February 24, 2004

CC:DOM:CORP:R (Notice 2004-2)
Room 5226
Internal Revenue Service
POB 7604
Ben Franklin Station
Washington, D.C. 20044

Re: Comments on Notice 2004-2 and Upcoming Treasury Guidance on Health Savings Accounts

Dear Sirs:

I am writing on behalf of the American Benefits Council ("the Council") regarding Notice 2004-2, I.R.B. 2004-2, and the upcoming guidance on Health Savings Accounts (HSAs) that the Treasury Department/ Internal Revenue Service is planning to issue in March and this coming summer. The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

The Council commends Treasury's prompt publication of Notice 2004-2 and efforts to issue further prompt guidance on HSAs. The goal of the guidance should be to encourage the use of HSAs and ensure that HSAs are a viable and cost effective means of providing health care coverage. Many of the Council's members have expressed an interest in offering an HSA option as part of their array of other benefits. However, flexibility in the rules and prompt clarification of outstanding issues will be key factors in determining whether they will offer an HSA as a benefit in 2005 and beyond. Many large employers need 6 months or more lead time to implement a new benefit option. Accordingly, we were encouraged to learn that Treasury anticipates issuing guidance on certain issues as early as next month.

We have prioritized our comments into two sections. In the first section, we offer comments that reflect top priority concerns requiring immediate resolution through guidance. These are:

- Coordination of HSAs with Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs);

- Discretion to allow employers to define preventive care, to offer certain benefits such as prescription drug coverage without a deductible, and to offer an HDHP as an option under an existing medical plan; and

- Clarification regarding application of nondiscrimination rules.

In the second section, we provide additional comments on other issues of importance that our members would like Treasury to address as soon as reasonably possible. Finally, we may offer comments on additional issues as they arise.

Of course, in issuing guidance, Treasury is subject to the constraints of the statute. However, the statutory language in many areas is ambiguous or silent. As such, Treasury has discretion to broadly and favorably interpret particular provisions. Favorable interpretation that provides flexibility for employers to adopt plan designs that accommodate the needs of their organizations is essential in order for HSAs to be a viable option for providing health care coverage. This is particularly critical with respect to the priority issues described in Section I below.

Section I

A. Coordination of HSAs with FSAs and HRAs

Issue

Many employers have expressed the desire to offer HSAs in addition to their current array of benefits rather than as a partial or whole replacement of health benefits or other medical reimbursement arrangements. Many of these employers maintain health FSAs and/or HRAs in which a significant number of employees currently participate. Allowing an individual to participate in an FSA and/or HRA and enroll in an HSA, if structured appropriately, could

significantly increase participation in HSAs and sponsorship by employers. If HSA participation rates are low, providing an HSA option will not make economic sense for employers and employers are likely to continue to offer more traditional forms of health plans, or HRAs, rather than adopting the HSA model.

Recommendation

Allow for FSA and/or HRA participation by stating in the upcoming guidance that an individual may participate in an HSA and/or FSA on an unlimited basis to the extent that the FSA and/or HRA provides dental or vision medical expenses reimbursements, or to the extent the HRA provides reimbursement for qualified long-term care premiums. In addition, allow for FSA and/or HRA participation to the extent that the FSA and/or HRA does not reimburse amounts covered under the HDHP. Finally, clarify that an individual may participate in both an HSA and an HRA in certain other circumstances, such as where the benefits under the HRA are not yet available to the participant (e.g., the HRA benefits are available upon retirement but the participant has not yet retired). There may be other, similar circumstances under which an HRA and an HSA can be used together without violating the underlying principles of the rules. We would recommend that the Treasury guidance provide enough flexibility to allow for the development of these plan designs.

Analysis

1. FSAs

Code section 223(c)(1) defines "eligible individual" as any individual who is covered under a high deductible health plan as of the first day of the month if such individual is not, while covered under a high deductible health plan, covered under any health plan which is (i) not a high deductible health plan *and* (ii) "*which provides coverage for any benefit which is covered under the high deductible health plan"* (emphasis added). The HSA statute allows an HSA participant to be covered by in addition to the HDHP, specifically enumerated types of coverage, including vision, dental and long-term care. Code section 223(c)(1)(B)(i).

