

Medicare in 2006: A Great Deal for Rural Nebraskans and Their Doctors?

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It's Just Around the Corner

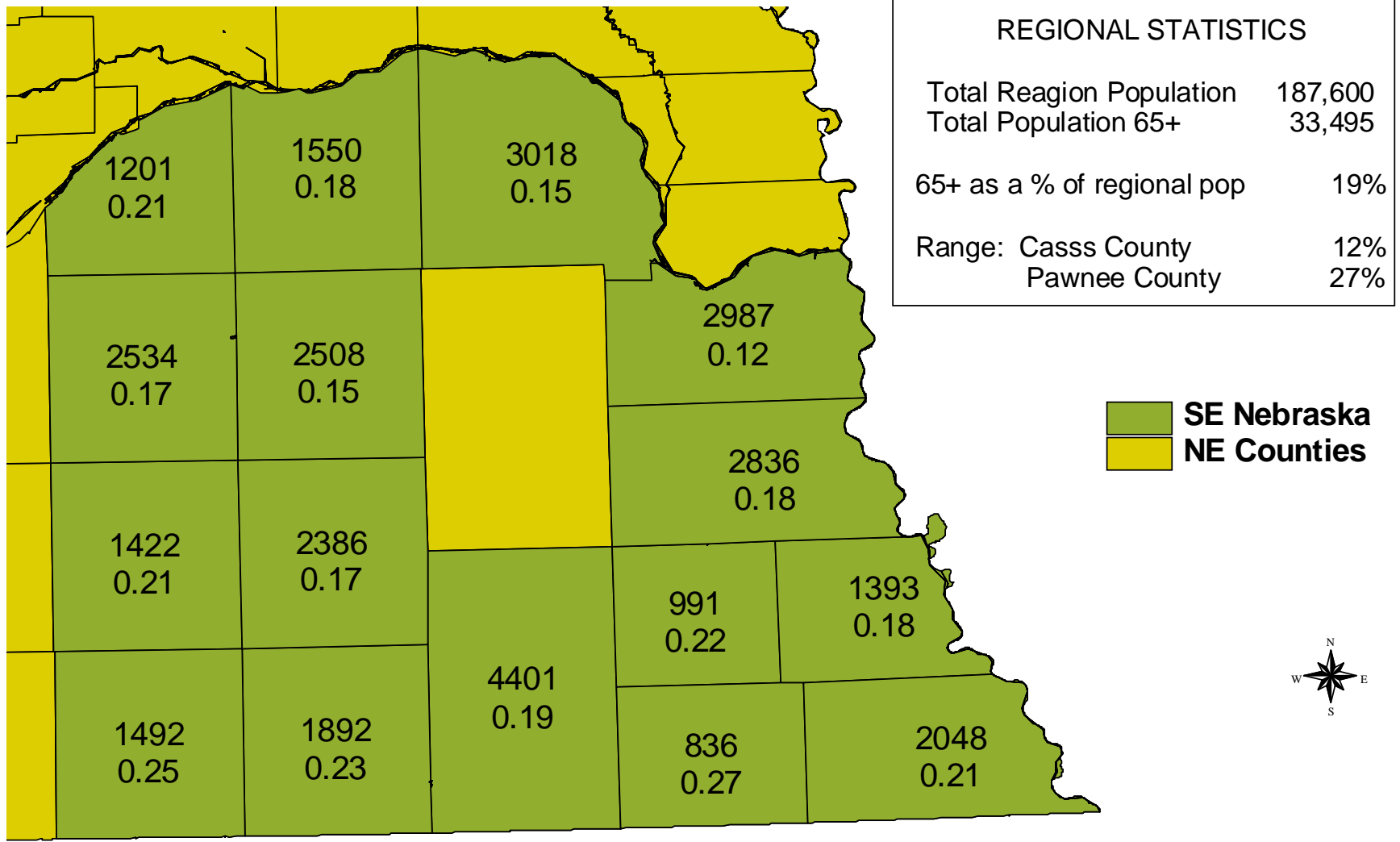
- Next week: CMS releases information on PDP and MA/PDP plans
- October 1: Plans begin marketing
- November 15: Beneficiaries begin enrolling
- December 31: Dual eligibles automatically enrolled
- January 1: Coverage begins
- May 15: Open enrollment ends



And it could affect many Nebraskans


- Over age 65: 226,820
- Disabled: 30,351
- Total: 257,171
- Over age 65 in Southeast Nebraska
(excluding Lancaster County) :

