

PROTECTION & ADVOCACY, INC.

MEMORANDUM

TO: Information and Referral Advocates
Attorney/Advocate of the day

FROM: Daniel Brzovic

RE: Medicare prescription drug benefit (Medicare Part D)
Essential information

DATE: November 11, 2006

This memo gives an overview of the most basic provisions of the Medicare Part D program. Many of the items described in this memo are described in more detail in other memos or other materials. The purpose of this memo is to give an overview of the Part D program while focusing on how it applies to people with disabilities, and particularly people who have both Medicare and Medi-Cal.

Following a brief introduction to the program, this memo describes what people have to consider in choosing a Medicare Part D prescription drug plan.

NOTE: In no event should anyone at PAI advise an individual to choose a particular drug plan, or choose a drug plan for them. PAI staff should advise individuals of their options so that individuals can choose the plan that is best for them.

Changes for 2007

There have been some changes in the Medicare Part D program for 2007. The following are some of the changes.

Open Enrollment

Beneficiaries who do not receive Medi-Cal can change plans between November 15 and December 1. The change will be effective on January 1.

Medi-Cal beneficiaries with zero share of cost can change at any time effective the following month. Medi-Cal beneficiaries with a share of cost who meet their share of cost at least four times per year can also change at any time effective the following month.

Copayment Amounts

Most copayments have been increased based on increases in the cost of medical care or the consumer price index.

Copayment	2007	2006
Full benefit dual eligibles (Zero share of cost Medi-Cal)		
Generic/Preferred multi-source drug	\$1.00	\$1.00
Brand name drug	\$3.10	\$3.00
All other beneficiaries who have a copayment		
Generic/Preferred multi-source drug	\$2.15	\$2.00
Brand name drug	\$5.35	\$5.00

Deductible/Coinsurance Amounts

Deductible and coinsurance amounts have also been increased for the standard benefit and the low-income subsidy based in increases in the cost of medical care.

	2007	2006
Deductible (Standard Benefit)	\$265	\$250
Initial Coverage Limit (Standard Benefit)	\$2,400	\$2,250
Out-of-Pocket (OOP) Threshold (Standard Benefit) (This is the “donut hole.”)	\$3,850	\$3,600
Total Covered Part D Spending at OOP Threshold (Standard Benefit) (Catastrophic benefit begins after total drug spending reaches this amount)	\$5,451.25	\$5,100
Deductible (Low-Income Subsidy, Group 4)	\$53	\$50

California Benchmark Plans

These are the plans that Low Income Subsidy (LIS) beneficiaries (including Medi-Cal beneficiaries) are eligible for without payment of a premium.

New benchmark plans will be offered by CIGNA Health Care (CIGNATURE Rx Value Plan) and RxAmerica (Advantage Star Plan).

WellCare is will be offering a new plan called the “Classic” plan. WellCare will continue to offer the “Signature” plan.

Unicare Medicare Rx Rewards plan beneficiaries will be shifted to the Medicare Rx Rewards Value plan. Health Net Orange Option (02) and Option (08) plan beneficiaries will be shifted to the Health Net Orange Option 1 plan.

United Healthcare has taken over PacifiCare. PacifiCare Saver Plan beneficiaries will be shifted to United Healthcare’s AARP Medicare Rx Plan – Saver. United Health Rx and AARP Medicare Rx Plan beneficiaries will also be shifted to AARP Medicare Rx Plan – Saver. Beneficiaries with formulary exceptions for 2006 will have those exceptions grandfathered in for 2007.

What is Medicare Part D?

Medicare Part D is the new Medicare prescription drug plan. It provides additional outpatient prescription drug coverage for Medicare beneficiaries. The program began January 1, 2006.

In the past, Medicare generally provided drug coverage for people in the hospital, or in a skilled nursing facility following a hospital stay. This coverage is provided as part of the hospital or skilled nursing facility benefit under Medicare Part A. Medicare also provides coverage for medications that generally have to be administered in a doctor’s office. This coverage is provided as part of the Supplementary Medical Insurance benefit under Medicare Part B. Those parts of the Medicare program will not change, and Medicare Parts A and B will continue to provide the drug coverage that Medicare has always provided just as it did before.

People with Medicare HMOs (Medicare Advantage plans) under Medicare Part C, such as Kaiser Senior Advantage, Secure Horizons or Health Net, can receive their Part D drug coverage through their HMO. There may be an additional premium for the drug coverage for people in Medicare HMOs who do not receive Medi-Cal or the Low Income Subsidy.

