



In This Issue

In this first issue of the McGraw Wentworth Benefit Advisor for 2004, we will examine the provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003. The primary intent of this legislation is to add a prescription benefit to Medicare. However, the law includes a number of provisions not related to prescription benefits at all. This Advisor will review in depth the provisions of this act and its affect on your plans.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“Medicare Part D”

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Not only does this landmark piece of legislation include a broad range of changes to Medicare, it includes other provisions that may affect your organization.

This Advisor covers the portions of this act pertinent to plan sponsors, including:

- **Part D** – A review of the prescription benefit offered to Medicare beneficiaries.
- **Retiree Health Plans** – The effect this act has on retiree plans.
- **Medicare Advantage (formerly Medicare + Choice) Plans** – A review of alternatives to traditional Medicare.
- **Health Savings Accounts** – A tax-favored account that can be set-up for individuals under certain circumstances.
- **Foreign Drug Importation** – The limited circumstances under which drugs can be imported from other countries.
- **1099 Issuance** – Changes in requirements on issuing 1099s on FSAs/HRAs that use debit cards.
- **Additional Medicare Changes**



This complicated act changes some key features of the Medicare program. We will review these issues in depth with a focus on how they may affect your plans.

Part D: The Benefits

Part D of Medicare will be a voluntary program and available to Medicare beneficiaries effective January 1,

2006. To be eligible for Part D, an individual must be entitled to Part A or enrolled in Part B. As with Part B, individuals will have an initial

enrollment period. For current Medicare-covered individuals, that period will begin on November 15, 2005. The Centers for Medicare and Medicaid Services (CMS) will dictate the enrollment parameters for individuals who become eligible after January 1, 2006.

Individuals are not required to enroll when they are initially eligible. Although the details have not been released, a premium penalty will apply to individuals who enroll in Part D late. The penalty will be waived under certain circumstances; for example, if an individual waived coverage because he or she was already covered under another plan.

The prescription benefits are outlined in the chart to the left.

The exact premium for Part D has not been set yet but is expected to be roughly \$35 a month. The premium is targeted to cover 25% of the Part D benefits expense. Low-income enrollees may qualify for premium subsidies.

The government is taking a unique approach to providing Part D benefits. Rather than the federal government creating and administering a negotiated fee structure, private plans will offer this benefit throughout the country. It is expected that pharmacy benefit managers, traditional insurance carriers and possibly Medicare Part C vendors will offer these plans. The legislation requires at least two plan options for most geographic regions wherever possible. The two plans could be a combination of two separate vendors managing programs. In effect, the government will be requesting bids and discount information for vendors to manage the program. The plan offered must be the standard plan outlined above or the actuarial equivalent. This simply means standard benefits may differ slightly in certain geographic regions. The plans that are established will be called prescription drugs plans (PDPs).

Prescription drug plans must be state-licensed, risk-bearing entities or meet federal solvency standards. The PDP will handle all plan management functions including:

- Negotiating discounts
- Meeting formulary requirements
- Achieving accessibility standards
- Providing required drug management programs

Individual Prescription Expense	Medicare Pays	Individual Pays
First \$250	\$0	\$250
Next \$251-\$2,250	75% of cost (up to \$1,500)	25% of cost (up to \$500)
Next \$2,251-\$5,100	\$0	\$2,850
\$5,101 + Catastrophic Coverage	95% of cost	Greater of 5% of cost or \$2 generic/\$5 brand name

The benefits are paid on a calendar year basis. Not counting premium payments, if an individual fills at least \$5,100 in prescriptions in a calendar year, the individual will pay \$3,600 of that expense. However, expenses above \$5,100 will have minimum cost share requirements.

The numbers in blue are indexed thresholds and will apply for 2006. These thresholds will be adjusted annually based on the projected rate of growth in per-capita spending in the Medicare population.

Individuals with incomes below 150% of the federal poverty level will receive cost sharing subsidies based on income level.

The PDPs are not just administering the plan. PDPs will receive enrollee premiums and government payments to fund providing the benefits. The PDP is subject to some risk when the plan's experience exceeds the prescription spending targets. The government will pay 80% reinsurance for drug claims that exceed the \$5,100 threshold.

