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MEDICARE REFORMS AND PRESCRIPTION DRUG COVERAGE

Key Implications for Sponsors of Health and Retiree Health Plans

Congress has passed and the President has announced his intention to sign H.R.1, a Medicare bill that contains a new prescription drug program (Medicare "Part D") for eligible Medicare enrollees and flexible savings vehicles from which individuals may pay for certain healthcare expenses on a tax-free basis. This *Milliman Information Bulletin* examines the law's key provisions as they relate to health benefit plans sponsored by employers for their workers. It does not cover the bills' numerous other provisions that relate to Medicare program changes. The information in this *MIB* is subject to updates as decisions are made by the administrative entity that will implement the program or by congressional alterations as the effects of the new law become known.

General Impact on Employer-Sponsored Plans: Under the new Medicare law, Part D prescription drug coverage will be the primary payor for prescription drugs for Medicare-eligible individuals that are no longer employed, which will reduce retiree drug costs for employer plans if the participant enrolls in the new Part D. Employer-sponsored plans are permitted to pay the new Part D premium for prescription drug coverage on behalf of participants. The new law also contains subsidies for employers and multiemployer plans for those participants that do not enroll in Part D, if such plan offers a drug benefit that is actuarially equivalent to the Part D benefit.

Prescription Drug Coverage: Overall Structure

The structure of the Medicare prescription drug benefit under the new law entails:

- voluntary coverage for prescription drugs under new Medicare Part D;
- "standard" prescription drug coverage (or an actuarially equivalent package);
- monthly premiums, deductibles, cost sharing, limited individual-pay-all costs, and catastrophic coverage;
- premium assistance, lower or zero deductibles, and lower or no co-payments for low-income beneficiaries (income of up to 150% of the federal poverty level);
- delivery of Part D drug benefits through private, stand-alone, prescription drug-only plans or through private "Medicare Advantage" options (replacing Medicare+Choice plans and consisting of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and similar networks that integrate benefits delivery and coverage); and
- an effective date of January 1, 2006, with a transitional prescription drug discount card program available for 2004 and 2005.

"Standard" Prescription Drug Coverage and Benefits

The standard prescription drug coverage may be illustrated by the following chart:

Feature	Part D Standard Plan
Deductible	$250
Initial Beneficiary Cost Sharing	25% of drug costs from $251 to $2,250
Beneficiary-Pay-All Gap	All amounts between $2,250 in drug costs and $3,600 in out-of-pocket expenditures
Catastrophic Coverage	Beneficiary pays at least 5% coinsurance for out-of-pocket expenditures above $3,600

All of the amounts on the chart are annual figures and are subject to annual percentage increases based on growth in per capita drug spending by Medicare beneficiaries.

"Out-of-pocket expenditures" in the above chart are amounts that have been paid by individuals, paid under Medicaid, or paid under a state pharmaceutical assistance program. Amounts that are reimbursed through an employer-sponsored retiree health plan or other private insurance are not included in the out-of-pocket expenditure figures. If there are no such reimbursements, then the initial level of the catastrophic coverage works out to be $5,100 in total drug costs for an individual.

The following chart shows, for various annual prescription expenditures by individuals, the amount a prescription drug plan provider will pay (net of premiums received from the individuals) versus what the individual will pay (including premiums paid). These amounts assume no employer-provided or other insurance coverage for the prescription expenditures, together with an estimated individual Part D premium of $420 annually (the actual premium will be based on a bid process by the market and is unknown at this time; premiums for beneficiaries that enroll after they are first eligible may be significantly higher).

Individual Total Cost of Prescription Drugs	Part D	
	Individual Out-of-Pocket (including premiums)	Cost to Prescription Drug Plan Provider (net of premiums)
$500	$733	-$233
$1,000	$858	$142
$1,500	$982	$518
$2,000	$1,108	$892
$2,500	$1,420	$1,080
$3,000	$1,920	$1,080
$3,500	$2,420	$1,080
$4,000	$2,920	$1,080
$4,500	$3,420	$1,080
$5,000	$3,920	$1,080
$5,500	$4,040	$1,460
$6,000	$4,065	$1,935

Federal Subsidies to Retiree Health Plan Sponsors

Employment-based plans (sponsored by a private employer, unions, or state and local governments for their own employees) that provide qualified retiree prescription drug coverage will receive federal payments (referred to as "reinsurance subsidies") for their retirees who are eligible for but do not enroll in a Medicare prescription drug plan. The subsidy equals 28% of the actual plan costs for each participant based on his or her prescription costs between $250 and $5,000, indexed for inflation. For example: assume a plan has a zero deductible and a 20% co-payment paid by the participant. Participant A incurs $6,000 in prescription drug costs and the plan pays $4,800. However, the expenses that qualify for the federal reinsurance subsidy are only those between $250 and $5,000 (i.e., $4,750). And because the plan requires retirees to pay a 20% co-payment amount, $3,800 (80% of $4,750) is the eligible employer cost for purposes of the subsidy. The subsidy paid by the government to the plan thus will be $1,064 (i.e., 28% of the $3,800).

Prescription drug coverage will be considered a "qualified retiree prescription drug plan" if it is a group health plan that provides at least the actuarial equivalent of the standard prescription drug plan described above. The actual plan provisions do not have to be the same as the standard plan. For example, the plan may require different deductibles and co-payments or may impose various other restrictions, such as pharmacy access provisions.

The new law does not specify any mechanism for implementing the reinsurance subsidy for employment-based plans. Instead, it leaves the process to be determined by an administrative agency between now and 2006. One possible approach is to force all pharmacies to develop a point-of-sale electronic mechanism that could automatically collect from the government their share of any purchases (i.e., the plan only pays the net amount to the pharmacy). At the other end of the spectrum is the possibility that every plan would submit claim data at the end of the year to the administrative agency in order to receive a reimbursement. Across this spectrum are many other permutations of a payment structure.

