AMERICAN BENEFITS COUNCIL

THE FINANCIAL SERVICES ROUNDTABLE

May 3, 2007

VIA ELECTRONIC AND HAND DELIVERY

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Re: Additional Guidance Requested Regarding New Health Savings Account Rules

Dear Mr. Reeder and Ms. Marks:

We are writing to you on behalf of the American Benefits Council, the U.S. Chamber of Commerce and the Financial Services Roundtable with respect to the Health Savings Account ("HSA") provisions that were enacted as part of the Tax Relief and Health Care Act of 2006 (the "Act") and the recent guidance issued in Notice 2007-22. We urge that additional guidance be provided under section 305 of the Act, which provides for full-year contributions to an HSA by individuals who become HSA-eligible after the start of the taxable year (the "full-year contribution rule"). Additionally, we request clarification and reconsideration of certain provisions in Notice 2007-22, which interpreted section 302 of the Act regarding qualified HSA distributions from Health Reimbursement Arrangements ("HRAs") and Flexible Spending Arrangements ("FSAs").

This letter follows our December 22, 2006 letter in which we asked for transition guidance on the provisions in section 302 of the Act that could significantly impact employer-sponsored health coverage and HSA administration at the start of the January 1, 2007 calendar year. The publication of Notice 2007-22 answered a number of those questions. We request the following additional guidance with respect to section 305 of the Act and certain modifications to Notice 2007-22:

- With respect to the "full-year contribution rule" in section 305 of the Act, all persons who are HSA-eligible as of December 1 of a calendar year are eligible to contribute up to the annual statutory maximum regardless of whether such persons were enrolled in a qualifying high deductible health plan "HDHP" at the start of the taxable year.

- For persons who move from self-only to family HDHP coverage after the start of the year, such persons are eligible under the "full-year contribution rule" to contribute up to the annual statutory limit for family HDHP coverage as long as they are covered by a family HDHP and otherwise HSA-eligible as of December 1 of the year.

- For persons whose HDHP coverage changes from family to self-only coverage after the start of the year, the applicable contribution limit to the HSA is prorated based on those months in the year for which they are enrolled in family coverage and those months for which they are enrolled in self-only coverage.

- For persons who attain age 55 no later than December 1 of a year, the "full-year contribution rule" allows an HSA catch-up contribution equal to the annual statutory maximum pursuant to Code section 223(b)(3).

- With respect to the requirements in Notice 2007-22 and section 302 of the Act, reconsideration of the rule requiring that employers and administrators use a "cash basis" definition of account balance for purposes of determining whether (i) an individual is eligible for a tax-free qualified HSA distribution, and (ii) an individual has "zeroed down" the balance in the FSA or HRA.

- With respect to the requirements in Notice 2007-22, an exception for amounts reinstated to an FSA or HRA following the close of the plan year that shall not render an individual HSA-ineligible or invalidate an otherwise tax-free qualified HSA distribution.

- With respect to the requirements in Notice 2007-22 and section 302 of the Act, an extension of the March 15, 2007 deadline for tax-free consolidations through the end of the calendar year. Additionally, we request the issuance of a correction rule similar to the IRA correction rules contained in Revenue Procedure 2006-27, which provides that a participant shall not fail to enjoy the benefits of a tax-free

> consolidation solely because an employer or third party administrator fails to effectuate the consolidation in a timely or otherwise required manner.

Guidance is requested regarding the category of persons who are eligible to make a full-year contribution to an HSA under the full-year contribution rule.

Contribution limits under Code section 223 generally are based upon an individual's eligibility to make contributions to an HSA in any given calendar month. Under prior law, to be eligible to make a full-year's HSA contribution, an individual was required to be enrolled in an HDHP and otherwise HSA-eligible for each month of the calendar year. This was the case even where the annual HDHP deductible was not reduced to reflect an individual's partial-year coverage under the HDHP.

Section 305 of the Act provides an important "fix" for certain partial-year enrollees by permitting an individual who "becom[es] eligible" to contribute to an HSA after the start of the year to make a full-year contribution to an HSA. Specifically, section 305 provides that, for purposes of determining the statutory maximum contribution limit:

> an individual who is an eligible individual during the last month of [the] taxable year shall be treated as… (i) having been an eligible individual during each of the months in such taxable year, and (ii) as having been enrolled, during each of the months… in the same high deductible health plan in which the individual was enrolled for the last month of such taxable year.

