MEDICARE PART D PRESCRIPTION DRUG PROGRAM BASICS

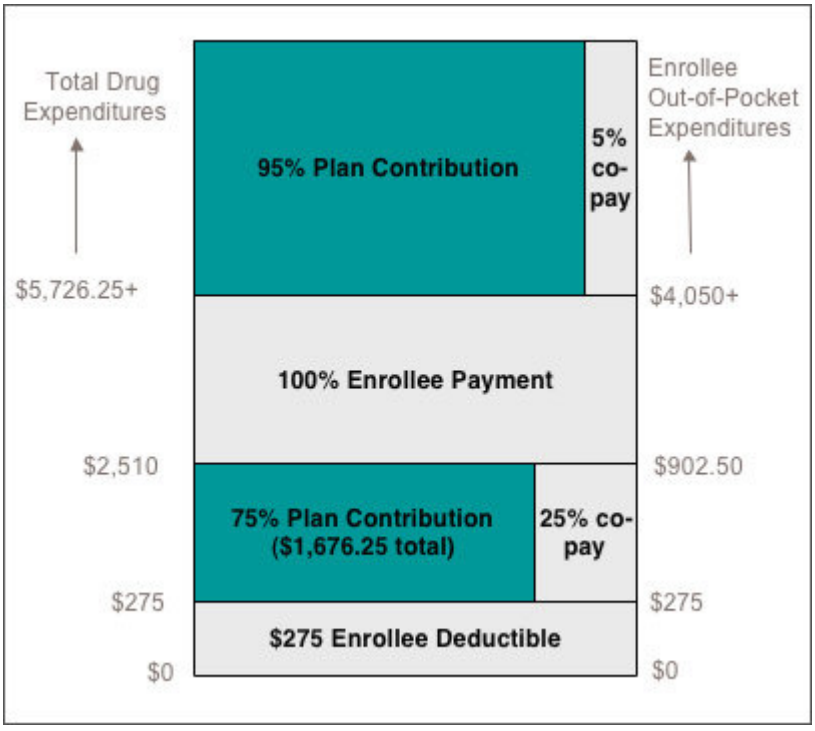
- Program began January 1, 2006.
- Coverage of Medicare Part D benefits is provided by private companies.
- Medicare pays a share of the program costs.
- Individuals entitled to Part A and/or enrolled under Part B are eligible to enroll in Part D plans.
- Part D plan coverage is provided through network pharmacies in the Part D plan's service area, except that PFFS plans generally do not use a pharmacy network.

TYPES OF PART D PRESCRIPTION DRUG PLANS

1. Stand-alone Prescription Drug Plan (PDP):
    - Beneficiaries can enroll in a stand-alone PDP if they have:
        - Original Medicare
        - MA Private Fee-for-Service (PFFS) Plan that does not include Part D coverage
        - Medicare Cost Plan
        - Medicare Medical Savings Account (MSA) Plan
2. Medicare Advantage-Prescription Drug (MA-PD) Plan:
    - A prescription drug plan combined with a Medicare Advantage Plan
3. Cost-PD Plan:
    - A prescription drug plan combined with a Medicare Cost Plan

PART D PLAN BENEFITS: STANDARD, 2008

- Part D plans must cover at least the Part D standard benefit or its actuarial equivalent.
- For 2008, the standard benefit requires the beneficiary to pay:
    - $275 deductible
    - 25% of costs between $275 and $2,510 = $558.75
    - 100% of the next $3,216.25 in drug costs (the "coverage gap"), then
    - After the beneficiary has paid $4,050 out-of-pocket, catastrophic coverage begins.
        - On any future prescriptions the beneficiary pays either a co-pay of $2.25 for generic drugs or $5.60 brand name drugs or a co-insurance of 5%, whichever is greater.



PRESCRIPTION DRUG PROGRAM BASICS

PART D PLAN BENEFITS: ALTERNATIVE

- Part D plan benefits may differ from the standard benefit under specific Medicare rules.
- In all cases the value of Part D benefits must be at least as good as the standard coverage.
- Some Part D plans may also include enhanced coverage for an additional monthly premium.

PART D DRUG MANAGEMENT TOOLS

- Part D plans commonly use a variety of prescription drug benefit management tools, including:
    - A formulary: A list of drugs covered by the plan
    - Co-pay tiers: A set amount for each prescription. Many plans group drugs into 3 or 4 tiers with lower tiers costing less than higher tiers, for example:
        - Tier 1: Generic drugs
        - Tier 2: Preferred brand-name drugs
        - Tier 3: Non-preferred brand-name drugs
        - Tier 4: High-cost drugs
    - Step therapy: One or more similar lower cost drugs must be tried before other more costly drugs are tried, if necessary.
    - Prior authorization: Requires the doctor to contact the plan before the plan will cover these prescriptions. The doctor must show the drug is medically necessary for it to be covered.

