



# AMERICAN ACADEMY *of* ACTUARIES

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March 30, 2004

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

Dear Ms. Elizabeth Purcell and Ms. Shoshanna Tanner:

This letter presents the comments of the American Academy of Actuaries'<sup>1</sup> Health Savings Account Subgroup regarding Notice 2004-2 issued by the Treasury Department and the Internal Revenue Service, which provides guidance on Health Savings Accounts (HSAs).

We have reviewed the HSA provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the subsequent guidance provided in Notice 2004-2. There were seven specific issues outlined in the notice for which comments were requested. We provide comments, where appropriate, on those issues, and we also comment on several additional issues where we feel our perspective is useful.

## **Treasury Issues**

### **1. The appropriate standard for preventive care in Section 223(c)(2)(C)**

A more specific definition of preventive care services is necessary to clearly delineate between preventive care services and nonpreventive care services. Treasury may want to defer to each state for specifics, within certain parameters, so as to keep these services in the spirit of preventive care. While they may not have been considered preventive in the past, certain services such as office visits, prescription drugs, and some surgeries could be considered preventive care by some health plans if the term is not clearly defined in the guidance. This could result in health plans adopting a broad definition of preventive care services that effectively provides substantial first dollar coverage, which does not appear to be the intent of the law.

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<sup>1</sup> The Academy is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification and practice standards, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of objective analysis. The Academy regularly prepares comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

An alternative to developing a restricted definition of preventive care services could be to limit the total amount of preventive services reimbursed on a first-dollar basis to a specific dollar amount or to a specific percentage of the High Deductible Health Plan (HDHP) deductible.

## **2. The relationship between HSAs and health FSA or HRAs**

Many employees are eligible for both health Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs), which have different rules and requirements than HSAs. These employees could also be covered under a HDHP, and could potentially qualify for an HSA. The interaction between HSAs and other forms of accounts such as FSAs and HRAs should be clearly defined and should address whether the existence of an FSA or HRA disqualifies an individual from being eligible for an HSA.

We recommend that the guidance specify that the presence of an HRA or FSA does not disqualify an individual from being eligible for an HSA. Both FSA and HRA accounts are benefits with many features that are distinct from those in a HDHP. Existing rules ensure that the accounts are also distinct from each other and from HSAs.

HSAs, FSAs, and HRAs are accounts that can be used by employees to obtain reimbursement for qualified medical expenses on a tax-advantaged basis. Each of these accounts allows employees a certain degree of flexibility in making health care purchasing decisions with the dollars allocated to the account. In addition, each type of account has unique features with respect to covered benefits, contributions, and ownership or portability of funds. Because each account can only be used to pay or reimburse the portion of medical expenses not already covered by another health plan, the use of an HRA or FSA in conjunction with an HSA is not necessarily inconsistent with the requirements for HSA availability under an HDHP. All three accounts could potentially be used to cover a different portion of expenses that accrue toward the deductible under the HDHP or they could be used for other expenses that may not be covered by the HDHP.

FSAs are most effective for employees with sizeable, known or expected medical expenses. These expenses would usually be predictable with respect to both approximate amount and timing (e.g., normal maternity, elective surgery, vision, or orthodontia expenses). In many cases, these expenses are not covered under an HDHP offered by an employer. The insurance feature of FSAs, or the availability of 100 percent of the account balance as of the first day of the plan year, may also be an attractive feature for many employees. This feature allows employees to obtain immediate reimbursement for a budgeted expense but to fund it via periodic payroll deductions. Existing rules already require employers to expressly limit the maximum account balance, and the “use-it-or-lose-it” feature limits employee contributions to amounts that they reasonably expect to use. This limits the potential for abusive or excessive contributions in an FSA plan, whether or not it is used in combination with an HSA.

HRAs are most effective for employers who prefer to design a plan that allows them to determine the scope of covered benefits and to retain their notional account balances of employees who subsequently terminate from the plan. Employers may wish to contribute only toward medical expenses that are also covered by the HDHP, which can be accomplished using an HRA vehicle. Some employees may also prefer the full availability of funds at the beginning of the plan year, which is a common feature of HRAs. Also, the employer does not

need to fund HRA balances until medical expenses are actually paid, which is a more attractive cash flow advantage when compared with HSAs. Because only employers may contribute to HRAs, they have no strong incentive to provide excessive contributions if the HRA is offered alongside an HSA.

HSAs offer the advantage of portability and ownership of accounts for employees. These features may make these accounts less attractive for employers. Because the employees own HSA contributions, employers may be reluctant to contribute to the accounts. Monthly employer HSA contributions may make the HSA less attractive to employees, because the full amount of the employer contribution is not available until the end of the plan year, while medical expenses may be incurred throughout the year. This may be especially true for lower-income employees without sufficient financial resources to fund their own medical expenses until the employer contributions are received.

