

December 15, 2003

RESEARCH MEMO

TIC INTERNATIONAL CORPORATION

TO: MANAGERS, CONSULTANTS, OTHER PROFESSIONALS

FROM: DAVID LIVINGSTON, DIRECTOR OF RESEARCH

RE: **GREATLY EXPANDED MEDICARE PROGRAM, INCLUDING PRESCRIPTION DRUG COVERAGE, SIGNED BY THE PRESIDENT – EFFECTIVE JANUARY 1, 2006**

... GROUP HEALTH PLANS THAT CURRENTLY PROVIDE RETIREE DRUG COVERAGE WILL NEED TO BE REEXAMINED

INTRODUCTION

After a closely contested battle between Republicans and Democrats, *The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Act)* passed the House by a vote of 220 to 215 and by a vote of 55-44 in the Senate. On December 8, 2003, President Bush signed the bill into law.

This 415-page bill (if downloaded from the Internet) provides for the first major expansion of Medicare since the program was first created in 1965 and will cost an estimated \$400 billion over the next 10 years according to the Congressional Budget Office. Other forecasters estimate the cost as closer to double that figure over the next ten years. **Whatever the cost, the final bill is lengthy and extremely complex. It will take a considerable period of time before its intricacies are understood, let alone implemented.**

The Act consists of 12 sections (referred to as “Titles”) and touches upon numerous aspects of Medicare. The Titles most relevant to group health plans are: *TITLE I – Medicare Prescription Drug Benefit* (establishing a new Part D under Medicare providing for a prescription drug benefit and a transitional drug card discount program, as well as providing a federal subsidy to group health plans offering retiree prescription drug coverage); *TITLE XI – Access to Affordable Pharmaceuticals* (directing the Secretary of Health and Human Services (HHS) to study the concept of allowing re-importation of drugs from Canada and certain other countries); and *TITLE XII – Health Savings Incentives* (establishing a Medical Savings Account (MSA) program).

The purpose of this Memo is to discuss those provisions that will have a direct impact on group health plans, namely: (1) the transitional drug discount card program which allows individuals to obtain discounts on prescription drugs, which is effective early next year through December 31, 2005; (2) the new Part D prescription drug program which is effective January 1, 2006; (3) a new federal subsidy for plan sponsors who currently extend drug coverage to retirees, also effective on January 1, 2006; and (4) the study of drug re-importation from Canada and other countries. The memo will also touch on a new health care financing arrangement called Health Savings Accounts, which are effective January 1, 2004.

The reader is cautioned that this memo only addresses the broad features of the Act. Each aspect of the Act discussed herein contains numerous details that will need to be reviewed to determine the actual impact on the various parties. Other features of the Act may be highlighted in this Memo but will not be analyzed until a later date.

For those of you who may be interested in the final version of the Act (415 pages), it may be downloaded at:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1enr.txt.pdf

The final House/Senate Conference Agreement (403 pages) may be downloaded at:

<http://www.eric.org/forms/uploadFiles/2E10000000E.filename.medicarerx.pdf>

The Conference Agreement explains in more understandable language the various provisions in the Act. It is a good resource to aid in understanding the Act, especially if the wording of the Act itself seems unclear.

The following abbreviations are used throughout this memo:

CA	= Conference Agreement (final version)
MA	= Medicare Advantage (The Act establishes the Medicare Advantage (MA) program under a new Part C of Medicare. The MA program replaces the prior Medicare+Choice (M+C) program. An MA-PD will be a Medicare Advantage plan that also offers prescription drug (PD) coverage under Medicare Part D)
PDP	= Prescription Drug Plan (a stand-alone plan offering Part D drug coverage)
Secretary	= Secretary of Health and Human Services (HHS)

DISCOUNT CARD DRUG PROGRAM AUTHORIZED FROM JANUARY 1, 2004 UNTIL JANUARY 1, 2006

A permanent Medicare drug program available to every Medicare beneficiary will NOT be available until January 1, 2006. Meanwhile, the *Title I* of the Act requires the Secretary to establish a prescription drug discount card program meeting certain requirements. This program is to be established **no later than 6 months after December 8, 2003**.

