

Trends

Winter 2004

Medicare Prescription Drug, Improvement and Modernization Act of 2003

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Prescription Drug Benefit

For the first time, Medicare will provide coverage for outpatient prescription drugs. Medicare-endorsed drug discount cards will be available from private pharmacy benefit managers by the summer of 2004, and will remain available until December 31, 2005. These cards may have an annual enrollment fee of up to \$30 and are expected to save users up to 15% of the cost of drugs.

Beginning in 2006, Medicare itself will offer a prescription drug benefit (called Medicare Part D). This benefit will have a \$250 deductible, 75% coverage up to \$2,250 in drug costs per year, self-insurance from \$2,250 to \$3,600 and 95% coverage after the \$3,600 mark is reached. The premium is expected to be about \$35 per month, although low income individuals will have access to a subsidy. The prescription drugs will be provided through private parties, not Medicare and, unlike other portions of

Medicare, there will be no maximum prices applicable to prescription drugs.

Because of concerns that plans that currently offer retiree drug benefits would discontinue them when Part D becomes available, retiree plans that offer an actuarially equivalent drug program will receive a 28% subsidy of drug costs between \$250 and \$5,000. The subsidy will be tax-free. Employers that do not wish to offer actuarially equivalent coverage will be permitted to provide premium subsidies and cost-sharing assistance for retirees who enroll in Medicare Part D, and plans also will be allowed to coordinate with Part D. However, plans that do not offer the actuarially equivalent coverage will not be eligible for the 28% subsidy.

Medicare Advantage Program

The Medicare + Choice Program (also known as Medicare Part C) is being replaced with Medicare Advantage. These plans immediately will have their reimbursement rates increased so that they are equivalent to the current Medicare fee-for-service rates. Over time, regional managed care Medicare programs will be made available.

Medicare Part B Premium

Currently, the Medicare Part B premium

is the same for all individuals who elect Part B coverage during their initial Medicare enrollment period. (The Part B premium is intended to cover approximately 25% of the benefits provided under Part B.) Beginning in 2007, the premium will be based on income, and individuals with incomes over \$80,000 (single) or \$160,000 (married) will be required to pay a higher percentage of the cost. The premium increase will be phased in over a five year period, and beginning in 2001 those at the highest income levels (\$200,000 single and \$400,000 married) will be expected to pay 80% of the cost.

Flexible Spending Account Debit Cards

The new law provides that 1099s do not need to be provided to providers if their services are paid for with a debit card under a flexible spending account plan.

Health Savings Accounts

As of January 1, 2004 individuals may participate in Health Savings Accounts. These "HSAs" are similar to medical savings accounts, but have significantly fewer restrictions. The main features of an HSA are:

1. HSAs may be created only in connection with a "high deductible"

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- health plan. A health plan is a "high deductible plan" if the in-network individual deductible is \$1,000 or more and the family deductible is \$2,000 or more.
2. The individual may not be covered by another non-high deductible medical plan. (Coverage under a dental, vision, disability, accident or long term care plan is not disqualifying coverage. Although not entirely clear, it appears that participation in an FSA that covers medical benefits would be disqualifying coverage in a non-high deductible health plan.)
3. The in-network out-of-pocket maximum cannot exceed \$5,000 per individual and \$10,000 per family.
4. Contributions may be made – on a tax-free basis – by the employer, employee, or both.
5. The maximum annual contribution (from all sources) cannot exceed the lesser of the deductible and \$2,600 for an individual or \$5,150 for a family. (Individuals aged 55 to 64 may make some additional contributions.) If both spouses are covered by high deductible plans, the lowest deductible is used. Excess contributions are subject to an annual 6% excise tax.
6. Individuals who are eligible for Medicare may not make contributions.
7. Employers who choose to make contributions must make comparable contributions (in terms of dollars or percent of the deductible) for all employees participating in the high deductible plan.
8. Contributions must be put in a trust administered by a bank, an insurance company or another entity approved by the IRS.

