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Preparing for Medicare Part D: An Opportunity for State Offices of Rural Health and State Rural Health Associations

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The Time is Now: Milestone Dates¹

September 2005

- 1st – Nov. 15th Medigap insurers send notices informing policyholders of their options.
- 1st – Nov. 15th Employers/unions notify insured retirees about their new prescription drug choices.

October 2005

- 1st Approved Part D plans begin marketing.
- 13th The Centers for Medicare & Medicaid Services (CMS) begins disseminating information describing Part D through the *Medicare & You 2006* handbook, 1-800-MEDICARE, a Drug Plan Comparison Web Tool, and a Medicare Personal Plan Finder on Medicare.gov.
- 27th CMS mails auto-enrollment information to dual eligibles.

November 2005

- 15th Enrollment period begins.
- 15th States and entities offering drug coverage provide written disclosure to Part D eligible individuals regarding actuarial equivalence.

December 2005

- 31st Medicaid drug coverage ends for full benefit dual eligibles.

January 2006

- 1st CMS Benefits Enrollment Urgency advertisement begins.
- 1st Part D coverage begins for all beneficiaries enrolled in a plan.
- 1st Dual eligibles' auto-enrollment takes effect.
- 1st Subsidies begin for Part D coverage for those eligible based on income and resources.
- 1st Medigap insurers prohibited from selling new policies with drug coverage.

March 2006

- 1st – 31st CMS identifies all beneficiaries not enrolled in a Medicare prescription drug plan.

April 2006

- 1st – 30th CMS mails spring enrollment reminder to beneficiaries.
- 1st – 30th CMS facilitates enrollment in a prescription drug plan for those determined to be eligible for subsidies but who have not yet enrolled in a plan (through May).

May 2006

- 16th Late enrollment penalty begins.

Note: Dates correct at time of publication.

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An Opportunity for State Offices and Associations to Help Rural Medicare Beneficiaries

Keeping with their organizational missions to improve and promote the health of rural Americans, state offices of rural health and state rural health associations have an inherent interest in helping beneficiaries access necessary health care services, including prescription medications. Implementation of Part D creates an opportunity to help beneficiaries through leadership, by connecting beneficiaries and those who serve them to resources that will help them react appropriately to changes in the program.

Enrollment into prescription drug plans (PDPs) will take place between November 15, 2005, and May 15, 2006. Beneficiaries are very likely to have choices to make among multiple plans. Initial submissions by preferred provider organizations (PPOs) in March of 2005 would have plans available in 21 of the 26 Medicare Advantage (MA) regions.² After the June 6 deadline for final bids from plans, the CMS Administrator offered an observation that PPOs would be available “virtually everywhere in the country.” CMS now has the task of sorting out duplication and applying standards to the June submissions—“industry sources” say there will be multiple choices based on the high volume of PDPs submitted to CMS.³

All beneficiaries receiving Medicaid benefits will participate in new Medicare plans, by mandatory assignment if necessary. Beneficiaries currently receiving insurance coverage as retirees from private firms will receive notification as to whether or not their plan is at least as comprehensive as the new Medicare benefit. With that information, they will make a decision to stay in their current plan or enroll in a new Medicare plan (assuming they want to continue coverage). Estimates vary on how many additional beneficiaries will be enrolling for the first time in private plans, but all will be receiving some form of notification of changes in the Medicare program and are therefore candidates for needing assistance understanding what is or is not happening. While multiple organizations will be engaged in working with beneficiaries and the Medicare program, state offices of rural health and rural health associations have a special role to play in being sure that beneficiaries are treated equitably in having opportunities to understand what is taking place, how it affects them, and actions they may want to take.