Eligible individuals would receive access to prescription drug discounts through card sponsors throughout the U.S. Any person entitled to or enrolled under Medicare Part A or enrolled under Part B would be eligible to participate in the discount card program. **The program is voluntary for eligible individuals.** The program will also provide transitional assistance for low-income persons enrolled in endorsed programs.

The Secretary is to establish a process through which a discount card eligible individual is enrolled and disenrolled in a discount card program. An individual may enroll in any card program, serving residents of his/her state, at any time beginning on the initial enrollment date and before January 1, 2006. Completion of a standard enrollment form, specified by the Secretary, is required.

A discount card sponsor may charge an annual enrollment fee, not to exceed \$30, for each enrollee. The sponsor will ensure that the annual enrollment fee (if any) is the same for all enrollees residing in the same state.

The Act also requires the Secretary to broadly disseminate information to individuals eligible for the discount card and prospectively eligible individuals. This information would include information on: (1) enrollment, (2) drug discount card features, and (3) the transitional assistance program. The Secretary will also provide information comparing the annual enrollment fee and other features of such programs and comparative prices for covered drugs.

The Act requires each discount drug card sponsor to make available to discount card eligible individuals information on enrollment fees and negotiated prices for covered drugs. Each discount drug card sponsor is also required to have a mechanism (including a toll free number) for providing, on request, such information to individuals enrolled in the program.

Drug discount card sponsors could be any nongovernmental entity that the Secretary determines is appropriate to offer a discount drug card program. Entities which may qualify include: a pharmaceutical benefit management company (PBM), a wholesale or retail pharmacy delivery system, an insurer, a Medicare Advantage provider, or any combination of these.

The Act requires each sponsor seeking approval to submit an application to the Secretary. The Secretary would review the application and determine whether to approve the program. The Secretary could not approve the program unless the program and sponsor complies with the applicable requirements of the Act and the sponsor enters into a contract with the Secretary to carry out such requirements. *(Above discussion based on CA at pages 62-67)*

How much will the discount be? It all depends on what discounts drug companies are willing to provide. Some of the big pharmaceutical companies already have their own discount cards for lower income seniors (e.g., those at or below 130% of the poverty line) but the new discount card will be available to all Medicare beneficiaries. The Department of Health and Human Services estimates **savings between 15% and 25% per prescription.**

Sometime early next year the government will accept applications from health insurers, chain drug stores, wholesalers, drug companies, and prescription drug managers that want to provide the discount card service. **There is no mandatory requirement that any of these entities authorize a discount card which leaves a bit of uncertainty at this time as to what drugs will ultimately be made available, by whom, and where.**

It is anticipated that the drug companies which already provide some type of discount card will keep offering their cards for now, even as they consider whether to apply to offer a Medicare-approved card.

Drug companies say that they will need to know more about how the cards will be structured before "diving in." The drug makers will also have to decide whether to play ball when the pharmacy benefit managers and other providers start trolling for discounts. *Wall Street Journal*, Section D, page 2, 11/26/03.

Remember: There is no mandate that drug manufacturers and pharmacies participate in this new discount card program, although the competitive marketplace would seem to suggest that most will elect to do so.

It is reasonable to expect a lengthy and complex set of federal regulations governing what entities may issue a discount card and what drugs must be offered at a discount price. This means that eligible individuals will have to shop around for the best discount card. Some confusion seems likely and current retirees may look to their group health plans for assistance.

Such "shopping around" may put a new premium on the services already provided by PBMs. PBMs are the companies that administer drug plans for many employers and insurers and issue the familiar drug cards that many employees already use to buy prescription drugs. As a general rule, PBMs have used their bargaining power to negotiate discounts of 10%-15% or more on behalf of a large groups of employers or groups of plans. Whether PBMs will be able to negotiate higher discounts under this new Medicare program remains to be seen.

