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[Medicare - Highlights of Bipartisan Agreement 11-18-03.pdf](#)

## **Highlights of Bipartisan Medicare Agreement**

The Bipartisan Agreement will give all Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. It will also preserve and expand private plan participation in Medicare, giving seniors more choices and better benefits. The agreement would provide enhanced prescription drug coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all beneficiaries until the full plan is available nationwide. Additionally, the proposal includes savings for many state governments; increased coverage for preventive services; and provisions for modernizing the drug delivery infrastructure.

### **More Choices, Better Benefits**

- **Preserves private health plan participation in Medicare** by increasing payments to such plans beginning January 1, 2004.
- **Expands private health plan participation in Medicare.** Beginning in 2006, these health plans, which will participate on a regional basis and provide coverage to beneficiaries in rural areas, will give seniors the same opportunity that Members of Congress and other Federal employees have to select the coverage that works best for them. While a final analysis of the agreement has not been completed, government actuaries have estimated that previous versions of the bill would result in roughly one-third of beneficiaries (roughly 14 million people) enrolling in private integrated health plans by 2009. That is nearly triple the current rate of private plan participation.
- **Makes more flexible coverage available to seniors.** Private health plans participating under any of the above options will compete for seniors' business by providing better coverage at affordable prices through marketplace competition, not government price-setting. Private sector competition will result in more innovation and flexibility in coverage. While the legislation would place some constraints on this flexibility, plans could use their ability to provide coverage more efficiently than traditional Medicare to provide seniors with more generous benefits.
- **Provides for fair and reasonable competition between traditional Medicare and private health plans.** The Bipartisan Agreement contains a six-year program of comparative cost adjustment in up to 6 Metropolitan Statistical Areas throughout the country. This demonstration would begin in 2010.



## Cost Containment

- **Requires more accurate accounting of – and greater accountability for -- Medicare's long-term liabilities.** The bill would require the Medicare Trustees to estimate annually the **combined** expenditures of the entire Medicare program (whether for hospitals, doctors or prescription medicines) and project when government transfers will account for 45 percent of total Medicare spending. These new accounting safeguards will put the program on a stronger financial foundation by alerting future Congresses and Presidents when the program's costs are rising faster than expected so they can address the problem.
- **Requires states to continue to share in the cost of providing Rx coverage to the poorest seniors.** Beneficiaries who are eligible both for Medicare and Medicaid would begin to receive their drug coverage through Medicare. But states will be required to continue to share in the burden of providing this coverage. States will pay the Federal Government 95% of what they would otherwise have spent on this population in 2006. That number would phase down to 75% over ten years and remain at that level permanently.
- **Reduces subsidies to the wealthiest seniors.** Under the Bipartisan Agreement, the wealthiest seniors will receive smaller Federal subsidies of their Medicare coverage. And monthly Medicare premiums will be higher for seniors with incomes above \$80,000, beginning in 2007.
- **Requires more rational cost-sharing in the Medicare program.** The deductible for services under Part B of the Medicare program has been set at \$100 since 1991 and has not been adjusted for inflation. The Bipartisan Agreement raises the deductible to \$110 in 2005 and indexes that amount for subsequent years.

## Employers

- **Encourages employers to continue to provide coverage to their retirees** by providing a Federal subsidy equal to 28 percent of drug spending by their retirees between \$250 and \$5000. The Federal subsidy to the employer is not subject to the corporate income tax.
- **Gives employers additional options**, including permitting them to become Medicare Advantage plans so that their workers can remain in the same plan when they reach age 65 and qualify for Medicare coverage.