For Medi-Cal beneficiaries who also receive Medicare (dual eligibles), most Medi-Cal drug coverage was transferred entirely from Medi-Cal to Medicare Part D beginning January 1, 2006. Most Medi-Cal drug coverage stops once a beneficiary also becomes eligible for Medicare. This is a change from how Medi-Cal and Medicare usually pay for health care for dual eligibles. Ordinarily, Medicare pays first, and Medi-Cal pays for any medical care that Medicare does not pay for. This change applies only to Part D covered prescription drugs for dual eligibles. In all other respects, Medicare and Medi-Cal reimbursement is not changed by Medicare Part D, including Medi-Cal drug coverage for Medi-Cal beneficiaries who do not receive Medicare.

The Low Income Subsidy (LIS) or “Extra Help” program pays premiums and most other drug costs for Medi-Cal beneficiaries and others who meet the program’s income and resource guidelines.

It will be easier to understand the Medicare Part D program if you have some basic information about the Medicare program in general. There are two useful publications that give a good basic overview of Medicare. The first publication is: “Understanding Changes in Prescription Drug Coverage for People with Disabilities,” published by the Health Policy Institute at Georgetown University. This publication focuses on Medicare for people with disabilities. It is available at: <http://hpi.georgetown.edu/rxchanges.html>. The second publication is: “Medicare & You,” the federal government’s Medicare handbook. The online regional versions of this publication also contain specific information about Part D plans available in each state. It can be found at: <http://www.medicare.gov/spotlights.asp#medicare2006>.

Who is covered by Medicare Part D?

The prescription drug plan is available to any Medicare beneficiary. This includes people who are enrolled in both Medicare and Medi-Cal (dual eligible beneficiaries).

NOTE: Drug coverage for beneficiaries with Medi-Cal only (no Medicare) will continue to be paid for by Medi-Cal. In addition, some drugs that are excluded entirely from Medicare Part D coverage will continue to be covered by Medi-Cal, even for Medi-Cal beneficiaries who also have Medicare. (This is explained in more detail later in this memo.)

How does Medicare Part D work?

The Medicare Part D prescription drug benefit is provided through private health insurance companies or private health maintenance organizations (HMOs). Most Medicare beneficiaries, including Medicare beneficiaries who also have Medi-Cal, will have to choose a Medicare Part D prescription drug plan in order to get the prescription drug coverage. However, if you have “creditable” health insurance coverage through an employee, retiree or government health plan you do not need to sign up for Part D to continue your drug coverage. “Creditable” coverage is drug coverage that is provided through Medicare Part D or is as good as coverage that is provided through Medicare Part D.

The prescription drug plans vary from company. Many companies offer more than one plan. There may be differences in premiums, cost-sharing requirements, drug formularies, drug utilization controls, and participating pharmacies. Plans can offer enhanced coverage upon payment of a higher premium. People will need to consider all of these things in order to choose the plan that is best for them.

Why is this program so complicated?

A majority of the members of Congress that enacted this program seem to believe that drug prices are best regulated through market forces rather than through direct government intervention. Therefore (so the theory goes) if the drug benefit is offered through competing private plans, the plans will hold drug prices down.

If you have concerns about the way the Medicare Part D program is set up (including the transfer of most Medi-Cal drug coverage to Medicare Part D) you

may want to contact your representatives in Congress and let them know your concerns.

Do I have to enroll in a Medicare Part D plan?

Medi-Cal beneficiaries. If you have Medi-Cal as well as Medicare, you will have to enroll in a Medicare Part D plan. Only a few categories of drugs are covered under Medi-Cal for dual eligible beneficiaries. (This is explained in more detail later in this memo.) If you have Medi-Cal and became eligible for Medicare, most of your Medi-Cal drug coverage will end when you become eligible for Medicare Part D. Your Medi-Cal drug coverage will end when you become eligible for Medicare Part D whether or not you are enrolled in a Medicare Part D drug plan. Therefore, if you do not enroll in a Medicare Part D drug plan you will have no coverage for most drugs.

If you have Medi-Cal and you also have Medicare and you do not choose a plan yourself, you will be auto enrolled in a Medicare Part D drug plan. If you were not auto enrolled, check with your pharmacist. If you do not like the plan that you were auto enrolled in, you can change to another plan.

