

Treatment of Account-Based Health Arrangements under the Medicare Modernization Act

Introduction

Beginning in 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides employer and union sponsors of qualified retiree prescription drug plans the ability to receive tax-free retiree drug subsidy payments for a portion of their plan's prescription drug costs. For each qualifying covered retiree, the sponsor is eligible to receive payments of 28% of allowable drug costs attributable to gross prescription drug costs between the cost threshold (\$250 in 2006) and the cost limit (\$5,000 in 2006).

This guidance addresses the extent to which account-based health arrangements sponsored by employers and unions, such as Health Reimbursement Arrangements (HRAs), Flexible Spending Arrangements (health FSAs), Health Savings Accounts (HSAs), and Archer Medical Savings Accounts (Archer MSAs), can qualify for such subsidy payments. The guidance also addresses the extent to which such coverage under account-based arrangements can qualify as "creditable coverage."

Background

To be eligible for the retiree drug subsidy, several requirements must be met, including the following: the sponsor's plan provides coverage of retiree health care costs, including prescription drugs, under a group health plan; the plan's retiree prescription drug coverage is creditable coverage (and Medicare beneficiaries are notified about that fact); and the plan sponsor submits an attestation that the actuarial value of the plan's retiree prescription drug coverage is at least equal to the actuarial value of the defined standard prescription drug coverage under Part D.

Group health plans. Under 42 CFR §423.882, accounts that are used for payment of medical expenses can be "group health plans" for these purposes "to the extent they are subject to ERISA as employee welfare benefit plans providing medical care (or would be subject to ERISA but for the exclusion in ERISA section 4(b), 29 USC §1003(b), for governmental plans or church plans.)" As noted in the preamble to the final rule at 70 Fed. Reg. 4402, HRAs and FSAs are generally treated as ERISA welfare benefit plans, while HSAs and Archer MSAs generally are not treated as such (even if an employer makes contributions directly into an HSA or Archer MSA).

In many cases, such accounts are provided in conjunction with other health coverage that has high deductibles (commonly referred to as high-deductible health plans or HDHPs). Participants can use funds from the accounts to pay for all or part of the expenses not

covered by the HDHP. Regardless of whether an account standing alone is a group health plan, the HDHP associated with that account can qualify as a group health plan if it is contributed to or otherwise established or maintained by an employer or union.

Actuarial equivalence. Section 423.884(d) of the final rule implements a two-prong actuarial equivalence standard that a sponsor's plan must meet in order to qualify for the retiree drug subsidy. The first prong is the gross value test, in which the expected amount of paid claims for the Medicare beneficiaries in the sponsor's plan must be at least equal to the expected amount of paid claims for the same beneficiaries under defined standard Part D coverage. The second prong is the net value test, which takes into account the employer financing of the coverage. The net value of the sponsor's plan, which must be at least equal to the net value of the defined standard prescription drug coverage, is calculated by subtracting the annual retiree premium/contribution from the gross value of the coverage under the sponsor's plan. The net value of the defined standard prescription drug coverage is calculated by subtracting the annual beneficiary premium from the gross value of the defined standard prescription drug coverage. See the Guidance on the Retiree Drug Subsidy Actuarial Equivalence Standard on the CMS website (<http://www.cms.hhs.gov/medicarerereform/pdbma/employer.asp>).

Creditable coverage. Creditable coverage is generally determined using the same standard as the first prong of the gross value test for the retiree drug subsidy. Prescription drug coverage is creditable if the total expected paid claims for Medicare beneficiaries under the sponsor's plan will be at least equal to the total expected paid claims for the same beneficiaries under the defined standard prescription drug coverage under Part D. See 42 CFR 423.56. The beneficiaries need this information because if their coverage is not creditable and they fail to enroll in Part D during their initial enrollment period, they can be subject to an additional Part D premium if they enroll in Part D at a later date. See the Guidance on Creditable Coverage on the CMS website(<http://www.cms.hhs.gov/medicarerereform/pdbma/employer.asp>).

With the release of the final Part D regulation was released in January, CMS requested comments on the extent to which account-based arrangements might qualify for retiree drug subsidy payments. This guidance, after providing an overview of the key characteristics of health care account-based arrangements, describes standards for applying the creditable coverage and actuarial equivalence tests to such arrangements.

Characteristics of Employer or Union Account-Based Arrangements

The major characteristics of the account-based arrangements addressed in this guidance are as follows:

HRAs

An HRA is described in Internal Revenue Ruling 2002-41 and Internal Revenue Notice 2002-45. In general:

- The account is funded solely by an employer and not (either directly or indirectly) through an Internal Revenue Code § 125 cafeteria plan;
- The account reimburses employees, retirees and/or other former employees, their spouses and dependents for incurred “medical care expenses” (as defined under 26 U.S.C. § 213(d)), which can include but need not be limited to prescription drug expenses; and
- Participants are credited up to a specified annual maximum dollar amount for a coverage period, with unused amounts carrying forward to subsequent coverage periods.

