



The ViewsLetter

IN THIS ISSUE

- Supplementing Medicare - The New Marketplace 1
- About the ViewsLetter 1
- Your Questions 3
- Did You Know 4
- Technical Corner 5
- Trend Tidbits 6

Supplementing Medicare - The New Marketplace

The Medicare Prescription Drug Improvement and Modernization Act of 2003 proposed the broadest and most significant changes to Medicare since the program was enacted in 1965. Although the primary purpose of this Medicare legislation was to create an outpatient prescription drug benefit, provisions in the legislation will also significantly affect how individuals supplement their Medicare coverage.

Currently, if individuals want to enhance Medicare coverage, they have three basic options:

- Traditional Medicare Supplement Plans
- Retiree Health Plans
- Medicare + Choice Plans

This article reviews the standard options for supplementing Medicare and how these options may change when Medicare begins to cover outpatient prescription drugs.



Traditional Medicare Supplement Programs

“Medigap” plans are designed to fill the gaps created by Medicare Parts A and B.

In order to understand Medicare supplement plans, let’s review Medicare benefits.

Medicare Part A is provided at no cost. It covers:

- Inpatient hospital care
- Skilled nursing facility care
- Hospice
- Certain home health care services.

Medicare Part B is voluntary and requires a monthly premium. It covers:

- Physician services
- Outpatient hospital treatment
- Other miscellaneous services, such as durable medical equipment

Continued on page 2

About the ViewsLetter

We welcome you to the first quarterly issue in Volume Seven of the McGraw Wentworth ViewsLetter. It is our mission to be the leader in the employee group benefits brokerage and consulting industry to mid-sized organizations.

We have established the ViewsLetter as an integral part of our commitment to keep

you informed of benefit trends, legislative and marketplace developments that may affect your group benefit programs.

We welcome your comments and suggestions regarding the ViewsLetter. You can pass your comments directly to your McGraw Wentworth Account Director or Account Manager, or you can reach us at www.mcgrawwentworth.com.

Reach us on the web at the McGraw Wentworth web site. Check it out at www.mcgrawwentworth.com.

Additional copies of the ViewsLetter are available on our website.

Supplementing Medicare - The New Marketplace, cont.

However, Medicare Parts A and B together do not pay expenses fully. A beneficiary for 2004 could have the following out-of-pocket expenses:

- \$876 deductible for first 60 days of hospital stay
- \$219 a day for 61-90 days of a hospital stay
- \$438 a day copay for 90+ days hospital stay
- Up to \$109.50 for skilled nursing care for days 21-100
- Part B annual deductible of \$100
- 20% copay for most Part B services
- 50% copay for Medicare approved outpatient mental health treatment

These are just some of the key copays associated with Medicare. Medigap policies generally follow one of ten plan designs originally developed by the National Association of Insurance Commissioners. The plans are commonly referred to as plans A-J. Each Medigap plan at a minimum covers certain core benefits. Beyond the core benefits, each plan offers different coverage options, such as skilled nursing care coinsurance, out of country emergency care, and so on. Plans H, I and J offer additional benefits for outpatient prescription drugs.

Individuals choose their Medigap coverage based on plans available locally, premiums associated with the plans, and benefits desired.

With the new Medicare Part D (prescription benefits), buying a supplemental policy will become more complicated. The new legislation will not allow an individual who elects Part D to purchase supplemental plans H, I or J. These plans will not be eliminated because there may be instances where an individual may not choose coverage under Medicare Part D. Medicare beneficiaries will need to weigh the cost/benefit of enrolling in Part D. This will be a complicated decision for many seniors who have eagerly awaited the new benefit.

The decision needs to take into account the following key factors:

- **Premium:** Part D premiums have not been set, but are expected to be approximately \$35 a month. A Medicare beneficiary will pay \$420 a year to receive a benefit.
- **Expected Benefits:** The standard plan requires significant out-of-pocket costs. Before Medicare covers any expense, an individual must meet a \$250 deductible. For prescription costs between \$251 and \$2,250, Medicare pays 75% and the beneficiary pays 25%. If an individual spends \$2,250

annually on prescriptions, the out-of-pocket is as shown in the table at the bottom of this page.

At this point, an individual has paid a total of \$1,170 to receive a \$1,500 benefit from Medicare. For beneficiaries who have low prescription costs, it may be more cost effective not to purchase Part D.

Expenses between \$2,250 and \$5,100 are not covered. After an individual spends \$5,100 a year, Medicare picks up the majority of the remaining expenses with minimal copays.

