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Medicare Part D Prescription Drug Program

Frequently Asked Questions

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This brochure is intended to provide, in question and answer format, a brief overview of the new Medicare Prescription Drug Program which becomes effective January 1, 2006. The material in this document is adapted from information provided in *Medicare & You, 2006* a publication produced for Medicare beneficiaries by the Centers for Medicare & Medicaid Services. At the end of this document is a listing of resources for those who would like more detailed information related to this new program.

What is Medicare Part D?

The Medicare Modernization Act of 2003 for the first time added a prescription drug program to Medicare with the intent of lessening the financial burden of prescription drug costs for beneficiaries, especially those with low incomes and those with extremely high out-of-pocket expenses. The prescription drug program under Medicare is also known as Medicare Part D.

Beginning in 2004, Medicare-approved drug discount cards became available. The drug discount card program was always intended to be a temporary program and will begin to phase out in January 2006 when Medicare Prescription Drug plans become available. After November 30, 2005 people may no longer enroll in the Medicare approved drug discount card program. Those who have Medicare drug discount cards may use them until May 15, 2006 or until they join a Medicare Prescription Drug plan, whichever comes first.

Beginning in 2006, Medicare will contract with private companies to offer voluntary prescription drug coverage. Under the new law Medicare Part D will provide outpatient drug coverage through Medicare-approved private drug plans, giving beneficiaries access to a standard drug benefit or its equivalent. Medicare has defined the minimum requirements for standard coverage. Some plans may offer additional benefits for a higher premium. While plans may vary, in general they will have a monthly premium based on the plan an individual chooses.

What Dates are Important to Remember?

The following are the key dates related to the initial enrollment and rollout of the Medicare Prescription Drug plans:

- Initial Enrollment Period:
  November 15, 2005 – May 15, 2006
- Initial Coverage Effective Date:
  January 1, 2006 for those who sign up prior to that date
- Next Enrollment Period:
  November 15, 2006 – December 31, 2006.

Who is Eligible to Enroll?

- Medicare Beneficiaries with Medicare Part A, Part B or both
- For those with Medicare Advantage Plans, prescription drugs are often included. If included, they must be at least comparable to the Medicare approved Standard Prescription Drug plan. (Information related to Medicare Advantage is further detailed below.)

What if People Enroll at a Later Date?

Like Medicare Part B, the Medicare Prescription Drug Program is voluntary but there can be penalties for delayed enrollment. In most cases, joining when the plan first becomes available to them will guarantee people the lowest possible premium.

Those who:

- are eligible to enroll
- do not currently have a drug plan that, on average, covers at least as much as the standard Medicare coverage but
- do not enroll prior to May 15, 2006

will have to wait for the next enrollment period, November 15, 2006 – December 31, 2006, to join. When individuals do join later, the premium will increase at least 1% per month for every month they have delayed enrollment. They will have to pay this penalty for as long as they have the drug coverage. If individuals join by December 31, 2006, coverage will become effective January 1, 2007.

What is the Premium?

Premiums will vary based on the plan individuals select. The average premium is expected to be around $37.00 per month for 2006. Some plans will offer more coverage at higher premiums. Others may offer lower premiums. Individuals can obtain the specifics regarding plan premiums for their area by calling Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Are All Prescription Drugs Covered?

The Medicare Plans will cover both generic and brand-name drugs, but plans may have different rules about what drugs are covered in different categories. Most plans will have a formulary which lists the drugs covered under the plan. The list must meet Medicare's requirements but can change over time. A company is required to inform the beneficiary at least 60 days before removing a drug the person may be using or if costs are changing. If a beneficiary's doctor feels a drug not on the list is needed, or if a drug an individual is taking is being removed from the list and is needed, the beneficiary or doctor can apply for an exception or appeal the decision.

Will Individuals Be Able to Use Their Current Pharmacies?

Prescription Drug plan providers are required to contract with local pharmacies. It is best for individuals to check with the drug plan they are considering to find out which local pharmacies may be used under this plan. They should also check with their own pharmacy to learn which Medicare-approved plans the pharmacy is participating in. Some plans will allow individuals to order medications through the mail.

How Does the Prescription Drug Plan Work?[1]

The chart below illustrates how the Medicare-approved standard Prescription Drug plan will work for 2006.

Medicare-Approved Standard Prescription Drug Plan – 2006		
Prescription Drug Costs	**Medicare Pays**	**Individual Pays**
$0 - $250 (annual deductible)	$0	100%
$250 - $2,250	75% of drug costs up to $1,500	25% of drug costs up to $500
$2,250 - $5,100	0% of drug costs	100% of drug costs up to $2,850
Subtotal:	**Up to $1,500**	**Up to $3,600**
Over $5,100 (Catastrophic Benefit)	95%	5% or $2 co-pay/generic or $5 co-pay/brand name

[1] *The New Medicare Prescription Drug Coverage: What You Need to Know*, AARP, 2005, www.aarp.org – The information for this question and the included chart is adapted in part from this AARP publication.

