



## **Employee Benefits Circular**—————**July 7, 2008**

### **HSA GUIDANCE UNDER IRS NOTICE 2008-59: SERVICE’S SUMMER RELEASE STARS OLD FRIEND BUT WITH SOME SURPRISING NEW TWISTS**

On Wednesday, June 25, the Internal Revenue Service (the “Service”) released new guidance on Health Savings Accounts (“HSAs”) in the form of IRS Notice 2008-59. Notice 2008-59 lists 42 formal questions and answers on the following general topics:

- Who can be an Eligible Individual with respect to an HSA.
- Further clarifications regarding what is an High Deductible Health Plan.
- Contributions to HSAs.
- Distributions from HSAs.
- Prohibited Transactions involving HSAs.
- Establishing and Administering HSAs.

While some of the issues discussed are substantially similar to previous guidance and merely serve to officially confirm certain wide-held assumptions, a number of the answers appear by their language to contain substantive changes to HSA use and governance. All but the “contributions” section is discussed in more detail below. The guidance contained in questions 16 through 26 is being further analyzed, and will be the subject of a second soon-to-be-released Employee Benefits Circular.

#### **Provisions of Notice 2008-59**

##### **Eligible Individuals**

Questions 1 through 11 discuss the impact of various other coverages and payment mechanisms on eligibility to contribute to HSAs. While some of these answers are merely restatements of previously understood guidance, some add significantly to the growing body of authority surrounding HSAs and how to best make use of HSAs. In the first section of Notice 2008-59, the Service discusses the impact on HSA eligibility status of other health coverage covering the eligible individual / account beneficiary (here called the “HSA owner”) or his or her spouse or beneficiaries.

Answer 1 starts the Notice off with a bang. In the first question, the Service confirms that reimbursement of HDHP premiums from a Health Reimbursement Arrangement (“HRA”) is not itself disqualifying coverage. (Q/A – 1). While many have

understood this to be true, it should nevertheless be comforting to small businesses or others wishing to maximize availability of individual insurance plans to employees when the business does not offer major medical group health coverage. In the next few questions, however, the Service reinforces the limitations on HRA and other employer-provided coverage. Specifically, an employer cannot pay or reimburse (directly or indirectly) any amount or portion of employee's medical expenses before the HDHP minimum deductible is satisfied without disqualifying the employee for HSA purposes, (Q/A – 3)<sup>1</sup> and plan designs using a post-deductible HRA or post-deductible Flexible Spending Account (“FSA”) must not reimburse any HDHP covered expense for any family member covered by the post-deductible HRA or FSA before at least the minimum statutory family deductible of \$2,200 for 2008 and \$2,300 for 2009 is met. (Q/A – 4a, Q/A – 4b; Q/A – 8). Please note, this guidance requires only that the minimum statutory deductible – not the Plan's actual deductible – be met prior to the post-deductible HRA or FSA beginning payment. In addition, while the Service's discussion is limited to family HDHPs, the same logic should extend to post-deductible HRAs and FSAs in a self-only HDHP setting. The self-only minimum statutory deductible limits are \$1,100 for 2008 and \$1,150 for 2009. Finally, as will be discussed below, Answer 8 regarding post-deductible HRA or FSA benefits with regard to dependents arguably runs directly contrary to interesting new guidance expressed in Q/A – 11 (discussed below).

One area where the Service does, however, allow employer contributions to health is through on-site clinics. In a potentially significant clarification, the Service has stated that access to health care that is free or at charges below fair market value from a clinic on an employer's premises will not disqualify an individual from HSA contributions as long as the care provided by the clinic does not exceed a certain level. (Q/A – 10). At this point, the IRS guidance is not as clear as it could be, since two different standards appear to be used in the two examples provided in Answer 10. Specifically, Example 10-1 states that the clinic cannot “provide significant benefits in the nature of medical care.” Example 10-1 states that general preventive care and disregarded benefits are not “significant benefits in the nature of medical care.” However, Example 10-2 seems to exclude only the much broader definition of “significant care in the nature of medical services.” Conservative employers would likely stick to preventive care and other services that are not “significant benefits.” However, the IRS guidance appears to open the door for more aggressive employers to push the line up to the level of “significant care.” Clearly, this is an area that the Service will need to revisit.

Regarding other “outside” (*i.e.*, non-employer sponsored) coverage, the Service officially recognizes that mere access to certain non-employer health benefits should not disqualify an individual from contributing to his or her HSA. Specifically, the Service

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<sup>1</sup> Of course an employer may contribute to an employee's HSA, but such contributions will be irrevocably owned by the employee and will almost certainly not be able to be on a “just in time and only as much as necessary” basis, as some employers have wished to do.

notes that an individual who is “eligible” for, but not actually “enrolled” in any of the various Medicare benefits (Parts A – hospital insurance, Part B – medical insurance, Part D – prescription drug benefits, or Medicare Advantage plans) is still eligible for HSA contributions. (Q/A – 5, Q/A – 6). Similarly, an individual who is eligible for, but does not receive Department of Veterans Affairs (VA) benefits beyond preventive care or disregarded coverage (vision, dental, etc.) will still be an “eligible individual for HSA purposes.” (Q/A – 9).