Given these statutory provisions, FSAs should be available with HSAs in the following circumstances. First, an FSA should be able to be used without

restriction by an HSA participant to the extent that coverage under the FSA is provided for dental or vision benefits.[1] Second, the HSA should be available as long as the FSA does not reimburse expenses for benefits covered under the HDHP. This is consistent with the HSA statute as well as FSA rules, which provide, in relevant part, "[A] health FSA may reimburse a medical expense only if...the medical expense...has not been reimbursed or is not reimbursable under any other health plan coverage." Prop. Treas. Reg. § 1.125-2, Q&A-7(b)(5). Accordingly, for example, the FSA should be able to be used for any of the following:

- Medical expenses that the HDHP may not cover at all (e.g., over-the-counter drugs or chiropractic care),
- Medical expenses that are covered subject to a treatment limit (e.g., physical or occupational therapy services),
- Medical expenses incurred prior to satisfaction of the deductible after any HSA balance has been exhausted, and
- Copay and coinsurance amounts.

In the event that there is a balance in the HSA, a rule similar to the "ordering rule" that the IRS adopted in Notice 2002-45 with respect to HRAs could be used- i.e., the plan sponsor could specify in the plan document which account would have to be used first or, if not specified, would be subject to a default ordering rule provided in the guidance.

We note that Notice 2004-2 broadly provides that a participant in an HSA is not an eligible participant if that individual is covered by a non-high deductible health plan, unless a specific statutory exception applies. (See Q&A-2 and Q&A-5). As such, Treasury has ignored the definition in Code section 223(c)(1)(A), which provides that HSA eligible individuals are only precluded from maintaining non-high deductible health coverage if that coverage includes any benefit which is covered under the high deductible health plan. This interpretation is both inconsistent with the statute and unnecessarily restrictive. If Treasury adopted a narrow interpretive view because of a concern that the majority of benefit coverage might otherwise be shifted from the HDHP to a non-high deductible health plan, we urge Treasury to recognize that this concern should not extend to FSAs.

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[1] An FSA may not be used to reimburse long-term care services (Code sec. 106(c)) or long-term care premiums (Prop. Treas. Reg. § 1.125-2, Q&A-7(b)(4).

FSAs are designed to supplement other health coverage. With respect to an FSA, employers are required to specify the maximum amount of salary reduction contributions available under the plan in the written plan document. Prop. Treas. Reg. § 1.125-2, Q&A-3; Prop. Treas. Reg. § 1.125-3, Q&A-3. Once the employer chooses a limit, that employer is potentially at risk for advancing that amount of money to a participant prior to the time that the participant actually makes corresponding salary reductions. See Prop. Treas. Reg. § 1.125-2, Q&A-7(b)(2)) (requires the employer to make the entire election available to the employee at the beginning of the year). Because this rule provides an incentive for an employer to choose a reasonable limit, it is unlikely that the FSA limit would ever rise high enough so that an individual is able to rely primarily on the FSA for health coverage rather than on the HDHP.

2. HRAs

The above analysis with respect to FSAs/HSAs applies to HRAs/HSAs as well. Accordingly, it should be possible, for the reasons described above, for an HSA participant to use an HRA to pay dental, vision and long-term care premium expenses without restriction, and to use HRA amounts to pay for medical expenses below the HDHP deductible as well as for copayments and coinsurance. As with an FSA, it is unlikely that the HRA limit would ever rise high enough so that an individual is able to rely primarily on the HRA for health coverage rather than on the HDHP. An HRA account must also be 100% employer contributions, with no amount attributable to employee contribution. This restriction provides the employer with a strong incentive to cap the amount available, and to offer the HRA merely to supplement other health insurance. Thus, Treasury should not be concerned that the HRA would ever take the place of coverage under the HDHP.

Unlike an FSA, an HRA allows participants to carry unused amounts forward into future years. Accordingly, there are additional circumstances under which an HRA should be able to be used with an HSA. One clear example involves an HRA that is dedicated to use for retirement. In that circumstance, allowing an HSA participant who is an active employee to also "participate" in a retiree HRA prior to the date of that individual's retirement should not conflict with the principle that underlies these rules- i.e., that coverage for an HSA eligible individual should primarily be through an HDHP. Under this arrangement, the individual would not be permitted to obtain benefits from an

HRA and to make contributions to an HSA at the same time. Accordingly, this type of arrangement should be viewed as consistent with the rules.[2]

A second example is where an employee contributes to an HSA and the employer contributes to an HRA for amounts subject to the deductible. The plan could include the rule that the employee would have to exhaust one account before using the funds of the other. Nothing in the statute appears to preclude additional sources of funding for the deductible. In addition, in this example the HRA would not be providing duplicative coverage because the amounts in the HRA would be used for services subject to the deductible.