Private and government health plan beneficiaries. If you have health coverage in addition to Medicare (such as coverage through employment, a retirement plan, a union-sponsored plan, or a state or federal government plan) you may not need to enroll in Medicare Part D. It depends on whether or not your health plan provides “creditable” (Medicare Part D or as good) drug coverage. Check with your health plan. If you have Part D or other creditable coverage through your health plan, ask for a notice of that in writing.

If you have federal health care coverage from the VA, TRICARE, or the Federal Employee Health Benefits Program (FEHBP), you do not need to enroll in Medicare Part D. If you have a Medigap policy, it is probably best for you to enroll in a Medicare Part D plan.

NOTE: If you have health coverage that already provides Medicare Part D drug coverage (including a retiree health plan that receives a federal subsidy to provide drug coverage) you should be careful about enrolling in a Medicare Part D plan. This is because you could potentially be disenrolled from your entire health plan if you sign up for a Medicare Part D prescription drug plan. Check with your health plan.

Medicare HMO (Medicare Advantage) beneficiaries. If you are part of a Medicare HMO (e.g. Secure Horizons, Kaiser Senior Advantage, Health Net) you can be automatically enrolled in your HMO's Medicare Part D plan. Check with your plan. You have a right to disenroll from the Medicare Part D coverage.

Medicare-only beneficiaries. If you do not have Medi-Cal, and you do not have other health coverage, but you do have Medicare, enrollment in a Medicare Part D prescription drug plan is completely voluntary. However, there is a penalty for late enrollment. (See the following section.)

When do I have to enroll?

Medi-Cal beneficiaries. If you have Medi-Cal as well as Medicare, you will have to enroll in a Medicare Part D plan as soon as you become eligible for Medicare Part D. This is because most Medi-Cal drug coverage for Medicare beneficiaries stops when the beneficiary becomes eligible for Medicare Part D.

Health plan beneficiaries with “creditable” coverage. If you have a health plan in addition to Medicare (such as coverage through employment, a retirement plan, a union-sponsored plan, or a state or federal government plan) you do not have to enroll in a Medicare Part D plan as long as the drug coverage under your health plan is “creditable coverage.” “Creditable coverage” means that the drug coverage under your health plan is either Medicare Part D coverage, or coverage at least as good as Medicare Part D drug coverage. Your employer or health plan will notify you if you have creditable coverage. If you do not get written notice of creditable coverage, ask your employer or health plan for it. Keep the notice for your records.

All other Medicare beneficiaries. If you currently have Medicare, but not Medi-Cal or a health plan with creditable drug coverage, you can enroll in a Medicare Part D plan during the same period in which you can enroll for Medicare Part B. After that, you can enroll between November 15 and December 31 for Part D coverage effective the following January 1.

What happens if I do not enroll by the deadline?

If you miss the initial enrollment date, then your monthly premium for Part D coverage will go up 1% for each month that you delay enrollment. This is 1% of

the national average premium. For people who receive Medi-Cal or the Low Income Subsidy, 80% of the penalty is paid for by the Low Income Subsidy.

For people who do not receive Medi-Cal or the Low Income Subsidy the 1% penalty is applied for months beginning June, 2006. This is because May 2006 was the last month in which people who were Medicare beneficiaries at that time could enroll for that year. For people who receive Medi-Cal or the Low Income Subsidy the penalty is applied for months beginning January 2007.

The purpose of this premium penalty is to encourage individuals to enroll in a Part D plan even if they do not have high drug costs yet. So if you do not have high drug costs, you may still want to consider whether enrolling in a Medicare Part D plan is best for you because you may have higher drug costs in the future, and the Part D plans will cost you more if you wait.

Consider the following: If an individual was a Medicare beneficiary in 2005 and did not enroll in a Medicare Part D drug plan by May 2006, that individual would not be able to enroll until between November 15, 2006 and December 31, 2006. The enrollment would be effective January 1, 2007. The base monthly premium for that plan would be increased by 7% of the national average premium (1% for each month beginning in June 2006). If the individual did not enroll in a plan by December 31 2006, the individual would not be able to enroll in a plan for 2007. The individual would have to wait until November 15, 2007 to enroll in a plan effective January 1, 2008. The base monthly premium for that plan would be increased by 19% (7% for 2006 and 12% for 2007). This is a hefty premium increase for waiting less than two years to join. However, in addition, if the individual developed a health condition that required drug coverage in the meantime, the individual would have to pay for all of the drugs out of pocket until the individual could obtain Part D drug coverage effective on the following January 1.

