Health Savings Account (HSA) Eligibility Rules

Many employers offer high-deductible health plans (HDHPs) to control premium costs, and then pair this coverage with health savings accounts (HSAs) to help employees with their health care expenses. An HSA is a tax-favored trust or account that can be contributed to by, or on behalf of, an eligible individual to pay qualified medical expenses.

HSAs provide a triple tax advantage—contributions, investment earnings and amounts distributed for qualified medical expenses are all exempt from federal income tax, FICA tax and most state income taxes. Due to an HSA's potential tax savings, federal tax law imposes **strict eligibility requirements for HSA contributions**.

Only an eligible individual can establish an HSA and make HSA contributions (or have them made on his or her behalf). An individual's HSA eligibility is determined monthly and, as a general rule, contributions can only be made for the months in which the individual satisfies all of the HSA eligibility criteria.

General Rule

An individual's eligibility for HSA contributions is generally **determined monthly as of the first day of the month**. The HSA contribution limit is calculated each month, and a contribution can only be made for months in which the individual meets all of the HSA eligibility requirements.

To be HSA-eligible for a month, an individual must:

- Be covered by an HDHP on the first day of the month;
- Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

The full-contribution rule that applies to individuals who are HSA-eligible on Dec. 1 is an exception to this general rule. Under this exception, an individual is treated as HSA-eligible for the entire calendar year for purposes of HSA contributions if he or she becomes covered under an HDHP in a month other than January and is HSA-eligible on Dec. 1 of that year. An individual who relies on this special rule must generally remain HSA-eligible during a 13-month testing period, with exceptions for death and disability.

Employee Status Not Necessary

An individual does not need to be an employee to be eligible for HSA contributions. Partners in a partnership, more-than-2% shareholders in a subchapter S corporation, sole proprietors and other self-employed individuals may be eligible for HSA contributions. However, since these individuals are not employees, they cannot contribute to an HSA with pre-tax salary reductions under a cafeteria plan, and they cannot receive pre-tax employer contributions to their HSAs. IRS Notice 2005-8 provides more information about the tax treatment of HSA contributions for partners and more-than-2% shareholders.

Employer Eligibility Verification

When an employer makes a pre-tax contribution to an employee's HSA, the employer should have a reasonable belief that the contribution will be excluded from the employee's income. However, the employee—not the employer—is responsible for determining eligibility for HSA contributions. IRS Notice 2004-50 states that an employer is only responsible for determining whether the employee is covered under an HDHP or any low-deductible health plan sponsored by the employer, including health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs).

HDHP Coverage

To be eligible for HSA contributions for a month, an individual must be covered under an HDHP as of the first day of the month and have no other impermissible coverage.

Example—HDHP coverage begins mid-month: *An employee begins HDHP coverage on the first day of a pay period, which is Aug. 16, 2023, and continues to be covered by the HDHP for the rest of 2023. For purposes of HSA contributions, the employee becomes eligible on Sept. 1, 2023.*

An HDHP is a health plan that provides "significant benefits" and satisfies requirements for minimum deductibles and out-of-pocket maximums. An HDHP can be insured or self-funded. No benefits can be paid by an HDHP until the annual deductible has been satisfied, with limited exceptions for certain types of benefits (for example, preventative care benefits).

Cost-Sharing Limits

For **plan years beginning on or after Jan. 1, 2023**, the annual deductible and out-of-pocket requirements for HDHPs are as follows:

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)		
Type of Coverage	**Minimum Annual Deductible**	**Annual Out-of-pocket Maximum**
Self-only	**$1,500** ($1,600 for plan years beginning in 2024)	**$7,500** ($8,050 for plan years beginning in 2024)
Family	**$3,000** ($3,200 for plan years beginning in 2024)	**$15,000** ($16,100 for plan years beginning in 2024)

Significant Benefits

An HDHP must provide "significant benefits," although it may be designed with reasonable restrictions limiting the plan's covered benefits. The restrictions will be reasonable only if significant other benefits remain under the plan in addition to the benefits subject to the restrictions. For example, a plan that restricts benefits to expenses for hospitalization or in-patient care, and excludes out-patient services, is not an HDHP because it does not provide significant other benefits in addition to the benefits subject to the exclusion. Also, a plan will not qualify as an HDHP if substantially all of its coverage is either "permitted insurance" or "permitted coverage" (for example, coverage for accidents, disability, dental care or vision care).

No Disqualifying Coverage

To be eligible for HSA contributions, an individual generally cannot have health coverage other than HDHP coverage. This means that an HSA-eligible individual cannot be covered under a health plan that provides coverage below the HDHP minimum annual deductible.

Being eligible for non-HDHP coverage does not make an individual ineligible for HSA contributions. To determine whether an individual is an HSA-eligible individual, the actual health coverage selected by the individual is controlling. Thus, it does not matter that the individual could have chosen, but did not choose, a low-deductible health plan or other coverage that would have disqualified the individual from contributing to an HSA.

Permissible Types of Coverage

Certain types of non-HDHP coverage will not prevent an individual from being HSA-eligible. These types of coverage include preventive care, permitted insurance or permitted coverage. An individual who has non-HDHP coverage with a deductible below the minimum HDHP deductible that is not preventive care, permitted coverage or permitted insurance will not be an eligible individual for HSA purposes.