There may be other, similar circumstances under which an HRA and an HSA can be used together without violating the underlying principle of the rules. It is our hope that the Treasury guidance will provide enough flexibility to allow the development of these plan designs.

B. Discretion to Allow Employers to Define Preventive Care, to Offer Certain Benefits Such as Prescription Drug Coverage without a Deductible, and to Offer an HDHP as an Option Under an Existing Medical Plan

Issue

Employers have a strong interest in offering and endorsing coverage options that promote the good health of their employees and reduce periods of sick leave and disability. For example, employers offer cost-effective prescription drug coverage to increase the likelihood that employees will seek and obtain

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[2] Such position would be consistent with the manner in which the statute operates with respect to Medicare-eligible individuals. The statute makes clear that an individual who will eventually be entitled to Medicare benefits is not precluded from contributing to an HSA prior to the time of eligibility for Medicare benefits, when that person has the ability to actually receive Medicare benefits. See Code section 223(b)(7) (contribution limit for HSA is reduced to zero for the first month an individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter). Similarly, the fact that benefits may someday be available under an HRA should not preclude participation under an HSA prior to the time that those HRA benefits do become available.

necessary medicine and drugs, and offer disease management programs, Employee Assistance Programs (EAPs) to provide employees with the ability to obtain services such as counseling for mental health or substance abuse, and other similar programs. Also, employers have a strong interest in encouraging employees to seek and obtain preventive care. HSAs could be an even more attractive option for employers if they can retain the ability to continue to offer benefits that promote good health, such as prescription drug coverage or EAPs, without requiring employees to satisfy a deductible. Similarly, it would be valuable for employers to have the discretion to determine which benefits constitute preventive care.

Recommendation

Grant discretion to plan sponsors to develop their own reasonable definition of preventive care. Also, state in the upcoming guidance that employers may offer certain types of benefits such as prescription drug coverage or EAPs with an HDHP, either as part of the same plan or as a separate plan without requiring the employee to satisfy a deductible, as long as the majority of benefits available under the HDHP are subject to the deductible.

Analysis

1. Preventive Care

Code section 223(c)(2)(C) provides that a plan shall not fail to be treated as an HDHP by reason of failing to have a deductible for preventive care. The term "preventive care" is not defined by the statute. Instead, the statute grants Treasury discretion to interpret this term. See Code section 223(c)(2)(C). We believe that Treasury guidance should provide that plan sponsors have the discretion to develop their own definition of preventive care, taking into account the demographics and needs of their particular workforce.

Preventive care needs may vary based upon industry, geographic location, or age of the workforce, or based upon the other benefits that the employer has made available. Allowing plan sponsors to develop a definition that accommodates the needs of their employees is critical. If the Department of Health and Human Services and/or Treasury develops a definition of preventive care without allowing this discretion, such definition may be too narrow in certain circumstances or as medical science develops over time. Accordingly, we urge Treasury not to adopt a specific list of items that are considered preventive care, particularly as there currently is no single

comprehensive list that is universally relied upon. We also urge Treasury not to limit the definition in any way, such as by stating that preventive care does not include care that is provided after the onset of a diagnosis or condition. A list or narrow definition such as this would potentially eliminate many services that are beneficial to the health of employees and their dependents such as smoking cessation, weight loss, diabetes management, high blood pressure management, and prenatal care programs.

We urge Treasury to recognize that allowing employers the discretion to draft a broad definition is unlikely to lead to abuse, particularly as it would not be in the financial interest of a plan to adopt an overly broad definition of preventive care for services that are not truly preventive in nature because the costs of such services would be borne entirely by the plan instead of the participant. Notwithstanding that this is an area where Treasury regulation appears unnecessary, we do agree that a rule could be adopted indicating that an employer's definition of preventive care should be reasonable.

