EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

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March 15, 2004

CC:DOM:CORP:R (Notice 2004-2)
Internal Revenue Service
Room 5226
PO Box 7604
Ben Franklin Station
Washington, DC 20004

Re: Health Savings Accounts Guidance (Notice 2004-2)

Dear Sir/Madam:

On behalf of the Employers Council on Flexible Compensation ("ECFC"), we express our sincere gratitude for the very timely guidance contained in Notice 2004-2, I.R.B. 2004-2, on Health Savings Accounts ("HSAs"). We also appreciate the receptiveness of the Treasury Department and Internal Revenue Service to input from the employer plan sponsor community. We are excited by the demonstrated promise that consumer-centric health care has shown for helping resolve the current health care cost crisis (e.g., through health reimbursement arrangements or "HRAs"). We believe that HSAs also will help to alleviate this crisis. However, as discussed more fully herein, we are concerned that several important issues may serve to impede the growth of HSAs, and literal application of some of the existing historical regulatory requirements associated with cafeteria plans under Section 125 of the Internal Revenue Code ("Code") may discourage employers from offering this valuable benefit to their employees.

ECFC is a non-profit membership association committed to the study and promotion of 401(k) plans, cafeteria plans, and other elective compensation plans. The more than 2800 members of ECFC are plan sponsors, corporations, governments, unions, universities, hospitals, and clinics as well as leading actuarial, insurance and accounting firms that design and administer flexible benefit plans. Founded in 1981, the Council's members have great experience in designing and administering compensation and benefit programs that offer flexibility for employers and employees.

In response to the request for further comment in Notice 2004-2 we would like to express several concerns that employers have relating to HSAs. In Section I below, we provide suggestions regarding the comments specifically requested in Notice 2004-2. In Section 2 we address additional issues of interest to the employer community.

Sincerely,

Kenneth E. Feltman, CFCI, CAE　　　　Bonnie B. Whyte, CFCI, CAE

Section I: Comments Requested By Treasury

1. Appropriate Standard for Preventive Care.

A. Issue: Section 223(c)(2)(C) of the Code provides a safe harbor for a plan that meets each of the requirements necessary in order to be a high deductible health plan ("HDHP"), but under which "preventive care" is provided without being subject to a deductible. The IRS and Treasury have requested comments regarding the appropriate standard for defining "preventive care".

Proposed Resolution: We propose the following definition: *"Preventive care is medical care rendered to promote general overall health and prevent future health problems. A safe harbor exists for the following forms of preventive care: well child care (e.g., immunizations and well child check-ups); well adult care (e.g., physical exams and screenings); prenatal care; maintenance drugs used prophylatically (e.g., medications prescribed to lower cholesterol levels); and any other medical care mandated by state or federal law to be provided by health plans as preventive care."*

One of the most important initiatives undertaken by self-funded employers and health insurers is preventive care and the use of so-called wellness programs. Preventive care and wellness programs are designed to promote better overall health now and prevent future health problems, both of which are essential to reducing the staggering increases in health care costs. Many group health plans already incentivize employees to take advantage of preventive care and wellness programs by not subjecting preventive care to the plan's deductible and co-pays. While this is obviously beneficial to health plan participants, the motivation behind these plan designs is purely economic – if the health plan can keep participants healthy, the health plan is likely to experience fewer future claims. Consequently, it is imperative that future HSA guidance not limit further innovation and development in this area.

Any preventive care definition must be flexible enough to enable plan sponsors to experiment with a wide range of wellness programs to determine which program or programs will best improve its particular participants' overall health as well as prevent the future health problems that its participants are likely to face (e.g. the health needs of an industrial plan sponsor's participants will differ from a professional organization's participants) and then implement such program or programs within a consumer-centric model. Adoption of a broad-based, flexible definition, such as the one we have suggested above, will not undermine Code Section 223. Group health plan sponsors and health insurers have no incentive to exclude services that are non-preventive from the plan's deductible because to do so would have no impact on future claims.

