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December 2003

New Medicare Legislation: Three Points for Employers

By Mark Poerio and Eric Keller

Last week, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "Medicare Modernization Act" or "MMA"). On three different levels, employers may find that the MMA opens the door for significant improvements to their group health plans for active or retired employees. The discussion that follows is divided accordingly.

Part 1. Health Savings Accounts ("HSAs"): the MMA makes it feasible for employers of all sizes to offer employees the opportunity to establish individual HSA investment accounts that may

- accept employee and employer contributions,
- avoid the "use it or lose it" rule that applies to health flexible spending accounts ("FSAs"), and
- make tax-free distributions for a wide range of health-related expenses.

Part 2. Coordination with Medicare: the MMA's legislative history should further reduce the risk that employers who want to tie benefit plan reductions to Medicare eligibility are violating ADEA.¹

Part 3. Retiree Benefits: the MMA promises a 28% subsidy for prescription drug coverage that employers provide for retirees (effective in 2006).

General Advice: Be Deliberate

The MMA's provisions relating to HSAs have the potential to revolutionize the health plan industry, and warrant immediate attention because they combine the best features of FSAs, health reimbursement accounts ("HRAs"), and medical savings accounts (MSAs). It is theoretically possible for employers to begin to offer HSAs at the start of 2004. This is feasible, however, only for employers that already maintain a group health plan that qualifies as a "high deductible

health plan" or "HDHP" (at least \$1,000 single, \$2,000 family; more below). For other employers, the process of evaluation, design, and enrollment makes their implementation of HSAs unlikely before mid-year 2004.

There is less pressure on employers to respond to the prescription drug subsidy, because it is two years away from becoming effective. Finally, the MMA's legislative history relating to ADEA merely makes it worthwhile for employers to consider benefit reductions tied to Medicare eligibility.

All of this suggests that the next few months are ideal for studying the MMA, and allowing federal agencies to issue relevant guidance. A deliberate approach by employers will also enable them to focus carefully not only on the alternatives that the MMA presents, but also on how they will communicate effectively with active and retired employees whose coverage or benefits will change or involve new choices.

1. Health Savings Accounts (HSAs)

For employees, HSAs offer the potential for long-term savings, on a pre-tax basis, with distributions being tax-free for healthcare, and tax deferred when accessed for other reasons. For employers, HSAs offer a simple vehicle by which to encourage health participants to be more judicious in their use of medical services, because employees will receive the benefit of any build-up in their HSA balances. As a result, we expect HSAs to quickly become a staple of employer-provided health plans.

The distinguishing features of HSAs are generally as follows:

- **Annual Contribution Limit:** \$2,600 for individual coverage; \$5,150 for family coverage (indexed annually).²

- *Source of Contributions:* employer contributions and/or employee contributions.³
- *Vesting:* 100% for all contributions, meaning in part that pre-tax salary reduction contributions are not subject to the “use it or lose it” rule that applies to FSAs.
- *Tax-free Distributions:* the owner of the HSA will not recognize income for distributions used to pay –
 - o medical expenses that meet the definition set forth in Section 213(d) of the Code (including over the counter medicine and supplies per recent IRS advice regarding health FSAs),
 - o COBRA and retiree medical insurance premiums,
 - o Medicare expenses (but not Medigap), or
 - o health insurance premiums either for long-term care insurance or during a period when unemployment compensation is being paid.
- *Taxable Distributions:* to the extent an HSA makes distributions for reasons other than those noted above, the recipient must recognize ordinary income. An additional 10% excise tax applies if the recipient is below age 65 or the distribution occurs for a reason other than the individual’s death or disability.
- *Investment Alternatives:* individually directed, as with IRAs. Life insurance is an impermissible HSA investment.
- *Rollovers:* HSAs are completely portable, unlike FSAs and HRAs, and permit employees to make rollovers from one HSA to another, and even to roll over Archer MSA balances into HSAs.
- *HSA Trusts:* in contrast to FSAs, the assets of an HSA must be held in a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account beneficiary. All contributions other than rollover contributions must be in cash.
- *Trustees:* The trustee of an HSA trust must be a bank or an insurance company, or otherwise satisfy the Secretary of Treasury of its qualification to serve as a trustee.
- *Miscellaneous Provisions:* The MMA’s rules applicable to HSAs are similar in many

respects to those that apply to IRAs (e.g., determining the time when contributions are deemed to be made and the allowance for custodial accounts).

High Deductible Health Plans (“HDHPs”)

A group health plan qualifies as an HDHP if its annual deductible is at least \$1,000 for individual coverage (\$2,000 for family coverage), and the sum of annual deductible and other annual out-of-pocket expenses required to be paid under the plan other than for premiums does not exceed \$5,000 (\$10,000 for family coverage), subject to an adjustment for inflation.

Technical Issues associated with Implementation

The MMA permits employers to use cafeteria plans as the vehicle by which employees may make pre-tax contributions to their HSAs. At this juncture, however, it is not entirely clear how the operational rules that apply to cafeteria plans (e.g., election changes) will apply to HSAs. Nor is it clear how other federal mandates affecting employer-sponsored group health plans (e.g., ERISA, COBRA, and HIPAA) will affect HSAs that receive employer contributions or employee pre-tax contributions through a cafeteria plan.

Because of these and other operational issues relating to HSAs, employers should consult with legal counsel before implementing any HSA-related health benefit program.