If I have Medi-Cal, can I drop my Medicare so that I can keep my Medi-Cal drug coverage?

No. Medi-Cal is what is known as a payer of last resort. Medi-Cal will require you to keep your Medicare as a condition for receiving Medi-Cal.

Are there different kinds of Medicare Part D plans?

There are basically two kinds of prescription drug plans available under Medicare Part D. There are stand-alone prescription drug plans (PDPs), and Medicare Advantage prescription drug plans (MA-PDs).

Stand-alone prescription drug plans are available for people who are enrolled in the traditional Medicare program (Medicare Part A and Part B) or a Medicare HMO and who do not have Part D or creditable drug coverage through their health plan.

Medicare Advantage prescription drug plans are available for people who are enrolled in a Medicare Advantage plan. A Medicare Advantage plan is a Medicare managed care organization or HMO.

An individual in the traditional Medicare program does not have to enroll in a Medicare Advantage plan in order to get prescription drugs under Medicare. An individual in the traditional Medicare program can enroll in a stand-alone prescription drug plan and remain in the traditional Medicare program.

Is there a Medicare Part D plan available in the area where I live?

Yes. In California, at the beginning of 2007, there were about 55 stand-alone plans that were available from about 23 different insurance companies. (This compares to about 47 plans offered by 18 companies in 2006.) All of these plans are available statewide to all Medicare beneficiaries.

Nine of these plans are available to Medicare beneficiaries who also have Medi-Cal and other low income subsidy beneficiaries without payment of a premium. These are called “benchmark premium” plans. These are the plans that have the lowest premiums.

There are also a number of Medicare HMO (Medicare Advantage) prescription drug plans (MA-PDs) that are available as part of a beneficiary’s Medicare HMO coverage. These plans vary county-by-county just as Medicare HMOs do. If a beneficiary is enrolled in a Medicare HMO that offers an MA-PD plan, the beneficiary can choose to enroll in that MA-PD plan. These MA-PD prescription drug plans are available to Medi-Cal and other low income subsidy beneficiaries without payment of the MA-PD premium.

What stand-alone prescription drug programs will enroll Medi-Cal and other low income subsidy beneficiaries without payment of a premium?

The following is a list of the nine stand-alone prescription drug plans that will enroll Medi-Cal and other Low Income Subsidy (LIS) beneficiaries in 2007 without payment of a premium. The list is current as of September 12, 2006.

There have been some changes in the list since 2006. Unicare is no longer offering a plan without payment of a premium. Individuals enrolled in the Unicare plan will have to change to another plan, effective January 2007, in order to avoid payment of a premium. CIGNA Health Care has added a plan, CIGNATURE Rx Value Plan. RxAmerica has added a plan, Advantage Star Plan by RxAmerica. WellCare has added a plan, WellCare classic. Unicare is dividing its plan into two plans and assigning LIS beneficiaries to the Medicare Rx Rewards Value plan. Health Net is transferring all LIS beneficiaries to Health Net Orange Option 1. Most confusing, United Health Care is dividing its AARP Medicare Rx plan into two plans and is reassigning LIS beneficiaries from its old United Health Rx and AARP Medicare Rx plans into the new AARP Medicare Rx – Saver plan. Because United has taken over PacifiCare, LIS beneficiaries in the PacifiCare Saver Plan will also be transferred into the AARP Medicare Rx – Saver plan. According to United, for Medi-Cal and other LIS beneficiaries who are being reassigned into the AARP Medicare Rx – Saver plan, all utilization management decisions and formulary exceptions for 2006 will be grandfathered in for 2007.