2. The relationship between HSAs and Section 125.

A. Issue: Do the Section 125 "irrevocable election" rules apply to elections to make HSA contributions through a cafeteria plan or can such elections be started or stopped on a prospective basis?

Proposed Resolution: We propose that pre-tax HSA contributions should be governed by rules analogous to 401(k) elections under a cafeteria plan. In other words, an employee who has elected to make an HSA contribution under a cafeteria plan may start, stop, increase, or decrease such election at any time as long as such changes are effective prospectively. This would ensure comparable treatment for HSA elections regardless of whether they are made through a cafeteria plan or after-tax (but deductible) payroll deduction contributions.

B. Issue: Under what circumstances can an employee make a mid-year election change from non-high deductible coverage to high deductible coverage to accommodate establishing an HSA?

Proposed Resolution: We propose that an employee can make a mid-year prospective election change from non-high deductible coverage to high deductible coverage to accommodate establishing an HSA; however, an employee may not change his or her Health FSA election mid-year solely to establish an HSA (i.e. the employee may only change his or her Health FSA election upon experiencing a qualifying change in status event).

C. Issue: Please confirm that payment of long term care insurance premiums by an HSA, which is permitted under Section 223(d)(2)(C)(ii) does not violate Code Section 125(f), which prohibits offering long term care insurance plans under the cafeteria plan, if the HSA is offered under the Code Section 125 cafeteria plan.

Proposed Resolution: It is not a violation of Code Section 125(f) where an HSA that is offered under the cafeteria plan reimburses HSA participants for long term care insurance premiums. In this instance it is the HSA, not the long-term care insurance plan, that is offered under the cafeteria plan.

3. Transition Relief

A. Issue: As noted herein, several unresolved issues currently remain concerning HSAs, qualifying HDHP coverage, and the application of existing tax rules.

Proposed Resolution: Any guidance concerning HSAs should be applied prospectively, and no sooner than the first plan year following publication with respect to employer-provided HSAs, or the first taxable year following publication with respect to an individual. Individuals adopting HSAs prior to such effective date should be entitled to the tax exclusion/deduction applicable to qualifying HSAs and HDHPs as long as such arrangements were adopted and administered in a good faith attempt to comply with existing guidance.

4. The Relationship Between HSAs and Health FSAs or HRAs.

A. Issue: If a particular service or treatment is entirely excluded from an HDHP in accordance with the terms of the HDHP (e.g. if OTC medications or speech therapy for developmental delay is excluded from coverage by the plan), can the individual maintain other non-high deductible coverage (e.g., an HRA or FSA) that provides benefits exclusively for those excluded services or treatments without jeopardizing his or her status as an "eligible individual"?

Proposed Resolution: An individual with both an HDHP and ancillary non-high deductible coverage (e.g., an HRA, health FSA, or other health plan) may still be an "eligible individual" with respect to an HSA so long as the ancillary plan only covers benefits that are specifically excluded from coverage under the HDHP in accordance with the terms of the HDHP.

B. Issue: Section 223(c)(1)(ii) indicates that an eligible individual covered under a high deductible health plan can be covered under another non-high deductible health plan that is not permitted insurance or coverage *to the extent the other plan does not provide coverage for any benefits covered by the high deductible health plan.* Many plan sponsors carve out certain benefits (e.g., prescription drug or mental health/substance abuse treatment) from their medical plan and offer them through separate plans. In most cases a separate administrator (such as a PBM or mental health vendor) administers such benefits. Such plans often have a separate deductible or copayment feature from the comprehensive health plan.

Proposed Resolution: For a variety of reasons it should be permissible to offer separate non-high deductible coverage under a carve-out plan. First, the language of the statute is broad enough to permit such arrangements. Second, it is the current practice of many employers to carve out certain coverage areas for cost control purposes. Indeed, the current carve-outs are generally motivated by an attempt to promote efficiency. For example, PBMs often require that certain maintenance medications be purchased through mail-order program, and use a variety of incentives (formularies and tiered co-payments) to encourage health care efficiency. Mental health plans often encourage out-patient treatment and discourage inpatient care. The purpose of continuing to permit separate carve-outs in conjunction with an HDHP is not to encourage sheltering money in the HSA for a few participants -- the purpose is to reduce overall costs for the employer and health plan participants.