Remember, actual benefits under Medicare Part D do not go into effect until January 1, 2006. To assist Medicare beneficiaries in the interim, the Department of Health and Human Services is required to establish a discount drug program no later than six months following December 8, 2003. This program will also be voluntary and subject to an annual fee not to exceed \$30. The program will provide approximately a 15-25% discount off the retail prescription prices for Medicare beneficiaries enrolled in the discount plan.

As with the Part D benefits, non-governmental entities that meet the requirements outlined by the act will be chosen to provide the discount plans.

Retiree Health Plans

One of the key discussion points involving adding a prescription drug benefit to Medicare was the effect it would have on retiree plans. It is estimated that at least 12 million Medicare beneficiaries (roughly 30%) have prescription drug coverage under an employer-sponsored retiree plan. If Medicare added a prescription drug benefit, the program would be paying primary coverage for beneficiaries that already have prescription coverage, thus causing significant increases in cost and risk to the Medicare program. This risk was already being held by employers. Also, there was concern employers would discontinue retirees' prescription benefits.

The challenge in creating the legislation was to create an equitable solution that would encourage employers to continue their prescription drug programs without change. The new legislation offers employers subsidy payments in certain situations:

- Plans are eligible for the subsidy if they provide a drug

benefit that has an actuarial value of the Part D benefit or greater.

- Although the details have not been released, plan sponsors will need to provide "attestation" to the government that their plan meets the actuarial equivalency test.
- Plan sponsors must keep adequate records to demonstrate the plan's actuarial equivalence and that subsidy payments are accurate.

To determine equivalency, plans will have to review the benefits their plans provide and the contributions that individuals make for the retiree coverage.

The subsidy is available for each qualified retiree. A qualified retiree is a retiree who is eligible for Part D but chooses not to enroll. The subsidy is equal to 28% of a qualified retiree's allowable drug cost between \$250 and \$5,000. Both of these limits are indexed and will change annually. Allowable costs include amounts the retiree and the plan pay for drugs (minus any discounts or rebates the PBM provides). Allowable cost does not include plan administration fees. Subsidy payments will be excluded income for federal tax purposes. No subsidy payments will be made for benefits that exceed \$5,000.

There is discussion that it is not fair to calculate the subsidy based on both retiree and plan payments. The fear is that employer plans would cut benefits significantly and still receive the same subsidy because it is calculated on employer and retiree payments. However, it is important to remember, plans must meet the equivalency test prior to qualifying for a subsidy.

What options should organizations that offer retiree prescription drug coverage consider?

Many plan sponsors have been considering this question since December 8. The answer, of course, is not particularly clear cut:

- The plan sponsor could certify the plan is the actuarial equivalent and take the tax subsidy. If your organization takes this approach, keep in mind:
 - Communication with your retirees is key. The subsidy is available **only** on retirees who do not enroll in Part D at all.

- The steps necessary to file for the subsidy have not been released. The process must be one your plan can implement.
- There is a question for ERISA plans if subsidies attributed to participants' payments are considered ERISA plan assets and would need to be held in trust. If these subsidies are considered ERISA plan assets, administering the plan becomes more complex.

The affect of these subsidies on FAS 106 is outlined below.

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EFFECT ON FAS 106

FASB initially indicated that it did not want employers' to reflect any changes related to the Medicare Act until more details were released regarding how subsidies would be calculated. Early in January, FASB reversed this position and will allow plan sponsors to choose immediate treatment or delayed treatment:

- **Immediate Treatment** - If a plan sponsor is fully prepared to reflect changes in its' financial statement, it can choose to include the changes in the accounting period which the law was enacted. This is dependent upon your plan's measurement date. If your plan operates its fiscal year on a calendar year with a January 1 measurement date, the changes can be included in the 2003 FAS 106 statement.
- **Delayed Treatment** - A employer does not need to adopt immediate treatment. A delayed approach is required if an employer is not prepared to measure the immediate impact of the law's affect. If an employer elects delayed treatment, it is precluded from accounting for the law until FASB issues further guidance on the issue.

