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New Medicare Law: opportunities, policy questions for employers

The recent enactment of the Medicare Prescription Drug, Improvement and Modernization Act has significant implications – and possible savings opportunities – for employers that sponsor health plans, especially retiree health plans. The addition of a drug benefit to Medicare was the highlight of the bill and the major impetus for its passing. The bill also expands alternative Medicare delivery systems and creates Health Savings Accounts for active employees.

Medicare Drug Benefits

By now you are probably aware that there is a drug benefit to Medicare that will begin in 2006 and that discount cards will be available around May 2004 to provide at least some financial relief to Medicare beneficiaries until the main program takes effect.

The standard Medicare drug benefit requires the participant to pay about 25% of the premium (an estimated $35 monthly participant cost in 2006). There is an annual deductible of $250 and the participant is responsible for 25% of costs between $250 and $2,250. Once the participant reaches the $3,600 out-of-pocket limit, he/she only has to pay 5% (or, if higher, $2 for general and $5 for brand drugs) of any future drug costs. These thresholds are all indexed to the average increase in Medicare drug costs, so if costs go up by 10%, the deductible, for example, would increase to $275.

Note: the $3,600 out-of-pocket limit must be the participant's costs and cannot be reimbursed by an employer or another plan sponsor's retiree health program. Thus, if an employer is reimbursing the retiree for all out-of-pocket costs, the retiree will never reach the 5% reimbursement category.

Also important is that the standard Medicare plan will not be the only option: the law not only allows but encourages alternative designs as long as they are actuarially equivalent to the standard plan. Further, plans will be administered in the private sector (by insurers, HMOs, etc.), not by the government, and each region of the country will be required to have at least two prescription drug plans available. Drug plans can be integrated with Medicare Advantage programs (described later).

Congress also did not want to create incentives for plan sponsors that currently provide retiree health benefits to abandon those programs, so the law includes incentives for such sponsors to maintain their plans. The new law also does not demand that employers use a "one size fits all" approach with respect to their existing retiree health plans in order to qualify for the subsidy; employers are given latitude on plan design, provider networks and drug formularies. Employers who have a retiree drug plan whose coverage is actuarially equivalent to – or better than – the standard new Medicare

Financial Summary of Medicare Drug Package

Impacted Party	Financial Impact
Average Person eligible for Medicare without insurance	Saves at least 40% of pharmacy costs [1]
People eligible for Medicare with private insurance	Savings varies by coverage
People eligible for Medicare with employer coverage	Savings varies by coverage
Employers	Saves up to 40% cost of Medicare pharmacy benefits, depending on benefits offered
Insurance Companies	Added opportunities
Pharmaceutical Companies	Potential for increased use but also increased pressure to lower costs
Pharmacy Benefit Managers	Added opportunities
Federal Government/Taxpayers	Costs $410 billion from 2004 to 2013 [2]
State Government/Taxpayers	Saves 15% of the over all state savings or $17.2 billion from 2004 to 2013 [3]

[1] "Medicare and Prescription Drug Spending Chartpack," by The Henry J. KAISER FAMILY FOUNDATION, June 2003. Note: if the participant was eligible for Medicaid the Act costs them money through a modest copayment. $1,974 per Medicare uninsured eligible person is the assumed average cost in 2006.

[2] "Prescription Drug coverage for Medicare Beneficiaries: A Summary of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," by The Henry J. KAISER FAMILY FOUNDATION, December 10, 2003.

[3] "Implications of the New Medicare Prescription Drug Benefit of State Medicaid Budgets," by The Henry J. KAISER FAMILY FOUNDATION. Note: several states are actually estimating that the Act will cost them money because of the complex nature of allocating funds.

benefit will receive a subsidy of 28% of a retiree's drug costs between $250 and $5,000. The 28% is of gross drug costs before retiree copayments. If, for example, an employer's plan requires a 25% copayment by retirees, the employer's net cost between $250 and $5,000 goes down by 37%. With most retiree drug costs falling within this range, it's easy to see how employer's costs are reduced considerably.

Employers that currently provide retiree drug benefits may also be encouraged, as an alternative to maintaining their existing plans, to subsidize the cost of retirees' participation in the new Medicare plan. And employers who currently pay for one of the standard Medigap plans should be aware that Medigap plans H, I & J will be eliminated for participants in the Medicare Drug plan.

With the decrease in costs, plan sponsors can expect their relevant financial statement disclosures (FAS106, SOP01-2, or GASB OPEB) to decline. FASB has issued a draft statement that it's currently premature to estimate the impact of changes, but plan sponsors who do cover drugs for Medicare retirees should disclose that there are changes to Medicare not reflected in their disclosures.

Alternative Medicare Delivery Systems

You may remember that back in 1997 Congress created Medicare+Choice to give Medicare beneficiaries access to alternative delivery systems such as PPOs, HMOs, and Point-of-Service plans. However, Medicare+Choice has since suffered significantly. Limited increases (and in some places decreases) in the reimbursements from Medicare resulted in many Medicare+Choice plans reducing their service areas, increasing premiums, or withdrawing altogether.

The new Act changes the Medicare+Choice program to Medicare Advantage (MA for short). There are new payment rates, many of which are higher in 2004 than the Medicare+Choice reimbursements. As a result insurers are allowed to rescind their decision to withdraw or reduce their service areas for 2004 and can modify their plan design and premium rates for 2004.

In addition, the Act creates new regional plans, effective in 2006, with a service area covering one or more broadly defined regions. Given the broad nature, many plans are likely to be structured as PPOs. Effective in 2006 there is also a new bidding process that limits the government's authority to negotiate the bid amounts. Finally, beginning in 2010, the government will sponsor a demonstration project to evaluate direct competition between MA plans and traditional Medicare in certain markets.

Healthcare Savings Accounts

The Medicare Act also created a new entity called a Health Savings Account (HSA). HSAs are primarily for active employees as a possible way to save for retiree health care expenses. Participants covered by a high deductible plan ($1,000 minimum) as their ONLY health coverage can contribute (or their employer can contribute) an amount up to the deductible (but no more than $2,600) into the HSA. Special additional contributions are also eligible for those ages 55–64. To the extent that the participant does not use all the money, it goes into the next year and can earn investment income. HSAs are trusteed and fully portable – like Individual Retirement Accounts.

We expect that HSAs will be popular with young and/or healthy employees (who have time to build up an account) and possibly for small businesses as a way to offer an additional benefit. However, the limitations of HSAs are probably not attractive to most employees covered by larger employers and Taft-Hartley plans. There is another option that is probably more attractive – a Healthcare Reimbursement Account (HRA). An HRA is like an HSA in that it provides an account that can build up but it does not have the limitations of the HSA. An employer could do an HRA with a $500 deductible plan, for example. The HRAs are not portable, so when a participant terminates, the money reverts to the employer or to the plan.

What should plan sponsors be doing?

- Familiarize themselves with the changes to Medicare and how it could impact their plans. They may want to estimate the impact on their financial statements to be ready when the accountants require it.
- Reflect Medicare changes in any multi-year forecasts. Plans going into collective bargaining or similar multi-year benefits contracts should be particularly aware of these changes.
- Be ready for change. This is a major change to a large system. The markets will adapt quickly, and there will be new options available. Many - but not all - will help control costs, and those plans that can identify the difference and take advantage of them will benefit.

Cheiron's sophisticated actuarial modeling tools can help clients perform the necessary analysis to guide decision-makers on the best way to respond to the new law. To learn more about the law or explore how Cheiron can help you evaluate which way to go, contact your Cheiron consultant or call the main Cheiron office at 877-CHEIRON or send an email to info@cheiron.us .

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