Public policy would seem to favor continued carve-outs and ease of access (subject to a copay rather than a high deductible) for care such as maintenance medications (e.g., anti-depressants and blood pressure medicine) and mental health/substance abuse treatment. The concern, of course, is that some individuals who truly need the medical care would opt not to receive it (if it were covered only under the HDHP) because they would be unable to pay for expensive medical care out-of-pocket up to the high deductible. It is important to note that not every participant in an HDHP will participate in an HSA, but the IRS and Treasury guidance that is issued with regard to HSAs will likely impact the way that all HDHPs are designed. With that in mind, we urge the IRS and Treasury to permit carve-out coverage areas in connection with an HDHP.

Finally, in many cases integration of the current carve-out arrangement with a deductible arrangement will, in most cases, prove administratively impossible and such employers may opt to drop the programs that are currently carved out. For the forgoing reasons, carve-out coverage offered through a separate non-high deductible health plan for benefits excluded from the HDHP should be permitted without jeopardizing an individual's status as an eligible individual.

C. Issue: It is not clear whether an ancillary plan (such as an HRA or Health FSA) that covers the same type of benefits otherwise covered by the HDHP but for a plan limitation other than the deductible (e.g. a co-insurance requirement or a limit on the number of visits) is allowed so long as the ancillary plan does not provide any benefits before the HDHP deductible has been satisfied.

Proposed Resolution: An ancillary plan that does not pay any benefits until after the HDHP deductible has been satisfied is also a high deductible health plan within the meaning of Section 223(c)(2) and would not, in and of itself, preclude an individual from establishing an HSA even if it covers services or treatments otherwise covered by the HDHP but for a plan limitation other than a deductible.

D. Issue: It is not clear whether an otherwise qualifying HDHP would fail to qualify merely because it has an HRA feature above the deductible:

Example: High deductible health plan has a $1000 deductible for single and $2000 for family with an 80/20% coinsurance limit above the deductible. The HDHP includes an HRA feature to cover the employees' 20% coinsurance responsibility for expenses above the deductible.

Proposed Resolution: A HDHP that offers an HRA feature for coverage of amounts in excess of the deductible (e.g., to cover the participant's coinsurance responsibility for expenses above the deductible) does not fail to qualify as an HDHP due to the HRA.

E. Issue: Assume an HSA account holder (not currently an eligible individual) currently participates in an FSA. Traditionally, FSAs have been payors of last resort, meaning that the FSA cannot reimburse an expense if there is another source from which reimbursement can be made. However, recent electronic payment card guidance appears to have revised this requirement. In Revenue Ruling 2003-43, the IRS modified the participant's certification requirements from certification that the expense will not be reimbursed from another source to certification that the participant will not *seek* reimbursement from another source. It is not clear whether, in light of the recent change in the participant certification requirement, the FSA can reimburse medical claims even though there is an HSA balance so long as the participant certifies that he or she will not seek reimbursement from the HSA.

Proposed Resolution: The Health FSA may reimburse expenses even though the participant also has an HSA with a positive balance so long as the participant certifies that he or she will not seek reimbursement from another source (including the HSA).

F. Issue: Individuals who have a current HRA or FSA account balance may be reluctant to elect the HSA in lieu of such coverage.

Proposed Resolution: Treasury and IRS should create a special rule for account-based plans (such as HRAs and FSAs) that allows an individual to have such coverage and continue to be an eligible individual. Such plans are by their very nature consumer-centric since they are funded by employees (FSAs) or include notional accounts that encourage consumer-centric behavior by

employees (HRAs). Failure to allow such arrangements along with an HDHP/HSA could dissuade individuals from adopting HSAs where either the employee (or spouse) has such coverage.

