

Medicare Drug Coverage 101: Everything You Need to Know About the New Medicare Prescription Drug Benefit

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I. What Is the New Medicare Drug Benefit?

1. What is the new Medicare Drug Benefit?

Starting January 1, 2006, Medicare will begin offering coverage for prescription drugs under a new part of Medicare (Part D). Private companies will provide the coverage.

Medicare Part A covers hospital and other inpatient services. Part B covers doctor visits and other outpatient services, including durable medical equipment. Part C, most commonly known as Medicare Advantage (previously Medicare+Choice), makes available Medicare-covered health care services through a Medicare private health plan, such as an HMO, PPO or PFFS plan.

2. How is the Medicare drug benefit different from the Medicare-approved discount drug cards?

The Medicare drug benefit and the Medicare-approved discount drug cards are two separate programs. Unlike the Medicare-approved discount drug cards, which offer some discounts, the Medicare prescription drug benefit offers insurance coverage. The cards may help you save on your drug costs until the Medicare prescription drug benefit (Part D) begins in 2006. If you have one of these drug cards, you can use it until your Medicare drug coverage begins or, if you decide not to enroll in the Medicare drug benefit, until May 15, 2006.

In addition, unlike with the Medicare-approved discount drug card, you may have to pay a premium penalty if you do not enroll in the Medicare prescription drug benefit when you first become eligible. If you currently have drug coverage that is at least as good as Medicare's you can delay enrollment without a premium penalty (see question 13).

3. Who can get Medicare prescription drug coverage?

Anyone who has Medicare Part A and/or Part B can get Medicare prescription drug coverage (Part D).

4. How can I get Medicare prescription drug coverage?

The Medicare drug benefit will only be available through private drug plan plans. There are two types of Medicare private drugs plans (Part D plans):

- **Stand-alone prescription drug plans (PDP).** "Stand-alone" plans only offer prescription drug coverage. You can continue to get all your other medical services (such as doctor visits, hospital stays) through Original Medicare (or through some PFFS plans if they do not offer drug coverage).
- **A Medicare private health plan (like an HMO, PPO or PFFS).** You can join or remain in a Medicare private health plan (Medicare Advantage) that provides all your Medicare-covered services, including prescription drug coverage.

Note: If you are in a Private Fee-for-Service (PFFS) plan or a Medicare cost plan that does not offer drug coverage, you can enroll in a stand-alone prescription drug plan. If you are in an HMO or PPO you must receive all of your medical and drug coverage through that plan.

5. Will I have a choice of Medicare private drug plans?

Yes, you will have at least two Medicare private drug plans to choose from in your area. At least one of the two must be a stand-alone prescription drug plan (PDP). Medicare indicates there will be several plans in most areas. All companies that offer Medicare private drug plans must offer at least one plan that provides same level of coverage as the Medicare's basic prescription drug coverage (see question 6).

6. Will Medicare private drug plans offer standard, uniform Medicare drug coverage?

No. The 2003 Medicare law outlined a plan that will be used as the standard for the overall value a plan must offer in order to be approved as a Medicare private drug plan. However, you may never see a plan exactly like the basic plan outlined in the law. Plans can structure their benefit differently as long as the overall value is at least as good as the Medicare basic plan. They can also offer better coverage, for which they will likely charge a higher premium.

According to the basic plan you would pay:

- The first \$250 of your drug costs for covered drugs each year (deductible);
- Coinsurance or copays worth 25% of the cost of covered drugs between \$251 and \$2,250;
- 100% of the cost of covered drugs between \$2,251 and \$5,100; and
- 5% of the cost of covered drugs above \$5,101—catastrophic coverage (or a copayment of \$2 for covered generics/preferred drugs and \$5 for covered brand-name drugs, whichever is greater).

Under this plan, you will have to reach \$3,600 in out-of-pocket costs in 2006 before you can receive catastrophic coverage.

You may get additional help to pay for your out-of-pocket costs if your income is limited (see questions 19 through 46).

7. Are there any criteria Medicare private drug plans must meet?

Yes. While companies have great flexibility to design their own plans, there are some criteria they have to meet. For example:

- The overall value of the drug coverage must be the same or greater than the basic plan outlined in the law (see question 6).
- The annual deductible cannot be more than \$250 in 2006.

- Catastrophic coverage must be at least as good as it is under the plan outlined in the law.
- Plans must cover at least two drugs in each drug class in their formulary (list of covered drugs—see question 62.)
- Plans must cover all or substantially all drugs in six categories: antidepressants, antipsychotics, anticonvulsants, antiretrovirals (AIDS treatment), immunosuppressants and anti-cancer.
- Plans must have a process in place for members to request exceptions to the plan's formulary if a non-covered drug is medically necessary (see question 69).
- Plans must have a network of pharmacies that meets federal standards for convenient access.
- Plans must make information about their pharmacy network and formulary easily available (some information is only required upon request—see question 66.)
- Plans must have a Medicare-approved transition process for new members whose condition has been stabilized on medications that are not on the plan's formulary (see question 69).

II. How Much Will the Medicare Drug Benefit Cost?

8. How much will my premium be for the new Medicare drug benefit?

In addition to your Part B premium, you will have to pay a monthly premium for the Medicare prescription drug benefit (Part D). Medicare is currently estimating that the average national premium will be \$32.20 a month (\$386.40 a year) in 2006, but what you pay could be more or less than that amount. What you pay will vary depending on where you live and which plan you choose. Premiums will likely increase every year.

You can choose to have the premium taken out of your monthly Social Security check (in addition to your Part B premium) or you can pay it directly to the company.

If your income and assets are low, you may have no monthly premium (see questions 19 through 46).

9. How much will I have to pay for my drugs with the Medicare drug benefit?

How much you pay for your drugs will depend on the plan you choose. Each plan has a great deal of flexibility in how it designs its prescription drug coverage.

In general, under any Medicare private drug plan, you will have to pay a monthly premium, an annual deductible (no more than \$250 in 2006) and varying amounts of coinsurance, depending on the total costs of the drugs you buy. In addition, you will likely have to pay the full cost of your drugs at some point (coverage-gap). (See question 6.)

After you have spent a maximum in out-of-pocket costs for covered drugs (\$3,600 in 2006), your costs will go down significantly (catastrophic coverage).

Note: The cost of any drugs not covered by your Medicare private drug plan will not count toward your out-of-pocket maximum.

You may get help paying for your out-of-pocket costs if your income and assets are low (see questions 19 through 46).

10. What is catastrophic coverage?

Catastrophic coverage is the much more comprehensive coverage that you receive after you have spent a set amount (out-of-pocket maximum) out of your own pocket for covered drugs (\$3,600 in 2006). The ceiling on out-of-pocket costs is intended to protect you if your prescription drug needs are very high. Once you have spent the maximum, your out-of-pocket costs go down dramatically, to 5% of the cost of covered drugs (or a copayment of \$2 for covered generics/preferred drugs and \$5 for covered brand-name drugs, whichever is greater).

11. What costs count to reach the out-of-pocket maximum?

Only payments for drugs on your plan's formulary count towards your out-of-pocket maximum (unless you received an exception to the plan's formulary). Medicare refers to these as True Out-of-Pocket (TrOOP) Costs. Some examples that **will** count include payments through a pharmacy in your plan's network made by:

- you as long as you are not reimbursed by an insurer;
- other individuals such as family members or friends, as long as they are not reimbursed by an insurer;
- a qualified State Pharmacy Assistance Program (SPAP) (SPAP payments for non-formulary drugs or excluded Part D drugs do not count toward the limit);
- a charitable organization that is not associated with an insurer or your employer;
- health savings, flexible spending or medical savings accounts;
- Pharmaceutical Manufacturer Patient Assistance Programs.

Note: Coinsurance or copayments that are waived or reduced by pharmacies for people in need on a case-by-case basis, or routinely for individuals who receive extra help will count toward the out-of-pocket limit as long as:

- the pharmacy does not advertise this policy
- the pharmacy is not partly or fully publicly funded.

Your Medicare plan will keep track of your out-of-pocket expenses for you.

12. What costs do not count towards my out-of-pocket maximum?

Here are some examples of drug costs that will **not** count toward your out-of-pocket maximum (TrOOP costs):

- Any payments made by:
 - group health plans (such as retiree coverage provided by a former employer or union)
 - Government programs such as TRICARE, Black Lung, Veterans health benefits and Indian Health Services;
 - Workers' Compensation;
 - automobile, no-fault, or liability insurance;
 - AIDS Drug Assistance Programs (ADAPs) (see question 85);
 - any other third-party payment arrangement;
- drugs purchased outside the U.S.;
- drugs not on the plan's formulary (unless you received an exception to the plan's formulary);

- drugs explicitly excluded from Medicare drug coverage (including over-the-counter drugs, benzodiazepines) even if your plan has enhanced coverage that covers them.

Note: The amount you pay for your monthly Medicare private drug plan premium also does **not** count towards your out-of-pocket maximum.

13. **Updated** What is the Medicare drug benefit premium penalty?

Although enrollment in the Medicare drug benefit (Part D) is voluntary, you may have to pay a premium penalty if you enroll in it after you are first eligible.

You could have to pay a Part D premium penalty if

- you do not enroll when you are first eligible; and
- you do not have coverage that is at least as good as Medicare's ("creditable coverage") for 63 days or more.

