

The Medicare Drug Benefit: Overview

1. What is the new Medicare drug benefit?

Medicare's drug benefit, which began on January 1, 2006, is outpatient prescription drug coverage available only through private companies. To get this coverage, you have to choose and enroll in a private drug plan. Enrollment is optional for most and only allowed during approved enrollment periods. Whether you should sign up for a Medicare private drug plan depends on your circumstances. Some people already enrolled in certain low income assistance programs may be automatically enrolled in a Medicare drug plan and get financial assistance.

2. What does the Medicare drug benefit look like?

Plans vary widely in their benefits.

Each plan has different costs, a different list of covered drugs (formulary) and a different network of pharmacies with which it works.

Costs in 2008

Costs vary by plan. With most plans you pay a yearly deductible, a monthly premium and a portion of the cost for each prescription you fill (a coinsurance or copayment). The national average monthly premium for 2008 is \$27.93. With many plans, you may have to pay 100 percent of the cost of all or some of your drugs (coverage gap) when your **total** drug costs reach a certain amount (\$2,510 in 2008 in most plans).

Note: It is best to have your Part D plan bill you directly for your monthly premium (instead of having it automatically withdrawn from your Social Security check like it is for Part B). This will ensure that you are charged the correct amount on a monthly basis.

A few rules hold true for all plans: No plan can have a deductible higher than \$275. No matter which plan you choose, after you spend \$4,050 out of pocket on covered drugs at in-network pharmacies, your costs will go down dramatically (catastrophic coverage). At that point, you will pay five percent of the cost of your prescriptions or \$2.25 for generics and \$5.60 for brand-name drugs, whichever is greater. You also have to continue paying your monthly premium.

If your monthly income and assets are low, you may qualify for Extra Help—a federal program that helps pay most of the costs of prescription drug coverage. If you have Extra Help, the benefit works differently. (See question 4.)

Covered Drugs

Each plan has its own list of covered drugs (called a “formulary”). Plans must cover at least two drugs in every class of drugs. Plans will generally only cover drugs on their formulary unless your doctor asks for an “exception” to have the prescribed drug covered. Plans provide incentives for you to use generic drugs by making your copay for generics lower than for brand-name drugs (cost-tiers). Certain classes of drugs are excluded from Medicare coverage (drugs to treat weight loss and gain, erectile dysfunction, cough and cold medications, non-prescription over-the-counter drugs, barbiturates, benzodiazepines, prescription vitamins and minerals—except prenatal and fluoride—and fertility drugs). Prescription drugs that will not be covered for the treatment of those conditions may be

covered if prescribed to treat other conditions (except drugs for erectile dysfunction). For example, prescription medications for the relief of cold symptoms may be covered by Part D if prescribed to treat something other than a cold, such as shortness of breath from severe asthma. Some Medicare drug plans can choose to cover excluded drugs with “enhanced” coverage.

Plans also can impose restrictions on access to covered drugs. They can require that you get special permission to get a drug that is on the plan’s formulary (prior-authorization), require that you take other cheaper drugs before they will cover a more expensive brand-name drug (step therapy), or impose limits on the amount of a drug they will cover (quantity limits).

If a drug is not covered by your plan, or you get it from a pharmacy outside your plan’s network, you will have to pay the full cost yourself.

Note: The Medicare drug benefit (Part D) covers **outpatient** prescription drugs. Drugs that you get during overnight stays in a hospital or nursing home are covered by Medicare Part A. Other drugs that your doctor administers to you or that you get at a dialysis facility are covered by Medicare Part B.

Pharmacy Network

Each plan has a network of pharmacies that it works with. Even with the same plan, costs for your drugs may vary from pharmacy to pharmacy.

Note: If you purchase a drug that is not on your plan’s formulary or that you buy at an out-of-network pharmacy, you will pay the full cost of your prescriptions and that payment will not count towards your out-of-pocket maximum (\$4,050 in 2008).