## Medicare Drug Benefit

- Beginning in 2006, Medicare beneficiaries will have access to the standard drug benefit described below. Although drug plan sponsors may change some of the specifications below, the benefit offered must at least be equal in value to the standard benefit. Standard coverage

includes, for a monthly premium of about \$35:

- A deductible of \$275;
  - Coinsurance of 25 percent up to an initial coverage limit of \$2200; and
  - Protection against high out-of-pocket prescription drug costs, with copays of \$2 for generics and preferred multiple source drugs and \$5 for other drugs, or 5 percent of the price, once an enrollee's out-of-pocket spending reaches a limit of \$3,600.
- Those beneficiaries with limited savings and low incomes will receive a more generous benefit package, as described below:
    - Beneficiaries with limited savings and incomes below 135 percent of the Federal poverty level (\$12,123 for individuals; \$16,362 for couples) will receive:
      - A \$0 premium
      - A \$0 deductible
      - No gap in coverage
      - Copays of \$2 for generics and preferred multiple source drugs and \$5 for other drugs, up to the out-of-pocket limit. (For dual-eligibles with incomes below 100% of the Federal poverty level, this cost-sharing is reduced to \$1 and \$3.); and
      - \$0 copay for all prescriptions once the out-of-pocket limit is reached.

Beneficiaries with limited savings and incomes between 135 percent and 150 percent of the Federal poverty level (\$13,470 for individuals; \$18,180 for couples) will receive:

- A sliding scale premium;
- A \$50 deductible;
- No gap in coverage;
- Coinsurance of 15 percent up to the out-of-pocket limit; and
- Copays of \$2 and \$5 once the out-of-pocket limit is reached.

### **Medicare-Approved Prescription Drug Discount Card**

- Medicare beneficiaries without prescription drug coverage will be eligible for the Medicare-endorsed Prescription Drug Discount Card, which will begin operation six months after enactment and continue until the full benefit is implemented.
- The card program is estimated to save beneficiaries between 10 and 25 percent on their prescription drug spending.
- Those with incomes below 135 percent of poverty will be given immediate assistance through a Medicare-endorsed prescription drug discount card with \$600 annually to be applied toward the purchase of their medicines.

### **Modernizing Drug Delivery Systems**



- The Bipartisan Agreement also calls for the use of electronic prescribing in the delivery systems that will bring prescription drugs to Medicare beneficiaries.
- Such systems should sharply reduce the substantial number of prescribing errors that occur each year by helping to better identify and thus prevent potentially adverse drug interactions. In addition, such changes can foster further use of data-driven disease management programs.

### **New Preventive Coverage**

- Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination, and all beneficiaries will be covered for cardiovascular screening blood tests, and those at risk will be covered for a diabetes screen.
- These new benefits can be used to screen Medicare beneficiaries for many illnesses and conditions that, if caught early, can be treated, managed, and can result in far fewer serious health consequences.

### **The Bipartisan Agreement and Health Savings Accounts**

- **Makes medical savings accounts – now known as health savings accounts, or HSAs – more attractive by eliminating restrictions that have prevented broad access to this product.** This is an important health care reform that will give consumers access to coverage that is affordable, flexible and portable.
- **Makes HSA open to everyone with a high deductible health insurance plan.** The only limitation on the health plan is that the annual deductible must be at least \$1,000 for individual coverage and at least \$2,000 for family coverage.
- **Excludes contributions to the HSA by an employer from the individual's taxable income.** Contributions by an individual are tax deductible. Total yearly contributions to an HSA can be as large as the individual's health insurance plan deductible, between \$1,000 and \$5,000 for self-coverage, and between \$2,000 and \$10,000 for family coverage.
- **Exempts interest and investment earnings generated by the account from taxation while in the HSA.** Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses, such as prescription and over-the-counter drugs and long-term care services as well as the purchase of continued health-care coverage for the unemployed individual (via COBRA). Amounts distributed which are not used to pay for qualified medical expenses will be taxable, plus an additional 10% tax will be applied in order to prevent the use of the HSA for non-medical purposes.

- **Increases health insurance portability** so that individuals are not dependent on a particular employer to enjoy the advantages of having an HSA. Like an individual retirement account (IRA), the account is owned by the individual, not the employer. If the individual changes jobs, the HSA goes with the individual.

- **Permits individuals over age 55 to make extra contributions to their accounts and still enjoy the same tax advantages.** In 2004, an additional \$500 can be added to the HSA. By 2009, an additional \$1,000 can be added to the HSA.



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