The penalty means you must pay a higher monthly premium, which increases every month until you enroll. If you have to pay a premium penalty, you will have to pay it for the rest of your life, and the penalty will likely increase every year.

The premium penalty will be at least 1% for every month you delay enrollment (1% of the average national premium). For example, if the average national premium in 2007 is \$45 a month, and you had delayed enrollment for 15 months, your premium penalty would be \$6.75, which would be added to the monthly premium charged by your Medicare private drug plan. ($\$45 \times 1\% = \$0.45 \times 15 = \$6.75$).

Note: If you are receiving extra help paying for your Medicare drug costs and your income is below \$12,919.50 a year for individuals (\$17,320.50 a year for couples) in 2005 (less than 135% of the federal poverty level), will only have to pay 20% of the premium penalty and you will only have to pay it for five years. So, using the above example, your monthly premium penalty would be \$1.35 ($\$6.75 \times 20\% = \1.35) in 2007.

14. **Updated** How do I pay the premium for Medicare prescription drug coverage?

You can choose to have the premium automatically deducted from your Social Security check (or Railroad Retirement or Office of Personnel Management check) each month (in the same way your Part B deductible is deducted) or you can pay it directly to the Medicare private drug plan in which you enroll (by check or electronic funds transfer).

Employers, State pharmaceutical Assistance Programs (SPAPs), state Medicaid agencies, and charitable organizations can also pay prescription drug premiums on your behalf.

If you choose to pay the premium to the plan, and you are in a Medicare private plan that combines all your Medicare benefits (like an HMO or PPO), the plan will likely combine the prescription drug coverage premium with the premium for your other coverage, so that you pay one lump sum to the plan. You can have the combined Medicare Advantage and Medicare Drug Coverage premiums taken out of your Social Security check, but you cannot separate them.

You will pay your out-of-pocket costs at the pharmacy, and your Medicare private drug plan will keep track of these costs for you.

15. Can the premium increase in 2007?

Yes. Premiums for Medicare private drug plans will likely increase every year. If you are paying a premium penalty, that penalty amount will increase as well.

III. Should I Get Medicare Drug Coverage?

16. Will Medicare prescription drug coverage help me?

Medicare prescription drug coverage may help you by lowering your prescription drug costs. Even if your costs are low today, having insurance means that if your drug costs ever increase dramatically, you will have help paying them. And if you do not enroll in the Medicare drug coverage when you are first eligible you may have to pay a premium penalty if you enroll later (see question 13).

Whether the drug benefit will save you money when it first becomes available depends on your situation. If you currently do not have drug coverage you may save money from the start if you have drug expenses, plans in your area offer coverage at a reasonable premium, have reasonable out-of-pocket costs and cover most or all of your drugs.

If your income and assets are low, the Medicare prescription drug benefit may lower your drug costs significantly (see questions 19 through 46).

17. I do not need or want Medicare prescription drug coverage now. Can I get it later?

Yes, but if you do not enroll during the Initial Enrollment Period when the benefit first becomes available (November 15, 2005, through May 15, 2006), you may have to pay a premium penalty if you enroll at a later date.

If you already have prescription drug coverage that is at least as good as Medicare's drug benefit ("creditable coverage"), you will not be subject to a premium penalty. In order to avoid a premium penalty, you cannot have been without comparable drug coverage for more than 63 days.

If you go without comparable drug coverage for more than 63 days after your initial enrollment period ends, you will have to pay the premium penalty for as long as you have Medicare drug coverage, and the penalty will likely increase every year (since it is 1% of the average national premium). (Some persons receiving extra help pay reduced premium penalties—see question 13.)

18. What if my drug costs are low?

If you currently have low or no drug costs, Medicare drug coverage may not save you money on drugs when you first get it. But you should consider that you may need coverage later if you become sick and use more prescription drugs. If you wait to enroll in the Medicare drug benefit, you may have to pay a higher premium because of the penalty for enrolling late (see question 13).

IV. Can I Get Extra Help Paying the Medicare Drug Benefit if My Income is Low?

19. **Updated** Can I get extra help if my income is low?

Yes. If your annual income is below 150% of the federal poverty level (FPL) (\$14,355 a year for individuals and \$19,245 a year for couples in 2005) and your assets are low (less than \$11,500 for individuals and \$23,000 for couples) you may be eligible for extra help paying for your Medicare drug costs (also referred to as the low-income subsidy or LIS).

Note: If you do not answer “yes” on the application when it asks if you intend to use part of your resources for your burial, your asset limit will go down to \$10,000 for individuals and \$20,000 for couples.

Even if your income or assets are above the limit, you may still qualify because certain types of income and assets may not be counted. Your house and cars are not counted. Also, part of your earned income will not be counted (see questions 33–35). In addition, some state Medicare Savings Programs (MSPs) have looser rules for counting income and assets, or do not consider assets altogether. If you do not directly qualify for extra help, ask a Medicaid counselor if you qualify for an MSP. If you are enrolled in an MSP you automatically qualify for extra help.

20. How do I get the extra help with my Medicare drug costs?

If you get **Medicaid**, a **Medicare Savings Program (MSP)** or receive **Supplemental Security Income (SSI)**, you **automatically qualify** for help. You do not have to apply for this extra assistance.

If you do not have Medicaid or an MSP, **you can apply** for extra help paying for your Medicare drug benefit through the Social Security Administration using either its paper or online application (available at www.ssa.gov), or over the phone at 800-772-1213. You will also be able to apply for it at your local Medicaid office. You can appoint someone to help you complete the application form (see question 37).

Keep in mind that applying for the extra help does not enroll you in the Medicare drug benefit. You still have to choose a private drug plan through which to get your drug coverage. (See questions 26–32 for more information about what happens if you fail to choose a plan yourself.)

21. Does it make a difference if I apply through Social Security or the Medicaid office?

Yes. The application process may be easier through the Social Security Administration. The Social Security application form allows you to self-attest to your income and assets. That means you do not have to submit proof of your income and assets up front. You can fill out the application on their web site, mail in a paper application, or apply over the phone. There is no need for an in-person interview. The Social Security Administration (SSA) will perform a computer check with other government agencies, such as the IRS. You may need to submit proof if SSA records differ considerably from the information you give on your application.

If you apply through your local Medicaid office, the application process will depend on the state in which you live. Your state can choose to use an application process that is more complicated

than the SSA process. For example, your state may require proof of your income and assets, and have you come to the Medicaid office for a personal interview.

SSA, however, will not screen you for additional benefits for which you may be eligible. State Medicaid offices, on the other hand, must screen all applicants for the Medicare Savings Programs and other benefits for which they may qualify.

In addition, some state Medicare Savings Programs (MSPs) have less strict rules for counting income and assets, or do not consider assets at all. If you do not directly qualify for extra help, ask a Medicaid counselor if you qualify for an MSP. If you are enrolled in an MSP you automatically qualify for extra help.

22. What do I have to do after I get extra help?

Once you are notified by mail that you will get extra help (either because you applied for it or because you automatically qualified for it), you should enroll in a Medicare private drug plan beginning November 15, 2005. If you want your coverage to start in January 2006, you should enroll in a plan by the end of 2005. To find the plan that best meets your needs—covers the drugs you need and works at the pharmacies you use regularly—starting in mid-October look in your “Medicare & You 2006” handbook, call 800-MEDICARE or visit www.medicare.gov.

If you do not enroll in a Medicare private drug plan by May 15, 2006, Medicare will randomly assign you to a plan. Your coverage will begin June 1, 2006. You should receive a letter in the spring of 2006 detailing which plan you will be enrolled in if you do not choose one yourself before May 15, 2006.

If you are currently in Original Medicare, you will be enrolled in a stand-alone drug plan whose premium is at or below the standard plan premium in your area. If you are in a Medicare private health plan (such as an HMO or PPO), you will be enrolled in the lowest premium prescription drug plan from the company that sponsors your Medicare health plan.

23. **Updated** I am eligible for extra help paying for my Medicare drug costs. How much do I have to pay for my medications?

There are different levels of extra help depending on your income. The chart below shows the different levels and how much you have to pay under each.

If you have Medicare and...	And your assets are...	Then your premium and deductible are...	And your copay is...
...Have Medicaid and			
have 2005 income below \$9,570— \$12,830 for couples (100% FPL)	Below State Medicaid asset limits	\$0	\$1/generic and \$3/brand-name (no copay after \$5,100 in total annual drug costs)
have 2005 income above \$9,570— \$12,830 for couples (100% FPL includes	Below State Medicaid asset limits	\$0	\$2/generic and \$5/brand-name (no copay after \$5,100 in total annual drug costs)

Medicaid spend-down)

**live in a nursing home
or other institution**

Below State
Medicaid asset
limits

\$0

\$0

**...Do not have
Medicaid and have**

**2005 income below
\$12,920—\$17,321 for
couples (135% FPL)**

Below \$7,500 for
individuals and
\$12,000 for
couples

\$0

\$2/generic and \$5/brand-
name (no copay after
\$5,100 in total annual
drug costs)

**2005 income below
\$14,356—\$19,246 for
couples (150% FPL)**

Below \$11,500
for individuals
and \$23,000 for
couples

Sliding scale
monthly premium
(see question 24) and
\$50 deductible

15% coinsurance
(\$2/generic and
\$5/brand-name copay
after \$5,100 in total
annual drug costs)

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- Notes:**
- Your premium may be higher if you choose a plan that costs more than the average premium.
 - Income limits may be higher if you support family members who live with you or if you live in Alaska or Hawaii.
 - Certain types of income and assets are excluded from calculations, so you may exceed the limits and still qualify (see question 35).