3. Should I get the Medicare drug benefit?

It depends on whether you already have drug coverage, your income, and how much you currently spend on drugs. People who have Medicaid, a Medicare Savings Program or Supplemental Security Income will be automatically enrolled in the benefit (see question 4).

- **If you have drug coverage as good as or better than Medicare’s basic benefit (“creditable”),** you should probably keep it. If you want to enroll in the Medicare drug benefit later, you can do so without penalty. Most employer drug coverage is creditable. If you’re not sure whether your coverage is creditable, call your human resources department or the company that provides your coverage and ask.
- **If you get Extra Help, the benefit is a good deal** because your out-of-pocket costs will be very low (see question 4).
- **If you have high drug costs and no other drug coverage, the benefit will likely help.** Look for a plan that covers the drugs that you take and the pharmacies you use.
- **If you have low drug costs,** having Medicare drug coverage could cost you more now, but could protect you from high drug costs in the future. There may be a Medicare drug plan in your area with a low monthly premium you can afford. If you do not enroll when you are first eligible, you will pay a penalty if you enroll later (for exceptions, see question 4). The penalty may be small (1% of the average national premium—\$27.93 in 2008—for every month you do not enroll). But you will not be able to enroll until the next enrollment period (Nov. 15 – Dec. 31 each year), so you will have no coverage if your drug needs change over the course of a year. Still, there may be other low-cost ways to get the drugs you need. To find out, call your State Health Insurance Assistance Program (call 800-MEDICARE for phone number).

4. When can I join or switch Medicare private drug plans?

Enrolling for the first time

When you first become eligible for Medicare, you can enroll in the Medicare drug benefit (Part D) during your **Initial Enrollment Period (IEP)**. Your IEP for the Part D will be the same as for Part B. It is the seven-month period that includes the three months before the month you become eligible, the month you are eligible and three months after that.

If you do not join a Medicare drug plan during your Initial Enrollment Period, you may not be able to enroll for the first time until the **Annual Coordinated Election Period (ACEP)**, which goes from November 15 to December 31 of every year, for coverage beginning January 1. You may also have to pay a premium penalty if you did not have any other kind of creditable coverage. The **premium penalty** will be at least 1 percent of the national average premium (\$27.93 in 2008) for every month you delay enrollment. **If you qualify for Extra Help**, you will not have to pay a penalty if you enroll in 2007 or 2008.

You can enroll late without having to pay a premium penalty if you have prescription drug coverage at least as good as or better than Medicare's ("creditable coverage") and you are not without it for more than 63 days before your new Medicare drug coverage starts. If you can prove that you were given inadequate information that your drug coverage was creditable, you may not have to pay the penalty.

Under certain other circumstances you may get a **Special Enrollment Period (SEP)** to enroll in a Medicare drug plan for the first time outside of standard enrollment periods. However, you may still have a penalty, for example, if you had drug coverage but it was not creditable. The length of your SEP and the effective date of your coverage will vary depending on the reason for your SEP.

Changing Plans

You can only switch plans and add or drop drug coverage at certain times of year. During the ACEP you can enroll or disenroll from the Medicare drug benefit or switch plans. During the Open Enrollment Period (OEP), which runs from January 1 to March 31 every year, you can switch your choice of Medicare health coverage, but you cannot choose to add or drop Medicare drug coverage. For example, if you are in a Medicare private health plan (such as an HMO) with drug coverage, during the OEP you can switch to a different Medicare private health plan that also includes drug coverage or to Original Medicare and join a stand-alone drug plan, but you cannot switch to a Medicare health plan without drug coverage. You also cannot just change your stand-alone drug plan during the OEP.

Under certain circumstances you might get an SEP to change drug plans, such as if you move out of your Medicare drug plan's service area, or your plan stops offering coverage. **If you have Extra Help, the federal program that helps pay most of the costs of the Medicare drug benefit, or are living in an institution**, you can change your Medicare private drug plan at any time, with your new coverage beginning the first of the following month.