5. The Application of the Nondiscrimination Rules in Section 125 to HSAs Oofered Under a Cafeteria Plan.

A. Issue: How do the Code Section 125 cafeteria plan non-discrimination rules apply to contributions made to an HSA under the cafeteria plan?

Proposed Resolution: The guidance should provide that, to the extent the Section 125 nondiscrimination rules apply to contributions made to an HSA through a cafeteria plan, the comparability rules do not apply. Legislative history and Q&A-32 of the Notice indicate that the comparability rules do not apply to contributions made to an HSA through a cafeteria plan, but additional guidance confirming that the comparability rules do not apply to any type of contribution to an HSA made under a cafeteria plan would be welcome. This would include salary reduction contributions to an HSA, as well as employer credits and employer matching contributions to an HSA made under a cafeteria plan (regardless of whether such employer contributions are "cashable" to the participant).

Additionally, the guidance should exclude catch-up HSA contributions made under a cafeteria plan from the Code Section 125 nondiscrimination rules. This would be consistent with the exception from nondiscrimination testing that exists for catch-up 401(k) contributions. Without such an exception, it might be very difficult, if not impossible, to offer catch-up HSA contributions on a salary reduction basis under a cafeteria plan.

> **On a related note, the guidance should clarify that employer-provided catch-up HSA contributions made outside of a cafeteria plan can meet the comparability rule, so long as all similarly-situated participants (i.e., those participants age 55 to 65) are treated comparably.**

6. The corrective procedures in instances where employer contributions exceed the statutory contribution limits

A. Issue: In many cases, consistent with Q/A 21 of the Notice, HSA deposits will be made in advance by employers and/or employees. This practice will be especially prevalent where the HDHP and HSA are offered as a single integrated health plan arrangement. Employer/plan sponsors and trustees will often be unaware of situations in which an eligible individual becomes ineligible (e.g., because spouse obtains disqualifying coverage). Q/A 22 notes that excess contributions by employers are taxable and that excess contributions by an employee are not deductible. Also, employer contributions that become taxable are not considered wages subject to income and employment taxes so long as the employer had reason to believe that the contributions would be excluded from income when they were made. Moreover, the trustee is required to report excess contributions.

Proposed Resolution: Neither the employer nor the HSA trustee has an adequate mechanism for determining whether an excess contribution has occurred. Neither the employer nor the trustee is required to investigate whether the individual is an eligible individual. The employer is not required to monitor contributions made from other sources (e.g. the employer is not required to compare its contributions to those made by family members of the individual). Also the trustee is not required to monitor contributions to the trust account below the family coverage maximum plus any additional contributions (which would include excess contributions for an individual over age 65). Consequently, the employee/HSA account holder must identify excess contributions to the trustee and request a distribution before the trustee has any obligation to report excess contributions. Upon notice from the account holder, the trustee should report such excess contributions (as well as earnings attributable thereto) and the employee HSA account holder must include such amounts in income. Moreover, the employer should not be responsible for employment taxes or withholding with regard to such amounts.

7. HDHP Plan Design Issues – e.g., relationship between statutory out-of-pocket limitations and reasonable lifetime maximums on benefits in health insurance plans

A. Issue: Many employers combine all health coverage options under a single "plan" for ERISA benefit plan reporting and disclosure purposes. In other words, many employers document all of their ERISA welfare plans under a single wrap-around plan and file a single Form 5500 and issue a single Summary Plan Description for all of their plans. If a wrap-around welfare plan includes an HDHP and non-HDHP option will the coverage qualify?

Proposed Resolution: An employer's integration of qualifying HDHP coverage with non-HDHP coverage in a wrap-around welfare plan will not, in and of itself, cause the HDHP coverage to fail to qualify under Section 223.

B. Issue: Will a health plan with an annual or lifetime benefits maximum qualify as a qualifying HDHP notwithstanding the possibility that the total expenses incurred may exceed the statutory out-of-pocket (OOP) maximums?