24. If my husband and I have income that is below 135% of the FPL but we have \$16,000 in the bank, which level of extra help do I qualify for?

You would qualify for the help given to people whose income is below 150% of the FPL because your assets exceed the limits for the higher level of help (see question 23).

25. How much will my premium be if my income is between 135% and 150% of the FPL?

If your income is between:

- 136% and 140% of the FPL, you will pay 25%;
- 141% and 145% of the FPL, you will pay 50%;
- 146% and 150% of the FPL, you will pay 75%;

of the average premium in your area (benchmark premium).

Note: The extra help only pays for the cost of the average premium in your area (benchmark premium). If you choose a plan that costs more than the extra help will pay, you will have to pay the difference.

26. I get drug coverage through Medicaid. Should I apply for the extra help paying for Medicare drug costs?

No. If you have Medicaid you automatically qualify for the extra help paying for your Medicare drug costs. You should have received a letter in May or June 2005 letting you know that you automatically qualify for the extra help and do not need to apply.

However, you do need to choose a plan through which to get your Medicare drug coverage. If you do not enroll in a Medicare private drug plan by December 31, 2005, you will be randomly enrolled in Medicare private drug plan. If you are currently in Original Medicare, you will be enrolled in a stand-alone drug plan whose premium is at or below the standard plan premium in your area. If you are in a Medicare private health plan (such as an HMO or PPO), you will be enrolled in the lowest premium prescription drug plan offered by that company.

You should receive a letter in the fall of 2005 detailing which plan you will be enrolled in if you do not choose one yourself before December 31, 2005. You should call 800-MEDICARE or visit www.medicare.gov to make sure the plan to which you have been assigned covers the drugs you need and that the pharmacies you use regularly are part of that plan's network. If not, ask the counselor to help you enroll in a plan that meets your needs.

Start using your new Medicare private drug plan on January 1, 2006, in order to get prescription drug coverage. Your only cost will be a small copayment for each prescription.

You will no longer have Medicaid drug coverage. Medicaid will continue to help pay your other Medicare out-of-pocket costs, including the deductible and coinsurance, and you will have a reduced or free drug plan premium. In addition, Medicaid programs in some states will help pay for drugs that Medicare does not cover, such as over-the-counter drugs and benzodiazepines.

If you have Medicaid, you will be able to change your Medicare private drug plan once a month.

Note: Your new plan must cover a one-time refill of your medication if your condition has been stabilized on it, and the medication is not on your new plan's formulary (see question 69).

27. What if I have Medicaid spend-down?

Once you spend down to Medicaid eligibility, you will automatically qualify for the extra help paying your Medicare drug costs for the rest of the calendar year. You will stay qualified for extra help even if you periodically lose Medicaid eligibility because you do not meet your spend-down in a given month. (**Note:** Because you have the extra help, your drug expenses will be lower and you may not be able to meet your spend-down as quickly or at all.)

You will automatically qualify for extra help for all of 2006 if you appear on your state's Medicaid rolls at any time from February 2005 through December 31, 2005. The rules may get stricter starting in 2006, but final guidelines have not yet been issued.

28. Updated I have a Medicare Savings Program. Should I apply for the extra help paying for my Medicare drug costs?

If you have a Medicare Savings Program (QI-1, SLMB or QMB) you automatically qualify for the extra help paying for your Medicare drug costs so you do not need to apply. You should have received a letter in May or June 2005 letting you know that you automatically qualify for the extra help.

However, you do need to choose a plan through which to get your Medicare drug coverage. If you do not enroll in a Medicare private drug plan by May 15, 2006, you will be randomly assigned a plan and your coverage will begin June 1, 2006. You should receive a letter in the spring of 2006 telling you in which plan you will be enrolled in if you do not choose one

yourself before May 15, 2006. If you currently have Original Medicare, you will be enrolled in a stand-alone drug plan whose premium is at or below the average plan premium in your area. If you are in a Medicare private plan (such as an HMO or PPO), you will be enrolled in the lowest premium prescription drug plan from the company that sponsors your Medicare health plan. You can switch plans each month.

If you want your coverage to start in January 2006, you should call 800-MEDICARE or visit www.medicare.gov to find the plan that best meets your needs—covers the drugs you need and works at the pharmacies you use regularly. Then enroll in that plan before the end of 2005.

29. Updated What if I receive Supplemental Security Income (SSI) benefits and am not on Medicaid?

No. If you receive SSI benefits, you automatically qualify for the extra help paying for your Medicare drug costs. You should have received a letter in May or June 2005 letting you know that you automatically qualify for the extra help and do not need to apply. (See question 28 for more details. People with SSI who are not on Medicaid will be treated the same as those who are in a Medicare Savings Programs, except that they can only switch plans one time after they are assigned to a plan.)

30. What happens if I was automatically enrolled in extra help because I have a Medicare Savings Program, Medicaid, or Supplemental Security Income (SSI), but I lose eligibility for these programs during the year?

If you were automatically enrolled in extra help paying your Medicare drug costs because you had Medicaid, a Medicare Savings Program or SSI, and you no longer qualify for that program, you will continue to have extra help for the rest of the calendar year. Medicare will let you know if you no longer qualify for extra help after 2006 and need to complete an application for extra help to continue getting it. If you still qualify for extra help, the amount of help you receive may be reduced. If you do not get extra help, you will have to pay your monthly drug plan premium and plan cost-sharing. If you drop your Medicare private drug plan and later want to enroll in another Medicare private drug plan, you may have to pay a premium penalty (see question 13).

31. What if I am in a Medicare HMO?

If you have Medicaid, you automatically qualify for the extra help. See question 26 for information about how to get coverage.

If you are in a Medicare Savings Program (MSP) or receive Supplemental Security Income (SSI), you automatically qualify for the extra help (see questions 28 and 29 for information about how to get coverage).

If your income and assets are low, but you are not enrolled in Medicaid, an MSP or SSI, you should apply for the extra help (see questions 20 and 21).

32. Can I be randomly enrolled in a drug plan with a premium that is higher than the extra help will pay?

Possibly. The extra help will not pay more than the extra help premium amount for your area. If you are enrolled in a Medicare Savings Program, receive Supplemental Security Income (SSI) or have Medicaid, you automatically qualify for the extra help and Medicare will enroll you in randomly assigned drug plan unless you pick one yourself.

If you are currently in a Medicare private health plan (like an HMO or PPO) you will be assigned to a plan offered by the same company that offers the lowest premium Medicare drug coverage. If that plan's premium for drug coverage exceeds the extra help premium amount for your area, you would have to pay the difference.

You can drop the Medicare private health plan and switch to Original Medicare and pick a stand-alone drug plan with a premium at or below the extra help premium amount for your area in order to avoid the extra charge.

33. How do I calculate my income to see if I qualify for the extra help?

Earned and unearned income are counted to determine if you meet the income limit for the extra help. If you are married and live with your spouse you have to include your spouse's income even if only one of you is applying for extra help. **Note:** Certain types of income are not counted (see question 35).

Earned income includes your wages, earnings from self-employment, and tips from a job (before taxes and deductions). However, less than half of your earned income will be counted, so don't be afraid to apply even if you think you earn too much money.

Unearned income is income from sources other than work, such as Social Security, state and private pensions, alimony and support payments, and income from a rental property. Unearned income also includes "in-kind support." You receive in-kind support if someone pays for your living expenses such as food and housing costs (including rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage and garbage collection services). How much "in-kind support" will be counted is limited to a maximum of \$193 a month for an individual and \$289.66 for a couple in 2005.

34. How do I calculate my assets?

If you are married and live with your spouse, you need to consider your combined resources even if only one of you is applying for the extra help.

You should include liquid assets (cash and other items that can be converted into cash within 20 days, such as stocks, bonds, IRAs and 401Ks), and real estate that is not your primary residence. The cash value of life insurance policies will be considered only if their face value (death benefit) is more than \$1,500 (\$3,000 for couples). Non-liquid assets like cars, the house you live in, household goods/furniture, and jewelry will not be counted.

35. Can I have more income and assets and still qualify for extra help?

Yes. Some of your income and assets are not counted under law. Some examples include:

- a \$20-a-month general income exclusion;
- about half of earned income;
- food stamps, heating, housing and weatherization assistance;
- earned income tax credit payments;
- tax refunds;
- expenses paid to enable you to work if you are disabled;
- cash value of life insurance policies with a face value of \$1,500 or less (**face value** means the same as "death benefit," which is the amount the insurance company will pay when you die; **cash value** means the amount you get if you cash in the policy today);

- burial spaces and plots (items such as gravesites and cremation urns, for example);
- \$1,500 for individuals and \$3,000 for couples in assets **intended** to be used for funeral/memorial services or cremation;
- your primary residence and the property it sits on if you own it;
- retroactive Social Security or Supplemental Security Income (SSI) payments
- a line of credit from a reverse mortgage.

In addition, if you support relatives who live with you, your income limits will be higher.