Plan Name 2006	2007 Changes	Plan Telephone Number	Website
Blue Cross – Blue Cross MedicareRx Value	No change	1-866-892-5340	www.wellpointrx.com
Not offered	CIGNA Health Care – CIGNATURE Rx Value Plan	1-800-735-1459	http://www.cigna.com/health/consumer/medicall/cignaturerx/1/7
Health Net – Health Net Orange	Health Net Orange Option 1	1-800-935-6565	www.healthnet.com
Humana Inc. – Humana PDP Standard S5884-090	No change	1-800-833-6578	www.humana-medicare.com
PacifiCare – PacifiCare Saver Plan	Reassigned to United Healthcare – AARP Medicare Rx Plan – Saver		
Not offered	RxAmerica – Advantage Star Plan by RxAmerica	1-800-770-8014	http://www.rxamerica.com
Sierra Rx	No change	1-866-789-0565	www.sierrarx.com
Unicare – Medicare RX Rewards	Medicare RX Rewards Value	1-888-892-5335	www.wellpointrx.com
United Health Care – United Health Rx	Reassigned to United Healthcare – AARP Medicare Rx Plan – Saver	1888-556-7052	www.unitedmedicarerx.com
United Healthcare – AARP Medicare Rx Plan	United Healthcare – AARP Medicare Rx Plan – Saver	1-888-867-5564	www.aarpmedicarerx.com
Not offered	WellCare – Classic	1-888-423-5252	www.wellcarepdp.com
WellCare – Signature	No change	1-888-423-5252	www.wellcarepdp.com

What are some examples of Medicare HMOs that offer Medicare Part D prescription drug plans?

The following are some Medicare HMOs that offer Medicare prescription drug coverage.

Plan Name	Plan Telephone Number	Website
Health Net of California	1-800-275-4737	www.healthnet.com
Secure Horizons	1-800-698-7505	www.securehorizons.com
Kaiser	1-800-579-7085	http://prospectivemembers.kaiserpermanente.org/kpweb/medicare/entrypage.do

What will a Medicare Part D plan cost?

Costs will vary. Some beneficiaries will have to pay a monthly premium. In 2007, the premium will be about \$24 per month on average. The benchmark premium for Medi-Cal and low income subsidy beneficiaries will be around \$20. (These amounts are less than the 2006 amounts.) Medi-Cal and most other Low Income Subsidy program beneficiaries will not have to pay the premium. (See next section for more information.)

The Medicare Part D premium is in addition to the Medicare Part B premium, which will be \$93.50 in 2007. The Medicare Part B premium is paid directly by Medi-Cal (or deducted from your Social Security check if you do not receive Medi-Cal). The Medicare Part D premium can also be deducted from your Social Security check if you want. If you receive Medi-Cal, the premium will be paid for you by the federal government as part of the low income subsidy program. If you do not receive Medi-Cal, you will be billed for the premium by your Part D insurance company.

Additional drugs or benefits (or reduced deductibles/coinsurance/copayments) can be obtained from some plans by payment of a supplemental premium. Medi-Cal and other Low Income Subsidy beneficiaries can pay this additional supplemental premium out-of-pocket in order to obtain the additional drugs or benefits. The additional benefits will vary by plan.

In addition to the Medicare Part D premium, some beneficiaries will also have an annual deductible, coinsurance (or copayment), and a coverage gap (donut hole). These beneficiaries will have drug coverage with payment of an annual deductible and coinsurance (or copayments) up to an initial coverage limit. They will then have to pay \$3,850 total out-of-pocket (including deductible and coinsurance/copayments) before they receive catastrophic drug coverage. Catastrophic drug coverage will pay for 95% of drug coverage.

Medi-Cal and most other Low Income Subsidy program beneficiaries will not have to pay deductibles or coinsurance, and will not have a coverage gap (donut hole). These beneficiaries will have to pay only copayments of \$1 to \$5.35. Full benefit Medi-Cal beneficiaries in long term care will pay nothing for covered drugs. (See next section for a description of the low-income subsidy, or “extra help” program.)

How does the Low Income Subsidy or “Extra Help” program work?

The Low Income Subsidy (LIS) or Extra Help program, as it is being called, provides an additional subsidy from the federal government for people with Medi-Cal and for other people with limited resources, and with incomes up to 150% of the federal poverty level (FPL). The LIS pays for all or some of the Medicare Part D premium, annual deductible, and cost sharing. People who receive LIS or Extra Help generally are responsible only for copayments of between \$1 and \$5.35. Full benefit Medi-Cal beneficiaries in long term care (LTC) will pay nothing for covered drugs.

Dual eligible beneficiaries do not have to apply for the LIS or Extra Help. They are enrolled automatically. Medicare beneficiaries who do not receive Medi-Cal, but who have limited resources, and incomes up to 150% of the FPL, have to apply. They can apply at the county welfare department, any Social Security office, or online at www.socialsecurity.gov. We recommend that people apply for the LIS at the county welfare department. This is because the county welfare department must screen for Medi-Cal eligibility when the person applies for LIS. Social Security, on the other hand, is not required to do this.