As noted above, there are many details yet to be worked out for the discount card program to be in effect between 2004 and 2006. However, one thing is certain: The federal government will be playing a major role in issuing new regulations and implementing the program, namely accepting, reviewing, and approving or rejecting applications from hundreds of insurers, drug manufacturers, and PBMs to become a discount card provider.

FULL-BLOWN MEDICARE DRUG PROGRAM BEGINS ON JANUARY 1, 2006

Beginning on January 1, 2006, pursuant to *Title I* of the Act, every Medicare beneficiary will be entitled to participate in Medicare's new Part D drug program for an initial estimated premium of **approximately \$35 per month, or \$420 per year.** (The actual premium may differ and is based on a complex mathematical formula). **Participation is voluntary.** A deadline will be set for filing the initial application; failure to join initially will mean that a higher monthly premium will be charged if a Medicare beneficiary decides to wait until a later date. The increased

premium will not apply, however, if a Medicare beneficiary is working or is retired and currently has drug coverage under a group health care plan.

The new **Medicare Part D** drug coverage will offer enrollees two coverage options. Beneficiaries could purchase either “standard coverage” or “alternative coverage” with “actuarially equivalent benefits”. The parameters of this alternative coverage are yet to be defined.

In 2006, “**standard coverage**” will have a \$250 deductible, 25% coinsurance for costs between \$250 and \$2,250 (at which point coverage ceases completely until out-of-pocket drug costs reach \$3,600), and catastrophic coverage after out-of-pocket expenses of \$3,600. Medicare will provide this coverage by utilizing either stand alone prescription drug plans (PDPs) or through Medicare Advantage (MA) plans that offer drug coverage, also called an MA-PD.

The complete absence of coverage between the first \$2,250 in drug costs and \$3,600 in out-of-pocket-expenses (often referred to by critics as the “the hole in the doughnut”) may be difficult for a Medicare beneficiary to understand but sponsors of the law claim that this was the only way to keep initial costs under control. One can easily understand that the average beneficiary may think that the \$3,600 refers to drug costs (as the \$2,250 does) instead of out-of-pocket expenses. In order for an individual to incur out-of-pocket expenses of \$3,600, **the person’s total drug costs will need to be at least \$5,100**. This is due to the fact that the first \$2,250 in drug expenses results in out-of-pocket expenses for the individual of only \$750. This is calculated as follows:

Deductible	\$250	
Coinsurance	<u>\$500</u>	(25% of costs between \$250 and \$2,250 (i.e. \$2,000))
	\$750	

In order to reach the \$3,600 out-of-pocket catastrophic coverage trigger, the individual must incur **\$2,850 more in drug costs** ($\$3,600 - \$750 = \$2,850$). Adding the initial drug costs of \$2,250 to the additional \$2,850 of drug costs needed to reach the \$3,600 in out-of-pocket expenses trigger **brings the total drug costs to \$5,100** before Part D coverage kicks in again. ($\$2,250 + \$2,850 = \$5,100$).

Once the beneficiary’s out-of-pocket expenses reach the \$3,600 out-of-pocket limit (\$5,100 total drug costs), the Medicare program would pay 100% of all costs, **except for nominal cost-sharing**. The cost-sharing is equal **to the greater of**: (1) a copayment of \$2 for a generic drug or preferred multiple source and \$5 for any other drug; or (2) five percent coinsurance, although a PDP or MA-PD could reduce these amounts. Thus, Medicare would pay at least 95% of covered drug expenses once an individual’s out-of-pocket expenses reach \$3,600 (\$5,100 total drug costs).

PDPs would be required to provide beneficiaries with access to discount drug prices, generally by means of a prescription drug discount card. PDPs are permitted to provide supplemental prescription coverage with either: (1) different deductibles, coinsurance percentage, and coverage limits, or (2) different drug coverage (including drugs which are excluded because of application of the Medicaid definition of “covered drugs”).