PRESCRIPTION DRUG COVERAGE

COVERED PART D DRUGS

- By law, Part D plans are permitted to cover any prescription drugs and biologicals that:
    - Must be covered by states that provide Medicaid prescription drug benefits and
    - Many Part D plans do not cover all of these drugs because in some cases several similar drugs are available to treat the same medical condition.
    - Plans include the drugs they will cover on formularies that are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
    - At least two drugs in each therapeutic category
    - Generic and brand-name drugs.

DRUGS EXCLUDED FROM PART D COVERAGE

- By law, Part D plans are not permitted to include the following under their Part D covered benefits:
    - Drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
    - Vitamins
    - Barbiturates
    - Benzodiazepines
    - Erectile dysfunction drugs (when used for sexual dysfunction)
    - Non-prescription drugs
    - Part B covered drugs
- Part D plans are permitted to offer supplemental benefits that cover drugs not covered under Part D.

MID-YEAR FORMULARY CHANGES

- Formulary changes must be approved by CMS
- Plans cannot make any formulary changes during the first 60 days of the contract year.
- After March 1st, plans may make some midyear formulary changes including:
    - Removal of a drug that is being withdrawn from the market by the FDA or manufacturer;

- Replacing brand name with new generic drugs, but only following 60 days notice to affected enrollees; and
- Other changes only if the enrollees currently taking the affected drug are exempted for the remainder of the year.

TRANSITION REQUIREMENTS

- Enrollees initially enrolling in Part D and those switching plans must receive coverage of a single 30-day fill of their non-formulary drugs during the first 90 days that they are covered under the plan.
- Enrollees who reside in a long-term care facility must receive coverage for multiple 31-day fills of their non-formulary drugs, as necessary, during the first 90 days that they are covered under the plan.
- During the transition period:
  - The plan does not apply prior authorization or step therapy rules.
  - The beneficiary and his/her physician can request an exception to the plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

REQUESTING EXCEPTIONS FOR DRUGS

- Beneficiaries have the right to request a formulary exception for coverage either of non-formulary drugs or of formulary drugs at a less costly formulary tier.
- If a doctor thinks a beneficiary needs a drug that is not on the list, the beneficiary or the doctor can apply for a formulary exception.
- To facilitate their request, a standard form is available on Part D plan websites for beneficiaries to request a coverage determination, including a formulary exception.

OUT-OF-POCKET CALCULATION

- Some drugs do not count toward the out-of-pocket cost total including:
  - Drugs not on a plan' s formulary, unless the beneficiary receives an exception under which the plan covers the drug;
  - Drugs purchased outside the United States; and
  - Over the counter drugs and other non-Part D covered drugs.

ASSISTANCE PROGRAMS

HELP FOR INDIVIDUALS WITH LIMITED INCOME/ RESOURCES

- If a beneficiary has limited income and resources, he/she may get extra help from Medicare to cover the Part D plan premium and cost-sharing.
- Income below 150% of the Federal Poverty Level (FPL) - $15,315 (individual)/$20,535 (couple) in 2007.
- Assets up to $11,710 (individual)/ $23,410 (couple) in 2007.

ENCOURAGE INDIVIDUALS WITH LIMITED INCOME/ RESOURCES TO APPLY TO THE STATE MEDICAID OFFICE

- Beneficiaries with limited income and resources should be encouraged to apply for extra help through the State Medicaid office or the Social Security Administration (SSA).
- Tell beneficiaries to call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for the State Medicaid office phone number. If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office will also check for eligibility for other low-income assistance programs too.
- Or call SSA at 1-800-772-1213 or apply online at: www.ssa.gov/prescriptionhelp to apply for help with Part D costs.
- After SSA or the State approves an application for extra help, it is effective the first day of the month in which the individual applied.

OTHER HELP FOR LOW-INCOME - PHARMACEUTICAL ASSISTANCE PROGRAMS

- Some pharmaceutical manufacturers operate programs directly or indirectly that assist low income individuals in obtaining drugs at reduced or no costs.
- During 2006, CMS provided guidance to clarify that these programs can continue if certain conditions are met.
- Some states have assistance programs designed specifically for their residents.
- Becoming familiar with your state's programs may help a beneficiary address cost-sharing for prescriptions, particularly in the coverage gap.

PREMIUMS, PAYMENTS & PENALITIES

PART D PREMIUM PAYMENT

- Part D enrollees have three options for paying their Part D premium.
    1. Automatic electronic monthly withdrawal from their checking or savings bank account;
    2. Direct monthly billing from the plan; or
    3. Automatic deduction from their monthly Social Security Administration (SSA) benefit check.
        - Typically it takes 2-3 months for SSA withholding to begin or end.
        - When withholding begins, it will be for the 2-3 months of premiums owed.
        - Some premiums have been incorrectly withheld from SSA checks.
        - If a beneficiary is considering this option, they should call the plan first.
- Generally the beneficiary must stay with the premium payment option for the entire year.