Reflecting the new Medicare law in FAS 106 accounting will present new concerns. Plan sponsors should consider:

- If planning to take the subsidy, how this should be calculated. FASB indicated a potential acceptable approach would be to immediately reflect the entire present value of future expected subsidy payments.
- The employer may choose to amend their plan design. This would need to be reflected on FAS 106 statement
- Acturial assumptions may be affected by the new law.

Employers should consult with their actuaries in determining the best course of action.

- Plan sponsors could change their prescription plan design. A plan design could be developed to supplement Medicare coverage. While this approach sounds attractive because it would limit risk under the employer portion of the prescription plan, there are a host of key considerations:

- Most important, the Medicare prescription program describes benefit payment for expenses over \$5,100 as “catastrophic” coverage. In order to qualify for the “catastrophic” coverage level, a Medicare

beneficiary must reach \$3,600 in out-of-pocket expense.

This expense cannot be paid or reimbursed by an employer plan. In order for a group health plan to transfer this catastrophic prescription coverage to Medicare, the plan design would have to create \$3,600 of cost that a beneficiary would need to absorb. For the majority of plans, this would be a significant cut in benefits.

- It is not clear whether employers will be able to reimburse retirees for Part D premiums to assist in reducing out-of-pocket expenses.
- It is important to understand that if you take a secondary approach, your plan would not meet the

eligibility requirements for the subsidy.

- As a plan sponsor, you could choose to eliminate prescription benefits under your retiree plan. However, your organization should consult legal counsel before taking this course of action to determine if it is permitted under your retiree arrangements.

Retiree health plans have time to determine how to handle retiree prescription drug coverage. The Medicare benefit becomes effective on January 1, 2006. Many of the details regarding how subsidies will



work have not been determined. Health plans should consider all options regarding their prescription plans and look for further guidance from

the governmental agencies that will administer the subsidies and coordination approaches.

Medicare Advantage Plans

Medicare Advantage is the new name for Medicare + Choice plans. Medicare + Choice options emerged about five years ago. Medicare + Choice plans were:

- Generally underwritten by insurance carriers.
- Primarily HMO plans.
- Funded by members’ premiums and government subsidies.
- Replacements for traditional Medicare Part A and B.

Many carriers pulled out of the Medicare + Choice market because they were unable to generate profits. The government limited increases to payment subsidies, premiums increased dramatically and many carriers were forced to reduce service areas or discontinue their products altogether.

The Medicare legislation introduces new provisions to renew interest in private alternatives to Medicare. The new programs are called Medicare Advantage programs. These programs will receive higher payment rates from the government. These higher payment rates will more closely align with the traditional Medicare fee for service costs.

Current Medicare + Choice plans will have the option to rescind any decisions to withdraw from a service area or reduce their service area because of the increased government financing. Plans can also modify their plan designs and premium rates for 2004.

The increased subsidies are not the only changes. New regional plans may be introduced. The new plans are expected to follow PPO plan design models. The government is implementing a bidding process to approve new plan designs.

The government would like to see private alternatives to Medicare succeed. The details of Medicare Advantage plans will be determined regionally. The market over the next several years will dictate plan designs affiliated with the Medicare Advantage programs. Finally, the government will also sponsor a research project to determine in the long term whether the privately managed Medicare Advantage programs are more cost effective than traditional Medicare.

Health Savings Accounts

The new Medicare legislation introduces Health Savings Accounts or HSAs. The HSA concept is new, although it borrows provisions from medical FSAs (Flexible Spending Accounts), Archer MSAs (Medical Savings Accounts) and HRAs (Health Reimbursement Arrangements).

HSAs are individually owned health care savings accounts like Archer MSAs, but are much more flexible. HSAs are fully portable and are similar to medical IRAs. In fact, these accounts are subject to rules similar to IRAs. The following are the requirements of HSAs:

- Accounts may be established only by individuals covered under a high-deductible medical plan. In order to qualify as a high-deductible medical plan, the plan must have a deductible of at least \$1,000 per individual or \$2,000 per family. The maximum out-of-pocket limit must be \$5,000 per individual, \$10,000 per family. These limits are not absolutes, simply maximums. For PPOs, these maximums apply only to the in-network coverage level.