In general, “covered drugs” include those drugs and biological products covered by Medicaid, insulin and medical supplies associated with the injection of insulin, and certain vaccines. Although not covered by Medicaid, smoking cessation drugs are covered under the new Part D coverage. *(Above discussion based on CA at pages 3, 6-8, 12-17 and 24-29)*

Whether a Medicare beneficiary will find it advantageous to join the Medicare drug program will not always be an easy decision because the formula for coverage is complex. Individual Medicare beneficiaries will probably find it necessary to sit down with a pencil and paper (preferably with a huge eraser and a legal pad!) and try to determine their current one-year out-of-pocket cost for drugs and what the one-year cost will be if they have a Medicare-approved drug card (which will cost a minimum of \$420 for the premium and \$250 for the deductible plus 25% of any drugs purchased after the deductible is satisfied up to \$2,250 where the Medicare coverage ceases until out-of-pocket expenses exceed \$3,600 [\$5,100 in total drug costs]). The Part D premium does not count towards the \$3,600 of out-of-pocket expenses.

According to one Medicare specialist at the Kaiser Foundation: "People with **less than \$800 in annual drug costs** would end up paying more in the form of premiums, co-payments, and the deductible than they would get in benefits. However, many seniors spend far more than \$800 a year on drugs. According to the Congressional Budget Office, spending by Medicare beneficiaries will average **about \$3,245** (or about \$270 per month) in 2006 when the Medicare drug program goes into effect.

At that level of spending (\$3,245), here is how the Medicare drug formula would be applied, **assuming that the Medicare beneficiary has no other drug coverage.** Allowing for the PDP benefit, a participant's out-of-pocket expenses would only total \$1,745 (excluding the premium cost) out of the total drug costs of \$3,245. This is calculated as shown in the table below. (right hand column).

The table shows how the Part D deductible and coinsurance would apply to any participant in general, as well as showing how the benefit would apply to the average participant who spends \$3,245 a year on prescription drugs. The left hand column of the table breaks down the dollar amount of prescription drug charges into bands which reflect the differing degrees of coverage under the Part D benefit. The middle column shows the coverage available at the various levels of expense shown in the first column. The right hand column shows how the benefit would affect the average participant who spends \$3,245 a year on prescription drugs. (Remember that \$3,600 in out-of-pocket expenses translates into total drug costs of \$5,100 due to the effect of the deductible and coinsurance provisions of the benefit.)

Average Participant's cost equals -

25% Coinsurance (between \$250 and \$2,250, which equals \$2,000)	\$ 500 (25% of \$2,000 = \$500)
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Looks like a fairly good deal. If we add in the \$420 in premiums to out-of-pocket expenses, then the participant's cost would be \$2,165 for drugs valued at \$3,245. Still not a bad deal. Moreover, once the participant's out-of-pocket expenses reach \$3,600 (which means that *this retiree* would have to incur **an additional \$1,855** in out-of-pocket drug costs before any Medicare coverage resumes (\$3,600 minus \$1,745 already incurred = \$1,855), the excess or catastrophic out-of-pocket expenses will require the participant pay only a 5% copay or \$2 per generic prescription or \$5 per brand name whichever is higher.

As the foregoing example illustrates, individual participants will probably "go bonkers" trying to figure out whether it pays to join the Medicare program and it will not be surprising to have retirees call the fund office for assistance!!! Of course, there are many

other factors that retirees will need to consider in addition to immediate costs versus benefits. After all, the Medicare drug program is an insurance program which means that beneficiaries are buying protection against unseen risks. Moreover, a \$1,000 drug bill for this year could turn into a \$5,000 drug bill for next year.

On the other hand, if a retiree currently has **supplemental drug coverage under a group health care plan**, there may be virtually no net benefit under the Medicare drug program (assuming that the current program remains unchanged and is as good as the Medicare program).