36. Will the income and asset limits increase in 2007?

Yes, income limits increase each year based on the federal poverty level (FPL). Asset limits will also increase every year, based on the increase in the U.S. consumer price index.

37. Do I need to show proof of my income and assets?

That depends. You can apply for extra help through either the Social Security Administration (SSA) or your local Medicaid office (see questions 20 and 21).

If you apply through SSA, you will be able to self-attest to your income and assets. You may later need to submit documents if SSA asks for them, though this is not expected to be common.

If you apply through your local Medicaid office, you may be required to show documentation at the time you apply.

38. Can I get help completing my application for extra help?

Yes. Many people can help you apply for extra help paying for your Medicare drug coverage, including:

- anyone authorized to act on your behalf under state law (like some state pharmacy assistance programs);
- someone acting responsibly on your behalf if you are physically or mentally not able to make decisions on your own (including someone with a health care Power of Attorney or a surrogate decision maker as defined by state law);
- anyone you request to act on your behalf to complete the application (such as a family member, friend, neighbor or State Health Insurance Assistance Program—SHIP—counselor).

39. Do I need to reapply for the extra help every year?

You will have to renew your eligibility for the extra help paying for the Medicare drug coverage at least once each year (“redetermination”). When and how you reapply will differ based on your circumstances and on the agency you applied through—your state Medicaid office or Social Security.

If you qualify for extra help before January 1, 2006 it will last through the end of 2006 unless you become eligible for Medicaid, Supplemental Security Income (SSI), or a Medicare Savings Program (becoming eligible for these benefits may qualify you for more help). If you apply after January 1, 2006, your eligibility for extra help will last one year except if you become eligible for Medicaid, SSI, or a Medicare Savings Program. For example, if you apply in February 2006, your eligibility for extra help will continue through February 2007.

If you have a Medicare Savings Program (MSP), SSI or Medicaid, you automatically qualify for the extra help and will not have to recertify as long as you continue to be enrolled in any of these programs.

Note: If a life-changing event (such as marriage, divorce or death of a spouse) changes your income, the amount of your extra help could increase, decrease or end. You can voluntarily report a life-changing event to Social Security.

40. How soon after I apply for the extra help paying for Medicare drug costs will my benefit start?

If you apply for and get extra help and join a Medicare private drug plan before December 31, 2005, you will begin receiving extra help and drug coverage on January 1, 2006. If you apply for the extra help between January 1 and May 15, 2006, or during an enrollment period (see questions 47, 48 and 49) you are eligible to start receiving the help on the first day of the same month that you applied.

If you are already enrolled in a Medicare private drug plan, it will be notified that you are eligible for extra help and must reduce the out-of-pocket costs you have been paying. If your plan already has charged you additional costs from the time you became eligible for extra help (the first of the month in which you applied), it must reimburse you for those costs.

If you have not chosen a plan yet, and do not choose one on your own, Medicare will randomly enroll you in a plan with a premium at or below the extra help premium amount for your area (see question 32).

You can apply for extra help outside of an enrollment period but when your coverage begins depends on whether or not you have already enrolled in the Medicare prescription drug benefit as described above. If you apply for extra help outside of an enrollment period and you are not already enrolled in a Medicare private drug plan, you cannot use your extra help until you can enroll in one. Your extra help would start when your drug coverage starts.

41. How will I find out if I qualify for the extra help paying for my Medicare drug costs?

You will receive a notice from either the state Medicaid office or the Social Security Administration (depending on which agency you applied through) telling you whether you qualify for extra help, which level of extra help you qualify for (see chart in question 23), your appeal rights if you did not qualify, and what to do if your situation changes.

In addition, if you applied through Social Security, you will get a worksheet with your verified financial information. You can take this to your local Medicaid office to apply for a Medicare Savings Program, which helps pay your Part B premium.

42. What do I do if my application for extra help is denied?

If you believe you do qualify for the extra help, follow the instructions on how to appeal that will be included in the notice you receive.

43. What if I become eligible for the extra help after I have already enrolled in a Medicare private drug plan?

You can apply for the extra help at any time. If you qualify for the extra help, Medicare will notify your drug plan and the plan will change your premium, deductible and copayment requirements to the appropriate level. The plan must reimburse you for any additional payments you may have made.

44. What if I get some extra help but later qualify for Medicaid, a Medicare Savings Program or Supplemental Security Income (SSI)?

You will then qualify for full extra help and have lower out-of-pocket costs. That means you pay no monthly premium (unless you join a plan that has a higher premium than the extra help premium amount for your area), no deductible, and copays of no more than \$0–2 for generics and \$0–5 for brand-name drugs (see question 23). If your plan charges you additional costs after you qualify for Medicaid, a Medicare Savings Program or SSI, it must reimburse you for those costs. Since you automatically qualify for the extra help, you will not have to recertify as long as you continue to be enrolled in any of these programs.

45. Will I lose my subsidized housing or Food Stamps if I get the extra help paying for my Medicare drug costs?

The extra help you get paying for your Medicare drug costs does not count as income. But if you have been deducting your drug costs from your income when calculating your income for housing assistance or Food Stamps, you would no longer be able to do so. Your rent may go up and your Food Stamp allowance may go down or be eliminated if you get the \$10 minimum allotment. However, Medicare estimates that what you gain in coverage of your drug costs will more than offset whatever you may lose in rent or Food Stamps.

Talk to your state social service agency to learn how the extra help with your Medicare drug costs might affect your other benefits.

46. I live in Puerto Rico. Can I get the extra help?

If you live in a U.S. territory (Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands), you may qualify for other special programs that help reduce the cost of the Medicare drug benefit. These programs vary by region. To find out more about the programs, call your Medicaid office, 1-800 MEDICARE.

V. How Do I Get the Medicare Drug Benefit?

47. When can I first enroll in the Medicare drug benefit?

You can enroll in the Medicare drug benefit (Part D) during your **Initial Enrollment Period (IEP)**.

- **If you currently have Medicare** or will be eligible for Medicare in January 2006, your IEP will be between November 15, 2005, and May 15, 2006.
- **If you will become eligible for Medicare during February 2006**, your IEP will be between November 15, 2005, and May 31, 2006.
- **If you will become eligible for Medicare during or after March 2006**, your IEP will be the same as for Part B. It will be a seven-month period that includes the three months before the month you become eligible, the month you are eligible and three months after the month you become eligible.

48. Updated When can I enroll if I delayed enrolling in the Medicare drug benefit or want to change my Medicare private drug plan?

You will be able to enroll in the Medicare drug benefit (Part D) or change your Medicare private drug plan once a year during the **Annual Coordinated Election Period**, which will be between November 15 and December 31. You may have to pay a premium penalty unless you had drug coverage from another source that is at least as good as Medicare's (see question 13).

You will also be able to join or change plans during a **Special Enrollment Period (SEP)**. Medicare has not yet specified how long all the various SEPs will be or when your coverage will start if you enroll during an SEP. Stay tuned for upcoming information. You qualify for an SEP when you:

- Move out of your plan's service area.
- Lose your prescription drug coverage (such as retiree insurance) through no fault of your own.
- Enroll in a Medicare private health plan (Medicare Advantage) during your first year of Medicare eligibility and return to Original Medicare.
- Enroll in a Medicare private health plan for the first time.
- Your Medicare private drug plan stops offering coverage, fails to provide benefits on a timely basis, or misled you about what benefits you would get.
- Receive inadequate information about whether your existing prescription drug coverage is comparable to Medicare's. (You can apply to Medicare to have your premium penalty waived in this situation.)
- Enroll or fail to enroll in a Medicare private drug plan because of a federal employee's error. (Your premium penalty may also be waived in this situation.)
- Enroll in a Program of All-Inclusive Care for the Elderly (PACE).
- Enter, reside in, or leave a long-term care facility.

Notes:

- If you have Medicaid or a Medicare Savings Program, you can change your Medicare private drug plan once a month.
- If you have a Supplemental Security Income (SSI), or if you applied for extra help and Medicare randomly assigned you to a Medicare private drug plan, you can change plans once before the next Annual Coordinated Election Period.
- The Open Enrollment Period offers another opportunity to change your Medicare drug coverage if you receive it through a Medicare private health plan (see question 49).

49. Updated What is the Open Enrollment Period?

Starting in 2006 you will only be able to change your Medicare health plan (Original Medicare or Medicare private health plan), two times a year (this is known as the "lock-in"):

1. During the **Annual Coordinated Election Period** (November 15 through December 31), when you can also change whether you elect Medicare drug coverage at all and your new coverage is effective January 1.

2. During the **Open Enrollment Period (OEP)**, when you cannot also change your choice of enrolling in the Medicare drug benefit. Your new coverage will be effective the first day of the month after the month the plan receives a completed enrollment form.

During the open enrollment period, which will be January through June in 2006, and January through March in 2007 and beyond, you can:

- Switch from a Medicare private health plan **with** drug coverage to another Medicare private health plan **with** drug coverage.
- Switch from a Medicare private health plan **with** drug coverage to Original Medicare **plus** a stand-alone drug plan.
- Switch from Original Medicare **plus** a stand-alone drug plan to a Medicare private health plan **with** drug coverage.
- Switch from a Medicare private health plan **without** drug coverage to another Medicare private health plan **without** drug coverage.
- Switch from a Medicare private health plan **without** drug coverage to Original Medicare **without** a stand-alone drug plan.
- Switch from Original Medicare **without** a stand-alone drug plan to a Medicare private health plan **without** drug coverage.

