



Frequently Asked Questions

The Medicare Modernization Act (MMA) provides for a new outpatient drug benefit under Medicare Part D. Because this is a new Medicare benefit, there are numerous questions related to how it will work, which drugs will be covered and how enrollees will pay for coverage. The answers to these questions will come from the federal agency that oversees Medicare, the Centers for Medicare and Medicaid Services (CMS). CMS determines the regulations governing the benefit, and approves the private companies offering the drug benefit.

When will I be able to get drug coverage from Medicare?

The new drug program will begin on 1/1/06 with an open enrollment period from 11/15/2005 through 05/15/2006. Coverage will be effective:

- On 1/1/06 if you enroll in a plan by 12/31/05; or
- The first day of the month following the month you join if you enroll in a plan after 12/31/05.

Will the new Medicare drug benefit help me?

The drug benefit may save you money, depending on your expected drug expenses. Whether you will save money will primarily depend upon three factors:

- Whether prescription drug plans (PDP) in your area offer coverage at a reasonable premium;
- Whether the drug benefit from a private plan (or from the government if a private plan is not available in your area), will cover the drugs you need; and
- Whether you can get your drugs at a lower cost through a discount drug plan.

What premium will I pay for drug coverage?

You will have to pay a monthly premium for Part D coverage. The premium will be about \$32 a month (\$384 a year) in 2006. Different companies will charge different premiums and cover different drugs. Premiums will most likely increase each year.

Will I have full drug coverage?

No. Your drug coverage will be limited. You will have to pay a monthly premium, and you may have an annual deductible and varying amounts of co-payments, depending on your total drug costs and the plan you choose. **After you have spent \$3,600 out-of-pocket for covered drugs in 2006**, your costs will decrease significantly. But if you buy a drug that is not on your plan's formulary—

a list of covered drugs for a given plan—that cost will not count toward the out-of-pocket limit.

Here is the breakdown of the standard drug benefit as described in the law. In 2006, in addition to the monthly premium, you will pay:

- The first \$250 of your drug costs each year (deductible);
- 25% of the cost of covered drugs between \$250 and \$2,250;
- 100% of the cost of covered drugs between \$2,250 and \$5,100; and
- 5% of the cost of covered drugs above \$5,100 or a co-payment of \$2 for covered generic drugs and \$5 for covered brand-name drugs—whichever is greater.

After 2006, your deductible, benefit limits, and catastrophic thresholds are indexed to rise annually with the growth in per capita Part D spending.

Your Annual Drug Costs	You Pay	Medicare Pays
Up to \$250 (annual deductible)	Monthly premium + 100% of drug costs	Nothing Nothing
\$250 up to \$2,250	Monthly premium + \$250 deductible + 25% coinsurance for drug costs	Nothing Nothing 75%
\$2,251 up to \$5,100	Monthly premium + \$750 (\$250 deductible + \$500 coinsurance for drug costs \$250 - \$2,250) + 100% (for drug costs \$2,250 - \$5,100)	Nothing \$1,500 Nothing
Over \$5,100	Monthly premium + \$3,600 (\$250 deductible + \$500 for drug costs \$250 - \$2,250 + \$2,850 for drug costs \$2,251 - \$5,100) + \$2 for generics and \$5 for brand-name drugs, Or 5% coinsurance for any drug (whichever is greater)	Nothing \$1,500 95%

In the above chart, numbers are rounded to nearest dollar.

You may only see a plan exactly like the one outlined above if no private company is offering a drug plan in your area and you get coverage directly through the government. Private companies can create their own set of criteria for coverage as long as the overall package is at least as good as the one outlined above. However, you must spend \$3,600 out-of-pocket (not including premiums) for covered drugs before your out-of-pocket costs are reduced substantially (catastrophic coverage). During catastrophic coverage, Medicare will pay about 95% of the drug costs. You will be responsible for either \$2 for generic drugs and \$5 for brand-name drugs or 5% of the drug costs, whichever is greater.

Can I buy insurance to fill some of the gaps in Medicare drug coverage?

You may be able to. Private companies that offer a Medicare drug plan (the Part D benefit) can, if they choose, sell enhanced plans to pay some of your out-of-pocket costs. You can only buy an enhanced plan from the same company from which you are getting your Medicare drug benefit.