MEDICARE BILL AUTHORIZES STUDY OF DRUG IMPORTATION

TITLE XI of the Act continues the ban on importing prescription drugs from foreign countries, such as Canada. This result was a great disappointment to many House members who several months ago approved H.R. 2427 by a vote of 243-186 authorizing reimportation from 25 industrialized nations, including Canada, without any requirement for FDA approval.

However, *TITLE XI* of the Act also addresses the issue of re-importing prescription drugs from Canada and certain other countries. (hence *Title XI's* name - *Access to Affordable Pharmaceuticals*). The Secretary, upon certification of safety and cost savings, is given authority to create a system for the importation of drugs from Canada by pharmacists, wholesalers, and individuals. The Act directs the Secretary, in consultation with appropriate government agencies, to conduct a comprehensive study that identifies current problems with the implementation of existing law as well as examines a range of issues associated with the importation of drugs. The Act directs the Secretary to submit a report providing the findings of this study to the appropriate committees of Congress **no later than 12 months after the date of enactment of this Act.** i.e. December 8, 2004.

In addition, the Act also directs the Secretary of Commerce, in consultation with the International Trade Commission, the Secretary of Health and Human Services and the United States Trade Representative, to conduct a study and report on drug pricing practices of countries that are members of the Organization for Economic Cooperation and Development and whether those practices utilize nontariff barriers with respect to trade in pharmaceuticals. The study shall include an analysis of the use of price controls, reference pricing, and other actions that affect the market access of United States pharmaceutical products. **Not later than 9 months after the date of enactment of this Act,** the report must be submitted to the Committees on Finance, the Judiciary, and Health, Education, Labor, and Pensions of the Senate, and the Committees on Ways and Means, the Judiciary, and Energy and Commerce of the House of Representatives.

In other words, the studies are to determine if the drug price controls imposed by other countries on American drug companies may be unfair and/or possibly illegal. Other countries' drug price controls have the indirect effect of keeping American drug costs high in comparison to these countries drug costs. In effect, American drug consumers are subsidizing the low drug costs of other countries as pharmaceutical companies shift their research and development costs entirely to American consumers in order to meet the apparently artificially low price requirements imposed by foreign countries. (*Above discussion based on CA at pages 382-385*)

This is not the place to argue the pros and cons of Canadian imports by group health plans but **a caveat is in order**: The legal situation is so fluid at the present time that prudence dictates that plan sponsors not launch any Canadian drug importation program **until the pending legal issues are resolved by Congress, by the regulators, or by the federal courts.** In point of fact, according to the front page of the December 10, 2003 issue of USA Today, the state of New Hampshire will begin a drug re-importation program *within two weeks*, making it the first state to openly defy the FDA and Boston will initiate a drug reimportation program in July 2004.

FEDERAL TAX SUBSIDY DESIGNED TO ENCOURAGE EMPLOYERS TO RETAIN RETIREE DRUG COVERAGE

It is estimated that at least 12 million of the 40 million Medicare beneficiaries (about 30%) already have prescription drug coverage under employer-sponsored plans. Many of these plans are multiemployer health care plans.

One of the original criticisms of the Medicare reform legislation was that some employers might be reluctant to continue sponsorship of retiree drug coverage if the retiree also has coverage under Medicare (even though the Medicare coverage is much less valuable or comprehensive and would cost a retiree \$420 in premiums per year, plus a \$250 deductible, plus a 25% coinsurance between \$250 and \$2,250, plus out-of-pocket costs of up to \$3,600 per year!). The Congressional Budget Office estimates that over 4 million individuals who currently have drug coverage might lose their coverage or have significantly reduced coverage if the Medicare bill was adopted as originally proposed.

In an effort to forestall any significant changes in current drug coverage for retirees by ERISA plans, the Act makes subsidy payments available to qualified retiree prescription drug plans. Under certain conditions, the Secretary is required to make special subsidy payments to employer-sponsors of qualified retiree prescription drug plans. These subsidy payments are to be made on behalf of an individual covered under the retiree plan, but who elected NOT to enroll in a PDP or MA-PDP.