2. Ability to Offer Benefits Such As Prescription Drug Coverage without a High Deductible

As noted above in (A.), the HSA statute (Code section 223(c)(1)) defines an eligible individual generally as a person who is covered under an HDHP and no other non-high deductible health plan that provides coverage for any benefits covered under the HDHP. This statutory language should clearly allow an employer to offer prescription drug coverage and other benefits through a separate non-high deductible health plan that is subject to its own deductible and/or cost-sharing provisions, as long as the HDHP does not duplicate the coverage. In addition, although the definition of a high deductible health plan sets minimum deductibles and provides a "safe harbor" for preventive care, the statute does not expressly state that preventive care is the only benefit that may be provided outside the deductible. See Code section 223(c)(2). Accordingly, Treasury could take the position that a plan will be considered to be a high deductible health plan as long as the majority of benefits offered under the plan are subject to the deductible, rather than viewing preventive care as an exclusive exception.

This interpretation would satisfy the concerns of plan sponsors, and would make sense from a health policy perspective. For example, removing prescription drug coverage from the HDHP deductible requirements would mean that individuals would be more likely to take necessary prescription drugs throughout the year, minimizing the risk of serious health problems that

will ultimately be more expensive to treat. This is particularly true with respect to preventive medication such as heart and blood medication or anti-depressants.

Similarly, many employers offer EAPs that provide a broad range of benefits, sometimes including mental health counseling. Such benefits are typically offered on a limited basis and are not intended to be a substitute for the type of coverage provided through a medical plan. We urge Treasury to clarify that an employee can participate in an EAP that includes such benefits and an HSA with a HDHP. Treasury guidance should give employers the ability to remove certain supplemental benefits from the HDHP deductible requirements or separately managed benefits such as disease management programs or coverage for mental health care services, as long as the majority of benefits offered under the HDHP remain subject to the deductible.

3. Ability to Offer an HDHP as an Option under an Employer's Existing Medical Plan

Code section 223 does not separately define the term "health plan." An employer who wishes to make a HDHP available to employees is likely to do so as one health care "option" within the employer's existing "medical plan." For example, an employer who offers two Preferred Provider Organization (PPO) options under the employer's medical plan may add an HDHP option to the existing medical plan rather than setting up a separate plan to accommodate an HDHP. We do not believe that such an arrangement would conflict with the statute, but confirmation of this point would be helpful.

C. Clarification Regarding Application of the Nondiscrimination Rules

Issue

In making HSAs available to employees, employers may wish to initially introduce the benefit only to certain groups, and to encourage employee participation through incentives such as an employer match. Employers who have a lot of turnover in employment may wish to reward employees based on length of service. A plain reading of the nondiscrimination rules would allow this ability.

Recommendation

State in the upcoming guidance that the sole nondiscrimination rules that apply to HSAs are set forth in Code section 4980G, and no additional nondiscrimination rules apply to HSAs. Also, confirm that employers are not precluded from offering an employer match or basing contributions on an objective criterion such as attainment of age 55 or length of service.

Analysis

Code section 4980G of the Code provides that, in the case of an employer who makes a contribution to the HSA of any employee during a calendar year, there is imposed a tax on the failure to satisfy rules similar to those set out in Code section 4980E. Code section 4980E provides that an employer is required to make available "comparable contributions" for "all comparable participating employees" for each coverage period during the calendar year, and is subject to a 35% excise tax on the aggregate employer contributions if it fails to do so. "Comparable contributions" are contributions which are the same amount or the same percentage of the annual deductible limit under the high deductible health plan covering the employees. "Comparable participating employees" are all employees who are eligible individuals covered under any HDHP of the employer and who have the same category of coverage (i.e., self-only and family coverage). Part-time employees (defined as employees who customarily work fewer than 30 hours per week) may be treated as a separate class.