One of the most interesting (and perhaps soonest to be revised) section of Notice 2008-59 is Q/A – 7 – “HDHP and other high deductible coverage.” In Q/A – 7, the Service opines that an individual may be covered by a second, non-HDHP health benefit plan providing the same major medical coverage as the HDHP, and still be an “eligible individual” for HSA contribution purposes as long as the second (non-HDHP) coverage requires a deductible equal to or in excess of the statutory minimum HDHP deductible. (Q/A – 7). This answer is extremely interesting since many insurance plans / policies have an internal “deductible” higher than that statutorily required for an HDHP, but are not HDHPs because, for example, they provide subsidized or below-market rate benefits before reaching the deductible. Presumably, one could be covered by such a plan as well as a bare-bones HDHP, receive benefits from the non-HDHP plan and still retain eligibility for an HSA.

Consider the following example: Employer A offers an HDHP with a family deductible of \$3,000. Employer A also offers a non-HDHP PPO plan with a \$5,000 family deductible, but also with a \$20 co-pay for doctor office visits and blood work, as well as a relatively typical 3-tiered prescription drug plan. The PPO has a deductible higher than the statutory minimum HDHP deductible, but is clearly not an HDHP. According to a literal reading of Answer 7, however, employees enrolled in both plans should be eligible to contribute to an HSA since “the deductible of the other [non-HDHP] coverage equals or exceeds the statutory minimum HDHP deductible, [therefore] the individual remains an eligible individual.”

In a relatively more minor, but perhaps more confusing departure from prior guidance, Q/A – 11 infers that dependents may be covered under both an eligible individual’s family HDHP and also a non-HDHP providing first dollar coverage without disqualifying the eligible individual. In Revenue Ruling 2005-25 it appeared that the service would allow the same family to have both qualifying HDHP coverage for some family members and non-HDHP for others without disqualifying an otherwise qualified individual. However, that past guidance specifically stated that one dependent was covered under the HDHP, while another was covered under the non-HDHP plan. In Answer – 11, the Service clearly states that “family HDHP coverage that covers dependents [who] have other, disqualifying, non-HDHP coverage” will not prevent an otherwise eligible individual from opening or funding an HSA. This answer opens the possibility of intentionally covering the same individual under two plans solely in order

to avail oneself of a higher HSA limit. Consider the following example: Wife (W) has family coverage under an employer's HDHP for herself and her child (C), who was born with significant medical issues. Simultaneously, Husband (H) has non-HDHP family coverage with a very low deductible for himself and the same child. While most of C's medical bills will likely be covered under H's plan, W will now be able to contribute an additional \$2,900 to her HSA.

In addition, Answer – 11 seems to be in conflict with Answer – 8, discussed earlier. Answer – 11 indicates that “other, disqualifying, non-HDHP coverage,” if also covering a dependent (but not a spouse) who is covered under an HDHP, should not disqualify the otherwise eligible individual from contributing to his or her HSA. However, under Answer – 8, a post-deductible HRA or FSA which reimburses 213(d) medical expenses of the same dependent would disqualify the individual. While presumably the Service meant “other than”, but clearly a post-deductible HRA or FSA is “other, disqualifying, non-HDHP coverage.” The Service will need to clarify Answer – 11, as well as probably a number of other answers in Notice 2008-59.

### **High Deductible Health Plans**

Questions 12 through 15 discuss certain issues with regard to which medical plans meet the Code Section 223(c) definition of a High Deductible Health Plan. Specifically, the Service has provided guidance regarding how deductibles must be calculated and expenses credited in order to remain a qualified HDHP for HSA purposes. When changing mid-year from a family HDHP to a self-only HDHP, amounts applicable towards the deductible for the HDHP should be credited towards meeting the lower self-only HDHP limit. How the paid deductible should be credited is left up to the HDHP and the plan sponsor, with the guidance that the method should be (a) reasonable, (b) compliant with COBRA requirements under Q/A -2 of Treas. Regs. § 54.4980B-5 [“what deductibles apply if COBRA continuation coverage is elected?”], and (c) applicable to all similarly situated plan participants. Examples of reasonable methods include crediting amounts incurred by the individual participant under the family HDHP him or herself, crediting a pro rata portion of the family deductible, or other similar methods. (Q/A – 12).

Questions 13 and 14 treat benefits in addition to major medical benefits found in most HDHPs. In Q/A 13, the Service notes that where significant other benefits (such as major medical benefits) remain available, an HDHP can subject certain specified benefits to a separate or higher deductible and remain an HDHP. In addition, payments towards that other benefit (for example, substance abuse benefits), will not be considered as applicable towards meeting the HDHP deductible. (Q/A – 13). However, the Plan cannot restrict payments only to “excludible benefits” which could be offered under a separate policy without affecting the participant's eligibility to participate in an HSA (for

example, hospitalization, cancer-only or in-patient care) or to certain other very limited benefit classes and still remain an HDHP. (Q/A -14).