Individuals 65 Years of Age and Over by County and as a Percent of Total County Population in Southeast Nebraska, 2000




Source: U.S. Bureau of the Census, SF3 Sampling File, 2000

Cartography: NE CRHR, UNMC, 2005



And there will be lots of choices

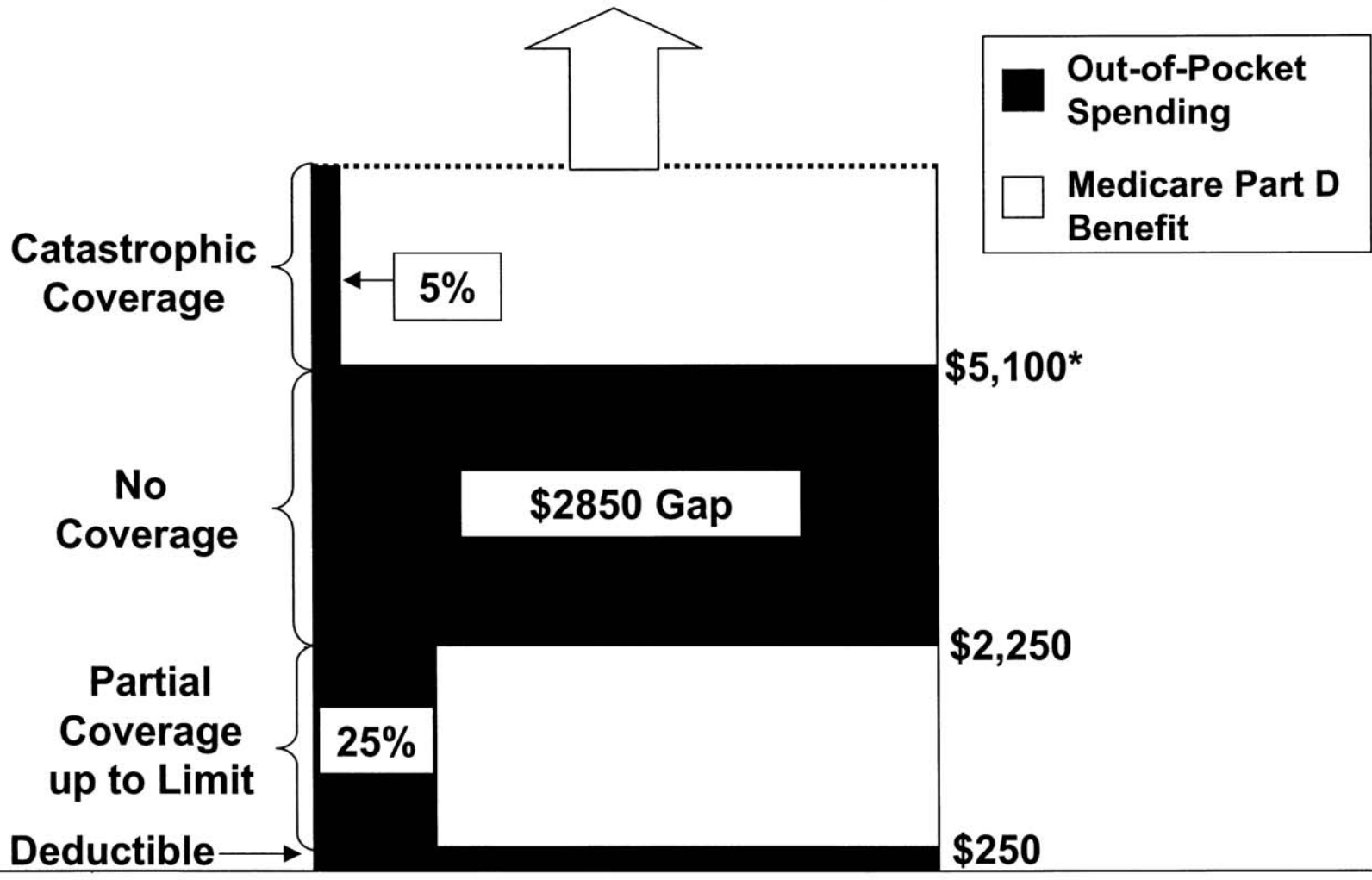
- In our region 17 organizations offering PDPs
- At least one regional MA (may not offer prescription drugs)
- Other MA plans with local area reach such as United, Humana



So just what is this new benefit?