HSAs are an appropriate vehicle for encouraging periodic savings by employees for future medical expenses. Allowing flexibility so HSAs can be coordinated with the other existing forms of tax-qualified accounts would let more employers and employees address their individual needs and situations.

### **3. The application of the nondiscrimination rules in Section 125 to HSAs offered under a cafeteria plan**

Employer contributions to HSAs raise many issues related to nondiscrimination rules that have not yet been addressed. Clarifying how the nondiscrimination rules apply to employer contributions will help facilitate the implementation of these plans and achieve the goals of the HSA provisions of the Medicare law while significantly minimizing the potential need for private letter rulings issued on a per-employer basis.

Since many employers apply rules or other conditions when providing benefits to their employees, guidance should address whether employers can place any rules or other conditions on money they deposit in an employee's HSA.

While HSAs are individual accounts, the ability to include employer contributions and payroll deductions for employee contributions may create administrative difficulties for employers.

Clarification is needed on the following questions:

- (1) Can an employer require using a particular account trustee as a condition for contributing employer funds?
- (2) Can an employer require using a particular account trustee as a condition for offering payroll deductions of employee contributions?
- (3) Can an employer require other similar conditions on contributions to facilitate the administration of employer or employee contributions?
- (4) Is there an exception to the nondiscrimination rule for situations where an employer is unable to contribute to an HSA for an employee because the employee is not eligible to receive contributions to an HSA (e.g., an active employee who is eligible for Medicare benefits and thus not eligible to contribute to an HSA)?

Matching employee funds is a common approach for employer contributions to qualified retirement plans (such as 401(k) plans), and therefore it may be a popular approach for HSAs. Guidance should be provided on specific contribution strategies that are acceptable under the nondiscrimination rules; e.g., could employers contribute to an employee's HSA on a matching-funds basis and still comply with the nondiscrimination rules?

Current guidance mentions equal dollar and equal percentage contributions as satisfying the nondiscrimination rules. Further guidance should clarify whether matching contributions as either a dollar amount (e.g., the first \$500) or as a percentage would also be acceptable. Additional guidance regarding criteria or principles that employers could use to test other contribution approaches for compliance should also be provided.

We also recommend that further guidance not require the application of additional Section 125 nondiscrimination rules beyond clarifying acceptable forms of "comparable contributions" as described above. The application of other Section 125 nondiscrimination rules (e.g., key employee test, eligibility test, or benefits test) may greatly increase the complexity of administering HSA plans for employers and could represent a significant barrier to adoption.

#### **4. The corrective procedures in instances where employer contributions exceed the statutory contribution limits**

The response to question 22 of Notice 2004-2 addresses the tax treatment of excess contributions by either an employer or employee. However, additional guidance should specifically address the acceptable corrective procedures for an employer who contributes an excess amount to an employee's HSA due to an administrative error or another cause. Errors could occur in the course of administering payroll deductions, employer contributions, and other aspects of employer-sponsored benefit plans, so reasonable corrective procedures may need to be considered.

If employers are unable to recoup excess contributions, further clarification should state that such mistakes or administrative errors alone will not cause the plan to fail to satisfy the nondiscrimination rules related to employer contributions to HSAs.

Subsequent guidance should consider allowing employers to recoup from an employee's HSA any excess contributions that are the result of an administrative error or that an employee would not normally be entitled to under the provisions of the employer's plan. This administrative relief may need to be applicable even in situations where the aggregate contributions do not exceed the statutory maximums. If the employer contributions have been appropriately designed to be nondiscriminatory, it may not be appropriate to penalize an employer (or reward an employee) as a result of purely administrative errors without the ability to take some corrective actions.

For example, assume that in December 2004 an employer makes a clerical error and contributes twice the agreed upon amount to an employee's HSA. Depending on the actual amount, this may or may not cause the employee to exceed the statutory maximum contribution. Absent additional guidance, it appears that the employer would forfeit the excess contribution and the employee could be subject to a tax penalty if his total contributions exceeded the maximum. This outcome does not appear to be consistent with the intent of the HSA provisions.

While the recent guidance addresses the tax treatment of excess contributions, it does not address the related issue of excess distributions from an HSA. Because medical claims are often reversed or adjusted due to errors in claim submission or processing, it would be possible for an employee to withdraw funds from an HSA to pay for or reimburse qualified expenses that are later reversed or are adjusted to different payment amounts. In such situations, individuals may later determine that they have withdrawn an amount from their HSA that is greater than their total qualified medical expenses to date. This may require individuals to pay tax penalties for distributions that they believed to be qualified expenses at the time the distributions were made.

Additional guidance should specify the acceptable corrective procedures for situations where amounts are withdrawn in error. One possible corrective measure would be to allow incorrect amounts distributed to be returned later and re-deposited to an HSA before the tax-filing deadline. This corrective measure could be limited to cases where claim adjustments, reversals, or other changes could be documented to support the position that the distributions were the result of a claim payment error.