Significantly, Congress has given Treasury broad discretion to interpret the above rules. Code section 4980G(c) provides that the Secretary shall issue regulations to carry out the purposes of Code section 4980G, including regulations providing special rules for employers who make contributions to Archer MSAs and HSAs during the calendar year. Clearly, Treasury has the authority to provide that matching contributions satisfy the "comparable contributions" requirement as long as the same match is available to all comparable participating employees. A plain reading of the statute leads to the conclusion that if all employees have the ability to obtain the same employer match by making an HSA election, then comparable contributions are "available". In addition, because Code section 223(b)(3) allows additional catch-up employee contributions for age 55 employees, employers should also be able to make additional catch-up contributions (which may or may not be structured as a match) for these individuals without violating the nondiscrimination rules. As an example, Treasury guidance should clarify

that if an employer wanted to make contributions to fund HSAs to the maximum extent allowed by law, the employer should be able to contribute an additional $500 for employees who are age 55 in 2004 without violating the nondiscrimination rules.

In our view, the fact that Congress did not reference any other nondiscrimination rules (e.g., Code section 125(b)(1)and (2)) indicates that Congress intended Code section 4980G to constitute the exclusive nondiscrimination rule for HSAs. Thus, Treasury should not impose additional rules that would eliminate an employer's flexibility to introduce HSAs to certain employer groups. If Treasury were to apply the nondiscrimination rules under Code section 125, it would be necessary to satisfy a key employee test, an eligibility test, and a benefits test under Code section 125(b)(1) and (2). This would dramatically increase the complexity of HSA administration and reduce the attractiveness to employers. Furthermore, such rules would not apply to HSAs established by individuals. From a policy perspective, the rules should be uniform for all HSAs, regardless of how the HSA is established.

Finally, Treasury guidance should indicate that employers may base contributions on length of service. Employers, particularly those in high turnover industries, view benefit programs as an important method of encouraging employees to remain with the company, and need the ability to reward employees who do so. Because length of service is an objective criterion, employer contributions based on this factor would not result in abuse, as long as all employees who have performed the same length of service are entitled to the same contribution.

Section II

Guidance on the following issues, while important to employers, is not as time-sensitive as those issues discussed above for purposes of being included in the next stage of guidance. However, the Council would like Treasury to address these issues as soon as reasonably possible. It is our understanding that the next stage of guidance will be limited to addressing the issues described in Section I above. If Treasury is considering ruling on any of the issues described in this Section II, we would appreciate the opportunity to supplement the information that we have provided here prior to the date that Treasury issues such guidance.

A. Cafeteria Plan Rules

Treasury should take the position that the employer has discretion to determine whether and to what extent the cafeteria plan rules under Code section 125 and the regulations thereunder apply. To the extent that the employee makes an election under the employer's cafeteria plan, the employer should have the ability to impose or to waive the rules that apply to all other cafeteria plan elections, including the mid-year change rules under Treas. Reg. § 1.125-4, and the substantiation requirements under Prop. Treas. Reg. § 1.125-2, Q&A-7. Because an individual can have an HSA in the individual market without restriction, the employer should have discretion to adopt rules that are just as flexible when the HSA is funded through a cafeteria plan.

B. Dealing with Conflicting State Law

In certain states it will be impossible to obtain an HDHP insurance policy that satisfies the definitions in Code section 223 due to state insurance laws that mandate first dollar coverage for certain benefits. Unless "preventive care" under Code section 223(c)(2)(C) is defined broadly enough to include these state mandates, the only option available to these employers would be to offer a self-insured HDHP to avoid them. Because not all employers are able to self-insure, Treasury should consider creating an exception to the definition of HDHP to take state mandates into account.

C. Debit Card Reporting Clarification

Treasury should clarify that when a debit card is offered with an HSA, no Form 1099 reporting requirement applies. Payments from an HSA account are made directly to the provider (the employer is not involved). Accordingly, the provisions of Code section 6041, which require all persons engaged in a trade or business and making payment in the course of such trade or business to report amounts in excess of $600, should be inapplicable. This would be consistent with Code section 6014(f), which was added as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

D. No Application of 105(h)

Treasury should clarify that Code section 105(h) does not apply to the HSA itself (although it may apply to the HDHP if self-funded). Section 105(h) sets forth nondiscrimination rules that apply to self-insured medical expense reimbursement plans. Code section 105(h)(6) defines a "self-insured medical

reimbursement plan" for purposes of section 105(h) as "a plan of an employer to reimburse employees for expenses referred to in subsection (b) for which reimbursement is not provided under a policy of accident and health insurance." Because HSA distributions for qualified medical expenses are excludable under Code section 223(f), not Code section 105(b), Code section 105(h) should not apply to HSAs. This argument is supported by the fact that there is no reference to Code section 105 in Code section 223.