As the chart above illustrates, once individuals have incurred over $2,250 in total drug costs, they must pay 100% of the costs between $2,250 and $5,100 ($5,100 - $2,250 = $2,850) with no co-payments by Medicare. You may hear this referred to as the donut hole. Once individuals have spent $3,600 out of pocket ($250 + $500 + $2,850), the Catastrophic Benefit schedule will remain in effect for all prescription drug costs beyond the initial $5,100 for the remainder of the calendar year. The monthly premium for the coverage is not included in the above out of pocket expenses.

What if Individuals Already Have Drug Coverage Under an Employer or Union Plan?

If individuals have a plan through an employer or union, they should receive information from the employer or union which explains how their current plan compares with the new Medicare Prescription Drug plan.

- If their current plan provides, on average, coverage at least as good as that provided by the Medicare standard prescription drug plan (called "creditable prescription drug coverage"), individuals can keep it as long as the employer or union offers it. Individuals will not have to pay a penalty as long as they join a Medicare prescription drug plan within 63 days after coverage ends under their employer plan, even if this occurs after May 15, 2006 when the initial Medicare Prescription Drug plan enrollment period ends.

- If their current plan provides, on average, coverage that is not at least as good as that provided by the Medicare standard prescription drug plan, individuals must join a Medicare Prescription Drug plan by May 15, 2006 to avoid a penalty if they decide to join later. If their current employee prescription drug coverage is not as good as the Medicare standard coverage, they should check with their benefits administrator to determine what their options are. (**Note**: Individuals who drop employer prescription coverage may not be able to get it back. They should also check whether dropping drug coverage from an employer or union will impact any health coverage they may have. Are the prescription coverage and health coverage connected? By dropping one, will individuals lose the other?)

What If Individuals Have Medicare A and B and Have Drug Coverage Under a Medigap Plan?

Coverage for prescription drugs is currently provided in some Medigap Plans. If individuals have a Medigap Plan which provides prescription drug benefits, they will receive a notice from their Medigap carrier describing their choices for prescription drug coverage. To have Medicare help pay for prescription drugs, individuals must join a Medicare-approved Prescription Drug plan.

Most prescription drug coverage under Medigap plans is not as good as the standard Medicare Prescription Drug plan. This means, that in most cases, individuals who retain their Medigap Plan with prescription drug coverage and elect not to join a Medicare Prescription Drug plan will incur a penalty should they decide to join a Medicare Prescription Drug plan at a later date.

Individuals should contact their Medigap provider before making any decisions. They could choose to switch to a Medigap plan that does not offer prescription drug coverage at a lower cost and then join a Medicare Prescription Drug plan.

What if Individuals are enrolled in a Medicare Advantage (e.g. HMO, PPO, PFFS Plan) or Other Medicare Health Plan?

- If individuals have drug coverage currently under a Medicare Advantage or other Medicare Health Plan, the Plan will send them a notice about available prescription drug choices.

- If individuals do not currently have prescription drug coverage under their Medicare Advantage or other Medicare Health Plan and they want to add it, they should contact their current health plan to see if it will offer a prescription drug benefit in 2006. If the plan will offer drug coverage considered to be at least as good as the Medicare-approved standard Prescription Drug plan, individuals will likely need to accept the new drug coverage if they want to stay with the plan or

  – they can switch to another Medicare Advantage Plan or Medicare Health Plan that offers prescription drug coverage or

  – they can switch to original Medicare and join a Medicare Prescription Drug plan. (**Note:** If individuals elect to stay in a current plan that is not offering drug coverage, they will have to pay a penalty if electing to switch to a plan with prescription drug coverage at a date beyond the initial enrollment period.)

What If Individuals Have Coverage under TRICARE (Military Benefits) or the Department of Veterans Affairs (VA), or the Federal Employee Health Benefits Program (FEHB)?

Individuals should contact their plan administrator before making any changes. In most instances, it is to the individuals advantage to retain any of the above coverages rather than electing to enroll in a Medicare Prescription Drug plan.

What If Individuals Have Medicare and Medicaid?

Beginning on January 1, 2006, Medicare, not Medicaid, will begin paying for prescription drugs for dually eligible individuals. Medicare will select a plan for Medicaid beneficiaries and notify them of that selection. There will be no annual premium for this plan and no deductible. Medicaid beneficiaries will be able to select a different plan if they choose. However, if that plan has a higher premium they will need to pay the difference. For all prescriptions, Medicaid recipients will have a co-payment of $1.00 to $2.00 for generic or certain formulary drugs and $3.00 to $5.00 for brand name drugs based on their annual income.

Are There any Special Considerations Based on Income for Those Who May Not Have Medicaid?

In addition to the considerations for dually eligible Medicaid and Medicare beneficiaries, assistance with the cost of the Medicare Prescription Drug program is available to certain individuals with limited income and assets. Assistance can be provided for covering the monthly premium, yearly deductible, and prescription co-payments.