Under IRS rules, an employer can continue to provide credits or contributions to an HRA after a person retires and/or becomes covered by Medicare.

FSAs

Health FSAs are generally defined as a benefit program which provides employees with coverage under which a *specified* incurred expense may be reimbursed, and the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage. See Internal Revenue Code Section 106(c)(2). Health FSAs are subject to a variety of restrictions, including rules that require that participants incur claims within the plan year or within a 2-1/2 month grace period following the plan year or forfeit unused funds; that the entire amount elected by a participant be available for reimbursement at a given time, regardless of how much the participant has contributed at that point; and that account balances *not* be used to pay for insurance. FSAs are typically funded by salary reduction, so their utilization by retirees is infrequent.

Archer MSAs and HSAs

Archer MSAs and HSAs are separate tax-favored trusts or custodial accounts that permit employer or employee contributions and withdrawals for medical expenses on a tax-free basis. While there are some significant differences (for example, Archer MSAs are only available to self-employed individuals and workers at small companies, while HSAs are not subject to that restriction), in many respects the two accounts are similar. Similarities include dollar limits on the amount of permitted contribution, and a requirement that contributions generally be made only when a person is covered solely by an HDHP that meets specified standards regarding minimum deductibles and maximum out-of-pocket expenses. Also, contributions to Archer MSAs and HSAs are specifically prohibited once the account-holder becomes entitled to Medicare. Details about HSAs are available at: <http://www.treasury.gov/offices/public-affairs/hsa/index.html>.

Guidance

Creditable Coverage

HRAs. In many cases an employer or union-sponsored HRA is offered in conjunction with an HDHP or other employer or union-sponsored group health plan (referred to here as the “non-account” benefit). If an individual participates in both the HRA and the non-account benefit, then for purposes of determining whether the individual has creditable coverage, amounts credited to the HRA in a given year should be treated as increasing the expected prescription drug claims payable from the non-account benefit for that year. Existing funds in the HRA that have been rolled-over from prior years will not be factored into the value of the arrangement. For HRAs that pay for both prescription drugs and other medical costs, a portion of a year’s allocation should be reasonably estimated and allocated to prescription drugs.

For example, a sponsor offers a group health plan that is an HDHP with an annual deductible of \$1,000 to its retirees. The group health plan provides an account-based HRA in conjunction with the HDHP. The HRA has an annual credit of \$500 for each participant. If retirees can utilize the HRA and the HDHP only for allowable prescription drug costs, then for purposes of determining whether this combined arrangement is creditable coverage, the sponsor is considered to provide drug coverage with a \$500 annual deductible. If the HRA covers both prescription drugs and other medical costs, then a portion of the credited amount should be reasonably allocated to prescription drug coverage and a portion to other benefits. A similar actuarial allocation would be required for the HDHP if it has integrated prescription drug and non-prescription drug provisions such as deductibles or annual coverage limits. See CMS Guidance on the Actuarial Equivalence Standard for the Retiree Drug Subsidy (April 7, 2005).

If an individual who participates in an employer or union-sponsored HRA does not also have non-account benefits sponsored by such employer or union, the analysis of whether the HRA’s coverage is creditable in a given year is determined by treating the HRA as if it were a plan with no deductible and an annual limit equal to the amount of the credit for that year. For example, if an individual has \$2,000 credited to an HRA by an employer and/or a union in 2006, then for creditable coverage testing purposes, the plan should be viewed as if it were a plan with no deductible or co-insurance payments and a \$2,000 annual limit. As noted above, if the HRA covers both prescription drugs and other medical costs, then a portion of the credited amount should be reasonably allocated to prescription drug coverage and a portion to the other benefits.

FSAs. While a FSA is a group health plan, it is extremely difficult to determine whether the plan was providing creditable coverage using generally accepted actuarial principles as required under §423.56, given the nature of FSAs (e.g., participants typically elect whether and how much to contribute in a given year, resulting in a wide range of coverage levels). The problem is that the actuarial value of the FSA to the individual cannot be determined prospectively, since an employer will not know in advance how much the beneficiary will contribute toward the FSA and what portion of that contribution will be spent on drugs. Accordingly, an employer or union sponsoring an FSA shall disregard such plan for purposes of determining whether an individual has creditable coverage.

