

CENTER NEWS

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Beginning January 1, 2006 Medicare will help pay for certain prescription drugs under a new section of Medicare called Part D. Most people will have to sign up for a drug plan if they want prescription drug coverage under Part D and will have to pay premiums and co-payments. Not all drugs will be covered and there will be many different plans to choose from. This issue of the *Center News* provides a summary of Part D and answers to some frequently asked questions about the new program.

WHO'S ELIGIBLE FOR MEDICARE DRUG COVERAGE?

People who have Medicare Part A *or* Part B will be eligible for Medicare drug coverage. If they want to get drug coverage through an HMO or PPO, they must have Medicare Part A *and* Part B. They can enroll in any of the Part D plans that serve the area where they live.

HOW DO YOU ENROLL?

In the first year of the program the enrollment period is November 15, 2005 - May 15, 2006. In future years the enrollment periods will be from November 15 – December 31 annually. During 2006 only, people may be able to change drug plans until May 15. In future years once people choose a plan they will not be able to change until the next enrollment period, except in certain special situations.

IS MEDICARE DRUG COVERAGE OPTIONAL?

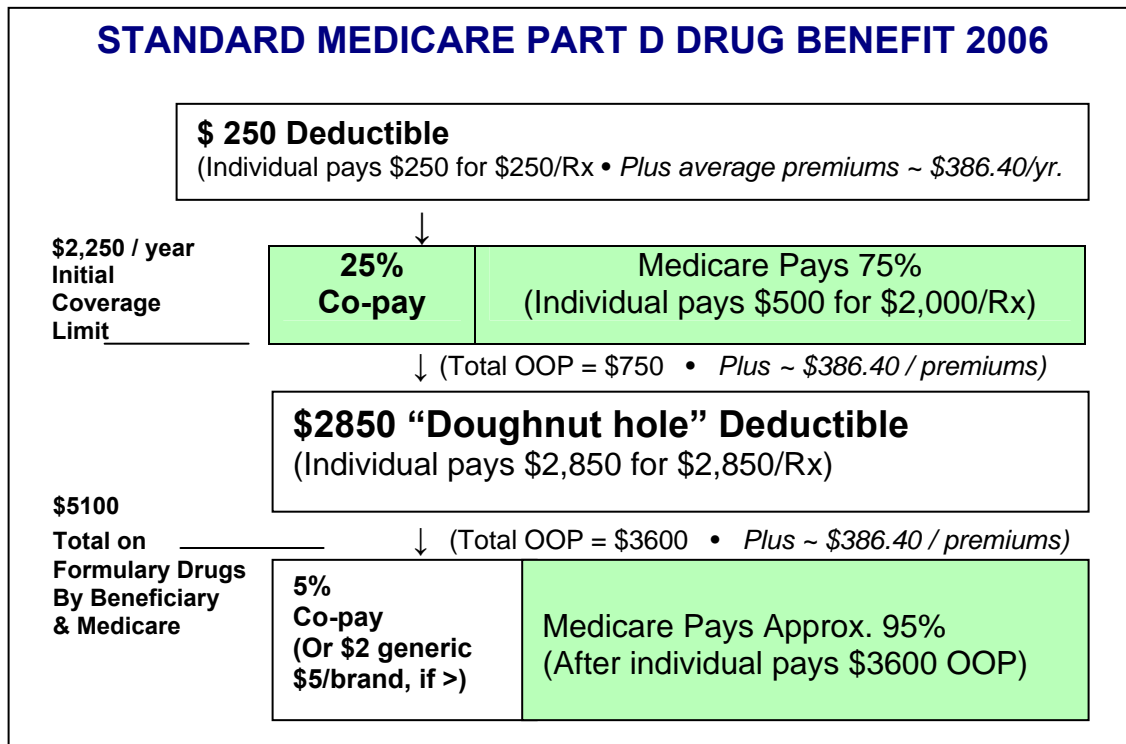
Yes. Medicare Part D is optional. People do not have to elect drug coverage and they will still be able to participate in Medicare Parts A and B if they don't. *But*, people who do not choose to enroll in Part D when they are first eligible will have to pay a higher premium if they decide to join later on. This penalty will be about 1% of the average national monthly premium for each month during which the individual could have been in Part D. *In 2006, the penalty will be 32¢/month.* People who qualify for a full low income subsidy will have a smaller penalty and it will be limited to five years. People who sign up late will have to pay this penalty unless the Medicare administration decides they had drug coverage that was as good as Medicare's during the time they did not enroll in Part D. This is known as "creditable" coverage.