9. The individual's account is vested immediately and may be rolled over much as an IRA may be rolled over.
10. Unused contributions may be carried over from year to year.
11. There is no limit on the size of the employer.
12. First-dollar preventive benefits are permissible.
13. Distributions for medical care are not taxed.
14. Distributions for non-medical care are subject to a 10% excise tax unless the participant is over age 65 or disabled.
15. An HSA may be included in the Section 125 plan.

There are a number of unanswered questions with respect to how these accounts will operate as a practical matter. The IRS has indicated it intends to issue additional guidance in the near future.

Drug Reimportation

The Department of Health and Human Services was given the authority to permit the importation of drugs from Canada, but only if HHS certifies that there will be no safety risk and significant cost reductions. As HHS has been unwilling in the past to certify that there is no safety risk, the legality of importing drugs from Canada remains essentially unchanged.

Flex Rollover Not Allowed

The provision that would have permitted individuals to carryover up to \$500 per year of unused contributions to a flexible spending account did **not** pass. •

The IRS has announced the dollar limits for the year 2004. There are a number of changes from the 2003 limits.

Annual Compensation Limit

\$205,000

(\$200,000 in 2003)

Key Employee

\$130,000

(\$130,000 in 2003)

Highly Compensated Employee

\$90,000

(\$90,000 in 2003)

Defined Benefit Limit

\$165,000

(\$160,000 in 2003)

Defined Contribution Limit

\$41,000

(\$40,000 in 2003)

401(k) Elective Deferral Limit

\$13,000

(\$12,000 in 2003)

403(b) Elective Deferral Limit

\$13,000

(\$12,000 in 2003)

Social Security Wage Base

\$87,900

(\$87,000 in 2003)

Defined Contribution and Defined Benefit Plans



What Exactly Is Post EGTRRA And What Does It Mean To Me?

First there was EGTRRA (the Economic Growth and Tax Relief Reconciliation Act of 2001), then comes post EGTRRA.

The post EGTRRA amendment is a “clean up” piece of legislation for the loose ends that EGTRRA created. Specifically, the major provisions of the amendment are as follows:

1. If catch-up contributions are permitted, then the catch-up contributions are treated like any other elective deferrals for purposes of determining matching contributions under the plan.
2. For plans subject to the qualified joint and survivor annuity rules, rollovers are automatically excluded in determining whether the \$5,000 threshold has been exceeded for automatic cash-outs (if the plan provides for automatic cash-outs). This is applied to all participants regardless when the distributable event occurred.
3. The minimum distribution requirements are effective for distribution calendar years beginning with the 2002 calendar year. In addition, participants or beneficiaries may elect on an individual basis whether the 5-year rule or the life expectancy rule in the plan applies to distributions after the death of a participant who has a designated beneficiary.

4. Amounts that are “deemed 125 compensation” are not included in the definition of compensation.

If your Plan is a Defined Contribution Plan (DC) (profit sharing, 401(k), ESOP), an amendment has been mailed to you for your signature. It is very important that this amendment be dated on or before the last day of the 2003 Plan Year. (December 31, 2003 for calendar year Plans.)

If your DC Plan is on the Nyhart prototype adoption agreement, you received an Employer level post EGTRRA amendment. Nyhart, as sponsor of the prototype adoption agreement, adopted the sponsor level post EGTRRA amendment. This included the required minimum distribution language or the 401(a)(9) regulations.

If your DC Plan is an individually designed plan document, you received a Model Amendment which contained the required minimum distribution language or the 401(a)(9) regulations.

If your Plan is a Defined Benefit Plan (DB), your compliance with post EGTRRA has been deferred until 2005. •

Group Health Plans

Congress has passed legislation extending the Mental Health Parity Act through December 31, 2004. This law (which originally was passed in 1996) prohibits group health plans from providing lower lifetime maximums and annual dollar limits for care of mental and nervous disorders. (Plans are permitted to cost-share, including higher co-pays, calendar year visit limits and lower co-benefit rates.)

Bills have been introduced in recent years to require identical benefits for mental and physical disorders, but have not passed due to concerns about cost and how to define the types of mental health issues to cover under such a law. •



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