Some have questioned whether the full-year contribution rule applies to only those individuals who enroll in an HDHP after the start of the year and continue to be enrolled and HSA-eligible as of December 1. While the mid-year enrollee fact pattern may have been an impetus for the enactment of the full-year contribution rule, the statutory language is not limited to that fact pattern alone. We ask that guidance confirm that any persons who are otherwise HSA-eligible as of December 1 of the taxable year be eligible for the full-year contribution rule. Thus, the right to contribute up to the annual statutory maximum also would apply to persons who are enrolled in an HDHP for the full year but who are otherwise ineligible to contribute to an HSA for some portion of the year prior to December 1 as a result of other disqualifying coverage, such as coverage under an FSA administrative grace period. We believe that this interpretation is fully consistent with the statutory language and, as a practical matter, would help resolve some (albeit not all) of the problems and administrative errors that may arise as a result of disqualifying coverage in FSAs, HRAs and spousal medical coverage.

Guidance is requested regarding the application of the full-year contribution rule to persons who move between self-only and family HDHP coverage after the start of the taxable year.

A related issue pertains to the application of the full-year contribution rule to persons who move from self-only HDHP coverage to family HDHP coverage after the start of the year. Under prior law rules, it was clear that in such cases individuals were required to prorate their annual contribution limit based on the months in which they were enrolled in self-only coverage versus

family coverage. In light of the enactment of the full-year contribution rule in section 305 of the Act, we request clarifying guidance that such persons may contribute up to the full annual statutory maximum for family coverage as long as they are enrolled in family HDHP coverage as of December 1 and are otherwise HSA-eligible as of that date.

With respect to persons who change their level of coverage in the "opposite direction" – i.e., from family HDHP coverage to self-only HDHP coverage after the start of the year – we ask for clarification that such persons may continue to determine their applicable contribution limit under existing law rules which allow an individual to determine his or her applicable contribution limit based on those months in a taxable year for which he or she is enrolled in self-only versus family HDHP coverage. We do not believe that the full-year contribution rule in section 305 was intended to decrease the level of contributions made to an HSA for periods of coverage prior to December 1. Preservation of the existing monthly proration rule makes sense because, prior to changing their coverage to self-only HDHP coverage, such persons are subject to the full annual deductible for family coverage. Thus, persons who transition to self-only HDHP coverage after the start of the taxable year should be able to take into account those months in which they have family coverage in determining their applicable contribution limit.

Guidance is requested clarifying that individuals who turn age 55 in a given taxable year are eligible to contribute up to the full annual catch-up contribution.

Under current law, individuals who are age 55 and above are eligible to make a catch-up contribution into their HSAs. For 2007, the statutory limit for catch-up contributions is $800. We request clarification that the full-year year contribution rule of section 305 of the Act applies to the catch-up contribution. Thus, individuals who turns age 55 on or before December 1 in a given taxable year will be eligible to contribute up to the statutory maximum catch-up limit, regardless of the number of months in which they are otherwise HSA-eligible, as long as they are covered by an HDHP and otherwise HSA-eligible as of December 1. We believe that such an interpretation is in accordance with our suggested interpretation of the full-year contribution rule as outlined above and is consistent with the statutory purpose of the catch-up rule, which is to allow increased HSA contributions to satisfy out-of-pocket health expenses at a time when an individual's claims experience typically begins to trend upwards.

Reconsideration should be given to the use of a "cash basis" definition of account balance in light of the administrative difficulties and loss of coverage associated with the rule.

Notice 2007-22 provides that a "cash basis" definition of account balance applies "for all purposes," including for purposes of determining whether (i) an individual is eligible for a tax-free consolidation of existing FSA or HRA funds, and (ii) whether an individual has "zeroed down" his or her FSA or HRA balance by calendar year end such that he or she is deemed HSA-eligible as of January 1st of the proceeding calendar year. Specifically, Notice 2007-22 states that "[f]or all purposes, balances are determined on a cash basis," and defines "cash basis" to mean "the balance as of any date, without taking into account expenses incurred that have not been reimbursed as of that date." Thus, "pending claims, claims submitted, claims received or claims under review that have not been paid as of a date are not taken into account for purposes of determining the account balance as of that date."