Finally, the Service confirms the general understanding that only qualifying medical expenses under Code Section 213(d) which are covered by the HDHP can be counted as applying towards an HDHP deductible for purposes of determining when a post-deductible HRA or post-deductible FSA can begin payments. (Q/A – 15).

## **Distributions**

Questions 27 through 33 provide guidance with regard to HSA distributions. At Q/A – 27, the Service confirms that an HSA cannot be limited by design only to payment and reimbursement of health care, but rather the funds must be available for any other purpose. Nevertheless, the HSA can use a debit card limited to health care payments as the primary means of distribution as long as account beneficiaries are offered alternative means by which to access the HSA funds. (Q/A – 27). Notice 2008-59 also confirms that Medicare Part D premiums for HSA owners, spouses and dependents are qualified medical expenses if the HSA owner is age 65 or older (Q/A – 29), as are dependent COBRA costs (Q/A – 31), health insurance premiums for dependents receiving unemployment benefits (Q/A – 32) and medical expenses for a child of the HSA owner under age 18 who is claimed as a dependent by a former spouse (Q/A – 33). However, the Service confirmed that Medicare premiums of any kind are not considered qualified medical expenses (and are thus subject to 10% excise tax penalties) if the HSA owner has not reached age 65, even if the HSA owner’s spouse is over age 65. (Q/A – 30). Finally, the IRS also recognizes that a third party (not the HSA owner and not the custodian / trustee) can exercise valid control over HSA funds, but reminds that the HSA owner remains liable for any excise tax for use of funds for other than qualified medical expenses prior to the HSA owner turning age 65. (Q/A – 28). Presumably, such third party will also be a disqualified person with regard to the HSA and could be subject to penalties for any prohibited transaction (such as dealing with the assets in his or her own interest).

## **Prohibited Transactions**

Questions 34 through 37 discuss prohibited transaction issues as they may impact HSAs. These Questions and Answers confirmed that establishment of a line of credit (Q/A-34, 35) or a loan (Q/A-36) secured by an HSA or with regard to which an HSA has been pledged as security is a prohibited transaction which can subject either or both the HSA owner or the HSA trustee / custodian to various penalties under the Code. The penalty with regard to HSA owners (account beneficiaries) is generally disqualification of the HSA and treatment of all amounts remaining in the account or removed from the

account after January 1 of the year as taxable distributions. (Q/A – 37). In addition, the 10% additional tax under Code § 223(f)(4) will apply to such distributions as had not been distributed during the year for qualified medical expenses. Custodians and trustees will similarly be subject to statutory penalties under the Code. (Q/A – 37).

However, the IRS does also announce a “innocent owner rule” whereby if the HSA owner is not directly engaged in the prohibited transaction, the owner will not be liable for excise taxes (Q/A – 37). Presumably this “innocent owner rule” would result in the HSA retaining its treatment as an HSA, and would apply even the HSA owner benefited from the prohibited transaction.

### **Establishing an HSA (Date of Establishment)**

Questions 38 through 41 relate to the date of establishment of an HSA. Since an HSA is a form of trust account, Answer 38 recognizes that state law and not federal tax law determines the formal date of establishment.<sup>2</sup> While not stated in Notice 2008-59, it should be noted that the applicable law should be the law of the state in which the trust is situated, not the state in which the HSA owner lives. In many states, an HSA will not be officially established until actually funded – until it actually holds some amount of assets. Further, Notice 2008-59 recognizes that HSA trustees and custodians cannot treat an HSA as established before that date determined under applicable state law. (Q/A – 39).

HSAs funded by or through a rollover or transfer of actual assets (presumably not work for FSA rollover) from another HSA or an Archer MSA will retain the original account’s date of establishment, even if not same trustee. (Q/A – 40). Similarly, a newly opened HSA established by an eligible individual who had established and maintained a prior HSA will revert to the establishment date of the prior HSA if that prior HSA had an account balance of any amount within the 18 months immediately prior to the new HSA. (Q/A – 41). The Service further confirms that multiple HSAs can be established and each relate back to the original establishment date.

### **Administering an HSA**

The last Question in Notice 2008-59 confirms that HSA administration and maintenance fees withdrawn by the trustee from an HSA are not considered distributions, but are reported on IRS Form 5498-A. (Q/A – 42).

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<sup>2</sup> The date that an HSA is established is of importance because only qualified medical expenses incurred on or after that date may be reimbursed tax-free.

### **Further Information**

Published text of IRS Notice 2008-59 can be found at:

<http://www.treas.gov/press/releases/reports/notice200859.pdf>

### **CONTACT US**

David A. Benoit  
dbenoit@benoitdiaz.com  
(770) 454-7575

Maria del Pilar Diaz  
pdiaz@benoitdiaz.com  
(770) 454-7471

[www.benoitdiaz.com](http://www.benoitdiaz.com)

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