Community-Based Assistance Will Be Needed in Rural Areas

Rural residents have limited experience selecting from multiple plans. Their choices will be based on their understanding of options, their financial resources, and their evaluation of options against personal health needs. Beneficiaries will need both access to information and assistance in understanding plan options. One-on-one counseling with beneficiaries will be essential, with someone they trust reviewing choices with them. Local providers, especially physicians and pharmacists, are likely to be queried and they will want local sources for assistance.⁴

More than 70% of beneficiaries say they know where to get information about Medicare, but less than 40% of beneficiaries were able to answer four knowledge questions about Medicare correctly. The Medicare & You Regional Survey findings also show that members of certain population subgroups present special challenges. These subgroups include the less educated, the under 65 disabled, those who are 80 years of age and older, African-Americans, Hispanics, Asians, American Indians and Alaska Natives, those who are in fair/poor health, and those who are dual eligible.⁵

What State Offices and Associations Can Do

Helping Beneficiaries

- Understand the changes, including the benefits for beneficiaries with limited income and resources.
- Find out who the key contacts are for your state, region, or county.
- Connect beneficiaries with resources and one-on-one counseling.
- Identify resources CMS should be including in the partnership program.

Helping Providers

- Understand the implications for providers facing annual decisions about contracting with MA plans and/or PDPs and answering questions from their patients.
- Help providers understand these implications.
- Direct providers to resources.
- Facilitate learning among providers.

Working with CMS Partners⁶

State offices and associations can connect beneficiaries with existing resources, many of which are available through groups partnering with CMS, and can use information from those sources in direct communications with beneficiaries and providers. CMS is looking to foster partnerships and build coalitions with private sector organizations and other government agencies to educate people with Medicare in rural communities and their caregivers as well as champion their causes. CMS is looking to leverage limited resources by incorporating Medicare education messages into partners' well-established communication channels. CMS will promote and support collaboration, communication, and networking among those who have an interest in reaching the rural beneficiary community.⁷

The CMS partner's Web site is <<http://www.cms.hhs.gov/partnerships>>.

CMS has awarded several contracts to extend outreach to populations otherwise difficult to reach, including these contracts that encompass rural populations:

- Interagency agreement with the U.S. Department of Agriculture to reach rural underserved audiences through county extension service educators
- Interagency agreement with the Indian Health Service to extend education and awareness to tribal staff and members
- Subcontract with the National Association of Community Health Centers to target low-income beneficiaries in medically underserved communities

For more information on rural health partnerships, e-mail the Division of Partnership Development at partnershipwebsite@cms.hhs.gov with the subject heading Rural Health Inquiry.

Organizations within the U.S. Administration on Aging's (AoA's) Aging Services Network (State Units on Aging, Area Agencies on Aging, and local service providers) can sign up to be partners in the AoA's Medicare Aging Network at <<http://aoa.gov/medicare/index.asp>>.

Resources to Tap Into

- BenefitsCheckUpRx (benefitscheckup.org/rx) helps people with Medicare and other older adults learn about and enroll in government benefits, including the new Medicare prescription drug coverage and other federal, state, and private programs.
- People with limited income and resources may qualify for extra help from Medicare in paying for their prescription drugs. More information about this help is available by calling Social Security at 1-800-772-1213.
- State Health Insurance Assistance Programs (SHIPs) have received a funding increase of 50% for a total of \$31.7 million in 2005. SHIPs are a key partner with CMS in their education and outreach effort.

A beneficiary can be referred to a state's SHIP by contacting 1-800-Medicare and asking for health insurance counseling. An easy-to-use Web site is available at Shiptalk.org which makes it easy for a beneficiary, a caregiver, or a state office or rural health association employee to find a state SHIP contact and a counselor down to a specific county or a nearby county.

A list of SHIPs can also be obtained from <http://www.medicare.gov/>.