PART D LATE ENROLLMENT PENALTY

- If a beneficiary does not enroll when first eligible, he/she may pay a penalty to join a Part D plan later.
- If there has been a period of at least 63 continuous days following his/her initial enrollment period for Part D during which the beneficiary did not have either Part D or any other prescription drug coverage that was creditable (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay), when the beneficiary joins a Part D plan, the premium will go up by 1% of the national average beneficiary premium for each month he/she did not have such coverage.
- In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage.
- CMS used its demonstration authority to waive the late enrollment penalty:
    - In 2006 and 2007 for beneficiaries who are eligible for the low income subsidy.
    - In 2006 for beneficiaries who reside in specific areas affected by Hurricane Katrina.

EMPLOYER GROUP PLANS & PART D DRUG COVERAGE

EMPLOYER COVERAGE OF DRUGS

- Employer or Union Coverage: Employers will tell their employees whether their prescription drug coverage is "creditable" (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay).
- If coverage is creditable and the beneficiary keeps it, they will not incur a premium penalty if they later lose or drop the employer coverage and join a Part D plan.
- If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during his/her initial eligibility period to avoid the late enrollment penalty.
- If a beneficiary has creditable drug coverage through TriCare, VA, or the FEHBP, he/she can compare that coverage with available Part D plans to decide whether enroll in Part D.
- Check with benefits administrator before making any change.
- If a beneficiary drops employer/union prescription drug coverage, they may not be able to get it back and also may lose health coverage.

- If the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare plan within 63 days, there will not be a late enrollment penalty.

MEDICARE SUPPLEMENT PLANS (MEDIGAP)

BENEFICIARIES IN ORIGINAL MEDICARE WITH MEDIGAP DRUG COVERAGE

- Medigap plans H, I, and J with drug coverage could no longer be sold as of January 1, 2006.
- Some beneficiaries may have decided to keep their Medigap policy with the drug coverage they had before January 1, 2006. Insurers are required to notify beneficiaries annually whether or not the prescription drug coverage they have is creditable (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay).
- For beneficiaries who decided to keep their Medigap policy with the drug coverage they had before January 1, 2006.
- If these beneficiaries choose a Part D plan now, they must pay a Part D late enrollment penalty unless their Medigap coverage was creditable.
- These beneficiaries may also keep their Medigap coverage with the drug portion of the coverage removed and enroll in a Part D PDP plan. They may also change to another Medigap plan offered by their insurance company regardless of their health status.

Note: See Session 1, Medicare Program Basics, for more information on Original Medicare and Medigap (Medicare supplement insurance).

MEDICAID

MEDICAID DRUG COVERAGE

- Most prescription drugs that were previously covered by Medicaid are now covered under Medicare Part D.
- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs if the beneficiary enrolls in a Part D plan.
- Medicaid beneficiaries can compare plans and choose a Medicare Part D plan.
- If they don't choose a plan, Medicare will select one for them.
- Medicaid beneficiaries can change Part D plans throughout the year.

SUMMARY

- Coverage of Medicare Part D benefits is provided by private companies.
- Individuals entitled to Part A and/or enrolled under Part B are eligible to enroll in Part D plans.
- There are 3 types of Part D prescription drug plans: stand-alone PDP, MAPD, and Cost PD plans.
- Part D plans must cover at least the Part D standard benefit or its actuarial equivalent. Part D plan benefits may differ from the standard benefit under specific Medicare rules. In all cases the value of Part D benefits must be at least as good as the standard coverage. Some Part D plans may also include enhanced coverage for an additional monthly premium.
- Part D plans commonly use a variety of prescription drug benefit management tools
- Formulary changes must be approved by CMS; Plans cannot make any formulary changes during the first 60 days of the contract year.
- Beneficiaries have the right to request a formulary exception for coverage either of non-formulary drugs or of formulary drugs at a less costly formulary tier.
- Part D enrollees have three options for paying their Part D premium
- If a beneficiary has limited income and resources, he/she may get extra help from Medicare to cover the Part D plan premium and cost-sharing. Beneficiaries with limited income and resources should be encouraged to apply for extra help through the State Medicaid office or the Social Security Administration (SSA).
- If a beneficiary does not enroll when first eligible, he/she may pay a penalty to join a Part D plan later. In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage.

- Employer or Union Coverage: Employers will tell their employees whether their prescription drug coverage is "creditable" (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay). If coverage is creditable and the beneficiary keeps it, they will not incur a premium penalty if they later lose or drop the employer coverage and join a Part D plan.
- Medigap plans H, I, and J with drug coverage could no longer be sold as of January 1, 2006.
- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs if the beneficiary enrolls in a Part D plan.
- Medicaid beneficiaries can compare plans and choose a Medicare Part D plan. If they donn't choose a plan, Medicare will select one for them. Medicaid beneficiaries can change Part D plans throughout the year.

FOR ADDITIONAL INFORMATION

www.medicare.gov/pdphome.asp

www.medicare.gov/pdp-basic-information.asp

www.cms.hhs.gov/PrescriptionDrugCovGenIn/

Medicare & You Handbook: www.medicare.gov/publications/pubs/pdf/10050.pdf

AHIP Medicare Prescription Drug Plan Guide: www.healthdecisions.org/guide/
Note: The AHIP guide is being updated for 2008.