The FPL is adjusted annually at the beginning of the year. It will be adjusted in early 2007.

The following people are eligible for the low income subsidy:

Group 1

1. All Medi-Cal beneficiaries with zero share of cost, except 250% Working Disabled beneficiaries. This includes SSI recipients; 1619(b); Pickle; zero share of cost DAC; 133% Aged and Disabled FPL.
2. Full-benefit dual eligibles with incomes at or below 100% federal poverty level (FPL). (For 2006, \$9,800 for an individual and \$13,200 for a married couple). This includes only Medi-Cal beneficiaries with a share of cost.

Group 2

Full-benefit dual eligibles above 100% of FPL (includes only Medi-Cal beneficiaries with a share of cost and 250% Working Disabled Medi-Cal beneficiaries)

Group 3

1. MSP (Medicare Savings Program) dual eligibles (QMB, SLMB, QI1) (“MSP” is a limited benefit Medi-Cal program for people with incomes below 135% of FPL and limited resources. It pays for Medicare Part A and B premiums, and some Medicare deductibles and coinsurance.)
2. Medicare only beneficiaries with incomes below 135% of FPL (for 2006, \$13,230 for an individual and \$17,820 for a married couple) and limited resources (\$6,000 per individual and \$9,000 married couple; plus \$1,500 for each individual for burial funds).

Group 4

Medicare only beneficiaries with incomes below 150% of FPL (for 2006, \$14,700 for an individual and \$19,800 for a married couple) and limited resources (\$10,000 individual and \$20,000 married couple; plus \$1,500 for each individual for burial funds).

The following chart shows what people who receive the low income subsidy will have to pay for their Medicare Part D drugs in 2007:

	Group 1	Group 2	Group 3	Group 4
Premium	\$0 (you pay nothing)	\$0 (you pay nothing)	\$0 (you pay nothing)	Sliding scale based on income
Deductible	\$0 (you pay nothing)	\$0 (you pay nothing)	\$0 (you pay nothing)	\$53 (\$50 in 2006)
Coinsurance/ copayment (up to \$3,600 out of pocket)	copay: \$1.00 generic \$3.10 brand \$0 LTC	copay: \$2.15 generic \$5.35 brand \$0 LTC	copay: \$2.15 generic \$5.35 brand	15% coinsurance
Catastrophic coverage	\$0 (you pay nothing)	\$0 (you pay nothing)	\$0 (you pay nothing)	copay: \$2.15 generic \$5.35 brand

How do I enroll in the low income subsidy if I have a Medi-Cal share of cost?

One way is to apply for the low income subsidy as described in the previous section. However, you can be automatically enrolled under some circumstances. If you incurred your share of cost at least once during the year, you will be automatically enrolled for the remainder of the year. If you incurred your share of cost at least once in July or later, you will be automatically enrolled for the following year as well.

Although you will be automatically enrolled in the low income subsidy, you will still have to enroll in a Medicare Part D prescription drug plan. You will have to pay the premium out of pocket for each month that you are not enrolled in the low income subsidy.

How long am I eligible for the Low Income Subsidy?

You are eligible until your income, resources, household size, or marital status change so that you are over the eligibility amounts. (A Social Security cost of living increase does not count as a change.) You must report any changes to the Social Security Administration.

When will my eligibility for the Low Income Subsidy be reviewed?

If you receive Medi-Cal with zero share of cost, there will be no review as long as you continue to receive Medi-Cal. If you have a share of cost for Medi-Cal and you incurred your share of cost at least once in July or later, you will be automatically enrolled for the following year as well. If you no longer qualified for Medi-Cal in July or later, Medicare will mail you a new application for the Low Income Subsidy. You should reapply for the Low Income Subsidy as soon as possible in order to be eligible next year.

If you do not receive Medi-Cal and you began receiving the Low Income Subsidy before May, your eligibility for the following year will not be reviewed unless there has been a change in your income, resources and household size. You will receive a letter from the Social Security Administration listing these amounts for the current calendar year. If these amounts have not increased and your marital status has not changed, you should do nothing. You will remain eligible for the Low Income Subsidy in the following calendar year. If any of these amounts have changed, you should notify the Social Security Administration. You will need to return the one-page letter that came with the notice from the Social Security Administration within 15 days. Social Security will then mail you a form called "Social Security Administration Review of Your Eligibility for Extra Help" (Form 1026B). If you fill out and return the form within 30 days, any change to the amount of the Low Income Subsidy you qualify for will be effective in January 2007 unless your marital status changed. Changes in marital status may result in changes to the amount of the Low Income Subsidy in the following month. Some people will receive Form 1026B because Social Security has information that there was a change in resources or income. Return the form to Social Security within 30 days.