- **Penalty Allowance:** A penalty will apply to those who enroll in Part D after the initial enrollment period. Late entrants' ability to enroll will be limited. The details about the penalties were not included in the initial act and are expected to be released in the future.

Although the act does not stipulate any changes to the standard Medigap supplemental plans, it will be interesting to see whether the standard plan options are modified to reflect the new prescription drug benefits. The new law assumes that Medicare beneficiaries will look for supplemental coverage to offset their potential \$3,600 out-of-pocket cost. However, the new Medicare legislation discourages supplemental pharmacy benefit plans. It will be interesting to see how the market positions itself to offer potential gap coverage with the prescription benefit.

Retiree Health Plans

Although retiree health coverage is becoming a benefit that few companies continue to offer, at least 12 mil-

	Individual Pays	Medicare Pays
Deductible	\$250	\$0
Coinsurance	\$500 (25% of \$2,000)	\$1,500 (75% of \$2,000)
Annual Premium	\$420	\$0
Total Cost	\$1,170	\$1,500

Continued on page 3

Supplementing Medicare - The New Marketplace, cont.

lion Medicare beneficiaries are covered under a retiree health plan.

Because the company designs its own retiree health plan, it can amend benefits or even end them. Companies that continue to offer retiree health plans have struggled tremendously with rising costs for outpatient drugs over the last decade.

Coordination matters when you consider retiree health plans. In general, Medicare is the primary payer on a retiree, and the retiree health plan is the secondary payer. Medicare Parts A and B shoulder a substantial amount of the cost for hospital and physician services, while retiree health plans typically pay expenses Medicare does not cover such as outpatient prescriptions. The retiree plan has been shouldering the full cost of these expenses.

A key concern when developing the Medicare prescription benefit was the transfer of risk from private plans to Medicare. If the prescription benefits follow the same secondary coverage rules, Medicare would begin shouldering much of the cost currently being paid by retiree health plans. This risk transfer concerned many retirees. The fear was that employers would substantially cut benefits if Medicare began covering outpatient prescriptions.

In response to this concern, the new Medicare legislation offers financial incentives to employers to maintain their current benefits. The coordination rules for the prescription portion of the plan also discourage plans from taking a secondary approach:

- **Employer subsidy:** The government will pay employers who maintain retiree prescription coverage that is the

YOUR QUESTIONS

- Q.** An employee just noticed that his first paycheck for this year showed a deduction for our medical flexible spending account. The employee chose to participate, but after reviewing the form, he realized he made a mistake. He had actually intended to elect our dependent care account. He simply recorded his election on the wrong line. I understand elections must be made in advance and can be changed only if family status changes, but I would like to help our employee. Can't we simply correct the mistake? The employee will never be able to use the money on medical expenses; it is just too much.
- A.** You are correct that for most enrollment situations, Section 125 requires participants to make prospective elections and also limits mid-year changes to those necessary because of family status changes. It would be easy to assume your employee is stuck with the election made at open enrollment. In fact, Section 125 does not explicitly allow employees to correct election errors.

Even though the regulations (Prop. Treas. Reg. Sec. 1.125-4) do not allow election changes for mistakes at all, the IRS officials have informally commented that an employee's election may be undone when the following conditions exist:

- "Clear and convincing evidence" showing your employee made a mistake.
- The mistake is of a type that can be corrected.
- The correction is appropriate.

To evaluate whether such evidence exists, employers generally use the two approaches explained below:

- **"Impossibility"** - This approach allows the change only if the evidence shows it was impossible for the employee to benefit from the mistake. In this case, unless your plan covers 100% of allowable expenses under your medical plan, there would not be enough evidence to support the contention that the employee could not benefit from the funds in the medical FSA.
- **"Facts and Circumstances"** - This approach allows you to correct errors if, after an in-depth look at the employee's situation, you can reasonably determine that a mistake was actually made. For example, let's assume for the last three years your employee has elected the dependent care account and has chosen not to participate in the medical account. Also, let's assume you have revised your form and the medical account election line is now in the same place the dependent care election line had been in the previous year. The employee inadvertently chose the wrong option, but brought the error to your attention as soon as he received his first paycheck of the year. In this example, it is fairly easy to show how a mistake could be made.

If you decide to allow the correction, you should ask your employee to sign a statement describing the mistake and the intended election.

Under either approach, so long as the "clear and convincing" standard is met, employees' clerical, arithmetic and data entry errors may be corrected retroactively. However, this guidance is informal. The IRS should address correction errors in the next set of final regulations regarding Section 125 plans.