2. Coordination of Health Benefits with Medicare Eligibility

The MMA includes legislative history that is designed to calm the concerns of employers who offer different health benefits, terms, and conditions to Medicare-eligible retirees because of their age.⁴

Unfortunately, employers have had reason for concern ever since 2000 when the Third Circuit held in *Erie County Retirees Association v. Erie County (“Erie County”)*⁵ that an employer violates ADEA if Medicare-eligible retirees receive lesser benefits than other retirees. The *Erie County* decision turned on the employer’s inability to establish that its age-based distinction would comply with ADEA’s equal benefit/equal cost standard.⁶

Within the health industry, some warned that the *Erie County* decision “would be the death knell for retiree benefits” if it is allowed to stand.⁷ The EEOC initially exacerbated the problem when, in late 2000, it adopted the *Erie County* standard as the EEOC’s national enforcement policy. The EEOC rescinded that policy in August 2001, and recently proposed regulations that include an

exemption for employee benefit plans that provide health benefits for retired participants that are altered, reduced or eliminated when participants are eligible for Medicare or a state-sponsored plan.⁸ The proposed exemption will also apply to spousal and dependent benefits if they are included as part of the health benefits provided to retired participants. However, these benefits need not be identical to the benefits provided to retirees.

Overall, the combination of the MMA's favorable comment on ADEA's legislative history and the EEOC's proposed regulations should provide employers with newfound comfort that Medicare-based distinctions in retiree benefits will not violate ADEA. In 2004, employers may consequently want to revisit the coverage they provide to Medicare-eligible retirees.

3. Retiree Benefits – Prescription Drug Subsidy

Before the MMA, employers who provided retiree medical benefits that included prescription drug coverage bore the full brunt of prescription drug costs, because Medicare did not provide such benefits. This employer liability typically creates significant financial expense under applicable accounting principles.

The MMA will change this dynamic, effective January 1, 2006, when Medicare begins to provide its own prescription drug program. There is concern that many employers will react by eliminating their prescription drug programs for retirees. Anticipating this, Congress included provisions within the MMA that encourage employers to retain their retiree prescription drug coverage. The incentive comes in the form of a requirement that Medicare pay a tax-free subsidy to employers who provide retiree drug benefits equal to 28% of prescription drug costs between \$250 and \$5,000 per retiree, as indexed annually by the percentage increase in Medicare per capita prescription drug costs.

The subsidy is only available if the plan sponsor certifies to the Administrator of the newly-created Medicare Benefits Administration that the plan's retiree prescription drug coverage plan is at least actuarially equivalent to Medicare's standard prescription drug coverage, and the subsidy will be limited to benefits provided to retirees who were eligible to enroll in Medicare's prescription drug program but declined to enroll. While the subsidy is unavailable for retirees who are receiving Medicare prescription drug benefits, an

employer may extend secondary coverage to them that is offset by the primary Medicare coverage.

Employers who provide prescription drug benefits for retirees have three basic choices:

- (1) continue their current program and collect the subsidy,
- (2) adjust their current program to become a secondary payor to Medicare, or
- (3) eliminate the benefit and the associated liability.

As with any possible change to retiree benefits, employers need to be careful to assess their commitments and the reaction of retirees to any changes. In a nutshell, employers should weigh (i) the extent by which the subsidy reduces the employer's after-tax cost of providing prescription drug benefits for retirees, against (ii) the employer's savings gained by reducing or eliminating these benefits, and foregoing the subsidy. Retirees may react less negatively to a cut-back in this benefit to the extent they qualify for Medicare's new prescription drug benefit. Note that while the full Medicare prescription drug program will not become available until 2006, Medicare is scheduled to introduce in the middle of 2004 a temporary 25% discount card by which eligible retirees may make prescription drug purchases.

Conclusion

The MMA seems likely to deliver on its promise of a dramatic impact on retiree medical coverage and benefits. It is too early to predict how employers will react to the planning opportunities described above. Nevertheless, they create significant opportunities to initiate positive changes in employer-provided benefits for active and retired employees.

Notes

¹ "ADEA" stands for the Age Discrimination in Employment Act of 1967 (29 U.S.C. § 623 *et seq.*).

² The HSA contribution limit actually applies on a monthly basis, and is \$500 higher in 2004 for those between age 55 and 65, and increases for them by \$100 for each of 2005 to 2009.

³ Employee contributions to an HSA may occur on a pre-tax basis through a cafeteria plan, or on a tax deductible basis through after-tax contributions outside a cafeteria plan.

⁴ Specifically, Section 1011 of the MMA's conference agreement states that "the conferees reviewed the ADEA and its legislative history and believe the legislative history clearly articulates the intent of Congress that employers should not be prevented from providing voluntary benefits to retirees only until they become eligible to participate in the Medicare program."

⁵ 220 F.3d 193 (3rd Cir. 2000). The *Erie County* case settled in 2002 with the employer's agreement to make payments that eliminated any perceived differences in benefits and contributions for Medicare-eligible retirees.

⁶ ADEA regulations generally require employers to establish that they either provide equal benefits to their employees regardless of age or that they employer spends equal amounts on, or incurs equal costs for, its young and older workers. See 29 C.F.R. § 1625.10.

⁷ See "HMOs May See Employer Market Shrink Under Federal Appeals Court Ruling," Managed Medicare and Medicaid, August 28, 2000, 2000 WL 9419849.

⁸ EEOC Prop Reg. § 1625.32, 68 F.R. 41542 (July 14, 2003).

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