SEGAL Bulletin

Benefits, Compensation and HR Consulting

January 2004

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). This *Bulletin* summarizes the highlights of the new law, which has far-reaching implications for the Medicare program, health plans that coordinate with Medicare and health plans in general.[1]

PRESCRIPTION DRUG BENEFIT FOR MEDICARE BENEFICIARIES

Beginning on January 1, 2006, as described briefly in this section, Medicare will provide a limited, voluntary benefit for outpatient prescription drugs.

New Medicare Program: Part D

Individuals entitled to benefits under Part A or enrolled in Part B of Medicare could elect to join the new Part D program during a six-month open enrollment period that will begin on November 15, 2005. Starting in 2006, there will be an annual opportunity to make an election. Those who enroll in Part D may not purchase or renew Medigap policies with prescription drug coverage.

The new drug benefit will be delivered by Medicare Advantage plans (an expanded version of Medicare-funded managed care approaches that are currently called Medicare+Choice) and stand-alone commercial prescription drug plans (PDPs). These plans could offer:

- The standard Medicare drug benefit,[2]
- An "actuarially equivalent" benefit, or
- A supplemental benefit for which covered individuals would pay a higher premium.

The legislation permits plan sponsors to pay all or part of the Medicare Part D premium for their retirees. They could also pay deductibles, coinsurance and other cost-sharing requirements. However, the amount paid by the plan sponsor would not count toward an individual's out-of-pocket maximum. Therefore, if a plan sponsor paid all of an individual's coinsurance amounts, the individual would never become eligible for the Medicare catastrophic coverage for drug costs because he or she would never have any out-of-pocket expenses.

Subsidies for Private Coverage

Sponsors of employment-based group health plans that offer retiree health coverage will be eligible for subsidies[3] if they provide actuarially equivalent (but not necessarily identical) coverage to the standard Medicare benefit.

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[1] For more information about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, see the three issues of The Segal Company's electronic publication *Capital Checkup* that were published on December 11, 2003, which can be accessed from the following Web page: www.segalco.com/publications/capitalcheckup/backissues.html

[2] Medicare beneficiaries will pay a not-yet-determined monthly premium and an annual deductible of $250, both of which will be adjusted annually to take into account increases in the cost of prescription drugs. In the first year, beneficiaries will have to pay 25 percent coinsurance up to $2,250 and 5 percent coinsurance above $5,100. There will be a coverage gap between $2,250 and $5,100 for which participants will receive no coverage under Medicare Part D. The annual out-of-pocket maximum will be $3,600. Payments for non-formulary drugs would not count toward the out-of-pocket maximum. (Amounts will be revised annually.)

[3] The subsidy is 28 percent of incurred prescription drug costs between $250 and $5,000 (maximum $1,330) per eligible individual. The dollar figures are indexed. Plan sponsors only receive subsidies for costs that are actually paid. Administrative costs and discounts/rebates cannot be included. Implementing regulations will provide additional guidance on how subsidies are calculated.

Temporary Drug Discount Card Program

To cover the period until the new Part D program starts, a temporary Medicare Prescription Drug Discount Card program will begin around April 2004 and continue through 2005. Medicare would endorse at least two drug cards per region. Card sponsors could charge beneficiaries an annual enrollment fee of up to $30.

OTHER MEDICARE CHANGES

Other important Medicare changes include:

- Part B will cover additional preventive services (*i.e.*, a physical upon enrollment and cardiovascular and diabetes screening).
- Reimbursement procedures are changed for many benefits (*e.g.*, covered hospital outpatient prescription drugs and ambulatory surgical center services).
- The Medicare Part B deductible will increase to $110 in 2005. Thereafter, it will increase by the same percentage as the Part B premium increase. In addition, Part B premiums will increase for high-income beneficiaries over a five-year period starting in 2007. These changes may affect the costs of employer-sponsored plans that reimburse retirees for these expenses.
- The Act renames Medicare's private sector Part C program "Medicare Advantage" (instead of Medicare+Choice), restructures it and changes reimbursement methodologies in a way designed to encourage new plans.

OTHER KEY PROVISIONS

The Act includes provisions that will affect people not yet eligible for Medicare. The most important ones are discussed in this section.

Health Savings Accounts

The Act creates new personal Health Savings Accounts (HSAs) effective for taxable years beginning January 1, 2004. HSAs permit tax-deductible contributions to an account by an individual, family member or employer *for individuals covered by a high-deductible health plan*. Medicare-eligible retirees may not contribute to an HSA. If an employer contributes to an HSA, it must make comparable contributions on behalf of all employees. Employee contributions may be made by salary reduction through a flexible benefits plan.

HSAs can be used to pay for qualified medical expenses, health insurance for unemployed individuals, COBRA coverage and retiree health insurance for those over age 65 (including Medicare Part B premiums). Distributions for non-health expenses would be subject to income tax and a 10 percent penalty. However, the penalty does not apply after death, disability or after an individual attains Medicare eligibility.

HSAs are portable. Amounts may be rolled over to another HSA within 60 days with no tax penalties. Therefore, an employee could transfer the account to an individual HSA or a new employer's HSA.

Form 1099 Not Required for Debit Cards

The Act provides that health plan sponsors who use a debit card for health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs) do not need to issue a Form 1099 to health care providers, pharmacies or other payees.

As with all issues involving the interpretation or application of laws, plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of the new Medicare law. Segal can be retained to work with plan sponsors and their attorneys to determine how the Act will affect the sponsor's health benefits.

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