Proposed Resolution: Health plans have historically placed a limit on their maximum lifetime exposure and annual exposure for certain expenses (e.g., fertility treatment or orthotics). Such limitations are used to set premium rates and are a fundamental element of prudent health plan underwriting. Implementation of a reasonable annual or lifetime maximum provision does not violate the annual statutory OOP limit requirement in 223(c)(2)(A).

C. Issue: Do plan penalties (e.g., penalty for failure to pre-certify treatment or for failure to seek a second opinion) accumulate toward the OOP maximum?

Proposed Resolution: HDHPs may implement reasonable penalties to incent participants to prudently use health care. Such provisions are similar to the "network" incentives allowed by Section 223(c)(2)(D). As a result, such penalties do not count toward the OOP limitations.

D. Issue: Can a qualifying HDHP have a deductible "carryover" feature? For example, can a qualifying HDHP provide that claims incurred in the last three months of the policy year that count toward a deductible carryover and apply to the subsequent year's deductible? Likewise, a common practice in the event of a mid-year coverage replacement (or "takeover") is to give credit for expenses incurred under the prior plan. Are such provisions permissible?

Proposed Resolution: Provisions such as a deductible carryover feature or credit in the case of a mid-year takeover are permissible. Such provisions impact the timing of when an incurred expense counts against the deductible rather than modifying the minimum statutory dollar threshold for the deductible.

E. Issue: Can a qualifying HDHP include coverage for which benefits are paid below the deductible due to a state law mandate? For example, some states require that certain benefits, such as hospice care or durable medical equipment, be covered subject to a nominal copayment in all cases. If a state law requires that benefits be paid (below the deductible) subject to a copay or other plan provision, will the plan qualify as a HDHP?

Proposed Resolution: A plan will not fail to qualify as a qualifying HDHP where benefits are paid below the deductible solely to ensure compliance with a state law benefit mandate.

F. Issue: Most health plans exclude certain specified treatments (e.g., OTC or prescription drugs, transplants, substance abuse, orthotics) and/or place caps or limitations on others (e.g., cap on chiropractic care visits, annual cap on prescription drug expenses). Health plans have historically imposed caps or limitations on certain types of expenses in an effort to preserve health care dollars for necessary medical treatment and/or reduce or eliminate potential waste for treatment perceived to be susceptible to abuse.

Proposed Resolution: Subject to certain federal and state mandates (e.g., mental health care) health plans may, by design, exclude certain treatments and/or impose a treatment-specific cap or limitation on the total benefits paid (or total number of treatments or days of coverage) for any specific treatment. The statutory OOP limitation requirement applies with regard to health coverage generally, and not to caps or limitations for a specified covered expense. HDHPs may also apply reasonable and customary (and similar cost-based) limitations on covered expenses without the excess (uncovered) amount applying toward the OOP limit.

G. Issue: Must copay expenses incurred for benefits subject to a copay feature (e.g., preventive care) be included for purposes of determining the plan's OOP limitation?

Proposed Resolution: Consistent with current health plan administration practice, covered expenses incurred under a permissible copay arrangement (e.g., preventive care) are not required to apply to the HDHP's OOP maximum.

H. Issue: Dental or vision insurance (clearly permitted insurance) can be offered along with a qualifying HDHP/HSA through a separate policy. Analytically, the inclusion of dental or vision permissible within the same policy as an otherwise qualifying HDHP should be permissible as well. However, technically speaking, literal application of the "no medical benefit before deductible other than preventive care" requirement under Section 223 for an HDHP causes concern.

Proposed Resolution: A qualifying HDHP can provide benefits for expenses covered by permitted insurance (as defined in Section 223(c)(3)) and/or other disregarded coverage (as defined in 223(c)(1)(B)(ii)) without regard to the deductible or OOP limitations included in Section 223. Where benefits for such expenses are paid below the deductible, they do not apply to the OOP limitation.