You cannot:

- Switch from a Medicare private health plan **with** drug coverage to join a Medicare private health plan **without** drug coverage (unless you drop the Medicare drug benefit altogether).
- Switch from a Medicare private health plan **without** drug coverage to join a Medicare private health plan **with** drug coverage.
- Switch from a Medicare private health plan **with** drug coverage to join Original Medicare **without** joining a stand-alone drug plan (unless you drop the Medicare drug benefit altogether).
- Switch from Original Medicare **without** a stand-alone drug plan to a Medicare private health plan **with** drug coverage.

Note:

- If you are in a stand-alone drug plan, you can only switch to another stand-alone drug plan during the Annual Coordinated Election Period (see question 48).
- Institutionalized individuals can change plans once a month. Leaving an institution allows you change plans for two months after you leave. Medicare has not released final details on how the open enrollment period will work for these persons. Stay tuned.

50. Can I change plans if my Medicare private drug plan stops covering the drug I need?

Not until the next Annual Coordinated Election Period. While a Medicare private drug plan can change the drugs it covers (its formulary) at any time, you do not have the right to a Special Enrollment Period if your plan stops covering a drug you need.

Note: If you have Medicaid or a Medicare Savings Program, you can change your Medicare private drug plan once a month. If you are living in a nursing home (institutionalized), you can change plans once a month. Leaving an institution allows you change plans for two months after you leave. Stay tuned for more information on this.

51. How can I compare Medicare private drug plans?

Starting in October, Medicare will have a comparison tool on its www.medicare.gov web site that will allow you to search for Medicare private drug plans in your area and compare their

costs, covered drugs and pharmacy networks. It should be available starting in October 2005. You can also call 800-MEDICARE.

In addition, information about Medicare private drug plans in your area will be mailed to you in the *Medicare & You 2006* handbook, which you should receive in the fall of 2005.

Some community-based tools may be available to help you compare your choices in the future. Stay tuned for more information about these tools.

52. Will there be a tool to help me compare the Medicare private drug plans with my existing drug coverage?

No. You will have to pick the Medicare private drug plan that best meets your current needs and then see how that plan's coverage compares to your existing drug coverage.

53. How do I join a Medicare private drug plan?

You can join a Medicare private drug plan by:

- **Completing a paper application.** Contact the company offering the drug plan to ask for an application. Once you complete it, mail or fax it back to the company.
- **Completing an online application on the plan's website.** Visit the plan's website to see if it allows you to apply online.
- **Completing an online application on the Medicare's www.medicare.gov website.** You can join a plan through Medicare's online enrollment center.

You or a representative who is authorized under state law can enroll you. A representative authorized under state law could include a health care or general Power of Attorney or a surrogate decision maker as defined by state law.

54. What if I accidentally sign up for more than one Medicare private drug plan?

During an enrollment period, if you have a Medicare private drug plan already and enroll in a new one, you will be automatically disenrolled from your previous plan. Additionally, if you make multiple plan selections during a month, the last one you make will become effective on the first of the following month. **Note:** you must be in an enrollment period to join a plan.

If you try to join a plan outside of an enrollment period you will be denied.

55. After I join a Medicare private drug plan, can the deductibles, premiums and coinsurance change?

The deductibles and premiums cannot change until the following calendar year. However, your coinsurance and overall out-of-pocket costs may change if the drug you need is moved to a different cost tier or is removed from the plan's list of covered drugs (see questions 64 and 65).

56. Will I need to reapply every year?

No. If you do nothing your current plan will continue, but you should reevaluate your Medicare private drug plan every year to make sure you are getting the best coverage for your needs.

57. Once I enroll in a Medicare private drug plan, when does the coverage begin?

If you join in 2005 (between November 15, 2005, and December 31, 2005), your drug coverage will begin on January 1, 2006. If you enroll in 2006 (from January 1, 2006, to May 15, 2006), your coverage will start the first day of the month after the month in which you signed up.

If you become eligible for Medicare drug coverage any time after that, your coverage will start on the month you become eligible if you joined in the first three months of your Initial Enrollment Period, or the month after the month in which you joined if you sign up during the last four months of your Initial Enrollment Period (see question 47).

Plan changes made during the Annual Coordinated Enrollment Period (November 15 to December 31 of every year) will become effective on January 1 of the following year.

Medicare has not yet specified when your coverage will start if you enroll or change plans during a Special Enrollment Period.

58. What should I do if I enroll in a Medicare private drug plan but don't receive a card or any information from it and I need my drugs now?

You should contact the plan immediately. If you do not get a timely response from the plan, you should contact Medicare at 800-MEDICARE.

59. Can my application to enroll in a Medicare private drug plan be rejected?

Yes, your application can be denied in the following situations:

- You are not eligible for Medicare drug coverage.
- You are not in the plan's coverage area.
- You are not eligible to enroll in a Medicare private health plan (Medicare Advantage) with drug coverage because you have End-Stage Renal Disease (ESRD) or do not have both Medicare Parts A and B.
- You try to apply for a Medicare private drug plan outside the Annual Coordinated Enrollment Period or a Special Enrollment Period.
- The plan is not accepting new members.
- You apply for a stand-alone drug plan but you are enrolled in a Medicare private health plan (such as an HMO, PPO or PFFS). (**Note:** if you are in a PFFS plan that does not offer drug coverage, you can enroll in a stand-alone drug plan.)

60. What can I do if my application is denied?

If a Medicare private drug plan denies your application to join and you believe you qualify for the Medicare drug coverage, you should call the plan and ask it to clarify the reason it did not approve your application. You can also contact Medicare if you believe the Medicare private drug plan is not addressing your concerns. (There is no formal appeals process for enrollment denials at this time.)

61. How can I disenroll?

If you want to disenroll from a plan you can:

- choose another Medicare private drug plan during the Annual Coordinated Election Period or your Special Enrollment Period, and you will be automatically disenrolled;
- send a letter to your plan asking to be disenrolled. If you do this outside of the Annual Coordinated Election Period or a Special Enrollment Period, you will not be able to enroll in another Medicare private drug plan. Therefore, you would have a premium penalty if you later signed up for another Medicare private drug plan unless you have drug coverage at least as good as Medicare's from another source (such as retiree insurance).

Note: Keep a copy of all letters you send or receive.

VI. How Does the Medicare Drug Benefit Work?

62. Which drugs will Medicare private drug plans cover?

Each Medicare private drug plan will have its own formulary (list of covered drugs), which will include both brand-name and generic drugs. Plans will be allowed to change their formularies at any time as long as they give a 60-day notice of the change. Information about any formulary changes will be posted on the plan's web site, and members affected by the change will also receive a written notice by mail. (60-day notice is not required if the drug is removed for safety reasons.)

Medicare private drug plans must offer at least two drugs under each drug class. In addition, plans must cover a majority of drugs in certain classes, including:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Antiretrovirals
- Anticancer
- Immunosuppressants

Medicare will give plans the breakdown of the types of drugs they must cover. While some drugs are explicitly excluded from Medicare coverage by law, some plans may cover them as an additional benefit.

63. Which drugs are excluded from Medicare coverage?

There are some drugs that are excluded from Medicare coverage by law. These include:

- drugs for:
 - anorexia, weight loss or weight gain;
 - fertility;
 - cosmetic purposes or hair growth;
 - relief of the symptoms of colds, like a cough and stuffy nose;
- prescription vitamins and minerals (except prenatal vitamins and fluoride preparations);
- non-prescription drugs (over-the-counter drugs);
- certain anti-anxiety and anti-seizure drugs (barbiturates and benzodiazepines).

Note: Some plans may offer enhanced coverage that includes these excluded drugs. However, payments for these drugs will not count towards meeting your out-of-pocket coverage limit (TrOOP) (see question 12).

64. What is a formulary?

A formulary is a list of prescription drugs that are covered by a plan. All plans must cover at least two drugs from each therapeutic class of drugs. A "therapeutic class" contains drugs that are similar based on the disease they treat or on the way they affect the body. Plans can change their formularies at any time but must give their members and the public 60-day notice of any changes on the plan's website. Members who use the drug must be notified in writing.

65. What is a "tiered formulary"?

Some Medicare private drug plans will most likely structure their formulary to have different cost-sharing tiers. That means your out-of-pocket costs for each prescription you fill would

depend on which “tier” the drug is in. Lower tiers have lower out-of-pocket costs and may include generic version of the drugs. Higher-tier drugs will cost you more. Plans can have multiple tiers.

Plans can put other restrictions on the use of certain drugs, such as requiring that you get permission from the plan before the drug is prescribed (prior-authorization), or allowing a drug to be covered only after you tried the plan’s preferred drugs and found they were not effective for you (“fail first requirements”).

66. How will I know if my Medicare private drug plan’s formulary changes its coverage of my drug?

Your plan must send you written notice at least 60 days before it changes its coverage of a drug you use. This might include ending coverage of a medication you take or changing how much you have to pay for it. Any formulary changes will also be posted on the plan’s web site prior to 60 days before the change. (Sixty-day-notice is not required if the drug is removed for safety reasons.)

The notice must include the reason for the change, the names of similar drugs that are covered and how much you have to pay for them, and information about filing an appeal.