In our December 22, 2006 letter, we indicated that a cash-basis definition would create administrative problems with respect to qualified HSA contributions from FSAs and HRAs. Our members' experience thus far in trying to implement Notice 2007-22 for the 2007 calendar year confirms that view. We request that you reconsider the application of the cash-basis rule in light of the administrative complexity that employers and administrators have experienced in trying to implement the rule for HSA consolidations and the FSA "zero down" rule. To be clear, we do not believe that there are significant administrative problems with respect to determining on a cash basis the September 21, 2006 balance that serves as the ceiling amount that may be contributed from an FSA or HRA to an HSA. With respect to the balance determined as of year-end, however, it is proving difficult to implement the cash-basis rule for purposes of the "zero balance" provision and the consolidation of FSA and HRA funds. We realize the Joint Committee on Taxation's description of the Act indicated that balances would be determined on a cash basis. However, we do not believe that this general description should be read to limit your regulatory authority when an alternative interpretation would appropriately implement the statutory rule and avoid what we believe are unnecessary complexities. For those reasons, we suggest that the guidance be amended to provide for a limited claims "run out" period in determining whether a balance has been "zeroed down" and for purposes of determining the amount that may be contributed to the HSA in a tax-free consolidation from an FSA or HRA. Such limited claims run out period might, for example, be allowed until March 15 of the following year, which would coordinate with the Notice 2007-22 deadline imposed for HSA consolidations from calendar year FSAs and HRAs.

Imposition of a "cash basis" definition is administratively complex and will require that a significant number of employers and plan administrators amend their current practices and/or information technology systems in order to provide a daily valuation of a participant's FSA and/or HRA account balance. This is the result because current practices and information technology systems have been designed only to track and monitor FSA account balances on a monthly or payroll period basis; they were not designed to provide a daily valuation of an individual's FSA account balance. Systems were designed in this manner in large part because of the uniform coverage rules under Code section 125, which provides that the maximum contribution in an FSA is available for the entire coverage period.

The imposition of a "cash basis" definition has the practical effect of reducing a participant's coverage period under the FSA to something less than the prescribed uniform twelve-month coverage period. See Proposed Treasury Regulation § 1.125-2, Q&A 7. This is because in order to ensure that all amounts are reimbursed such that a participant has a zero balance as of the close of the plan year, participants will have to factor in the time it takes to incur claims, submit claims for reimbursement, have the claims processed by the employer and/or administrator and effectuate the actual reimbursement (*e.g.*, the time required to cash the check, etc.). It is our understanding that in many instances, all of these actions could take well in excess of two to four weeks to complete. Thus, participants seeking to zero down their FSA balances by the close of the plan year will have to cease incurring claims well in advance of the close of the uniform coverage period in order to ensure that all of their claims can be submitted and processed by the employer/administrator prior to the close of the plan year. This would appear to run counter to the prescribed twelve-month uniform coverage period and result in an "unfriendly" rule for participants.

Employees and employers are familiar with the manner in which FSAs operate under existing rules that have been in effect for many years, including with respect to the use of claims "run-out" periods and the uniform coverage rule. Changing the rules now for persons that seek to take advantage of the additional rights provided for by the Act will lead to a great deal of confusion among employers and employees. Additionally, use of a "cash basis" definition will result in two sets of differing rules – one set of rules for persons that seek to continue FSA or HRA coverage (which allows for the use of claims "run-out" periods and preservation of a full twelve-month coverage period with respect to FSAs) and a different, more restrictive set of rules for persons who seek to make a tax-free consolidation or "zero down" their FSA or HRA accounts by year-end (which precludes claims "run-out" periods and effectively results in a reduced coverage period). Guidance that builds upon rather than changes existing law rules will assist employers and employees in complying with both existing law rules and the new rules provided by the Act.

Use of a "cash basis" definition also will create a gap in coverage for certain individuals who are unable to reimburse otherwise valid Code section 213 medical expenses from either an existing FSA or HRA, or a newly established HSA. This is because, pursuant to Notice 2007-22, amounts in an FSA or HRA must be "frozen" as of the close of the plan year in order to have a tax-free consolidation. Thus, an individual is not permitted a "run-out" period during which he or she may reimburse expenses incurred during the taxable year. Notably, this is in contrast to existing Treasury rules that generally allow for the use of administrative run-out periods following the close of a plan year. Additionally, because existing rules applicable to HSAs preclude an individual from reimbursing claims incurred prior to the establishment of an HSA, individuals will be unable to reimburse their otherwise valid claims from their HSA after a consolidation of FSA or HRA funds to the HSA. The practical effect is that many persons may confront greater out-of-pocket exposure than they had expected and, as a result, may be required to use monies earmarked for other purposes to satisfy this increased out-of-pocket exposure. For these reasons, we request that you reconsider the use of a "cash basis" definition of account balance and provide that a limited claims run-out period may be used.