I. Issue: HDHPs that offer family coverage often include a "stacked" deductible feature under which benefits are paid for an individual that incurs expenses in excess of a lower "embedded" individual deductible. Such a feature encourages adoption of HDHPs because it helps soften the financial (cash-flow) impact that would arise where a single covered individual incurs a large medical expense (e.g., in a car accident). Moreover, consumerism is still fostered for other family members (up to the deductible). Under Notice 2004-2, Q/A-3, coverage with an embedded deductible is not permitted unless the lower individual deductible is above the $2,000 family limit. While Q/A-3 is consistent with existing MSA guidance, it is not directly required by Section 223, and will greatly discourage families from adopting HDHPs because of the potential for financial hardship. Moreover, insurance carriers must undertake the time-consuming process of re-filing otherwise qualifying HDHP coverage to eliminate the embedded deductible.

Proposed Resolution: Treasury and IRS should reconsider their position on this issue. Such a position works a financial hardship on families without further fostering consumerism. Families may resist HDHP options where their exposure for a single catastrophic event is set at the family deductible level. At a minimum, a transition rule should apply (until 2005 or later) enabling carriers adequate time to refile policies without an embedded deductible

Section II: Additional Areas of Concern

1. Contributions

A. Issue: What responsibility does a contributing employer have to ensure that an individual is an "eligible individual" before making contributions (either employer non-elective contributions or pre-tax contributions under the cafeteria plan) to an HSA? This question is significant in the following two aspects of HSA contributions:

1. Employer contributions are *not* considered "wages" for purposes of income and employment tax withholding so long as it is "reasonable to believe that the

employee will be able to exclude such payments from income under Section 106(d)". If an employer makes contributions to an HSA for an individual without determining whether the individual is an "eligible individual", to what extent must the employer investigate the status of the individual as an "eligible individual" to ensure that the "reasonable belief" standard is satisfied?

2. The Medicare Bill amended the deferred compensation provisions of Code Section 125 to allow employers to offer HSAs under the employer's cafeteria plan. To what extent must an employer investigate the status of those electing to make pre-tax contributions to an HSA as "eligible individuals" to ensure tax qualification status of the cafeteria plan?

Proposed Resolution: An employer may assume an HSA contribution made on behalf of an employee (e.g., via salary reduction) is on behalf of an eligible individual as long as the amount is within the statutory limits for the employee's coverage category (e.g., $2600/5150 plus the additional contribution amount for being over 55 where appropriate). An employer may rely on an employee's certification that they are an "eligible individual", but the employer is not required to obtain certification from the employee.

B. Issue: The individual's "family members" may make contributions on behalf of an eligible individual and the individual is entitled to a deduction (to the extent statutory requirements are otherwise satisfied) for such contributions. What is the definition of "family member"?

Proposed Resolution: A "family member" is any lineal ascendant or descendant of the eligible individual or a lineal ascendant or descendant of the eligible individual's spouse.

2. Distributions

A. Issue: Can an employer and/or trustee (by plan or trust provisions) require substantiation that a distribution is for an eligible medical expense before making the distribution?

Proposed Resolution: An employer or trustee by plan or trust provision can impose limitations on HSA distributions as long as a distribution can ultimately occur at some point (e.g., upon termination of employment, death, or disability).

B. Issue: The 10% excise tax does not apply to distributions for other than medical expenses if an individual is entitled to Medicare due to age (see Section 223(f)(4)(C)). Are those entitled to Medicare due to ESRD or disability exempt from the 10% excise tax?

Proposed Resolution: Yes. Any individual entitled to Medicare is exempt from the excise tax.

C. Issue: Health plans have disparate run-out periods for filing claims. In many cases (e.g., claim appeal or overlapping coverage), ultimate claim resolution may not occur for years after an expense is incurred. Can HSA distributions be deferred? If not, how soon after a medical expense is incurred must the HSA distribution occur.

