



Medicare Part D



Medicare Drug Benefit Overview

- Beginning January 1, 2006, Medicare began to offer Prescription Drug Coverage through private companies.
- There are two types of plans offered
 - Stand Alone Prescription Drug Plans (PDP)
 - Medicare Private plans (HMO, PPO or PFFS)
- Companies have flexibility to design their plans as long as it meets Medicare's Basic plan.

Medicare Basic Plan

- \$250 annual deductible.
- After the deductible is met, members will have to pay a coinsurance of 25% of the cost of covered drugs between \$251 - \$2,250 (\$500).
- Members will pay 100% of the cost of covered drugs between \$2,251 and \$5,100 (\$2,850).
- Members will have to reach \$3,600 in out-of-pocket costs in 2006 before catastrophic coverage is available. At that point the coinsurance will be 5% of the cost of covered drugs.

Costs

- In 2006, California members will pay a monthly premium at an average of \$26.00.
- Applicable co-payments and deductibles will vary depending on plan.
- A penalty will be assessed for those who do not enroll in a plan by May 15, 2006.
- Low Income assistance is available for those who are below 150% of the Federal Poverty Line.

Enrollment

- HMO, PPO and PFFS members are automatically enrolled by their insurance plan.
- Medicare members should sign up for a plan that meets their needs by reviewing their plan choices based on their zip code and current medications.
- Members enroll by completing an application for their plan choice.
- Members can only change plans during a valid enrollment period.

Part D Coverage

- Drugs will continue to be purchased through a retail pharmacy and / or mail order.
- Plans must offer at least 2 drugs under each therapeutic class and cover the majority of drugs in certain drug classes, including:
 - Antidepressants
 - Antipsychotics
 - Anticonvulsants
 - Antiretrovirals
 - Anticancer
 - Immunosuppressants

Plan Requirements

- Transition process must be established for patients when:
 - Their current medication is not on the plan's formulary for new members and/ or when a change of care setting occurs.
- Plans are required to provide Therapy Management to members meeting the following criteria:
 - Multiple chronic conditions
 - Taking multiple medications
 - With high drug expense

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- Exemption Process
 - Members have the right to request plans to cover drugs that are not on the plans formulary when...
 - The plan removed the drug from their formulary
 - Doctor prescribes a non formulary drug
- Who can file an exemption for drugs not listed on a plan formulary?
 - Members
 - Member Representatives
 - Their physician
- Prior Authorizations
 - If a drug is not on the plan's list of covered drugs or is subject to restrictions such as prior authorization, your plan must cover a **one-time supply** (90-180 days) of the drug for new members or for a change of care setting.

Resources

- www.medicare.gov
 - www.medicareinteractive.org
 - www.ssa.gov
- 1-800-MEDICARE