If you enroll in the Medicare drug benefit (Part D), you cannot also have a Medicare supplemental insurance policy with drug coverage. If you purchased one of the Medicare supplement plans with a drug benefit before January 1, 2006, you can only keep it if you choose not to enroll in the Medicare drug benefit. If later you want to drop the drug coverage from your plan and buy the Medicare drug benefit, you may have to pay a premium penalty.

Do I have to enroll in the Medicare prescription drug benefit?

No. Just like Medicare Part B, which pays for doctors and other medical services, the Medicare drug benefit is voluntary. However, if you do not enroll during the six-month open enrollment period when the benefit first becomes available, you may have to pay a premium penalty if you choose to enroll at a later date. The **premium penalty** is estimated to be 1% of the national average premium for every month you delay enrollment.

If you already have prescription drug coverage at least as good as Medicare's drug benefit, 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.

How do I get the Medicare prescription drug benefit?

You can sign up for Part D during the initial enrollment period (a six-month period starting November 15, 2005). There are three possible ways to get Part D drug coverage:

- You keep original Medicare and sign up for a stand-alone Medicare drug plan offered by a private company.

- You keep original Medicare and, if no stand-alone plan is available, you get drug coverage directly from the government.
- You enroll in or remain in a Medicare Advantage plan, like an HMO or PPO, which will offer the drug benefit as well as all your other Medicare-covered services. (If you're already in one of these plans, the company may charge you an additional monthly premium.)

No matter which plan you choose, **you can only change plans once a year.**

What if I already have drug coverage through Medicaid?

If you have Medicaid, you will lose your Medicaid drug coverage and instead get drug coverage through Medicare. Medicaid will still help pay your other Medicare out-of-pocket costs, including the deductible and coinsurance, and you will not have to pay the drug plan premium. You will have to pay a co-payment for each prescription. The Medicare drug benefit may not be as good as the Medicaid coverage you had.

What if I already have drug coverage through a state prescription drug plan?

States can choose to offer coverage to supplement the Medicare drug coverage for individuals eligible for the state's drug plan.

What if I already have drug coverage through a former employer?

If your former employer chooses to continue to offer prescription drug coverage you can choose:

- To keep it and not buy Medicare drug coverage. (You will not have to pay a premium penalty if you later lose your retiree coverage and want to enroll in a Medicare drug plan if your coverage is at least as good as Medicare's drug coverage. Your former employer is obligated to inform you whether or not their plan meets this requirement.)
- To keep it and buy Medicare drug coverage. (You will still have to spend \$3,600 dollars out-of-pocket for Medicare-covered drugs before the more substantial Medicare coverage begins.)
- To drop it and buy Medicare drug coverage if it costs more and/or covers less.

Will the Medicare prescription drug benefit cover all drugs?

No. Each company that offers Medicare drug coverage will have its own formulary (list of covered drugs). They will likely provide incentives for you to use generic drugs. If a drug is not on the formulary, you will have to pay the full cost. In addition, the cost of drugs not on your plan's formulary will not count towards your out-of-pocket costs. Formulary information will be available through the plan's website, customer service center, and through company marketing materials.

Will I be paying lower prices for drugs I buy through the Medicare drug plan?

You need to look at each plan offered to determine this. Each private company offering the drug benefit will individually negotiate prices for their members. If there are no private drug plans available in your area and you have Medicare drug coverage through the government, the price of the drugs you buy will probably be higher because the new Medicare law specifically forbids the government from negotiating with pharmaceutical companies for lower-priced drugs.

Will I get extra help with drug coverage if my income is low?

Yes. If your annual income is below 150% of the Federal Poverty Level (FPL) and your assets are below specified limits (see chart below for details), you can apply for one of the programs below, which will offer less costly Medicare prescription drug coverage.

Overview of Low-Income Part D Benefits, 2006			
Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL (\$9,570/individual in 2005)	\$0	\$0	\$1/generic \$3/brand-name; no copays after total drug costs reach \$5,100
Full-benefit dual eligible; Income greater than 100% FPL	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug costs reach \$5,100
Income less than 135% FPL (\$12,920/individual in 2005) and assets <\$6,000/individual; \$9,000/couple	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug costs reach \$5,100
Income 135%–150% FPL (\$12,920–\$14,355/individual in 2005 and assets <\$10,000/indiv; \$20,000/couple)	sliding scale up to \$35	\$50	5% of total costs up to \$5,100 catastrophic limit; \$2/generic \$5/brand-name thereafter
All others (non-subsidy eligible)	\$35	\$250	25% up to initial coverage limit; 100% up to \$3,600 out-of-pocket spending

SOURCE: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.