HSAs/MSAs. As indicated above, no contributions can be made to HSAs or Archer MSAs once the retiree becomes entitled to Medicare. Accordingly, these types of accounts cannot be taken into account in determining whether an HDHP qualifies as creditable coverage. (Similarly, they cannot be taken into account in determining whether the HDHP can qualify for the retiree drug subsidy.)

Creditable Coverage Notices

Since a HRA can be creditable coverage on either a stand-alone basis or in conjunction with a HDHP, sponsors of HRAs must provide notices to the Medicare beneficiaries in those account-based plans, as discussed in the Creditable Coverage Guidance. The notices must advise them whether the coverage provided through the HRA, either on a stand-alone basis or combined with an HDHP, is creditable.

Since FSAs, HSAs and Archer MSAs are not to be taken into account in determining whether a beneficiary is receiving creditable coverage, sponsors will not have to send creditable coverage notices regarding these account-based arrangements to beneficiaries. However, creditable coverage information would be required for HDHPs and other non-account benefits available to participants with these accounts.

The Retiree Drug Subsidy Actuarial Equivalence Test

HRAs. If a retiree participates in both a non-account benefit and an HRA sponsored by an employer or union, and if the arrangement on a combined basis satisfies the first prong of the actuarial equivalence test under the standards described above, then any contributions required of a retiree to the HRA (e.g., after-tax contributions for COBRA beneficiaries) will be taken into account in determining the retiree premium for the combined arrangement under the second prong in the actuarial equivalence test (“net value” test) for the retiree drug subsidy. Rules for allocating premiums among prescription drug and other medical coverage are described in the final rule at §423.884(d)(5)(ii)(B). Claims paid from an HRA for Part D drugs will be eligible for retiree drug subsidy payments in the same manner as claims paid from a non-account benefit.

FSAs. Because FSAs are not taken into account in determining creditable coverage, they are also disregarded in determining eligibility for or payments under the retiree drug subsidy. However, pursuant to §423.100 of the final rule, FSAs are personal savings vehicles. Funds from such vehicles do not adversely affect the true out of pocket (TrOOP) calculations for individuals who choose a Part D plan. (Once an individual’s TrOOP level hits a specified threshold - \$3,600 in 2006 – the person is entitled to catastrophic coverage in a Part D plan.) Thus, an individual can withdraw funds accumulated in an FSA on a tax-free basis to pay for cost-sharing in a Part D plan without delaying the point at which the policy begins providing catastrophic coverage.

HSAs/MSAs. As indicated above, contributions to HSAs or Archer MSAs are not permitted after a person becomes entitled to Medicare. Such accounts will not be treated as satisfying the first prong of the retiree drug subsidy actuarial equivalence test, nor can

amounts in those accounts be taken into account in determining whether an HDHP meets the actuarial equivalence test.

While employers and unions cannot receive retiree drug subsidy payments with respect to HSAs and Archer MSAs, the MMA provides other options for sponsors and retirees utilizing these accounts. For example:

- HSAs and Archer MSAs (like FSAs) are personal savings vehicles under §423.100 of the final rule for purposes of the TrOOP rules. Thus, a retiree can withdraw funds accumulated in an HSA or Archer MSA on a tax-free basis to pay for cost-sharing in a Part D plan and have it counted towards their \$3,600 out-of-pocket limit in order for the policy's catastrophic coverage to take effect.
- Sections 220 and 223 of the Internal Revenue Code also permit a retiree who is at least age 65 to withdraw funds from the accounts on a tax-free basis to pay premiums for Part D policies. (And such payments do not affect TrOOP calculations.)
- The MMA made permanent rules that permitted the establishment of Medicare Savings Accounts (Medicare MSAs) combined with a Medicare MSA plan (a HDHP plan under the Medicare Advantage program). Under these rules, CMS makes contributions to the accounts (which are similar to Archer MSAs) and makes payments toward the cost of qualifying HDHP coverage. Rules describing these accounts are set forth in Internal Revenue Code Section 138 of the Social Security Act. Rules describing Medicare MSA plans are set forth in Section 1859(b)(3)(A) of the Act, and rules describing Medicare MSAs are set forth at Section 1853(e) of the Act. Although contributions by employers or other entities to Medicare MSAs are not permitted, a retiree plan sponsor could, for example, provide Part D coverage to retirees to supplement any Medicare MSA they might choose to establish, if one is made available to them. Thus, Medicare MSAs as enhanced by the MMA should represent an additional option for employers and unions that assist retirees in obtaining drug coverage.

For More Information

Questions about the application of creditable coverage and the retiree drug subsidy to consumer-driven and account-type plans and arrangements can be submitted to <http://mmaissuesform.cms.hhs.gov>.