Select "Search Tools"

Select "Find Helpful Phone Numbers and Websites"

Select "Find a Specific Organization"

Select "SHIP" from drop list

- State Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) information is available at:
 - <http://www.cms.hhs.gov/medicarerereform/states/>. Highlights include:
 - State Executive Branch Checklist – This checklist serves as a guide for state executive branch officials and agencies to refer to as they implement MMA in their state. This checklist can be accessed at http://www.cms.hhs.gov/medicarerereform/states/checkllist_Executive.pdf.
 - CMS Regional Campaign Manager Contact Information:

Region I, Boston	Carol Maloof	617-565-1313	Carol.Maloof@cms.hhs.gov
Region II, New York	Danielle Liss	212-616-2217	Danielle.Liss@cms.hhs.gov
Region III, Philadelphia	Patti Lalor	215-861-4152	Patricia.Lalor@cms.hhs.gov
Region IV, Atlanta	Wilma Cooper	404-562-7240	Wilma.Cooper@cms.hhs.gov
Region V, Chicago	Greg Chesmore	312-353-1487	Gregory.Chesmore@cms.hhs.gov
Region VI, Dallas	Julie Kennedy	214-767-6420	Julie.Kennedy@cms.hhs.gov
Region VII, Kansas City	Kathryn Coleman	816-426-6518	Kathryn.Coleman@cms.hhs.gov
Region VIII, Denver	Mark Levine	303-844-7070	Mark.Levine@cms.hhs.gov
Region IX, San Francisco	Cate Kortzeborn	415-744-3661	Catherine.Kortzeborn@cms.hhs.gov
Region X, Seattle	Michelle Dillon	206-615-2368	Michelle.Dillon@cms.hhs.gov

Resources to Tap Into (*continued*)

- State MMA information (*continued*)
 - For a list of the regional state captains, go to <http://cmsnet.cms.hhs.gov/projects/mmacomm/co/>.
 - The MMA_States listserv was created to give states information on the MMA and to update states on any issues or changes pertaining to the MMA. To join this listserv go to <http://www.cms.hhs.gov/maillinglists/default.asp?audience=14>.
- CMS partners can obtain professional training materials and presentations on the Medicare program to increase knowledge and awareness within their own organization and among their constituencies. Tailored Medicare materials for hard-to-reach populations are also available to help promote awareness of the Medicare program.⁸ Many of these resources are easily available at <http://www.cms.hhs.gov/partnerships/>. Some of the resources available include an outreach toolkit, publications, fact sheets for beneficiaries, tip sheets, handouts, presentations, calendars, and timelines. By linking directly to <http://www.cms.hhs.gov/partnerships/tools/materials/default.asp>, an information folder can be found that provides basic education on the Medicare prescription drug coverage that can be customized to fit an audience. The Outreach Toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance to their clients on the Medicare prescription drug coverage. The 2005 Medicare Preventive Benefits Outreach Materials are materials aimed toward the local media and community to promote the new 2005 Medicare preventive benefits. Also available are resources for caregivers. Many of these resources and materials are also available in Spanish.
- Medicare prescription drug coverage information for providers can be found at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.
- Medicare prescription drug coverage information for beneficiaries can be found at <http://www.medicare.gov/medicarereform/>.
- Rural health information resources can be found at <http://www.cms.hhs.gov/providers/rh/>.
- A brochure, *Information for Rural Health Providers, Suppliers, and Physicians: Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003*, is available to download at <http://www.cms.hhs.gov/medlearn/RuralHealthBrochure.pdf>.
- The Henry J. Kaiser Family Foundation's main Medicare page can be found at <http://www.kff.org/medicare/index.cfm>, which includes comprehensive information on Medicare and the MMA including fact sheets on the Medicare prescription drug benefit and low-income assistance under the Medicare drug benefit.

Many Rural Beneficiaries Can Benefit

In 2005, there were 9,008,480 rural Medicare beneficiaries. Approximately 12% of elderly beneficiaries have household incomes below the federal poverty guideline, and approximately 14% have incomes between 100% and 150% of poverty. Beneficiaries with limited income are especially likely to benefit from Part D (see Tables 1 and 2).