Currently, individuals may qualify for assistance based on their income and if their assets (including savings and stocks but not counting a car or home) are less than $11,500 for a single person or $23,000 if married and living with a spouse. In general, the high end of income for any assistance is $14,355 for an individual and $19, 245 for a couple. However, if individuals live in Alaska or Hawaii or pay more than 50% of the living expenses of dependent family members, income limits are higher.

Medicare has already mailed letters to individuals who automatically qualify for assistance. Additionally, the Social Security Administration (SSA) sent applications to individuals who may qualify based on their incomes. If individuals feel they may qualify they can call 1-800-772-1213 or visit www.socialsecurity.gov on the web. Additionally, details regarding income limits for various types of assistance available are outlined in *Medicare & You, 2006*.

(**Note**: Individuals who are currently eligible for state prescription drug assistance programs within their state should check to see how these programs might be impacted by the new Medicare Prescription Drug plans.)

USEFUL PUBLICATIONS

- *Your Guide to Medicare Prescription Drug Coverage* (CMS Pub. No. 11109), Centers for Medicare & Medicaid Services, October 2005. Available at http://www.medicare.gov/Publications/Pubs/pdf/11109.pdf, or by calling 1-800-MEDICARE.

- *Medicare &You, 2006* (CMS Pub. No. 10050), Centers for Medicare & Medicaid Services, September 2005. Available at www.medicare.gov, or by calling 1-800-MEDICARE.

- *The New Medicare Prescription Drug Program,* AARP, 2005, available at www.aarp.org.

RESOURCES

Medicare

The Medicare Website can be accessed at www.medicare.gov. It contains local and state specific information on available Medicare Prescription Drug plans, an individual plan comparison capability based on an individual's Medicare number and demographic information, a formulary finder to allow individuals to search formularies in their state in relation to medications they are currently taking, and a section about the plans called "Want to Hear More About the New Medicare Prescription Drug Coverage?" This section contains information and tools, including a calculator that allows individuals to compare whether the new program will provide savings based on their current out of pocket drug costs, a discussion of things to think about when comparing plans and a 4-page introductory discussion of the coverage that can be downloaded and printed. Individuals may also call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. When calling it is helpful for individuals to have their Medicare Card, a list of the medications they take and the name of the pharmacy they use so that those assisting can provide the most individualized and effective information.

State Health Insurance Assistance Programs

These programs are available in each state and can help individuals with any questions related to Medicare, including information about the new Medicare Prescription Drug Program. The telephone contact numbers for each of the states are listed below.

Alabama - 1(800)243-5463

Alaska - 1(800)478-6065 in-state calls only

Arizona - 1(800)432-4040

Arkansas - 1(800)224-6330

California - 1(800)434-0222 in-state call only

Colorado - 1(888)696-7213

Connecticut - 1(800)994-9422 in-state calls only

Delaware - 1(800)336-9500 in-state calls only

Florida - 1(800)963-5337

Georgia - 1(800)669-8387

Hawaii - 1(888)875-9229

Idaho - 1(800)247-4422 in-state calls only

Illinois - 1(800)548-9034 in-state calls only

Indiana - 1(800)452-4800

Iowa - 1(800)351-4664

Kansas - 1(800)860-5260

Kentucky - 1(877)293-7447

Louisiana - 1(800)259-5301 in-state calls only

Maine - 1(800)750-5353 in-state calls only

Maryland - 1(800)243-3425 in-state call only

Massachusetts - 1(800)243-4636

Michigan - 1(800)803-7174

Minnesota - 1(800)333-2433

Mississippi - 1(800)948-3090

Missouri - 1(800)390-3330

Montana - 1(800)551-3191 in-state calls only

Nebraska - 1(800)234-7119

Nevada - 1(800)307-4444

New Hampshire - 1(800)852-3388 in-state calls only

New Jersey - 1(800)792-8820 in-state calls only

New Mexico - 1(800)432-2080 in-state calls only

New York - 1(800)333-4114

North Carolina - 1(800)443-9354 in-state calls only

North Dakota - 1(800)247-0560

Ohio - 1(800)686-1578

Oklahoma - 1(800)763-2828 in-state calls only

Oregon - 1(800)722-4134 in-state calls only

Pennsylvania - 1(800)783-7067

Rhode Island - 1(401)462-0508

South Carolina - 1(800)868-9095

South Dakota - 1(800)536-8197

Tennessee - 1(877)801-0044

Texas - 1(800)252-9240

Utah - 1(800)424-4640

Vermont - 1(800)642-5119 in-state calls only

Virginia - 1(800)552-3402

Washington - 1(800)562-6900

Washington D.C. - 1(202)739-0668

West Virginia - 1(877)987-4463

Wisconsin - 1(800)242-1060

Wyoming - 1(800)856-4398

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