Example: An HSA holder contributes $5150 per year to his HSA in each year from 2004 until 2013. This $51,500 in deposits has resulted (with investment earnings) in an account balance on January 1, 2014 of $100,000. The account holder has also incurred and paid $7,000 in eligible expenses each year (for a total of $70,000) and has adequate documentation substantiating the incurrence of such expenses, but has elected to pay for medical expenses with non-HSA funds to allow the HSA to increase in value. On January 1, 2014, the account holder withdraws $70,000 and uses the amount to take a vacation. Is any amount taxable?

Proposed Resolution: An HSA account holder may defer distributions for medical expenses. There is no time limitation on when the distribution must occur. Properly substantiated medical expenses build up a basis entitling the HSA account holder to a tax-free distribution whenever funds are withdrawn.

D. Issue: Many HSA trust arrangements will allow for trustee fees to be taken from the HSA. Will such fees be treated as an eligible medical expense? IRS has informally indicated that similar “account administration fees” can be paid on an excludable basis from an FSA or HRA.

Proposed Response: HSA trustee fees may be deducted from an HSA. Such deductions, where related to HSA administration costs, will be treated as an eligible medical expense. Therefore, such amounts will be excluded from income and exempt from the excise tax applicable to non-medical distributions.

3. HSA Trusts and Trustees

A. Issue: In many cases, individual HSA accounts will be small -- and outside administrative and trustee fees may be cost-prohibitive. However, outside fees may possibly be reduced if an employer sets up a "group HSA" (analogous to a group IRA) and hires a recordkeeper to separately allocate earnings, etc on the individual participant sub-accounts.

Proposed Resolution: The IRA rules should be applied, and a group HSA sponsored by an employer should be permissible.

While existing HSA guidance and legislative history do not specifically indicate whether group HSAs are permitted, group IRAs are permitted under Code Section 408(c). The IRA statute states that a trust created by an employer for the exclusive benefit of his employees or their beneficiaries shall be treated as an individual retirement account, if the trust satisfies the IRA requirements and there is a separate accounting for each employee's interest. If these requirements are met, the assets of the trust may be pooled together in a common fund. Reg. Sec. 1.408-2(c) also states that group IRAs created by an employer are permissible. Subsection (c)(4)(i) states that the term separate accounting means that separate records must be maintained with respect to each employee for which the trust is maintained. The assets may be held together in a common trust fund or investment fund for the account of all the employees with an interest in the trust.

Further support can be found in Section 223(d)(1)(E). If group HSAs were not permitted this provision would not be needed – i.e., an individual's "interest in their account" would be superfluous, as the statute could have referred to the individual's interest in the HSA.

B. Issue: Section 223(d)(1)(B) indicates that the trustee must be either a bank, an entity that is approved by Treasury or an insurance company as defined in Section 816. Section 816 refers to life insurance companies; however, a broader definition of insurance company is included in Section 816(a). Moreover, Notice 2004-2, Q 9 indicates that "any insurance company" can be a trustee. Thus, it would seem that any insurer (as defined in Section 816(a) can be an HSA trustee without IRS approval?

Proposed Resolution: Any entity licensed as an insurer in a state automatically qualifies as an HSA trustee.

C. Issue: Notice 2004-2 indicates that HSA trustees will have the same reporting requirements as they would otherwise have for MSAs (e.g. reporting gross distributions made from the trust during the year). In some cases HSA trustees will know whether a medical expense has been incurred. Confirmation that trustees will have no additional reporting requirements such as reporting distributions made for non-medical purposes (to the extent the trustee knows that the distribution is not for medical purposes) would be welcome.

Proposed Resolution: HSA trustee reporting requirements will be limited to those requirements currently imposed upon MSA trustees. It is solely the responsibility of the individual to report distributions for non-medical purposes even if the trustee requires certification/substantiation as to the purpose of the distribution.

The Employers Council would be pleased to discuss the proposals at any time. We appreciate the opportunity to submit our views on behalf of ECFC.

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