Order Code RL33257

CRS Report for Congress
Received through the CRS Web

Health Savings Accounts: Overview of Rules for 2006

January 31, 2006

Bob Lyke
Specialist in Social Legislation
Domestic Social Policy Division

Health Savings Accounts: Overview of Rules for 2006

Summary

Health Savings Accounts (HSAs) are a recently available 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 2006, the deductible for self-only coverage must be at least $1,050 (with an annual out-of-pocket limit not exceeding $5,250); the deductible for family coverage must be at least $2,100 (with an annual out-of-pocket limit not exceeding $10,500).

The annual HSA contribution limit in 2006 for individuals with self-only coverage is $2,700 or 100% of the insurance deductible, whichever is lower. For family coverage, the annual contribution limit is $5,450, 100% of the overall deductible, or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members, whichever of the three is lowest. Individuals who are at least 55 years of age but not yet eligible for Medicare may contribute an additional $700.

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 relatively new, the extent to which they will further these objectives is not yet known. Among other things, it remains to be seen how many people will eventually establish accounts, how much they will contribute to them, and how much they will carry over to subsequent years.

This report is limited to 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.

For current information about legislative proposals to change HSA rules, see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance and Expenses*, by Bob Lyke. For a comprehensive analysis of HSAs and the issues they raise as of March, 2005, see CRS Report RL32467, *Health Savings Accounts,* by Bob Lyke, Chris Peterson, and Neela Ranade.

Contents

HSA Rules 2
- What is an HSA? 2
- Who May Have an HSA? 3
- What Is a Qualifying Health Plan? 3
  - Minimum Deductible 4
  - Out-of-Pocket Limit 5
- What Is Disqualifying Coverage? 5
- Who May Contribute to an HSA? 5
- When and How May Contributions be Made to an HSA? 6
- How Much May Be Contributed to an HSA? 6
  - Regular Contributions 6
  - Catch-Up Contributions 7
  - Rollovers 7
  - Interaction with Medical Savings Accounts 7
  - Excess Contributions 7
  - Comparability Requirement 8
- What Is the Tax Treatment of HSA Contributions? 8
- What Is the Tax Treatment of HSA Withdrawals? 9
- What Happens to HSAs at Death? 10
- What Administrative Provisions Apply to HSAs? 10
- Are HSAs Covered by ERISA? 10
- What State Requirements Apply to HSAs ? 11

Conclusion 11

Health Savings Accounts: Overview of Rules for 2006

Health Savings Accounts (HSAs) are a recently available 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 2006 of at least $1,050 for self-only coverage and $2,100 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.[1]

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 relatively new, the extent to which they will further these objectives is not yet known. Among other things, it remains to be seen how many people will eventually establish accounts, how much they will contribute to them, and how much they will carry over to subsequent years. Their effect on health care use is largely speculative, as is their effect on insurance and health care costs.

---

[1] 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 Bob Lyke and Chris L. Peterson. Also see Internal Revenue Service publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans.*

However, many individuals and employers are interested in HSAs, and additional information about them is likely to emerge 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. For current information about legislative proposals to change HSA rules, see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance and Expenses*, by Bob Lyke.

CRS Report RL32467, *Health Savings Accounts,* by Bob Lyke, Chris Peterson, and Neela Ranade, provides a comprehensive analysis of HSAs and the issues they raise as of March, 2005. That report will not be updated; instead, it will be replaced by shorter reports on various HSA trends and issues.

HSA Rules

Rules governing HSAs are laid out primarily in Section 223 of the Internal Revenue Code and guidance issued by the Internal Revenue Service (IRS). 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 was amended once by the Gulf Opportunity Zone Act of 2005 (P.L. 109-135, Section 404(c)) to make minor changes in the definition of a dependent. IRS guidance about HSAs was issued in a number of notices, revenue procedures, and revenue rulings throughout 2004 and 2005.

HSAs 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.

---

[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.

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 form of disqualifying coverage) within the past three months.

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 even though she has her own HSA.

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.

---

[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 *entitled* to Medicare, provided they do not enroll in either Part A or Part B.

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 2006 must be at least $1,050; for family coverage, it must be at least $2,100. 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.

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 preform 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 copay requirements. However, in order to allow health plans time to adjust to this requirement, the IRS delayed its effective date until January 1, 2006.[6]

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.

---

[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.

[6] Similarly, the IRS ruled that until January 1, 2006, a plan could qualify as a HDHP even if state law required that certain benefits be provided without a deductible or below the minimum annual deductible. Extensions beyond that date are limited to certain non-calendar year health plans.