How does the Medicare Part D standard benefit work?

The following is the standard plan for people who do not receive Medi-Cal or Low Income Subsidy. This is the minimum federal requirement. This standard plan may be changed by the actual Part D plans. Part D plans must provide actuarially equivalent benefits. Most plans do this by replacing the deductible and coinsurance with copayments. The copayments vary depending on which tier a particular drug is on.

Medicare Standard Drug Benefit – 2007

(For people who DO NOT receive Medi-Cal or Low-Income Subsidy)

Drug coverage category	If your total drug costs in calendar year 2007 are:	Medicare drug plan pays:	And you pay (assuming no other drug coverage):
Initial benefit	\$0-265	\$0 (Medicare pays nothing)	Up to \$265 (deductible)
	\$265-\$2,400 (initial coverage limit)	75%, up to \$1,601.25	plus 25%, up to \$533.75 (coinsurance)
Coverage gap ("donut hole")	\$2,400- \$5,451.25	\$0 (Medicare pays nothing)	plus 100%, up to \$3051.25 (additional out of pocket)
Total drug costs before catastrophic coverage (Initial benefit plus coverage gap amount)	\$5,451.25 Total	\$1,601.25 Total	\$3,850 Total (out of pocket threshold)
Catastrophic coverage	Over \$5,451.25	95%	Greater of: 5% or \$2.15 copay/generic \$5.35 copay/brand name

You receive catastrophic coverage only if the drugs you pay for in the coverage gap (donut hole) are covered by the Part D drug plan. These coverage gap costs cannot be paid for by insurance or most government programs. They can be paid for by family, friends, or private charities.

What drugs are covered under Medicare Part D?

All medically necessary drugs are covered unless they are excluded entirely from coverage. Excluded drugs are drugs that continue to be covered under Medicare Part A, e.g., drugs provided in the hospital, and drugs that continue to be covered under Medicare Part D, e.g., drugs that must ordinarily be provided in a doctor's office.

The following classes of drugs are generally excluded from Medicare Part D coverage:

- Barbiturates
- Benzodiazepines (diazepam [Valium], Ativan, Xanax)
- Smoking cessation
- Over the counter (nonprescription) drugs
- Vitamins
- Weight drugs

Some drugs are covered without utilization controls. This means that if they are prescribed, they will be covered without the need for any paperwork other than a prescription. Utilization controls may be required for some drugs, particularly brand name drugs for which there is a generic version or substitute.

What are utilization controls?

There are a number of utilization controls, beginning with the drug formulary. The plan's drug formulary and most other utilization controls are available on the plan's website, or can be obtained by calling the plan.

Drug Formulary. The primary utilization control is the drug formulary. A formulary is a list of drugs prepared by the drug plan. These drugs can be prescribed with no paperwork other than a prescription. If a drug is not on the formulary, or there is an additional utilization control, more paperwork is required.

The drug plans have been given a lot of leeway in deciding which drugs to list on their formularies. Generally, a plan is required to list only two or more drugs in each therapeutic class. Therefore, there can be wide variations in what plans offer.

However, the federal government requires all plans to list all or substantially all drugs in the following classes:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Immunosuppressants (transplant drugs)
- Antiretrovirals (AIDS drugs)
- Antineoplastics (Cancer drugs)

For these classes of drugs the plans will have to provide all formulations, but may not have to provide all dosages.

The drug plans can change their formularies at any time. If a plan removes a drug you are taking from the formulary, the plan must give you 60-days notice.

Tiering. A formulary can vary the standard Medicare Prescription drug benefit by replacing the standard deductible and co-insurance amounts with co-insurance or other cost sharing amounts that vary with each drug. This kind of formulary has multiple “tiers.” The copayment or other out-of-pocket cost of the drug depends on which tier it is on. Most plans have established formularies with tiers. On these formularies, generic drugs are generally preferred drugs (lowest cost tier), while the brand name equivalents are on tiers with higher copayment or cost sharing amounts. For Medi-Cal or low income subsidy beneficiaries there will be only two tiers with \$1.00/\$3.10 copayments, or \$2.15/\$5.35 copayments, depending on the beneficiary’s income.