E. Restrictions on Rejoining HSA

Employers should have the discretion to impose restrictions to prevent employees from dropping coverage under the HDHP when the employee anticipates large medical expenses, and then rejoining the HDHP after those medical expenses are paid under another employer health coverage option. There is nothing in the statute that would appear to prohibit an employer from imposing such restrictions, but confirmation on this point would be helpful. Moreover, such flexibility would appear consistent with the intent of HSAs, which conditions eligibility upon HDHP coverage.

F. Ability to Purchase Insurance With HSA Funds Prior To Age 65

The statutory restriction under Code section 223(d)(2)(B) that prohibits individuals from purchasing insurance with HSA funds prior to attainment of age 65 does not accommodate individuals who take early retirement. These individuals will likely experience a gap in coverage. Treasury should consider whether there is a way to ameliorate the harsh affects of this rule, such as liberally construing the provision that allows payment of COBRA premiums (Code section 223(d)(2)(C)(i)) to include not only COBRA coverage, but also coverage that is similar to or offered in place of COBRA coverage to individuals who take early retirement.

G. Continued HSA Participation for an Age 65 Individual Who is Working and Has Employer Coverage

Code Section 223(b)(7) prohibits a person who is Medicare eligible from continuing to make contributions to an HSA. However, an individual who is age 65 and still working may be covered under an employer's plan. In this event, the employer plan is the primary source of coverage rather than Medicare. Accordingly, it does not appear that Medicare eligibility should preclude this individual from continuing to make contributions to his or her

HSA account. Treasury should consider issuing guidance to allow continued contributions to the HSA in this circumstance.

H. One Time Conversion from HRAs to HSAs

To promote the use of HSAs and mitigate the harsh consequences associated with forfeiture, Treasury should allow individuals to make a one-time conversion from their HRAs to HSAs. Given that the statute allows rollovers from HSAs and Archer MSAs, it would not appear to be inconsistent with congressional intent to allow a one-time rollover from an HRA, which is similar in purpose to an HSA and MSA.

I. Advancement of Funds

Treasury should clarify that employers have the ability to apply the uniform coverage rule under Prop. Treas. Reg. § 1.125-2, Q&A-7(b)(2) with respect to the HSA. This would give the employer the ability to provide an advance to employees for expenses in excess of the current HSA balance without adverse tax consequences, ensuring that the employee has a method of paying for medical expenses, even in the beginning of the year.

J. Administrative Fees

Treasury should clarify that it is permissible to debit the HSA account to pay administrative fees without creating adverse tax consequences for the HSA participant, and that it is permissible to assess administrative fees outside the HSA without these fees being considered an HSA contribution. There is precedent for these clarifications in the area of Individual Retirement Accounts. Further, the IRS has taken the informal position that an FSA account may be debited to pay administrative fees. The payment of HSA administrative fees should be treated in the same manner.

K. Annual or Lifetime Maximum on Benefits/ Treatment Limits

Treasury should clarify that it is permissible to impose reasonable annual or lifetime maximums on benefits without violating the HSA rules concerning out-of- pocket maximums. Many group health plans impose reasonable annual or lifetime maximums. These limits help ensure that benefits will be available to all covered individuals. Accordingly, confirmation that such limits do not violate the HSA rules would be helpful. Similarly, employers should have the

ability to impose maximum limits on particular treatments without violating the out-of-pocket limitations.

Conclusion

We believe that Treasury has the authority to issue guidance on all of the recommendations described in this letter. However, if Treasury does not agree, we urge Treasury to seek statutory changes to obtain clarifications that provide flexibility for employers, which will allow more employers to implement HSA plans for their employees.

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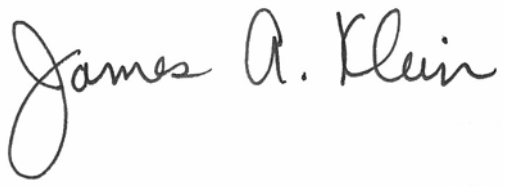
Thank you for consideration of our comments and recommendations. If we can be of additional assistance, you may contact me at (202) 289-6700.

Sincerely,



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