Continued on page 4

Supplementing Medicare - The New Marketplace, cont.

actuarial equivalent of Medicare's standard benefit. The subsidy will be equal to 28% of an individual's allowable drug cost between \$250 and \$5,000. The subsidy is only payable on a "qualified retiree," that is, a Medicare-eligible retiree or dependent who does not enroll in Medicare Part D.

The actual process for determining and paying this subsidy has not been established. More guidance is expected this year. However, since Medicare beneficiaries' out-of-pocket expenses will be higher under Medicare than they would be under most retiree plans, it will be interesting to see whether employers cut back prescription benefits. Offering prescription benefits in retiree plans was important because retirees would have a difficult time securing comprehensive prescription drug coverage elsewhere. When Medicare offers prescription benefits, will employers choose to cut back

their benefits or will they offer slightly better benefits in order to qualify for the subsidy?

- **Prescription Coordination:** The act discourages employers from taking a secondary stance to Medicare on the prescription drug benefit. It refers to coverage for prescriptions that exceed the \$5,100 annually as "catastrophic coverage." Once an individual attains the catastrophic level, Medicare picks up a large portion of the prescription expense. An individual reaches the catastrophic level by paying \$3,600 out of pocket for prescriptions. The new act will not allow any employer-reimbursed expense to count toward the \$3,600 out-of-pocket maximum.

In theory, if an employer decided to cut back prescription drug coverage and cover on a secondary basis prescription expenses that are not paid by Medicare, the individual would need to pay \$3,600 out of

pocket at some point before Medicare would assume the catastrophic risk. The details surrounding this provision are vague, but it appears to limit severely a plan's ability to pay secondary to Medicare and still provide a comprehensive prescription drug benefit.

Over the next ten years, it will be interesting to see how employers decide to coordinate their retiree plans with Medicare. For example, an employer plan could choose to cover expenses Medicare doesn't pay. At the point an individual reaches the \$5,100 "catastrophic" coverage level, the plan could pay 75% for prescription expenses and the individual would pay 25%. The plan could cap its liability at any point. If the cap is set at \$14,400 of prescription cost paid at the 75% level, the employee's 25% would reach the \$3,600 in out-of-pocket cost needed to qualify for catastrophic coverage. By offering a middle level coverage to help an employee, the \$3,600 out-of-pocket maximum can be spread over more of the prescription expense. A plan may offer this approach when average prescription drug use is not excessive on a per employee per year basis. If each individual has an average prescription expense of \$2,500, Medicare would cover \$1,687.50 of the expense and the plan would pay \$812.50.

Many plans may choose not to modify benefits and encourage their participants to waive Medicare Part D coverage. In this instance, the plan would be entitled to the employer subsidy offered by the government. Other plans are eager to pass along primary

DID YOU KNOW?

More employees are caregivers to both children and seniors. According to ComPsych Corporation (2003), 8% of employees take a significant amount of time each week to care for a child or an older adult. Every week they spend:

- 10.4 hours on childcare tasks such as bathing, feeding, making childcare arrangements, and so on.
- 9.6 hours participating in children's extracurricular activities.
- 4.7 hours making elder care arrangements, such as health care, social, financial, and so on.
- 4.5 hours driving the children to school.
- 4.1 hours performing elder care tasks.

Continued on page 6

Supplementing Medicare - The New Marketplace, cont.

payment responsibilities to Medicare. These employers need to consider the financial impact taking a secondary stance could impose on their participants. The plan may modify benefits to allow primary coverage by Medicare but offer additional coverage to help their participants meet the \$3,600 out-of-pocket maximum.

Medicare + Choice Plans

The Medicare legislation will expand the options available through private insurers. The new plans will be called Medicare Advantage plans. Medicare Advantage is simply a new name for the Medicare + Choice options; however, the benefits available, delivery systems and pricing functions are expanding.

Knowing the history of Medicare + Choice will help you understand the new Medicare Advantage plans. Medicare + Choice was a government attempt to offer private alternatives to Medicare coverage. Medicare, even with government-negotiated favorable pricing, has no internal managed-care programs. Therefore, the initial Medicare + Choice programs used HMOs to deliver care. The plans were designed to help Medicare provide more comprehensive coverage by using HMOs as gatekeepers for Medicare beneficiaries' medical care.

Many Medicare HMOs had to withdraw from the market. The initial marketing costs were high. At the time, most Medicare beneficiaries had never participated in a managed-care program and the process of using a gatekeeper was completely new to them. In addition, the delivery system was so complex that insurers had to have meetings with Medicare beneficiaries to introduce their products.

Continued on page 7

Technical Corner - What Are Employers Putting Online?