Alternatively, the plan can provide you the written notice after the change has taken effect as long as they cover a 60-day supply of the drug when you refill it at the pharmacy.

67. Where can I find the list of drugs each plan covers?

You can call the Medicare private drug plan, visit its web site or go to www.medicare.gov (starting in October) to find out which plans in your area cover the medications you need.

68. Will my Medicare private drug plan cover medications that I am currently getting covered by Medicare?

No. If Medicare is currently covering some of your outpatient drugs, they are being covered under Medicare Part B. Drugs currently covered under Part B (such as some oral cancer drugs, immunosuppressants, antivirals, antigens and anti-emetics) will continue to be covered under Part B and will not be covered by the new Medicare private drug plans. The cost of drugs covered by Part B in no way affects your out-of-pocket costs for your new Medicare drug coverage (Part D).

69. What happens if my new Medicare private drug plan does not cover the medications that I currently take?

Your plan must have a transition process for you. These processes will vary with each plan, but could include a one-time refill or attempts to explore substitutions with you and your doctor before the new coverage is effective. Plans must include their transition process on their website and provide it to individuals upon request. To obtain long-term coverage of your medication, you will probably need to file an exception. (See question 91.)

70. Where can I get my prescriptions filled?

You must use pharmacies in your Medicare private drug plan’s network to get Medicare coverage for your drug costs. You can get coverage of drugs from an out-of-network pharmacy **only** if you cannot reasonably be expected to obtain such drugs at a network pharmacy **and** you do not get the drugs at an out-of-network pharmacy on a regular basis. In those instances you

may need to pay for the prescription at the pharmacy and then ask for reimbursement from the plan for it. The plan can charge you more for using an out-of-network pharmacy (the difference between the out-of-network pharmacy's customary price and the plan's allowance for the drug).

If you live in a nursing home the same rules will apply, so make sure the Medicare private drug plan you choose has the pharmacy your nursing home works with in its network.

If you move out of your plan's service area, you will have a Special Enrollment Period to choose a new plan.

If you regularly spend a few months of the year in another state, you should consider enrolling in a national drug plan that partners with pharmacies all around the country.

71. What if I need an emergency prescription when traveling outside my Medicare private drug plan's service area?

You can get the medication if you can show that you could not reasonably obtain the medication from a network pharmacy and you do not routinely use out-of-network pharmacies. You may need to pay for the prescription at the pharmacy and then seek reimbursement from the plan for it. The plan can charge you more for using an out-of-network pharmacy (the difference between the out-of-network pharmacy's customary price and the plan's allowance for the drug).

72. Can network pharmacies charge different prices for the same covered drug?

It depends. If you are getting the extra help paying for your Medicare drug costs (the low-income subsidy), you will pay no more than \$5 for your drugs as long as you go to a pharmacy that is in the plan's network. It does not matter what network pharmacy you go to.

If you are not getting the extra help, what you pay for drugs may vary, depending upon how the plan sets up its network. Medicare private drug plans can have preferred and non-preferred network pharmacies. You will pay less at preferred network pharmacies than you will at non-preferred network pharmacies. Also, you may pay less if you use a mail-order pharmacy through your plan than if you get your drugs from a network retail pharmacy.

73. How will I know how much I have to pay for my drugs?

Your out-of-pocket costs will be detailed in your plan's benefits outline, which you can get on the plan's web site or by calling its toll-free customer service number. You can also find out on the www.medicare.gov web site. In addition, at the time you fill a prescription, your pharmacist can tell you how much you will have to pay.

74. Who will keep track of how much I spend on drugs?

The plan is required to do this. When you enroll in a Medicare private drug plan, you will get a card to use when you fill your prescriptions. This is how the plan keeps track of your out-of-pocket expenses. Your plan is required to send you a statement every month showing how much has been spent for the year and how close you are to reaching the out-of-pocket maximum for catastrophic coverage (\$3,600 in 2006). You can also request this information from your plan at anytime. Some plans may make this information available on their web sites.

VII. What Happens to Prescription Drug Coverage I Have Now?

75. **Updated** What will happen to my employer or retiree drug coverage when the Medicare drug benefit begins?

If you already have prescription drug coverage through your employer or union, check with your plan or benefits administrator to learn how your plan coordinates with Medicare drug coverage.

It does not matter whether you are currently working or retired.

The company providing your employer or retiree drug coverage will send you a letter this fall letting you know whether your drug coverage is at least as good as Medicare's standard drug coverage ("creditable coverage"). Be sure you have this information before deciding whether to enroll in the Medicare prescription drug benefit. Contact the company's human resources department if you do not receive the letter by the end of the year.

If your current or former employer chooses to continue to offer prescription drug coverage you have three choices:

1. **If your current or retiree drug coverage covers at least as much as Medicare's basic coverage**, you may want to keep it and not buy Medicare drug coverage (if your coverage is at least as good as Medicare's drug coverage, you will not have to pay a premium penalty as long as you do not go for more than 63 days without creditable coverage). However, you may want to compare the cost and coverage of your current coverage (including premiums, copays and list of covered drugs) with the cost and coverage of Medicare private drug plans in your area, to see which offers you the best coverage for the your money. (Keep in mind that if you drop your current drug coverage you may not be able to get it back in the future. Also, make sure you can drop your drug coverage without losing your hospital and doctor coverage as well.)
2. **If your current or retiree drug coverage covers less than Medicare's basic drug coverage**, you may want to drop it and buy Medicare drug coverage. If you do not join a drug plan by May 15, 2006, you may need to pay a premium penalty. **Note:** Before making a decision, ask your employer if you can drop your drug coverage without losing your other supplemental insurance for doctor and hospital services. Once you drop your existing coverage, you may not be able to get it back.
3. **If your current or retiree coverage will fill in the gaps in Medicare's drug coverage**, you may want to keep it and enroll in the Medicare drug benefit as well. (Keep in mind, however, that you will still have to eventually spend \$3,600 dollars in out-of-pocket costs for Medicare covered drugs before your Medicare drug costs go down a lot—catastrophic coverage—because payments made by other insurance do **not** count toward your out-of-pocket costs, even for covered drugs—see question 12.) **Note:** Medicare has said they do not expect employers will offer this option.

76. What will happen to my Medicare private health plan when the Medicare drug benefit begins?

If you are enrolled in a Medicare HMO or PPO you can

- get your prescription drug coverage through that company (if the company offers it);
- choose another Medicare HMO or PPO with Medicare drug coverage; or
- drop your plan and enroll in a stand-alone drug plan and get the rest of your Medicare benefits through Original Medicare.

If you are enrolled in a Medicare Private Fee-For-Service plan (PFFS) or Medicare cost plan, you can

- get your drug coverage through that plan (if the company offers it);
- choose another Medicare private health plan (HMO, PPO or PFFS) that does offer drug coverage;
- keep the plan and get your drug coverage through a stand-alone drug plan; or
- drop your plan and enroll in a stand-alone drug plan and get the rest of your Medicare benefits through Original Medicare.

77. What happens to my Medigap policy with drug coverage when the Medicare drug benefit begins?

If you enroll in the Medicare drug benefit you cannot also have a Medicare supplemental insurance policy (Medigap Plans H, I and J) that offers drug coverage. If you have Medigap H, I or J you can:

- **Cancel your existing Medigap policy and switch to another Medigap policy that does not offer drug coverage and enroll in a Medicare private drug plan.** To avoid a premium penalty (see question 13) you must do so before May 15, 2006. In most cases, you can enroll in certain Medigap policies offered by the same Medigap insurer, regardless of your health as long as you apply within 63 days after your Medicare drug coverage starts. You cannot be charged more because of previous or current health problems, and a preexisting condition exclusion cannot be applied to you. Some states offer better protections. Call your state Insurance Department for More information.
- **Keep your Medigap policy but without the drug coverage and enroll in the Medicare drug benefit.** Keep in mind that premiums for these Medigap policies will probably increase faster than Medigap policies that never offered drug coverage. To avoid a premium penalty (see question 13) you must do so before May 15, 2006
- **Cancel your Medigap policy and join a Medicare private health plan that includes Medicare drug coverage.** You will not need your Medigap policy because it cannot pay premiums or co-insurance for Medicare private health plans (keep in mind you may not have a right to buy a Medigap policy later); or
- **Keep the Medigap policy and choose not to enroll in the Medicare drug benefit.** If later you want to drop the Medigap drug coverage and enroll in the Medicare drug benefit, you may have to pay a premium penalty. You should notify your Medigap insurer of your Medicare drug coverage immediately so they can remove the drug coverage and adjust your premium. Since the premium for this type of Medigap plans is usually high and the drug coverage is limited, you are probably better off enrolling in the new Medicare prescription drug coverage

Note: Medicare prescription drug coverage will be better than most drug coverage provided by Medigap policies. However, some plans in Minnesota, Massachusetts and Wisconsin, as well as some older “pre-standardized” Medigap policies, may be considered to have coverage that is at least as good as Medicare basic drug coverage (“creditable coverage”), which means you will not have to pay a premium penalty for late enrollment.

If your Medigap policy covers drugs, sometime between September 15, 2005 and November 15, 2005, your Medigap insurer will send you a letter telling you how the new Medicare drug coverage will affect your Medigap policy.