Without such guidance, employees could be forced to delay distributions or reimbursements from an HSA for a period of time sufficient to ensure that no further claim adjustments would be likely to occur.

**5. The relationship between limits on out-of-pocket expenses in section 223(c)(2)(A) and reasonable lifetime maximums on benefits in health insurance plans**

Lifetime benefit maximums are a common feature in most medical plans. Insurers and self-funded employers, as prudent risk managers, try to understand and limit their liabilities, thereby increasing the stability and availability of these plans in the marketplace. Requiring unlimited lifetime benefit maximums may reduce the availability and popularity of HDHP plans in the marketplace.

If the intention of HDHPs is to provide comprehensive catastrophic coverage, then lifetime maximums should be significantly large. One approach could be to set a minimum level of lifetime benefit for HDHPs at a fixed, high dollar amount. Many comprehensive major medical plans of this type currently have maximum benefit levels of at least \$1 million.

To prevent having to periodically reset this level, the stated minimum level could be indexed to inflation on the same basis as that used for deductibles and out-of-pocket maximums.

**Additional Issues**

**6. State-mandated nonpreventive first-dollar benefits**

Some state insurance regulations may require that plans pay certain nonpreventive benefits on a first-dollar basis. In these situations, it may be interpreted that HDHPs, and therefore HSAs, are not available. Additional guidance should clarify the impact that these mandates have on the availability of HDHPs and HSAs in the affected areas.

One approach would be to issue guidance declaring that the existence of these kinds of mandated benefits does not prevent a health plan from being an HDHP, thereby making an HSA available to individuals.

#### **7. The application of indexed amounts**

Certain items, such as deductibles and out-of-pocket maximums, will be periodically indexed to inflation. It is unclear how the timing of these updated indexed amounts will impact the eligibility of the plans.

For example, if an individual purchases a \$1,000-deductible HDHP and contributes to an HSA effective July 1<sup>st</sup>, but the minimum amount is increased effective the following January 1<sup>st</sup>, is the individual required to change the plan deductible mid-year to comply with the updated indexed amounts?

Many employers make decisions early in one calendar year as to the structure and design of their health plan for the following calendar year, which could create another difficulty. If the new indexed amounts are not released until late in the planning process, employers may find it difficult to administer and manage them, so may be slow to adopt HSAs.

We recommend that additional guidance clarify the application and timing of indexed amounts as they apply to HDHPs and HSAs. One approach could be to allow a grace period of one year from the effective date for a plan to convert to the newly indexed minimum HDHP amount. Another approach could be to require a plan or policy to have the newly established indexed amounts if it is issued or renewed on or after the effective date of the change.

#### **8. The use of a deductible credit**

Many insurance plans allow for a deductible credit from a prior carrier when insurance is being replaced. This allows for a less disruptive transition when an individual moves from one plan to another in the middle of a policy year.

Guidance should address whether the usage of a deductible credit will disqualify a plan from being an HDHP. We recommend that a deductible credit be considered an acceptable method of practice, as it will allow members more freedom to move to another insurance plan between calendar years.

#### **9. Benefits provided outside the HDHP**

The response to question 6 of Notice 2004-2 states that “permitted insurance” includes “insurance that pays a fixed amount per day (or other period) of hospitalization.” Guidance should be provided to determine if the following types of plans are considered “permitted insurance”:

- a. Policies that cover a specific category of services such as prescription drugs
- b. Policies that pay a specified dollar amount of benefit per service when the benefit is not dependent on (but is typically much less than) the cost of the service
- c. Policies that cover a series of specified diseases or illnesses

## 10. The definition of disability

Question 25 of the notice addresses the taxation of distributions for an HSA. The response to question 25 states that “any amount of the distribution not used exclusively to pay for qualified medical expenses...is subject to an additional 10% tax....except in the case of distributions made after the account beneficiary’s death, disability, or attaining age 65.”

It is unclear whether this exception applies to individuals who are partially disabled, temporarily disabled, or permanently disabled. Defining the term *disability* in this context will improve understanding of and compliance with this provision. Additionally, would an individual need to be disabled for a certain period of time for this exception to apply?

Additional guidance should clearly define an acceptable standard of disability.

Thank you for the opportunity to comment on these issues regarding HSAs. We feel that providing additional guidance addressing the topics outlined above will help achieve the intended goals of the HSA provisions.

Members of the American Academy of Actuaries are available to assist in developing guidance to address the issues surrounding HSAs. If you would like additional information or assistance, please feel free to contact Holly Kwiatkowski, the Academy’s senior health policy analyst (federal), by phone at (202)-223-8196 or by e-mail at [kwiatkowski@actuary.org](mailto:kwiatkowski@actuary.org).

Sincerely,

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