

MEDICARE PART D THE BASICS

- Participation is voluntary.
- The income level and assets of beneficiaries determine the level of prescription assistance they will receive.
- Beneficiaries with incomes over 150% of the Federal Poverty Level are not eligible for low income subsidies, but Medicare will pay for a portion of these beneficiaries' drug costs.
- Beneficiaries with incomes under 150% of the Federal Poverty Level and with limited assets may be eligible for the low income subsidy (or "extra help" as Medicare calls it).
- Individuals should apply for the low income subsidy now. This does not enroll them in a plan; it will only let them know what level subsidy, if any, for which they are eligible. Beneficiaries looking to apply for low income subsidy may do so on line at www.ssa.gov or may request a paper application by calling 1-800-772-1213. Beneficiaries may also apply at state Medicaid offices.
- Dual eligibles—beneficiaries who are eligible both for Medicare and Medicaid—are automatically eligible for the low income subsidy and do not need to fill out an application.
- Beneficiaries must enroll in a specific drug plan to be covered by Medicare Part D, unless they are dually eligible for Medicare and Medicaid (dual eligibles). Dual eligibles will be automatically enrolled in a plan.
- Medicare Part D will not cover barbiturates, benzodiazepines, weight loss and weight gain medications.
- Drug plans will not need to make available every covered medication, but they do need to make available at least two medications in every therapeutic class. Six drug classes of special concern have been specified in which all drugs will be on formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressants, anti-psychotics, anti-depressants and anti-convulsants. Plans may also offer more comprehensive coverage through enhanced or supplemental coverage.
- Drug plans will contract with certain pharmacies, which will be their pharmacy network. These drug plans may but are not required to contract with Federally qualified health centers, rural health centers or other federally funded safety net providers.
- Beneficiaries may change plans once a year except for dual eligibles who may change plans whenever they want.

MEDICARE PART D THE FEES

For individuals at 150% of Federal Poverty Level and above: (Basic benefit)

Income	Asset test	Premium	Deductible	Co-pay	Coverage gap	Catastrophic coverage
150% FPL and above	NONE	\$32.50 per month on average Premiums vary depending on geographic region and specific plan	\$250 Some plans waive the deductible	After deductible, 25% up to \$2,250 in drug costs	No coverage for drug costs between \$2,250 and \$5,100	After \$5,100* in total drug costs paid by beneficiary and Medicare, co-pays of \$2/ generic and \$5/brand <i>* beneficiary pays \$3,600 to reach catastrophic coverage</i>

**For individuals not eligible for Medicaid, but under 150% of Federal Poverty Level:
(Low income subsidy)**

Income	Asset test	Premium	Deductible	Co-pays	Coverage gap
Under 135% FPL	\$6,000 for individual \$9,000 for couple	NONE	NONE	\$2/generics \$5/brands	NONE After \$3,000 of out of pocket expenses no further co-pays
Between 135% and 149% FPL	\$10,000 for individual \$20,000 for couple	Income based sliding fee scale	\$50	After deductible, 15% of drug cost	NONE After \$3,000 of out of pocket expenses, co-pays of \$2/generics and \$5/brands

For individuals eligible for Medicaid: (Low income subsidy)

Income	Asset test	Premium	Deductible	Co-pays	Coverage gap
Under 100% FPL	State rules apply	NONE	NONE	\$1/generic \$3/brands	NONE After \$3,600 of out of pocket expenses no further co-pays
Over 100% of FPL	State rules apply	NONE	NONE	\$2/generic \$5/brands	NONE After \$3,600 of out of pocket expenses, no further co-pays

MEDICARE PART D DEDUCTIBLES, CO-PAYS AND THE COVERAGE GAP (OR DOUGHNUT HOLE)

- Beneficiaries who do not receive the low income subsidy must pay the first \$250 of their drug costs out of pocket.
- After the \$250 deductible, Medicare will pay 75% of the cost of each prescription and the beneficiary will pay 25% up to \$2,250 in total costs.
- The costs paid out of pocket by beneficiaries are called True out of pocket expenses (TrOOP). These costs may be paid by the beneficiary or another person or entity, as long as that entity is not an insurance plan. Premium costs do not count toward TrOOP.
- Once a beneficiary reaches \$2,250 in drug costs (i.e., the combination of what Medicare and the beneficiary have paid) he or she is at the coverage gap or doughnut hole. Beneficiaries will reach the doughnut hole once they have spent \$750 out-of-pocket—the \$250 deductible and 25% (\$500) of the next \$2000 in costs.
- Once a beneficiary reaches the doughnut hole, Medicare will stop covering his or her drug costs until the beneficiary spends another \$2,850 on medication. These costs may be paid by the beneficiary or another person or entity, as long as that entity is not an insurance plan. For example, charities, a relative, a church or a service organization can pay these drug costs and they will count toward the beneficiaries' TrOOP.
- Some state pharmacy assistance programs which have previously assisted Medicare beneficiaries with their drug costs may continue to do so in one of the following ways:
 - Paying the Part D premium
 - Pay the deductible and/or co-pays
 - Pay prescription drug costs in the doughnut hole
 - Pay for drugs not covered by a plan
 - Cover drugs not covered by Part D

Each state program will determine whether or to what extent it will do any of these.

- Once the beneficiary has paid the \$2,850 in drugs costs he or she is eligible for catastrophic coverage. Catastrophic coverage starts when a beneficiary has incurred \$5,100 of drug costs (costs paid by both the beneficiary and Medicare). At this point, depending on whether he or she receiving the low income subsidy, drug costs could be nothing, \$2 for generics and \$5 for brand names or 5% of the cost of the prescription.

MEDICARE PART D IMPORTANT DATES

Prior to January 1, 2006 Medicare automatically enrolled dual eligible beneficiaries in drug plans and Social Security implemented processing of low income subsidy applications.

- **January 1, 2006:** Medicare Part D coverage begins. Medicaid no longer pays for prescription coverage.
- **Early April, 2006:** CMS will identify beneficiaries eligible for low income subsidies who have not enrolled in a plan.
- **Late April, 2006:** CMS notifies beneficiaries, plans and state Medicaid agencies of plans to which beneficiaries will be assigned if they do not enroll in a plan on their own. This is CMS's "facilitated enrollment."
- **May 15, 2006:** Last day to enroll in Medicare Part D without incurring monthly penalty (1% of monthly premium cost). Last date for beneficiary eligible for low income subsidy to self enroll in a plan.
- **May 16, 2006:** Beneficiaries enrolling after this date must wait until November to enroll. Unless the beneficiary has had "creditable" drug coverage s/he will have to pay a penalty for every month they delay enrolling. This penalty will be added on to monthly premiums for as long as the beneficiary is enrolled in Part D.
- **June 1, 2006:** Facilitated enrollment takes effect for beneficiaries eligible for low income subsidy. These beneficiaries have one additional opportunity to change plans.
- **November 15- December 31, 2006:** Annual open enrollment period for Medicare drug plans for the following calendar year.

2005 HHS Poverty Guidelines (continental U.S. only)*

Persons in Family Unit	100% FPL	135% FPL	150% FPL
1	\$ 9,570	\$12,919.5	\$14,355
2	12,830	17,320.5	19,245
3	16,090	21,721.5	24,135
4	19,350	26,122.5	29,025
5	22,610	30,523.5	33,915
6	25,870	34,924.5	38,805
7	29,130	39,325.5	43,695
8	32,390	43,726.5	48,585
For each additional person add	3,260	4,401	4,890

* income levels higher in Alaska and Hawaii