5. Can I get Extra Help to help pay for the Medicare drug benefit if my income is low?

Yes. If you have or become eligible for Medicaid or a Medicare Savings Program (an "MSP" such as QMB, SLMB or QI-1), or you receive Supplemental Security Income (SSI), you automatically qualify for Extra Help—you do not have to apply.

If you do not have Medicaid, an MSP or SSI, and your income and assets are limited you should apply for help through the Social Security Administration (SSA) using the agency's print or online application (www.ssa.gov). When you submit your application through SSA, you can simply state what your income and assets are; you will not have to provide proof.

Even if you qualify for the Extra Help paying for your Medicare drug costs—whether you applied for it or automatically qualified—you should select and enroll in the Medicare prescription drug plan that best meets your needs. If you do not join a plan on your own, you will be automatically enrolled in a randomly selected plan that may not meet your needs.

If You Have...	With Assets...	You Qualify For...
Medicaid¹ and income below 100% FPL (below \$10,400 ² a year for singles and \$14,000 a year for couples)*	Below the limit necessary to qualify for Medicaid in your state	Full Extra Help <ul style="list-style-type: none"> • No monthly premium³ • No deductible • \$1.05/generic and \$3.10/brand-name⁴ in 2008. (no copay after \$5,726.25 in total covered drug costs)
Medicaid and income above 100% FPL⁵ (above \$10,400 ² a year for singles and \$14,000 a year for couples)*	Below the limit necessary to qualify for Medicaid in your state	Full Extra Help <ul style="list-style-type: none"> • No monthly premium • No deductible • \$2.25/generic and \$5.60/brand-name in 2008 (no copay after \$5,726.25 in total covered drug costs)
Income below 135% FPL and do not have Medicaid (below \$14,040 a year for singles and \$18,900 a year for couples)*	Below \$7,790 for individuals and \$12,440 for couples ⁶	Full Extra Help <ul style="list-style-type: none"> • No monthly premium • No deductible • \$2.25/generic and \$5.60/brand-name in 2008 (no copay after \$5,726.25 in total covered drug costs)
Income below 150% FPL and do not have Medicaid (below \$15,600 a year for singles and \$21,000 a year for couples)*	Below \$11,990 for individuals and \$23,970 for couples ⁶	Partial Extra Help <ul style="list-style-type: none"> • Sliding scale monthly premium • \$56 deductible or the plan's deductible, whichever is less. • 15% coinsurance or the plan's coinsurance, whichever is less (after \$5,726.25 in total covered drug costs, you pay \$2.25/generic and \$5.60/brand-name copay or 5% of the cost of the drug, whichever is greater).

¹Institutionalized individuals with Medicaid, at all income levels, pay no copay, deductible or premium.

²Income limits are based on federal poverty levels, which change every year between February and March.

³Your premium is free with Full Extra Help as long as you choose a plan that offers basic coverage at or below the Extra Help premium amount for your area.

⁴Indexed to Consumer Price Index.

⁵ This includes "spend-down" for medically needy individuals, who spend a portion of their income to qualify for Medicaid.

⁶ If you answer "no" to the question on the application that asks if you intend to use any of your assets for funeral or burial expenses, then your asset limits will be reduced by \$1,500 for singles or \$3,000 for couples.

6. How do I get the Medicare drug benefit?

There are two kinds of Medicare drug plans you can choose depending on how you get your Medicare health benefits. If you have:

- a. **Original Medicare**, you should choose a plan that only offers drug coverage or a "stand-alone" plan (PDP).
- b. **Medicare private health plan (like an HMO, PPO)**, and you want to stay with it, you generally need to get drug coverage from the same company as part of your health benefits package (MA-PD). If you choose to join an HMO or PPO to get your drug coverage, you will have to use the doctors and hospitals in that plan's network. (If you join a private plan that is an MSA or PFFS without drug coverage, you can have a PDP.)