If an individual ceases to be covered by a high-deductible medical plan, the individual owns the account and its balance, but cannot make any new contributions while not covered by a high-deductible plan.



In order to be considered a high-deductible plan, the only benefits that can be paid without satisfying the deductible are preventive care benefits.

- The individual determines contributions to the accounts. (This feature may change as a plan design function if an employer group offers it, although this point is not particularly clear.) Monthly contributions are limited to one-twelfth of the lesser of the plan deductible or \$2,600 per individual or \$5,150 per family. These limits apply to

combined employer and individual contributions. If both an employee and employer contribute to the account, their combined contribution cannot exceed the maximum. The law allows for catch-up contributions for individuals aged 55-64. The maximum catch up amount is \$500 for 2004. Any contributions that are made to the account that exceed the above limits are subject to a 6% excise tax.

- Accounts must be trustee by a financial institution, an insurance company or another IRS approved entity. The trust requirements are similar to IRA requirements:
 - Cash contributions only (except for rollovers); rollovers are permitted from MSAs or other HSAs.
 - No investments permitted in life insurance.

- Interest in trust is nonforfeitable.
- No prohibited transactions.
- HSA assets pledged as security are taxable as a distribution.
- An individual can deduct contributions to the account up to the account limits when determining adjusted gross income. Employer contributions are excluded from income and wages.
- Interest earnings on the account are not taxed.
- Distributions for qualified medical expenses are not taxable. Qualified medical expenses include distributions made for medical care as defined by Section 213 (d). Health insurance generally does not qualify as a medical expense except for:
 - COBRA premiums.
 - Health insurance premiums while unemployed.
 - Long-term care premiums.
 - Health premiums once individual reaches age 65.

These accounts are not required to be administered by a separate administrator. It will be the individual's responsibility to prove a distribution was made for a qualified medical expense if audited.

Because these accounts are not required to be used for out-of-pocket medical expenses, they can be considered tax shelters.

Distributions not used for qualified medical expenses are considered income and subject to a 10% penalty. Transfers in divorce situations are not

taxable. Distributions made after death if beneficiary is a spouse are not taxable. If beneficiary is not the spouse, the fair market value of the HSA is taxable.

- Aside from being covered by an eligible high-deductible medical plan, individuals must meet additional eligibility requirements:
 - Individuals cannot be covered under a spouse's or dependent's comprehensive employer group health plan. However, there are exceptions to the other coverage rule. An individual can have "permitted insurance" and still be HSA eligible. "Permitted insurance" includes workers' compensation, liability coverage, property insurance, limited scope policies (such as cancer insurance) and hospital indemnity insurance (flat dollar per day of confinement).
 - Dual coverage under a health FSA or HRA is permitted only if the covered expenses under these accounts are limited to specific benefits not covered by the high-deductible health plan.
- Employers can offer HSAs. The employer must contribute an equal dollar amount or percentage to the HSA for all eligible individuals. The non-discrimination requirements mean comparable coverage must be offered for all classes (single vs. family). Tests can be applied separately for full- and part-time workers.

Employers can offer these accounts under a Section 125

plan. The new law amends part of Section 125 and, for these plans only, allows a year-over-year rollovers. In addition, the deferred compensation exclusion is not applicable to these accounts. It is not clear, however, if mid-year status changes will be permitted with these accounts.

HSAs were designed to help individuals save to meet their health care expense needs. HSAs are more flexible than Archer MSAs.

While the parameters of the HSAs are fairly clear, it will be interesting to see how these accounts are integrated into the current health care system.

The IRS recently released additional clarifications for HSAs. This additional guidance can be found at <http://www.irs.gov/pub/irs-drop/n-04-2.pdf>.

These accounts may spur growth of consumer-driven health care plans. They are more portable than HRAs and could be used in a consumer-driven health strategy.