HOW WILL PART D WORK?

Medicare drug coverage will be provided by a variety of private plans, not by the Medicare program itself. This is different from the way Parts A and B work. Also, unlike Parts A and B, people will have to take action to enroll in Part D. They can choose a separate Prescription Drug Plan (PDP) and stay in the traditional Part A and B Medicare program, or they can choose a Medicare Advantage plan that has a prescription drug benefit (MA). Some types of MA plans may not offer a drug benefit; people in these MA plans can choose a separate PDP. On the other hand, people in an MA plan that does offer a prescription drug plan will have to use their MA plan's drug benefit unless they disenroll from the Medicare Advantage plan.

WHAT IS THE STANDARD PART D BENEFIT?

The Part D drug benefit will cover some of the costs for certain drugs. There will be a monthly premium for all Part D plans. The average national monthly premium will be \$32.20 per month. Individuals will have the option of having the premium taken from their Social Security check, paying the premium directly, or having the premium taken directly from a bank account. Under the standard benefit, people will have to pay the first \$250 as a deductible each year and then Medicare will pay 75% of the next \$2000 worth of drugs on their Plan’s formulary. (A formulary is a list of the Plan’s covered drugs.) After this initial payment cap is reached, people will have a gap in coverage, known as the “doughnut hole”. During this coverage gap, beneficiaries will be responsible for all drug costs until they have paid another \$2850 out-of-pocket. At that point, Medicare will begin paying about 95% of the cost of covered drugs until the end of the calendar year. Some plans may offer drug coverage that is slightly different as long as the overall value is the same.



WHAT WILL COUNT TOWARD THE YEARLY OUT-OF-POCKET LIMIT?

Only certain payments count towards the yearly \$3600 out-of-pocket (OOP) limit. Payments that count are the deductible and co-payments for drugs on the formulary made by the individual, family members or charitable organizations, and payments made by a State Pharmaceutical Assistance Plan (SPAP, known as ConnPACE in Connecticut). Medicare’s payments for Part D’s Low Income Subsidy (LIS) will also count towards the OOP Limit. Payments made by other insurance, including employer-sponsored plans, will *not* count towards the OOP limit. Also, premiums, and payments for non-formulary drugs will *not* count toward the limit.

WILL THE PART D DRUG PLANS DIFFER?

Yes. Each drug plan can set and change its own benefit so long as its coverage is considered at least equivalent to the standard benefit. In some circumstances the plans can have different co-payments for different kinds of drugs. (For example, a lower co-pay for generic drugs than for brand name drugs.) The plans can also choose what drugs to include on the list of drugs for which they make payment.

IS THERE HELP AVAILABLE FOR PEOPLE WITH LOW INCOMES?

People Who Have Medicaid

The law eliminates Medicaid drug coverage for people who are dually-eligible for both Medicare and Medicaid and entitles these individuals to prescription drug coverage under Medicare Part D. These individuals will have no Part D premium, deductible or “Doughnut Hole.” In 2006 their co-payment will be \$1 or \$2 for generic/preferred drugs and \$3 or \$5 for other drugs, depending on their income. There is no co-pay for dually-eligible individuals who reside in nursing homes, homes for people with mental retardation and certain other institutions. In some states, including Connecticut, Medicare Part D will increase co-payments and decrease the drugs that are currently covered under Medicaid, unless the State acts to fill these gaps.