Rural beneficiaries are more likely than their urban counterparts to

- Be users of prescription drugs
- Be in fair or poor health
- Have low income
- Not have any drug coverage
- Have chronic or life-threatening conditions for which prescriptions drugs are essential to reduce morbidity and mortality⁹

Regardless of whether or not they had prescription drug coverage, rural beneficiaries spent more out-of-pocket on prescription drugs in 2003 than did urban beneficiaries, and rural beneficiaries without any prescription drug coverage spent an average of \$500 more than did rural beneficiaries with drug coverage.¹⁰

Table 1. Overview of Part D Benefits, 2006

Category of Beneficiaries	Out-of-Pocket Costs
Enrolled in Medicaid, with income up to 100% of the federal poverty level (FPL), \$9,670 per individual in 2006 ¹¹	No premium or deductible Per prescription co-payments of \$1 for generics or \$3 for brand-names, until total out-of-pocket cost limit (OOPL) of \$3,600 is reached, after which there is no further cost to beneficiary
Enrolled in Medicaid with income greater than 100% of the FPL Income less than 135% of the FPL and assets less than \$6,000 for individuals, \$9,000 for couples	No premium or deductible Per prescription co-payments of \$2 for generics or \$5 for brand-names, until OOPL of \$3,600 is reached, after which there is no further cost to beneficiary
Income between 135% and 150% of the FPL and assets less than \$10,000 for individuals, \$20,000 for couples (an additional \$1,500 for individuals and \$3,000 for couples is allowed for burial or funeral arrangements)	Premium subsidy of 75% for those with income from 135% to 140% of the FPL, 50% for those with income from 140% to 145% of the FPL, and 25% for those with income from 145% to 150% of the FPL \$50 annual deductible Coinsurance of 15% after the deductible until OOPL of \$3,600 is reached After OOPL is reached, co-payments of \$2 per generic prescription and \$5 for brand-name prescriptions
All others	Full premium; average monthly premium will be \$32.20 \$250 annual deductible 25% co-insurance of costs between \$250 and \$2,250 100% co-insurance of costs between \$2,250 and OOPL of \$3,600 After OOPL is reached, greater of 5% co-insurance or co-payments of \$2 per generic prescription and \$5 per brand-name prescription

Sources: Medicare Drug, Improvement, and Modernization Act of 2003; Medicare Final Rule for Titles I and II; U.S. Bureau of the Census; and Centers for Medicare & Medicaid Services, Medicare Fact Sheet. "Medicare Premiums Will be Lower Than Expected; Consumer Choice, Competition Will Help Beneficiaries. August 9, 2005.

Table 2. Drug Benefit Savings for a Beneficiary with \$2,400 in Drug Spending

Beneficiary Group	Annual Spending	Out-of-Pocket Spending Under Part D	Percentage Savings After Premium	Dollar Savings After Premium
Beneficiary with standard coverage with incomes at or above 150% of FPL	\$2,400	\$697.50	53%	\$1,262.50
Beneficiary with income under 150% FPL and low assets	\$2,400	\$348.50	77%	\$1,831.50
Beneficiary with income below 135% FPL and low assets or beneficiary dually eligible for Medicaid above 100% FPL regardless of assets	\$2,400	\$109.85	95%	\$2,290.00
Beneficiary dually eligible for Medicaid with income at or below 100% FPL	\$2,400	\$62.77	97%	\$2,337.23
Beneficiary who is dually eligible for Medicaid and a nursing home resident	\$2,400	\$0	100%	\$2,400.00

Source: Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees. Medicare Fact Sheet. January 21, 2005. Accessed July 21, 2005 at <<http://www.cms.hhs.gov/media/press/release.asp?Counter=1324>>.

Explanatory Notes: \$2,400 is close to the projected median spending for all beneficiaries in 2006. Beneficiary out-of-pocket and percentage savings assume 15% cost management savings by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between \$0 and \$440. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of \$65 and an average co-pay of \$3.50 and \$2, respectively. The “percentage savings after premium” column differs from other numbers presented in the text because it reflects an individual case and includes premium, whereas the text represents average coverage across the various income groups and does not include premium.

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