Foreign Drug Importation

Importing drugs is becoming a more popular way to manage prescription drug costs. Many states and municipalities are pushing the federal government to allow their participants to import prescription drugs from countries that provide socialized medicine. The appeal, of course, is the lower cost. Prices are generally fixed in socialized programs and can be 20-80% less than retail cost in the United States.

The debate over importing drugs has been heated. Importing prescription drugs is illegal for individuals or entities (other than pharmaceutical manufacturers). The FDA is stepping up efforts to prevent large scale importations. Many expected the Medicare legislation would legalize imported drugs.



It did not. The legislation allows US pharmacies to import and dispense Canadian drugs, providing the Secretary of Health and Human Services certifies to Congress that the imported Canadian drugs pose no additional risk to the public's health and safety.

At this point, Tommy Thompson, Secretary of Health and Human Services, has indicated that he could not make this certification. This issue will continue to be a hot topic. Even if the FDA and the Department of Health and Human Services reach an acceptable solution, organizations still need to be concerned with how the Canadian government will respond. Four major drug manufacturers have begun limiting their exports to Canada to discourage Canada from exporting the prescriptions back to the U.S. Additional government intervention will be needed to implement a safe and effective importation program.

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1099 Issuance

Last year the government issued guidance on how to use debit cards to pay claims under medical FSAs and HRAs. The guidance outlines the proper claim process plans need

to implement in order to substantiate claims. One of the consequences of using debit cards is the payment process under these accounts has changed. Previously, these accounts were, for the most part, reimbursement models. An individual would pay the bill, submit a claim and be reimbursed for the expense. With a debit card, the plan began paying for medical expenses directly. With this change, plans were required to issue 1099s on certain providers where payments exceeded a specific dollar threshold annually.

The 1099 requirement added an administrative burden to plans. Under the Medicare Act, plans that allow FSA or HRA claims to be processed with a debit or stored value card are not required to file 1099s.

Additional Medicare Changes

The act also includes a host of additional changes to the Medicare program. The following are the highlights of these changes:

- **Part B Premium Changes:** Part B premium was an annually indexed premium designed to cover approximately 25% of the cost to provide the Part B benefits. Beginning in 2007, premiums for Part B will be increased proportionally for high income individuals. The increases will be phased in over a 5-year period. In 2011, when the phase-in is complete, individuals with annual incomes of \$80,000 and

couples with \$160,000 or more will pay a higher premium percentage for Part B. Individuals with over \$200,000 of annual income will pay 80% of Part B premiums.

- **MSP Enforcement Strengthened:** Currently, the Medicare Secondary Payer provisions allow Medicare to recoup primary amounts paid incorrectly only from employers. Most employers have received



a demand letter from Medicare in the last ten years. Organizations look to their insurer or TPA to help correct the situa-

tion. Medicare, however, was limited to collecting only from employers.

The Medicare Act now allows Medicare to recoup primary amounts incorrectly paid not only from employers but also insurers or third party administrators, health plans or others. By broadening these provisions, Medicare hopes to save \$9 billion over the next ten years.

- **Reduction in the availability of certain Medicare supplement policies:** Medicare supplement policies H, I and J will be eliminated as options for individuals who enroll in Part D. These policies provided additional coverage for prescription drugs that will no longer apply if an individual enrolls in Medicare Part D.
- **New Preventive Care Benefits:** Medicare has added new

preventive care benefits. Upon enrollment into Medicare, beneficiaries are covered for an initial physical exam. Medicare will also cover cardiovascular and diabetes screening tests. Mammography coverage will be enhanced as well. Medicare will offer disease management programs to beneficiaries living with chronic conditions such as high blood pressure and diabetes.

Conclusion

The Medicare Prescription Drug Improvement and Modernization Act of 2003 is a very complex piece of legislation. Many of the ideas outlined above are merely concepts; the methods for actually implementing them have yet to be determined. It will take many months of evaluation to really understand how this Medicare legislation will affect group health plans. Employers that offer retiree prescription drug benefits will need to analyze the best course of action for their organizations.

We expect the government to release technical guidance on how to implement the provisions of this legislation. McGraw Wentworth will keep you up to date on all further developments. **MW**

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