levels thereof) and cash. Governed by Section 125 of the Internal Revenue Code, they have their own nondiscrimination rules.

Spending Account or Health Reimbursement Account balances to their HSAs, they must allow any eligible individual covered under their HDHPs to do so.

Employers may accelerate part or all of their contributions for employees who have incurred qualified medical expenses that exceed the employer's cumulative contributions to that point in the year. Accelerated contributions must be available on an equal and uniform basis to all eligible employees.

Employers may limit contributions just to employees who participate in the employers' HDHPs; however, if they make contributions to employees who participate in other HDHPs they must make comparable contributions to all employees with HDHPs.

Different treatment is allowed for full-time and part-time employees, and for self-only and several types of family coverage. Larger contributions may be made for non-highly compensated employees than for highly compensated employees (as defined by the Internal Revenue Service). Employees covered by collective bargaining agreements may be disregarded.

The comparability requirement does not apply to HSA contributions to people who are not considered "employees," including independent contractors, partners in a partnership, and sole proprietors.

What Is the Tax Treatment of HSA Contributions?

Individuals who contribute to their HSAs may claim a deduction on their federal income tax. The deduction is "above-the-line," that is, it is made in determining adjusted gross income; it may be taken by all taxpayers, even those who claim the standard deduction instead of itemizing deductions.

No deduction may be claimed for a one-time contribution from an IRA (though the IRA distribution is not taxed, as it otherwise might be) or for rollovers from MSAs, other HSAs, or a Flexible Spending Account or Health Reimbursement Account.

Contributions made by employers are excluded from gross income of employees in determining their income tax liability. In addition, employer contributions are exempt from Social Security and Medicare taxes for both employers and employees.¹³ In addition, employer HSA contributions are exempt from federal unemployment insurance taxes. If employees contribute to their HSAs through salary reduction cafeteria plans, the contributions are considered to be made by the employer and are exempt from these three employment taxes.

State income taxes generally follow federal rules with respect to deductions and exclusions. However, some states may elect different treatment.

¹³ If an individual is self-employed, contributions are not taken into account in determining net income from self-employment; as a consequence, they are not exempt from Social Security and Medicare taxes.

What Is the Tax Treatment of HSA Withdrawals?

Withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses described in Section 213(d) of the Internal Revenue Code,¹⁴ except for health insurance. Beginning in 2011, over-the-counter medications that are not prescribed by a physician are no longer considered a qualified medical expense.¹⁵

While payments for health insurance are considered qualified expenses under Section 213(d), they generally are not qualified for purposes of HSAs withdrawals. Thus, accounts cannot be used to pay some or all of the premiums of the associated HDHP. However, payments for four types of insurance are considered to be qualified HSA expenses: (1) long-term care insurance,¹⁶ (2) health insurance premiums during periods of continuation coverage required by federal law (e.g., COBRA), (3) health insurance premiums during periods the individual is receiving unemployment compensation, and (4) for individuals age 65 years and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy.

Withdrawals not used for qualified medical expenses are included in gross income in determining federal income taxes and are subject to a penalty. Beginning in 2011, the penalty will be 20% (raised from 10% in prior years).¹⁷ The penalty is waived in cases of disability or death and for individuals age 65 and older. There is no requirement, as there is for qualified retirement plans, that individuals begin to spend down account balances at a certain age.

There is no time limit on when HSA withdrawals are made to pay (or reimburse payments for) qualified expenses, provided adequate records are kept. However, HSAs may not be used to pay expenses incurred before the HSA was established.

HSA withdrawals are not subject to nondiscrimination provisions applying to self-insured medical reimbursement plans.

What Happens to HSAs at Death?

If a surviving spouse is the designated beneficiary of an HSA, it becomes an HSA for that widow or widower.