You will have to compare Medicare private drug plans in your area and sign up for the one that best meets your needs—covers the drugs you take, works at the pharmacies you use and makes sense financially. You can compare and sign up for plans by calling 800-MEDICARE, visiting www.medicare.gov, or calling plans directly. Once you choose a plan, you should call 800-MEDICARE to enroll.

If you enroll in a Medicare private drug plan during the Annual Coordinated Election Period (November 15 to December 31, annually) your coverage will begin January 1 of the following year. If you enroll at any other time (such as during a Special Enrollment period) your coverage will begin the first day of the month after the month during which you enroll.

Note: It is usually best to enroll as early in an enrollment period as possible to make sure your coverage starts when it should.

7. Do I have any protections?

Yes. If you are new to your Medicare private drug plan, you are entitled to a **one-time fill of drugs that you had already been taking before you joined the plan**. This is called a **transition policy**. Every plan must have a transition policy and must cover at least a 30-day supply of drugs that are either

- not normally covered under your drug plan's formulary; or
- have restrictions such as prior authorization or step therapy placed on them.

You can use your plan's transition policy at any time within your first 90 days in your new plan. Your pharmacist may need to request an override code from your Medicare drug plan to be able to bill the plan for the drug.

While you are using your plan's transition policy, it is important to take action. You should talk to your doctor about either switching your medications to one covered by your plan (or to one that has no restrictions placed on it) **or** asking your plan for an **exception** to its formulary.

You have the right to ask for an exception to the plan's formulary (list of covered drugs) when

- Your doctor prescribes a drug **not** on your plan's formulary (list of covered drugs) because your doctor believes the drugs on the formulary will not work for you.

- Your plan replaces a brand-name drug you are taking with a generic version, and only the brand name will work for you.
 - Your plan **has restrictions on the drug you need**, for example, it limits the amount of medication you can get (quantity limits); requires that you get special permission before it will cover a prescription (prior authorization); or requires that you try lower cost medications on its formulary before it will cover your more expensive prescription (step therapy).
 - Your plan drops a drug from its formulary during the year for any reason other than safety.
- **You have the right to request that your plan lower your copay for a medically necessary drug when:**
 - you are prescribed a “non-preferred,” more expensive drug because your doctor thinks it is the only medication on the formulary that will work for you (there is no good generic or “preferred” alternative).

You **cannot** request that your plan lower the cost if the drug you need is in a “specialty tier” (plans sometimes label drugs that cost \$500 or more as “specialty drugs”) or if it is in “tier 2” (which means that lowering the cost of the drug would put it at the same cost as a generic).

Note: You cannot ask for an exception for drugs specifically excluded from Medicare coverage, including certain anti-anxiety drugs, weight loss and gain drugs, and over-the-counter drugs.

Your doctor must submit a letter certifying that the drug prescribed is medically necessary because other drugs are not as effective or may be harmful for you. Generally, plans must grant these requests—called exceptions—when they determine that it is medically appropriate to do so (except for Medicare excluded drugs—see question 2). Each plan will create its own process for how members can ask for an exception.

Plans must respond to your request within 72 hours. You can also ask for 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 your exception request, you can appeal the plan’s decision through the government.

Note: If your drug plan removes a drug you are taking from its formulary, places it on a higher cost-sharing tier or adds restrictions on coverage (such as quantity limits), **it should continue to cover the drug for you** (at the same cost-sharing level) for the remainder of the calendar year. However, the plan can stop covering the drug for you if a new generic substitute becomes available, the plan removed the drug for safety reasons, or new clinical guidelines justify it.

For More Information

- **Medicare Rights Center**
800-333-4114 (General consumer Medicare hotline)
877-794-3570 (Professional Part D technical assistance hotline)
888-466-9050 (Part D appeals hotline)
www.medicareriights.org/drughelp.html
- **State Health Insurance Assistance Program (SHIP)**
800-MEDICARE will give you the number for your state

- **Medicare**
800-MEDICARE
www.medicare.gov
- **Social Security Administration**
800-772-1213
www.ssa.gov