Web sites are no longer an option, but a necessity for most businesses. According to a recent study conducted by WorldatWork and Buck consultants, nearly 95% of all companies have a publicly accessible Web site and 84% of those have an employee-only accessible Intranet site. Almost 46% of firms offer employees Internet access at work and an additional 30% offer Internet to 75% of their workforce. Some even offer Internet access through community accessible kiosks.

With so many companies sponsoring Web sites and a large majority of employees having Internet access at work, what type of information is common on company Web sites? The most common content is the corporate history, which is included on 91% of all corporate Internet sites. Other popular content includes:

- The corporate vision or mission statement - 88%
- Annual and quarterly reports/shareholder information - 55%
- General employee benefit information - 52%
- Business goals and progress reports - 48%
- Compensation philosophy - 18%
- Organizational charts - 16%
- General base and incentive pay information - 14%

General information found in typical marketing materials, corporate history and mission statements is almost universally included; the next most common content piece is shareholder information. A 33% drop in percentage occurs between companies providing mission statements and those that include quarterly reports. The philosophy for most corporate Web sites is simply to provide publicly accessible information. A large percentage of organizations have no plans to provide specific information regarding compensation philosophy and general base and incentive pay.

Most companies (85%) post job openings electronically. This accounts for 41% of all job listings. Employers do not only post jobs on corporate sites but also on commercial job boards and their Intranet sites. Companies typically post jobs internally before posting them on a publicly accessible site.

Many companies are expanding their Intranet sites to include more specific, useful information. Companies are recognizing that they can increase efficiency by automating many human resources and administrative functions. Most company Intranet sites include the following:

- General benefits information and 401(k) information - 80%
- Links to benefit vendors - 76%
- The ability to make 401(k) plan changes - 70%
- Retirement planning information - 69%
- Links to other resources - 55%
- Employee training online - 55%
- Organizational performance goals - 48%

Intranets have proven to be an efficient way to communicate with employees. However, most companies do not post compensation and other sensitive information on the Intranet.

With so many companies offering Internet and Intranet access in the workplace, automating more administrative functions isn't that far in the future. Over the next ten years, many of an organization's tasks will become more automated and Internet access in the workplace will become commonplace. **MW**

Supplementing Medicare - The New Marketplace, cont.

High marketing budgets and low government subsidies meant many plans were losing money on their Medicare HMO block of business.

Under the new Medicare legislation, private plans have more flexibility than they had under Medicare + Choice plans. Carriers may offer approved PPO plan designs under Medicare Advantage. They also will receive greater subsidies from the government to help pay plan costs. Plans are encouraged to offer disease management programs to help manage the cost of treating chronic conditions. The government intends to research the performance of Medicare Advantage plans to determine whether private insurers can control cost more effectively through better plan management and discount arrangements.

Medicare Advantage plans will most likely be developed nationally by regional carriers. Whether they will be an effective alternative to Medicare has yet to be determined. Many participants were disappointed in the constraints of Medicare HMOs and chose to switch back to Medicare.

The new Medicare prescription drug bill has made supplementing Medicare much more complex. Many seniors will be challenged by the difficulty

of the decision. Medicare beneficiaries will need to weigh the additional premium costs against the potential benefits. Individuals covered under retiree plans may have a change in benefits when the new Medicare prescription drug coverage goes into effect. Others will need to review their traditional supplemental plans.

Any new Medicare beneficiaries have much to consider regarding the new Part D benefits. The benefit structure is confusing and many individuals may

end up spending more in the long-run if they choose Part D benefits. The marketplace will change as a result of the new benefits under Medicare. It will be interesting to see how many options emerge for Medicare beneficiaries depending on whether regional markets offer Medicare Advantage plans or supplemental plans for prescription "gaps" in Medicare coverage. **MW**

TREND TIDBITS

According to Mercer 2003 National Survey of Employer-Sponsored Health Plans:

- \$ The average total annual health benefit cost increase for active employees was 10% in 2003. The increase was 15% for 2002. The result was achieved primarily by shifting more costs to employees.
- \$ The average expected cost increase for 2004 is 13%.
- \$ The average total annual health benefit cost (including medical, dental, and other health benefits) in 2003 was \$6,215, compared to \$5,656 in 2002.
- \$ Only 22% of employers managed to reduce their per employee health benefit costs in 2003. These employers reduced costs by changing plans, reducing covered services or eliminating highest cost plan options.

THE VIEWSLETTER

Our newsletters are written and produced by the McGraw Wentworth staff and are intended to inform our clients on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

McGraw Wentworth
3250 West Big Beaver Road, Suite 500
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com