Preventive care includes (but is not limited to):	•Periodic health examinations, 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; •Obesity weight loss programs; •Screening services; and •Tobacco cessation.
Permitted insurance includes:	•Insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (for example, homeowners or auto insurance) or similar liabilities as specified by the IRS; •Insurance for a specified disease or illness (for example, cancer insurance); or •Insurance that pays a fixed amount per day (or other period) of hospitalization (for example, hospital indemnity insurance).
Permitted coverage includes coverage for:	•Accidents; •Disability; •Dental care; •Vision care; or •Long-term care

Health FSA and HRA Coverage

Individuals who are covered by general-purpose health FSAs or HRAs are not eligible for HSA contributions. A general-purpose health FSA or HRA is one that pays or reimburses all qualifying medical expenses of the employee. It does not matter whether an individual is covered by a general-purpose health FSA or HRA **as an employee or as a dependent whose medical expenses can be reimbursed**—both types of individuals are ineligible for HSA contributions.

Example—spouse covered by HRA: *An employee, Dan, has family HDHP coverage through his spouse's employer. Dan's spouse is also covered by her employer's HRA, which reimburses out-of-pocket medical expenses of employees and their eligible family members, including Dan's medical expenses. Because of this general purpose HRA coverage, both Dan and his spouse are ineligible for HSA contributions.*

In addition, an individual's HSA eligibility may be affected when a health FSA incorporates a grace period or a carry-over feature.

- *Grace Period:* Coverage by a general-purpose health FSA with a grace period will disqualify an employee from contributing to an HSA during the FSA's grace period, unless the employee had a zero balance in the FSA at the end of the plan year.
- *Carry-over Feature:*An individual who has coverage under a general-purpose FSA solely as a result of a carryover of unused amounts from the prior year is not eligible for HSA contributions for the current year. The IRS has provided two alternative approaches that allow health FSA carryovers while preserving HSA eligibility. These approaches include:
  - Carrying over unused amounts to an HSA-compatible health FSA (that is, a limited-purpose FSA or a post-deductible FSA); and
  - Allowing individuals participating in a general-purpose FSA to decline or waive the carryover.

HSA-compatible Health FSAs and HRAs

Although general-purpose health FSA or HRA coverage will prevent an individual from being eligible for HSA contributions, certain health FSA or HRA designs preserve HSA eligibility. These include:

- **Limited-purpose health FSA or HRA**—This type of health FSA or HRA pays or reimburses qualifying medical expenses that are permitted coverage, permitted insurance or preventive care (for example, dental or vision coverage).
- **Post-deductible health FSA or HRA**—This type of health FSA or HRA pays or reimburses medical expenses incurred after the individual has met the minimum annual deductible within the HDHP.
- **Suspended HRA**—A suspended HRA, pursuant to an election made before the beginning of the HRA coverage period, does not pay or reimburse at any time, any medical expenses incurred during the suspension period, except preventive care, permitted insurance or permitted coverage.
- **Retirement HRA**—A retirement HRA pays or reimburses medical expenses incurred after the individual retires.

TRICARE, VA and IHS Benefits

TRICARE	An individual who receives health benefits under TRICARE (the federal health care program for active duty and retired members of the uniformed services, their families and survivors) is NOT **eligible to make HSA contributions**. IRS Notice 2004-50 explains that the coverage options under TRICARE are disqualifying coverage because they do not meet the minimum deductible requirements for an HDHP.
VA benefits	An individual who is eligible to receive benefits through the Department of Veteran Affairs (VA), but who **has not actually received VA benefits during the previous three months**, is eligible for HSA contributions. However, an individual is not eligible to make HSA contributions for a month if he or she has received medical benefits from the VA at any time during the previous three months, other than benefits for preventive care or permitted coverage. As a special rule, an individual will not lose his or her HSA eligibility for any month solely because he or she receives hospital care or medical services from the VA for a **service-connected disability**. To simplify the administration of this special rule, any hospital care or medical services received from the VA by a veteran with a **disability rating from the VA** is considered hospital care or medical services for service-connected disability.
Indian Health Services (HIS) benefits	An individual who is eligible to receive medical services from an Indian Health Services (IHS) facility but **has not received these services during the previous three months** will be considered HSA-eligible. However, an individual who has received medical services from an IHS facility during the previous three months generally will be ineligible to make HSA contributions unless the medical services qualified as permitted coverage or preventive care.

Medicare Entitlement

An individual who is entitled to Medicare benefits is not eligible for HSA contributions. To be entitled to Medicare benefits, an individual generally must be both eligible and enrolled. Eligibility for Medicare benefits alone does not make an individual ineligible for HSA contributions.

IRS Notices 2004-50 and 2008-59 confirm that a Medicare-eligible individual who is not actually enrolled in Medicare Part A, Part B, Part D or any other Medicare benefit may contribute to an HSA until the month that he or she is enrolled in Medicare.

***Retroactive Effective Date**—In general, an individual's Medicare coverage starts six months back from the date the individual applied for Medicare, but no earlier than the first month of Medicare eligibility (that is, turning age 65). Individuals cannot contribute to an HSA for the period of retroactive coverage. Thus, to avoid making excess HSA contributions, **individuals may need to stop contributing to their HSAs before applying for Medicare**.*

Tax Dependent

An individual who can be claimed as a tax dependent of another individual is not eligible for HSA contributions. In general, a taxpayer may claim an individual as his or her tax dependent if the individual is:

- The taxpayer's child and under age 19 at the end of the tax year;
- The taxpayer's child, a student and under age 24 at the end of the tax year; or
- A member of the taxpayer's household for whom the taxpayer provided over half of the support for the year and whose gross income does not exceed the personal exemption amount.