Other Low-Income People

A full subsidy referred to as “extra help,” is available for people with incomes up to 135% FPL and assets not more than \$6,000/individual or \$9,000/couple. In 2005 the income eligibility limits for this subsidy are \$12,920/year for an individual and \$17,321/year for a couple. (People who sign up in 2005 will be eligible in 2006). These individuals will also pay no premiums or deductible and will not have a “Doughnut Hole” gap in coverage. Co-payments for these individuals will be \$2 for generic/preferred drugs and \$5 for other drugs. The same subsidy is available to people receiving federal Supplemental Security Income (SSI) benefits and to people receiving benefits under a Medicare Savings Program (MSP). Persons in these groups do not have to apply for the subsidy.

A partial subsidy is available for people with incomes up to 150% FPL and assets not more than \$10,000/individual or \$20,000/couple. In 2005 the income limits for this group are \$14,355/year for an individual and \$19,245/year for a couple. These individuals will pay a sliding scale premium from about \$0-\$386.40/year, a \$50 deductible and will not have a “Doughnut Hole” Gap in coverage. They will be required to pay 15% per prescription, up to the catastrophic threshold, and then \$2 for generic/preferred drugs and \$5 for other drugs for the remainder of the year.

LOW INCOME SUBSIDY GROUPS AND COSTS

Group Getting help with Prescription Drug Program Costs	Group 1 Dual Eligibles	Group 2 MSP (QMB, SLMB,QI) SSI w/o Medicaid	Group 3 Income ≤ 135% FPL Resources Below \$6,000/ \$9,000	Group 4 Income ≤ 150% FPL Resources Below \$10,000/ \$20,000
Premium \$32.20/month	\$0	\$0	\$0	Sliding scale (\$0 - \$32.20) Based on income
Deductible \$250 per year	\$0	\$0	\$0	\$50
Cost Sharing * up to \$3600 out-of-pocket	co-pays: \$0 if institutionalized \$1/\$3 ≤ 100% FPL \$2/\$5 > 100% FPL	\$2/\$5 co-pay	\$2/\$5 co-pay	15% coinsurance
Catastrophic Coverage 5% or \$2/\$5 co-pay	\$0	\$0	\$0	\$2/\$5 co-pay

*Individuals in these four groups do not have the “Doughnut Hole” gap in coverage.

SPECIAL CONSIDERATIONS FOR PEOPLE WHO HAVE INSURANCE THAT COVERS PRESCRIPTION DRUGS

Some Medicare beneficiaries may have prescription drug coverage through other insurance. Whether or not they can continue with that coverage or should switch to a Part D plan depends on what kind of insurance the individual has. To help decide what an individual should do, consider whether the person's drug coverage is:

- **Through a Medicare HMO or other Medicare Advantage plan.** *If so, the individual must keep getting drug coverage through that plan if she wants to stay in the Medicare Advantage plan.*
- **Through their own or a spouse's current employment or through a retiree health plan.** *If so, has the employer or former employer told the individual whether the insurance is as good as or better than Medicare's coverage (i.e., "creditable coverage")? If it is creditable coverage, the individual may stay in that plan without getting a late penalty on the premium if she later decides to change to a Medicare drug plan. The individual must check with the employer to learn if enrolling in a Part D plan will cause her to lose the employer coverage.*
- **Through a Medigap (Medicare supplemental) policy.** *If so, has the insurer told the individual whether the insurance is creditable coverage? If it is not creditable, the individual will have to pay a late penalty on the premium if she keeps her Medigap drug coverage and later switches to a Medicare prescription drug plan.*
- **Through the Veteran's Administration, TRICARE, Federal Health Employee Benefit Plan, Railroad Retirement Board, Program for All-Inclusive Care for the Elderly (PACE), or Indian Health Services.** *Individuals may continue receiving prescription drug coverage through one of these plans without risking a penalty if their coverage is as good as what is offered from Medicare prescription drug coverage.*

MEDICARE PART D TIMELINE 2005 – 2006

May 2005

- SSA begins notifying beneficiaries who may be eligible and must apply for the low-income subsidy

June 2005

- CMS sends notices to beneficiaries who are deemed eligible for the low-income subsidy to tell them they do not have to apply for the subsidy

July 1, 2005

- SSA offices and state Medicaid agencies begin making eligibility determinations on applications for the low-income subsidy
- Applications will also be taken on-line and by telephone.