Out-of-Pocket Limit. For self-only coverage, the annual limit on out-of-pocket expenditures for covered benefits must not exceed $5,250 in 2006. For family policies, the limit must not exceed $10,500. 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 what the legislation calls "other 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.

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.

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 could also be made by state governments.

Contributions by one individual or entity do not preclude contributions by others, provided they do not exceed annual contribution limits.

Contributors cannot restrict how HSA funds are to be used. For example, employers may not limit HSAs just to medical expenses, even for funds they contribute. (Account owners always can make withdrawals for other purposes, though nonqualified withdrawals are subject to taxation, as discussed below.) In contrast, employers can restrict the types of medical expenses for which flexible spending account may be used.

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, 2006, through April 15, 2007), provided they do not exceed the allowable annual limit described below.

As with IRAs, contributions to HSAs must be made in cash; contributions of property are not allowed.

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

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. For example, an individual who was eligible for seven months could contribute seven-twelfths of the annual limit for that year. 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 2006 for self-only coverage is $2,700 or 100% of the insurance deductible, whichever is lower. The

---

[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.

annual limit for family coverage is $5,450, 100% of the overall deductible, or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members, whichever of the three is lowest.[8] The $2,700 and $5,450 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. If both spouses have family coverage, the joint contribution limit will be the least of $5,450, the lower of the two overall deductible limits, or the lower of the two embedded deductibles multiplied by the number of covered family members.

Catch-Up Contributions. These contributions may be made by individuals who are at least 55 years of age but not yet eligible for Medicare. In 2006, they may contribute an additional $700. The annual catch-up amount will increase by $100 each year through 2009, when it will be $1,000. These amounts are not indexed for inflation.

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.

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. Rollovers are not taken into account for purposes of the annual limits on HSA contributions. Rollovers are not permitted from Health Reimbursement Accounts or health care Flexible Spending Accounts.

Excess Contributions. Contributions exceeding annual limits might occur for a number of reasons, including failure of employees to take account of employer

---

[8] Family coverage may have both an overall deductible (applying to expenses for all covered members) and an embedded deductible (applying to expenses for just one covered member); the health plan would begin to pay benefits once either amount is exceeded. To be a qualified HDHP, the embedded deductible cannot be less than the minimum annual deductible ($2,100 in 2006).

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.[9] 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.[10]

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 family coverage.

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.

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.[11] (Social Security taxes are 6.2% of wages up to $94,200 in 2006; Medicare taxes are 1.45% of total wages.) In addition, employer HSA contributions are exempt from

---

[9] The comparability requirement is in Section 4980G of the Internal Revenue Code, which references rules for MSAs in Section 4980E.

[10] 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.

[11] 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.

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.

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,[12] except for health insurance. 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,[13] (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; they also are subject to a 10% penalty tax. 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.

---

[12] 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.

[13] 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.

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.[14] If there is 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.[15] 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

---

[14] This rule applies even if the non-spouse designated beneficiary is someone whose medical expenses could have been paid from the account (such as a dependent child).

[15] However, trustees and custodians may not accept contributions that exceed the annually-adjusted dollar amounts (e.g., $2,700 and $5,450) and allowable catch-up contributions.

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 make contributions to the accounts, provided employer involvement is otherwise limited.[16] 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 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.[17]

What State Requirements Apply to HSAs ?

States do not have to approve HSAs for them to become available within their jurisdictions. However, individuals cannot establish or make contributions to HSAs unless they have a qualifying HDHP. States might not allow the sale of insurance that meets the conditions for these plans if they require all insurance to include certain benefits with no or low deductibles and if those benefits do not fall within the IRS definition of preventive benefits. The IRS granted a waiver until January 1, 2006, that temporarily allowed insurance in these states to be considered HDHPs, giving the states time to change their laws.

This regulatory barrier does not apply to employers that self-insure since ERISA generally exempts their plans from state insurance mandates.[18] It does apply to employers that purchase insurance from insurance companies as well as to insurance that is sold in the individual market and small group market.

Conclusion

By the beginning of 2006, most of the rules needed to implement HSAs have been issued. However, gray areas remain, and further guidance may be forthcoming. In addition, as HSAs become more common and new health plan arrangements emerge, additional questions are likely to arise. Congress may also want to consider whether further changes to the 2003 legislation are warranted.

---

[16] Department of Labor, *Field Assistance Bulletin* 2004-1, Apr. 7, 2004.

[17] Department of Labor Advisory Opinion 2004-09A, Dec. 22, 2004.

[18] For additional information, see CRS Report RS20315, *ERISA Regulation of Health Plans: A Fact Sheet*, by Hinda Ripps Chaikind.