If someone other than a surviving spouse is the designated beneficiary, the HSA is terminated as of the date of death and the fair market value becomes taxable income to that person.¹⁸ If there is

¹⁴ Qualified medical expenses are described generally in Section 213(d) of the Internal Revenue Code; they include expenditures for a spouse and dependents, even if they are not eligible to have an HSA themselves. IRS publication 502, *Medical and Dental Expenses*, provides a good overview. The principal purpose of Section 213(d) is to describe which expenses may be taken into account in determining the itemized deduction for medical expenses. However, qualified medical expenses under section 213(d) also include over-the-counter medicines (i.e., medicines available without a prescription), for which a deduction is not allowed.

¹⁵ See Sec. 9003 of PPACA.

¹⁶ The IRS considers payments for long-term care insurance to be qualified expenses even if the HSA is funded through a salary reduction agreement under a cafeteria plan, notwithstanding the explicit provision in Section 125(f) of the Internal Revenue Code prohibiting cafeteria plans from including long-term care insurance; the rationale is that it is the HSA that is paying for the insurance, not the cafeteria plan.

¹⁷ See Sec. 9004 of PPACA.

¹⁸ This rule applies even if the non-spouse designated beneficiary is someone whose medical expenses could have been (continued...)

no designated beneficiary, the remaining assets become part of the estate and the fair market value becomes taxable income to the deceased individual on the final return. In these instances, amounts included in gross income are reduced by qualified expenses incurred by the deceased before death and paid within one year.

What Administrative Provisions Apply to HSAs?

The IRS has proposed model forms that banks, insurance companies, and other approved entities can use as trust or custodial agreements with eligible individuals. The proposed agreements, which are not mandatory, provide a safe harbor definition of these institutions' responsibilities. Among other things, the proposed forms clarify that trustees and custodians may rely on account owners' representations about their age, that they are covered by a HDHP, and that their contributions do not exceed the maximum allowed.¹⁹ In addition, the proposed forms state that trustees and custodians are not responsible for determining whether distributions are used for medical expenses.

HSA funds may be invested in investments approved for IRAs, such as bank accounts, annuities, certificates of deposit, stocks, mutual funds, and bonds. However, trustees and custodians need not make available all of these options. There is no requirement that funds be invested in vehicles that do not lose value. HSA funds may not be invested in life insurance contracts or most collectibles (i.e., tangible property).

Administration and account maintenance fees may be withdrawn from the HSA (in which case they will not be considered taxable income) or paid separately (in which case they will not be taken into account with respect to contribution limits).

Trustees and custodians may place reasonable restrictions on the frequency and minimum amount of HSA distributions.

Are HSAs Covered by ERISA?

The Employee Retirement Income Security Act (ERISA) establishes requirements for employee benefit plans. Among other things, it establishes reporting, disclosure, and fiduciary standards for employers, superceding state laws on these matters. Benefit plans with minimal employer involvement are exempted.

The U.S. Department of Labor (DOL) has determined that HSAs generally will not be considered ERISA plans, even if employers open and make contributions to the employees' accounts, provided employer involvement is otherwise limited.²⁰ For the exemption to apply, employers must not limit employees' ability to move funds to another HSA, impose additional conditions on using HSA funds, make or influence investment decisions regarding HSAs, represent that HSAs

(...continued)

paid from the account (such as a dependent child).

¹⁹ However, trustees and custodians may not accept contributions that exceed the annually-adjusted dollar amounts (e.g., \$3,000 and \$5,950) and allowable catch-up contributions.

²⁰ Department of Labor, *Field Assistance Bulletin* 2004-1 (April 7, 2004) and *Field Assistance Bulletin* 2006-02 (October 27, 2006).

are employee welfare benefit plans established by the employer, or receive any payment or compensation in connection with HSAs.

The DOL has also determined that certain cash contributions offered by HSA trustees or custodians as an incentive to establish an HSA are not a prohibited transaction under ERISA.²¹

Author Contact Information

Janemarie Mulvey
Specialist in Aging and Income Security
jmulvey@crs.loc.gov, 7-6928

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²¹ Department of Labor Advisory Opinion 2004-09A, December 22, 2004.