Fall 2005

- **Oct. 1** – Drug plan sponsors begin marketing drug plans
- **Oct. 15** – CMS mails *Medicare & You 2006 Handbook* to all Medicare beneficiaries

October 27 – November 10, 2005

- CMS notifies dual eligibles of the Part D plan in which they will be auto-enrolled as soon as enough information about Part D is available
- Employers and Medigap issuers notify beneficiaries whether their coverage is as good as Medicare

November 15, 2005 – May 31, 2006

- Initial Enrollment Period for all Medicare beneficiaries

January 1, 2006

- Medicare drug coverage begins

HELP UNDERSTANDING AND ENROLLING IN PART D

The new Medicare Part D law is complex and help paying for medications is important. Contact your local State Health Information and Assistance Program (SHIP) for help. For the telephone number of the SHIP in your state call 1(800) MEDICARE.

In Connecticut, contact the CHOICES program at (800)994-9422

CONSIDERATIONS FOR SELECTING A PART D PLAN

FACTORS TO CONSIDER WHEN CHOOSING A PRESCRIPTION DRUG PLAN:

- The amount of the monthly premium
- Whether the plan formulary includes:
 - The particular drugs needed by the Medicare beneficiary
 - The strengths and dosages of the drugs needed by the beneficiary
- Whether the plan's network includes:
 - The pharmacies used by the beneficiary
 - The pharmacy used by the long-term care facility in which the beneficiary resides
- Whether there are price differentials among pharmacies in the network
- Whether mail-order is allowed or required
 - The price differential for mail-order
- The plan's utilization management tools:
 - The prior authorization requirements for obtaining certain medications
 - Whether the plan requires step therapy (Requirement that an individual try particular medications before those prescribed by the beneficiary's physician)
 - Whether the plan uses tiered cost-sharing (Different co-pays for generics, brands, or for specific drugs)
 - The number of cost-sharing tiers
 - The co-payments/co-insurance per tier
- Whether there are quantity limitations:
 - On number of prescriptions in a month
 - On number of pills in a prescription
- Whether the plan offers supplemental benefits that are important to the individual
- How the plan coordinates with the State Pharmaceutical Assistance Program (SPAP, known as ConnPace in Connecticut)
- Whether the plan sponsor is a known, reliable entity
- The "Transition" process used by the PDP (Allowance for temporary use of drugs not covered by the plan)
- The "Exceptions" process used by the PDP (Appeal if beneficiary's drug is not covered by the plan)

STANDARD PART D PLAN
2006 ANNUAL COST SHARING RATES

National Average Premium: \$32.20 / month

Annual Deductible: \$250

Initial Co-Pay: 25% co-insurance up to \$2250 initial coverage limit

Gap in Coverage (Doughnut Hole): No Medicare coverage from
\$2251 to \$5100 in covered drug costs

Out-of-Pocket Limitation (OOP): \$3,600

Catastrophic Co-Pay (After OOP reached): Approximately 5%
until end of calendar year

For more information about Medicare Part D and issues related to Medicare, Medicaid and access to health care, visit the Center for Medicare Advocacy's website: www.medicareadvocacy.org. Or call the Center in Connecticut at (860) 456-7790 or in Washington, DC at (202) 216-0028.

CENTER NEWS
Medicare Part D Edition # 2

NON-PROFIT ORG.
U.S. POSTAGE
PAID
HARTFORD, CT
PERMIT NO. 3202

CENTER FOR MEDICARE ADVOCACY, INC.

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Fall 2005

Vol. V, No. 1