78. Will Medigap Plans H, I and J be sold after December 31, 2005?

Perhaps. Insurance companies that sell Medigap policies can choose to continue to offer plans H, I and J (and other policies in Massachusetts, Minnesota, and Wisconsin that have included prescription drug coverage), but they will have to remove any drug coverage. Also, their premiums will probably increase faster than other Medigap policies that never had drug coverage.

Two new Medigap policies (Plans K and L) will be offered in 2005. These policies are designed to have lower premiums because they require you to pay a portion of your deductibles and coinsurance for most Medicare-covered services until you have spent a certain amount out of pocket each year. After you reach that limit (\$4,000 for Plan K and \$2,000 for Plan L), the policy will pay 100% of your costs.

79. What happens to my State Pharmacy Assistance Program (SPAP) when Medicare drug coverage begins?

It will depend on where you live. Some states are choosing to end their programs. If states are continuing their programs, they can choose to offer coverage as they always have or fill in the gaps in Medicare drug coverage for individuals enrolled in the state's drug assistance plan. Each state will have to decide how its plan will coordinate with the Medicare private drug plans. Your state will send you information about how your SPAP drug coverage will be affected by the Medicare drug benefit. You should contact your state if you have questions before you get this information.

If you continue to have drug coverage from an SPAP when your Medicare drug coverage begins, Medicare will always be your primary coverage. That means when you get your prescriptions filled at the pharmacy, Medicare always pays first and the SPAP can choose to “wrap around” a Medicare private drug plan by paying your premium, deductible, coinsurance and other out-of-pocket costs. It can also choose to cover drugs not on your plan's formulary and those explicitly excluded from Medicare coverage.

Payments made by an SPAP will count toward your out-of-pocket maximum (\$3,600 in 2006) to get to catastrophic coverage (unless they are for drugs not on your plan's list of covered drugs or are explicitly excluded from Medicare coverage).

80. Updated What happens to my COBRA drug coverage when Medicare drug coverage begins?

If you have drug coverage through COBRA and you want to keep it, you should find out if that coverage is at least as good as Medicare's basic drug coverage (“creditable”). You should receive a letter this fall from the company providing your COBRA coverage letting you know whether your drug coverage is as good as Medicare's. Be sure you have this information before deciding whether to enroll in Medicare prescription drug coverage. Especially if it is creditable, you may want to keep your COBRA coverage and delay enrolling in Medicare drug coverage. Many COBRA plans will not allow you to drop your drug coverage and keep your other medical coverage. Also, if you enroll in Medicare drug coverage after November 15, 2006, you will not have to pay a higher premium (premium penalty) as long as you join within 63 days of losing creditable coverage.

If your COBRA drug coverage is not creditable and you decide not to enroll in the Medicare drug benefit during your Initial Enrollment Period, you will have to pay a premium penalty if

you want to enroll in Medicare drug coverage at a later date (see question 13). Also, you will need to wait until the next Annual Coordinated Election Period to enroll (November 15 through December 31)

Note: To have both COBRA and Medicare at the same time, you have to become eligible for COBRA **after** you already had Medicare. If you already have COBRA when you become entitled to Medicare, your COBRA coverage ends on the date you become entitled to Medicare (unless you are entitled to Medicare because of End-Stage Renal Disease (ESRD)).

81. Updated What happens to my TRICARE For Life (TFL) drug coverage when the Medicare drug benefit begins?

Your TRICARE coverage will remain the same and you will not have to join a Medicare drug benefit (Part D) to keep it. (Note: This is different from medical coverage under TRICARE which requires you to enroll in Medicare Parts A and B.)

Since TRICARE coverage is more comprehensive than Medicare's drug coverage (so it is considered creditable) you may be better off keeping your TRICARE and not enrolling in the Medicare drug benefit. If you decide you want to enroll in the Medicare drug benefit later, you will not have to pay a penalty as long as you enroll within 63 days of dropping or losing TRICARE coverage. Contact TRICARE for more information.

If you do join a Medicare private drug plan and keep TRICARE, Medicare will pay first and TRICARE will pay second.

Note: If you qualify for full extra help your co-pays for covered drugs may be less than if you just kept TRICARE. However, TRICARE's list of covered drugs could be broader than those of Medicare private drug plans in your area and TRICARE will cover drugs not on its list for a higher copay.

82. Updated What happens to my VA benefits when the Medicare drug benefit begins?

Your Department of Veterans Affairs (VA) drug coverage will remain the same, and you probably do not want to enroll in a Medicare private drug plan. VA coverage is more comprehensive than Medicare drug coverage. Also, Medicare only wraps around VA benefits in limited instances (only when you have VA permission to get services in a non-VA facility). Since VA pays first and Medicare pays second, you will not need Medicare to supplement your VA drug coverage. In addition, if you ever do want to enroll in the Medicare drug benefit later, VA drug coverage is "creditable coverage," so you will not have to pay a penalty as long as you enroll in the Medicare drug benefit within 63 days of losing VA benefits.

Note: With no premiums and no or limited co-pays for prescriptions, VA coverage is comparable to Medicare drug coverage with extra help.

You may want to join a Medicare private drug plan if you live very far from a VA facility and the Medicare private drug plan includes nearby pharmacies in its network, or if you live in a nursing home that does not accept your VA drug benefits.

83. What happens to my coverage through a Program of All-Inclusive Care for the Elderly (PACE) when the Medicare drug benefit begins?

If you are enrolled in a PACE organization that offers drug coverage as of December 31, 2005, do not sign up for a Medicare private drug plan. (If you do enroll in a Medicare private drug plan, you will be disenrolled from all PACE coverage.) Beginning January 1, 2006, you will get Medicare drug coverage through PACE, and you will not have any premiums, deductibles, copayments, coinsurance or other out-of-pocket costs for your prescription drugs.

84. What happens to my Medicare-approved drug discount card when Medicare drug coverage begins?

If you have a Medicare-approved drug discount card, your card will expire when your Medicare drug coverage begins or on May 15, 2006, whichever comes first.

85.  What happens to my ADAP coverage when Medicare drug coverage begins?

AIDS Drug Assistance Programs (ADAPs) vary among states, so how Medicare drug coverage affects your ADAP coverage will depend on your state. You should call your ADAP to determine how it coordinates with the Medicare drug benefit.

If you currently receive your drug coverage through and ADAP, you probably want to keep your ADAP benefits and enroll in the Medicare drug benefit. ADAPs can require you to enroll in a Medicare private drug plan to continue receiving ADAP benefits. Also, most ADAPs will be not considered as good as Medicare's basic drug coverage, so if you decide to enroll in a Medicare private drug plan after your initial enrollment period, you will have to pay a premium penalty and wait until the annual coordinated election period (November 15 to December 31 of every year) to enroll. (Private insurance paid for by ADAPs will probably offer coverage that is, on average, at least as good as Medicare's basic benefit).

It may very important continue receiving ADAP assistance. Some ADAPs will supplement the Medicare drug benefit, paying your out-of-pocket costs and covering drugs that your Medicare private drug plan does not. These payments do not count toward meeting your annual out-of-pocket maximum (\$3,600 in 2006, also called TrOOP). Some states will allow you to use ADAP payments to spend down to Medicaid, If you qualify for Medicaid spend-down for more than one month, you will automatically qualify for extra help (see question 27).

86. What happens if I currently get my prescription drugs through my nursing home?

Medicare private drug plans must provide convenient access to long-term care facility pharmacies in their networks. If you are living in a nursing home or other medical institution and qualify for Medicaid for at least one full month, you will be automatically eligible for the extra help paying for Medicare drug coverage and you will not have any out-of-pocket expenses for your drug costs. If you join a Medicare private drug plan with a premium that is higher than the extra help premium amount, the difference is a medical expense that counts towards the monthly amount you must contribute toward the cost of your care ("share of cost").

If you do not have Medicaid, you will have the same out-of-pocket costs as other plan members.

Note: federal law requires nursing homes to cover the costs of medications if they will not be covered by the plan or are excluded from Medicare coverage.

In addition, entering, residing in, or leaving a nursing home will entitle you to change your Medicare private drug plan. Nursing home residents can change plans every month. Persons who leave a nursing home can change plans within two months after leaving the institution. Details on this are still being worked out. Stay tuned.

87. Could enrolling in a Medicare private drug plan disqualify me from drug assistance provided by certain pharmaceutical companies?

It is up to the companies. Some pharmaceutical assistance programs require that you do not have any other drug coverage to qualify for the program. Stay tuned to find out what these programs decide to do once the Medicare drug benefit is available.

VIII. Do I Have Any Protections?

88. What are my enrollment rights?

You have the right to enroll in any Medicare private drug plan available in your area during the Initial Enrollment Period (except if you have End-Stage Renal Disease and want to enroll in a Medicare private plan—HMO, PPO—with drug coverage). Plans are also required to provide you “prompt notice” of whether it has accepted or denied your enrollment. Medicare will provide more information about how this must be done. Stay tuned.

89. What is my Medicare private drug plan required to tell me?

Medicare private drug plans are required to provide information to their enrollees (and prospective enrollees) about their service areas, the benefits offered under the plan, the cost-sharing amounts, formularies, pharmacy network, and any other aspect of coverage. This information must be provided in writing at the time of enrollment and annually after that, and it must also be available on request and on the plan’s web site. The plan must also operate a toll-free number during business hours and be able to give you this information. In addition, plans and pharmacists are required to tell you if you could save money by using a generic drug.