Subsidy payments will equal 28% of the actual cost (i.e. net of discounts and rebates) of covered retiree plan-related prescription drug costs greater than \$250 but less than \$5,000 for each retiree. In other words, this means there is a \$4,750 *per retiree* cost maximum per year to which the 28% subsidy would be calculated against. ($\$5,000 - \$250 = \$4,750$). These amounts (\$250 & \$5,000) will be adjusted annually by the percentage increase in Medicare per capita prescription drug costs. Copayments and other amounts paid by retirees themselves would not count towards this *per retiree* cost limit corridor. (i.e. costs between \$250 and \$5,000).

There would be no subsidy to the plan for retirees who incur less than \$250 a year in prescription drug costs. But, for retirees who incur large prescription drug costs, the subsidy can add up. For example, if **the plan incurred actual retiree-related drug costs of \$5,000 for one eligible retiree in a year the subsidy would be \$1,330!!** ($\$4,750 \times 28\% = \$1,330$). Subsidy payments for the average Medicare covered retiree who incurs \$3,245 per year in prescription drug costs

would be \$838.60 per year. ($\$3,245 - \$250 = \$2,995$; $\$2,995 \times 28\% = \838.60). If a plan has a number of retirees who incur covered prescription drug costs between \$250 and \$5,000 per year, the subsidy may be very attractive.

In order to qualify for the subsidy, qualified employer-sponsored retiree prescription drug plans must provide the Secretary with an attestation that the actuarial value of prescription drug coverage under the plan is at least equivalent to the actuarial value of the standard prescription drug coverage available under Part D. (*See CA at page 53*) The Secretary is to establish processes and methods for determining the actuarial valuation of prescription drug coverage.

The subsidy would begin in 2006, **the same year Medicare would be expanded to provide a prescription drug benefit. Like most changes in public policy, the 28% federal subsidy must await detailed regulations before we can understand precisely how the subsidy will be calculated.** Of course, like any other federal subsidy, the percentage and method of calculation of the subsidy can be changed in subsequent years depending on expense factors. It is estimated that the employer (or plan) subsidy would total more than \$80 billion over a ten-year period. This direct financial subsidy may appeal most to multiemployer plans that may already have ongoing commitments for retiree drug coverage under long-term bargaining agreements which cannot be easily changed.

WHAT DOES THE NEW MEDICARE LAW MEAN TO GROUP HEALTH CARE PLANS THAT ALREADY PROVIDE RETIREE DRUG COVERAGE?

Such plans may wish to consider changes in plan design involving some kind of “carve out” or coordination with the Medicare Part D coverage in order to avoid duplication of coverage. Since Medicare is covering 75% of the drug costs between \$250 and \$2,250 and essentially 95% of total drug costs over \$5,100 for individuals enrolled in Part D, a group health plan may wish to consider picking up certain out-of-pocket expenses as is clearly allowed under the Act.

Employment-based retiree health coverage may provide coverage that is supplemental to benefits provided under a prescription drug plan or MA-PD plan to enrollees in such plans. (*CA at page 53*)

It is not yet clear whether a plan may pay the \$35 monthly premium on behalf of the retiree. As you know, payment of the Medicare Part B premium by an employer-sponsored health plan is not permitted.

Plan sponsors may wish to consider **picking up the \$250 deductible** for drug costs just as some supplemental plans currently pick-up deductibles and copays for Medicare beneficiaries for Part A and Part B of Medicare. Once the deductible is satisfied, Medicare Part D starts to pick-up **75% of the drug costs between \$250 and \$2,250** (which may or may not save the plan much money compared with its current plan). **When drug costs reach over \$5,100, the savings becomes much more pronounced with Medicare picking up 95% of the costs. Of course, the more the plan reduces its costs by shifting costs to Medicare, the less will be the tax subsidy to the plan.**

As this discussion of the financial implications of the Medicare law for group health plans illustrates, deciding on the best course of action for coordinating any supplemental drug program with Medicare will require very careful study by the fund consultant and/or fund actuary plus consideration of some basic policy questions regarding how far a fund wishes to go in assisting retirees with their drug bills. The TIC Research Department expects to publish additional reports on this new law and its implications for group health plans as interpretations of specific provisions become clearer and regulations are issued.