An exception is needed to clarify that in certain cases amounts reinstated to an FSA or HRA following the close of the plan year shall not render an individual HSA-ineligible or invalidate an otherwise tax-free qualified HSA distribution.

We request that future guidance provide an exception whereby dollar amounts that are reinstated to an FSA or HRA following the close of the plan year shall not render an individual HSA-ineligible or invalidate an otherwise tax-free qualified HSA distribution. Such a rule would be limited to situations in which dollars have been reinstated to the account as a result of subsequent events or information.

We believe that the establishment of an exception is necessary to ensure that individuals are not penalized unfairly for inadvertently failing to spend down all of their FSA or HRA monies by the close of the plan year. Additionally, we believe such a rule is necessary in light of the administrative realities of FSA and HRA claims administration. With respect to both FSAs and HRAs, employers and/or administrators are required under existing law to substantiate submitted claims as a qualified Code section 213 medical expense prior to reimbursement. Although well-intentioned employers and administrators work hard to comply with this rule, on occasions amounts

may be reimbursed from an FSA or HRA as a qualified expense only to later be deemed disqualified for reimbursement as a result of inadequate substantiation or new information. As a result, amounts previously reimbursed may end up back in an individual's FSA or HRA following the close of the plan year or an otherwise tax-free qualified HSA distribution. Additionally, it is our understanding that state laws may sometimes require that unclaimed reimbursements (i.e., unclaimed checks, etc.) be reestablished or otherwise set aside for the account participant. Thus, to help ensure that participants achieve their intended goals (*i.e.*, to zero down their FSA or HRA account or to make a tax-free consolidation) and to ensure that employers and plan administrators are not forced to choose between a less-than-desired result for employees or state law compliance, we urge Treasury to provide an exception that would address these situations in which employers and administrators have reasonably determined that amounts had been properly paid from the FSA or HRA for purposes of complying with the cash-balance rule.

An extension of the March 15, 2007 deadline for tax-free consolidations with respect to existing 2006 FSA or HRA amounts is needed to ensure that employers and third party service providers have sufficient time to execute such consolidations.

Pursuant to Notice 2007-22, amounts remaining in a participant's FSA or HRA account as of December 31, 2006, must be deposited into the participant's HSA by March 15, 2007, in order to constitute a qualified HSA distribution pursuant to section 302 of the Act. In light of the administrative complexities of executing such consolidations and the need for employer education regarding this new consolidation right, we respectfully request an extension of the March 15, 2007 deadline through the end of the 2007 calendar year. Such an extension will help ensure that all participants and employers that seek to consolidate 2006 amounts pursuant to section 302 of the Act have a meaningful opportunity to do so.

Correction rules like those provided for IRAs in Revenue Procedure 2006-27 are needed to ensure that participants are not penalized by third party error.

Corrections rules are needed to ensure that participants are not unduly penalized by an employer or third party service provider's failure to effectuate a qualified HSA distribution in a timely or otherwise required manner. Such rules are not uncommon. The IRS has provided similar rules with respect to Simple and SEP IRAs as part of the Employee Plans Compliance Resolution System ("EPCRS") as contained in Revenue Procedure 2006-27. Specifically, the correction rules provide that an employer may correct a failure to deposit employee deferrals without any adverse tax consequences for IRA participant employees. Similarly, the IRS has issued guidance in the form of Revenue Procedure 2003-16, which provides for an automatic waiver of the 60-day rollover requirement where the failure to meet the 60-day rule is the product of provider error. To help ensure that all participants do not fail to enjoy the benefits of a tax-free consolidation solely because an employer or third party provider or financial institution fails to effectuate the consolidation in a timely or otherwise required manner, we respectfully request that Treasury and the IRS provide correction rules similar to those provided for by EPCRS and/or with respect to the 60-day rollover rule.

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We hope that these comments are helpful to you. We would be happy to meet with you to discuss any of our comments or other issues that you are considering with regard to the Act or Notice 2007-22.

Very truly yours,

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