Health Savings Accounts

Under the new law, beginning in 2004 health savings accounts (HSAs) could be established by anyone who is covered by a "high deductible" health plan, which requires an annual deductible of at least $1,000 for self-coverage ($2,000 for family coverage) and an annual out-of-pocket limit of no greater than $5,000 for self-coverage ($10,000 for family coverage), indexed for inflation. Individuals or employers will be able to contribute an amount equal to 100% of the health plan deductible, but not more than the maximum amount allowed for a high deductible plan associated with the current law medical savings accounts (MSAs), which for 2004 is $2,600 for individual coverage and $5,150 for family coverage. Any contribution to an MSA reduces the maximum allowable contribution to the HSA. Individuals who have attained age 55 may contribute an additional $500 beginning in 2004, phasing up in $100 annual increments to $1,000 in 2009. Contributions to an HSA are not allowed once the individual is eligible for Medicare.

HSAs will exist alongside current-law MSAs, and though similar to each other, HSAs are more flexible by their lack of many of the restrictions (e.g., eligible individuals, the number of MSAs that can exist, the type of health insurance that must be purchased alongside MSAs, and the duration of MSA availability) that apply to MSAs.

HSAs must be held in a tax-exempt trust. Individual contributions to HSAs are deductible and employer contributions are not included in income. The contributions may come from individuals, employers (including via salary reduction under a cafeteria plan), and rollovers from MSAs.

Distributions from HSAs that pay for "qualified medical expenses" of the individual, spouse, or family member will be excludable from income. Qualified expenses are those defined under the tax rules (section 213(d) for itemized deductions for medical care), but generally do not include premiums for health policies until the individual is eligible for Medicare. Once an individual is eligible for Medicare, HSA disbursements may be used for such items as Medicare Part A or B premiums and premiums for employer-sponsored retiree health insurance. Distributions made for nonqualifying purposes are subject to income tax and a 10% penalty. The distributions may be used to meet expenses currently (e.g., the high deductible), or remain in the HSA for medical expenses in a future year, including after retirement.

Employer contributions to an HSA must be made on a comparable basis to all employees in a similar high deductible plan. Contributions are comparable if they are the same percentage of the deductible amount or are the same dollar amount. If the requirement for comparable contributions is not met, then a 35% excise tax must be paid by the employer on the actual contributions made. For purposes of this comparability rule, all companies under common control are treated as a single employer.

Form 1099 Requirements on FSAs and HSAs

Flexible spending accounts (FSAs) and HSAs that have or will adopt the use of debit, credit, and stored value cards for payments to medical service providers need not issue Forms 1099. Absent this statutory change, the IRS previously stated that employers must issue Forms 1099 from the plan to all service providers.

Retiree Health/ADEA Provisions

The new law contains no provision reversing the 2002 appeals court ruling in the Erie County, Pennsylvania case that the county violated the age discrimination laws when it provided retiree health benefits only to non-Medicare-eligible retirees. The conference report, however, includes a statement that the conferees reviewed the legislative history and concluded that making a distinction under the age discrimination laws between Medicare- and non-Medicare-eligible retirees is permitted. What effect this legislative history will have on future age discrimination cases is difficult to determine.

Other Provisions

By the new law's sweeping Medicare reforms, employer-sponsored health plans are likely to be affected by provisions beyond those discussed above. Some of the indirect effects can be expected from the law's provisions governing:

- beneficiary protections;
- Medicare prescription drug program enrollment process;
- method by which federal subsidies are calculated for drug providers, for low-income individuals, and for retiree health plans;
- availability of private prescription drug providers in a given area;
- communications with employees;

- payment formula for Medicare Advantage plans;
- required package of benefits and covered medical providers;
- changes to Medigap policies;
- increases in costs for individuals for currently covered services;
- increases in premiums under Medicare Part B;
- payments to rural providers;
- payments to hospitals;
- physician payment adjustments; and
- Medicare claims appeals.

Accounting Impact

The enactment of Medicare prescription drug coverage and related provisions could have a significant impact on the financial reporting by employers that sponsor retiree health plans. The proposed new reinsurance subsidies to plan sponsors under the prescription drug plan will reduce plan liabilities with respect to retirees who have not opted for the Medicare coverage. If the employer responds to the new Medicare drug coverage by significantly curtailing the employer-provided prescription drug coverage, then the liability carried for retiree health coverage would likewise decrease. The accounting profession is currently reviewing the new Medicare drug prescription program and is expected to provide guidance on the rules for reflecting these reductions in current expense and disclosures. Of course, broad socioeconomic changes effected by the new Medicare drug coverage would no doubt alter the market for health care for the elderly, eventually increasing or decreasing a company's retiree health liability, depending on whether those changes are negative or positive.

Conclusion

The new Medicare law will require careful analysis of current retiree health plans, especially those plans that provide prescription drug benefits. Plan sponsors will need to evaluate different plan designs for their impact on current and future costs, taking into account both the fact that Part D will be primary payor for covered prescription drug benefits for those beneficiaries who enroll and that sponsors will receive a federal subsidy for beneficiaries who do not enroll. The coverage gap between $2,250 and $5,100 under Part D where covered retirees pay 100% of costs will be very unpopular with retirees who have high prescription drug costs. Employers that do not design an actuarially equivalent benefit that will qualify for a subsidy may instead want to design a plan that provides some protection to Part D enrollees for this gap in coverage. There is also a great deal of uncertainty built into the new law because of the many determinations that must be made by Medicare and which will affect both participant premiums and subsidies.

This *Milliman Information Bulletin* was written by Milliman USA's Employee Benefits Research Group, located in Washington, D.C.