HEALTH SAVINGS ACCOUNTS OFFER HOPE RELIEF FROM MEDICAL EXPENSES FOR TAXPAYERS

The Act also creates health savings accounts (“HSAs”). HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents that are subject to rules similar to those applicable to individual retirement arrangements. Unlike Flexible Spending Accounts (FSAs), HSAs are not subject to an annual “use it or lose it” rule. Unused monies can accumulate in the HSA tax-free.

Within limits, contributions to health accounts are deductible if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. **Distributions from HSAs for qualified medical expenses are NOT includible in gross income.** Qualified medical expenses generally are defined under IRS Code Section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses.

Qualified medical expenses do not include expenses for insurance other than for: (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, and (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law. Distributions that are not for qualified medical expenses are includible in gross income and subject to an additional 15 percent tax. The additional 15 percent tax does not apply after death, disability, or the individual attains the age of Medicare eligibility (i.e., currently age 65).

Individuals eligible for HSAs are individuals who are covered by a “high deductible health plan” and no other health plan that is not a high deductible health plan. Individuals entitled to benefits under Medicare are not eligible to make contributions to an HSA. Eligible individuals do not include individuals who may be claimed as a dependent on another person’s tax return.

A “high deductible health plan” is a health plan that has a deductible that is at least \$1,000 for self-only coverage or \$2,000 for family coverage and that has an out-of-pocket expense limit that is no more than \$5,000 in the case of self-only coverage and \$10,000 in the case of family coverage. As under present law, out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the

plan. The rules for HSAs generally follow those of Archer Medical Savings Accounts unless otherwise provided. Qualified health insurance premium payments are allowed and include, for example, Medicare Part A and Part B premiums, Medicare HMO premiums, and the employee share of premiums for employer-sponsored health insurance, including employer-sponsored retiree health insurance. (*Above discussion based on CA at pages 397-399*)

The provision is effective for taxable years **beginning January 1, 2004**. Health Savings Accounts will be discussed in greater detail in future Research Memos.

POST SCRIPT

TOTAL PARITY LEGISLATION SCHEDULED FOR DELAY

It was reported in *Research Memo 2003-47* (11/13/03) that the House and Senate might pass a bill (H.R. 953 and S. 486, identical bills) during this congressional session requiring group health plans to provide total parity for the coverage of mental illnesses and physical illnesses. Different deductibles, different copays, and other limitations imposed on the treatment of over 400 mental illnesses versus physical illnesses would no longer be allowed. Both of these bills have strong bipartisan support.

However, Senators Pete Domenici (R-NM) and Senator Edward Kennedy (D-MA), chief sponsors of S. 486, announced on **November 6th** that the Senate would not act on its bill before Congress adjourned on November 21, 2003. But during a brief exchange on the Senate floor, they indicated that the Chairman of the Senate Health, Education, Labor and Pension Committee, Judd Gregg (R-NH) and Senate Majority Leader, Bill Frist (R-TN) have given S. 486 a high priority for early next year (2004).

This delay of any action on total parity legislation is welcome news for group health plans because it will forestall any significant increase in overall health plan costs attributable to the treatment of mental illnesses, at least for 2004.

Although action on total parity was postponed until next year, Congress did recently pass legislation **providing for a one-year extension** (i.e. December 31, 2004) of *The Mental Health Parity Act of 1996* which requires group health plans which cover mental illnesses to apply the **same annual and lifetime dollar limits** to the coverage of mental illnesses as the plan applies to physical illnesses. However, a plan is still permitted to apply different deductibles, copays, limits in numbers of outpatient visits, etc., to the treatment of mental illnesses than are applied to physical illnesses.

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