- Covers all basic drugs (CMS has reviewed formularies)
- Monthly premium as low as zero, benchmark in our region of \$32.88
 - 4 plans under \$20
 - 5 plans between \$20 and \$25
 - 6 plans between \$25 and \$30
 - 13 plans between \$30 and \$35
- Deductible of \$250
- Out of pocket ceiling of \$3,600, then 5% co-pay

Out-of-Pocket Drug Spending for Medicare Beneficiaries Under Medicare Conference Agreement



Medicare Conference Agreement

+ ~\$420 in annual premiums

*Equivalent to \$3,600 in out-of-pocket spending:

\$3,600 = \$250 (deductible) + \$500 (25% cost-sharing on \$2,000) + \$2,850 (100% cost-sharing in the "gap").

Table 1. Overview of Low-Income Part D Benefits, 2006

Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL (\$9,570/individual in 2005)	\$0	\$0	\$1/generic \$3/brand-name; no copays after total drug costs reach \$5,100
Full-benefit dual eligible; income greater than 100% FPL	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug costs reach \$5,100
Income less than 135% FPL (\$12,920/individual in 2005) and assets <\$6,000/individual; \$9000/couple	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug costs reach \$5,100
Income 135%-150% FPL (\$12,920-\$14,355/individual in 2005 and assets <\$10,000/indiv; \$20,000/couple	sliding scale up to ~ \$37	\$50	15% of total costs up to \$5,100 catastrophic limit; \$2/generic \$5/brand-name thereafter
All others (non-subsidy eligible)	~ \$37	\$250	25% up to initial coverage limit; 100% up to \$3,600 out-of-pocket spending

Source: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.

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.



Key questions to consider

- How will my patients make their choices and who will help?
- What will be the impact on me and my practice?
- What will be the impact on other health care providers (hospitals and pharmacies)?




MMA and Impacts on Beneficiaries

\$\$\$\$ Coverage for Prescription Drugs

Particular rural relevance


- 9,008,480 rural beneficiaries
- 12% of elderly beneficiaries in households with below poverty incomes
- 14% have incomes between 100% and 150% of poverty
- Rural beneficiaries more likely than urban to users of prescription drugs
- Rural beneficiaries less likely to have current coverage, and spend more out-of-pocket



MMA and Impacts on Beneficiaries Needing to Make Choices

Why MA plan and which one?

- Comprehensive benefit package from one source
- Could be lower monthly premium (combined Part B and Part D premiums)
- But what is the coverage?
- And who are the providers?
- And what is the sustainability of the plan in my county?
- PPO? HMO? FFS?



MMA and Impacts on Beneficiaries Needing to Make Choices

Why PDP and which one?

- Satisfied with current coverage for services other than prescription drugs
- Insure against unknown liability associated with prescription drugs
- Might be a dual eligible facing auto-enrollment
- Myriad of national and regional plans offered to me
- Choice based on cost, coverage, access

How to make the choice?

- Help from CMS web site
- Help from state health insurance assistance programs
- Help from other CMS partners
- Help from people in this room




MMA and Beneficiaries: Summary

- Major change in the program
- With implications for out-of-pocket expenses
- And lots of decisions to be made



Who can help?

- Medicare (CMS) through web site, 1-800 number, state contacts
- Medicare partners
- Nebraska Medicare Prescription Drug Benefit Coalition
 - Led by State Health Insurance Assistance Program and AARP
 - Next briefing is September 29
 - Includes over 600 individuals including NMA
 - Last broadcast had 51 sites and over 1000 viewers
 - Will have volunteers in most Nebraska communities by November
 - www.hhss.ne.gov/med/training.htm
- benefitscheckup.org/rx




How does this affect physicians?

- Patient inquiries to office staff
- E-prescribing goal of the program
- May hear about formularies
- **PAYMENT** from MA plan




What's a Doc to do?

- CMS partner site provides some help, including tool kits (cms.hhs.gov/partnerships)
- Use the Nebraska coalition for resource
- Negotiate with MA plans




What about rural hospitals, especially CAHs?

- Not a protected category in the legislation and regulation
- Expected to be tough negotiators
- Caution in signing contracts
- And be aware of public reporting (hospital compare)
- Physicians may want to pay attention to consequences for hospitals



What about rural pharmacies, especially independent pharmacies?

- Monitor contract terms
- Sign if at all possible
- Invoke any willing provider clause if necessary and affordable
- Help beneficiaries understand consequences of networks and formularies



Watchword is cautious participation

- Could be quite beneficial for beneficiaries
- Could lead to more effective care (patient compliance with treatment)
- But confusion could be the order of the day
- And bad choices could be made by all



Thank you!