90. Will my Medicare private drug plan help me manage what prescription drugs I am taking?

Medicare private drug plans are required to provide therapy management programs to members who

- have multiple chronic conditions;
- are taking multiple medications; and/or
- have high drug expenses.

These programs will pay pharmacists to spend time counseling members who meet the above criteria to improve their overall health and reduce adverse drug interactions. Stay tuned for more information about these programs.

91. What if I am out of my Medicare private drug plan’s coverage area and I need to get a prescription filled?

Call your Medicare private drug plan. You can get coverage of drugs from an out-of-network pharmacy if you cannot reasonably be expected to obtain such drugs at a network pharmacy **and** you do not get the drugs at an out-of-network pharmacy on a regular basis (see questions 70 and 71).

92. What if the medication I need is not on my Medicare private drug plan's formulary?

You have the right to request that your plan cover a medically necessary drug not on its formulary (list of covered drugs) when:

- You are using a drug currently covered by your plan, but that drug is removed from your plan's formulary for reasons other than safety.
- Your doctor prescribes a drug not on your plan's formulary because your doctor believes the drugs on the plan's formulary will not work for you.

Once you realize the drug you need is not covered, you should contact your plan to request an exception. You will need an oral or written supporting statement from your doctor to demonstrate you need the drug. Generally, plans must grant these requests—called exceptions—when they determine that it is medically appropriate to do so. Plans must respond to your request within 72 hours. You can also ask for a faster response (an expedited request) when your “life, health or ability to regain maximum function” is in jeopardy. Plans must respond to expedited requests within 24 hours. If a plan denies an exception request, you can appeal the plan's decision.

If a plan grants your request, it must continue to cover refills as long as the doctor continues to prescribe that drug, it continues to be safe, and the calendar year has not expired.

Note: You cannot ask for an exception for drugs specifically excluded from Medicare coverage (see question 63).

93. What if the medication I need is in a high cost-sharing tier?

You have the right to request that your Medicare private drug plan lower your drug copayment for a medically necessary drug (cost-sharing tier) when:

- You are using a drug currently covered by your plan, but the plan raises your copayment for that drug.
- Your doctor prescribes a drug on your plan's formulary that requires a higher copayment because your doctor believes the drugs covered by the plan with a lower copayment will not work as well for you, would be harmful to you, or both. (**Note:** plans may exempt “high cost or unique drugs” from the exceptions process).

Once you realize the drug you need is not covered, you should contact your plan to request an exception. You will need an oral or written supporting statement from your doctor to demonstrate you need the drug. Generally, plans must grant these requests—called exceptions—when they determine that it is medically appropriate to do so. Plans must respond to your request within 72 hours. You can also ask for a faster response (an expedited request) when your “life, health or ability to regain maximum function” is in jeopardy. Plans must respond to expedited requests within 24 hours. If a plan denies an exception request, you can appeal the plan's decision.

If a plan grants your request, it must continue to cover refills at that copayment as long as the doctor continues to prescribe that drug, it continues to be safe, and the calendar year has not expired.

If a plan denies an exception request, you can appeal the plan's decision.

Note: You can also request an exception to other coverage restrictions, such as dose and dosage limitations and substitution requirements.

94. What can I do if my plan denies an exception to its formulary?

You can appeal. There are several levels in the appeals process.

- 1. Redetermination by your Medicare private drug plan.** If your Medicare private drug plan denies your exception request for the drug you need (see questions 91 and 92), you can request a second review within 60 days of receiving notice of the plan's decision. (Exceptions to the 60-day rule include sickness, death or illness of family member, incorrect information from the plan and destroyed records.) The plan must respond no later than seven calendar days from the date it receives the request (72 hours for an expedited appeal). If the plan fails to act within these timeframes, the plan must forward your appeal to the Independent Review Entity within 24 hours of the missed deadline (see below). Plans must expedite appeals if your doctor certifies that your health requires it.
- 2. Reconsideration by the Independent Review Entity (IRE).** If your plan denies coverage after a redetermination request you can request a review by an IRE within 60 days of getting the notice of denial of your redetermination from your plan. That notice should also explain how to appeal to the IRE. An IRE is an independent agency that contracts with Medicare to handle these appeals and is not affiliated with any Medicare private drug plan. The IRE must get the input of your prescribing doctor either orally or in writing and respond no later than seven calendar days after receiving your request (72 hours for an expedited appeal).
- 3. Administrative Law Judge (ALJ) hearing.** If you disagree with the IRE's decision, or if the IRE fails to act, you can request an ALJ hearing within 60 days of the IRE decision if the amount in question meets the minimum amount that Medicare will announce annually (\$100 in 2005). You can combine multiple appeals to meet this amount, meaning that you will project the cost of the drug to include all of the refills you will need for the calendar year. The timeframe for a decision is 90 days, but that period can be extended for several reasons.
- 4. Medicare Appeals Council (MAC).** If you disagree with the ALJ's decision, you can appeal within 60 days to the Medicare Appeals Council, which is the part of the Department of Health and Human Services that reviews ALJ decisions. The MAC can also review the ALJ decision on its own initiative.
- 5. Judicial Review.** If you disagree with the MAC's decision or if the MAC denied the request for appeal, and the amount in question meets the minimum amount that Medicare will announce annually (\$1,050 in 2005), you can request Judicial Review in federal court.

Note: Your prescribing doctor or a representative acting on your behalf can appeal for you. A representative is someone authorized under state law to act for you (such as a health care proxy) or someone you appoint in a written statement you send to Medicare.

95. I was told I won my appeal. How soon can I get my drugs covered?

Reversal of coverage determinations and redeterminations. Your Medicare private drug plan must process your request for benefits within seven calendar days (72 hours for an expedited

appeal) from the date the plan received your request for redetermination. If you requested payment, the plan must authorize it within seven calendar days and pay within 30 calendar days from the date it received your request for redetermination.

Reversal of plan decision by IRE, ALJ, MAC or Judicial Review. Your plan must process your request for benefits within 72 hours (24 hours for an expedited appeal) from the date the plan received the decision. If you requested payment, the plan must authorize it within 72 hours and pay within 30 calendar days from the date it received your request.

96. Can private health or drug plans make unsolicited calls to me about their products (telemarket)?

Yes. In addition to marketing their Medicare private drug plans, insurance companies can market additional products and services to you by phone. However, plans cannot use information that they have obtained from you (such as your name and address) to market non-health-related products and services without your written consent. There are some restrictions:

- Telemarketers cannot enroll you in their plan.
- Plans must abide by the “Do Not Call” List, honor “Do Not Call Again” requests, and must comply with federal and state consumer protection laws for telemarketing.

97. What happens if my Medicare private drug plan leaves my area?

You will have a Special Enrollment Period to enroll in another Medicare private drug plan (see question 48). You can go to Medicare’s www.medicare.gov web site to look for Medicare private drug plans in your area and compare their costs, covered drugs and pharmacy networks. You can also call 800-MEDICARE for help finding a new private drug plan.

98. What happens if I lose my current drug coverage and want to enroll in the Medicare drug benefit?

It depends on whether your current drug coverage is at least as good as Medicare’s (“creditable coverage”) and why you lost your coverage.

If your coverage was at least as good as Medicare’s and

- **you lost your coverage through no fault of your own**, you will get a Special Enrollment Period in which to enroll in a Medicare private drug plan. To avoid paying a premium penalty, you should enroll within 63 days of losing your drug coverage.
- **you decide to drop your drug coverage**, if you decide to drop your drug coverage and it was at least as good as Medicare’s, you will not get a Special Enrollment Period. You can enroll in a Medicare private drug plan during the Annual Coordinated Election Period (see question 47). To avoid paying a premium penalty, make sure you are not without your drug coverage for more than 63 days.

If your drug coverage was not at least as good as Medicare’s, you can enroll in the Medicare drug benefit during the Annual Coordinated Election Period (see question 47), but you will have to pay a premium penalty for each month that you did not enroll after your Initial Enrollment Period (see questions 13 and 47).

99. If I move out of my Medicare private drug plan’s service area, can I change plans?

Yes. You will have a Special Enrollment Period in which to enroll in a new Medicare private drug plan (see question 47). If you are eligible for the extra help paying for your Medicare drug costs and enrolled through Social Security, you do not need to reapply when you move.

100. If my health condition significantly changes and my plan does not cover the drugs I need, can I switch plans?

Generally no. A change in your health condition does not entitle you to change your drug plan. You can request an exception to the plan's formulary (see questions 91 and 92) and change plans during the Annual Coordinated Election Period (see question 47).

However, if you have Medicaid you can switch plans at any time, and if you enter or leave a long-term care facility, you will probably have the chance to change plans. Stay tuned for more information.

101. Can I get free help understanding my options?

Yes. For help comparing your Medicare private drug plan options you can call 1-800-MEDICARE, visit the Medicare web site at www.medicare.gov, or call your State Health Insurance Information and Assistance Program (SHIP). For help filling out the application for extra help paying for your Medicare drug costs if your income is low, call Social Security at 800-772-1213 or your SHIP. You can get the telephone number of your local SHIP by calling 1-800-MEDICARE.

For regular updates on Medicare consumer issues, subscribe to the Medicare Rights Center's free weekly e-newsletter, Dear Marci, at www.medicarerights.org/dearmarci.html.