Prior Authorization. If a drug is subject to prior authorization, your doctor must first contact the plan and show that drug is necessary to treat your condition.

Step Therapy. If a drug is subject to a step therapy requirement, you must generally first try certain less expensive drugs that have been proven effective for most people with your condition.

Quantity limits. The plan may limit you to a 30-day supply of certain drugs, or a 90-day supply for mail order. A plan could also limit the length of time that certain drugs can be prescribed.

Other utilization controls. Other utilization controls include such things as substitution of one drug for another drug that is considered by the plan to be equally effective, and therapy management, which is a requirement that your use of the drug be reviewed or monitored in some respect.

How do I get a drug that is not on the formulary or that is subject to other utilization controls?

If the drugs you need are not on the plan formulary (or are removed from the formulary), you or your doctor may request an “exception” from the plan for coverage of the exact brand of medication you require. You can also request an exception if you need to pay a lower tier price for a higher tier drug.

If you need an exception, contact the plan, or have your doctor or pharmacist contact the plan. The plan may have forms that it wants you to use to request an exception. In addition, you can use the CMS exception form.

Requesting an exception is supposed to be a simple process. It can be done over the telephone or by fax. The CMS exception form is two pages. If the request is made over the phone, the plan can require follow-up in writing. If there is any doubt about whether the plan will grant the exception it is best to request the exception in writing. A written request is necessary in order for you to request an expedited appeal. The plan can request additional documentation from your doctor to support the exception request but this should not include a request for voluminous medical records.

In the exception request your doctor should indicate why the drug is medically necessary to treat your medical condition. If your doctor has prescribed a brand name drug when there is a generic substitute available your doctor should indicate that other drugs have been tried and are not as effective and explain why, or your doctor should explain why because of your medical condition it is necessary for you to take a certain drug.

What if my plan removes a drug from the formulary or my new plan does not cover a drug I have been taking?

Each drug company must have a transition plan. You can get at least a 30-day supply of drugs (90-days if you are in long-term care). The plan also has to give you notice of formulary changes and may have to continue providing the drug without utilization controls for the remainder of the year. Also you can request an exception in order to obtain a non-formulary drug.

What drugs continue to be covered by Medi-Cal?

As discussed above, Medicare Part D plans have wide leeway in deciding which drugs to cover. However there are certain drugs that are excluded from the Medicare Part D program. These drugs will continue to be covered under the Medi-Cal program to the extent that they have been covered by Medi-Cal in the past.

California will continue to cover the following drugs under the Medi-Cal program whether or not people are enrolled in a Medicare Part D Plan:

- Barbiturates
- Benzodiazepines (diazepam [Valium], Ativan, Xanax)
- Smoking cessation
- Some cough/cold
- Some prescription vitamins
- Some over-the-counter drugs
- Weight drugs

When people go to the pharmacy they will have a Medicare Part D card and a Medi-Cal BIC card. The pharmacist should first swipe the Medicare Part D card to see if a drug is covered under the Part D plan. The pharmacist should then swipe the BIC card to see if the drug is one of the classes that continues to be covered under Medi-Cal.

PLEASE NOTE: Medi-Cal will no longer cover drugs that can be covered by Medicare Part D plans. This is true whether or not the covered drugs are actually on the Part D plan formulary. Therefore, people will have to be careful to select the Part D plan that has a formulary with the drugs they need.

What other changes will there be to Medi-Cal and other programs as a result of Medicare Part D?

For Medi-Cal beneficiaries who **do not** receive Medicare, there will no changes in Medi-Cal drug coverage, or any other aspect of Medi-Cal as a result of Medicare Part D.

Pharmacies can waive Medicare Part D copayments but they cannot advertise that they will do this. Pharmacies can refuse to provide the drug if the beneficiary does not pay the copayment. This is a change from existing Medi-Cal law which requires pharmacies to provide drugs to beneficiaries who cannot afford to pay the copayment.

Medi-Cal will no longer pay the Medicare HMO premium for Medi-Cal beneficiaries who are also enrolled in a Medicare HMO. This means that Medi-Cal beneficiaries who are in a Medicare HMO may have to pay monthly premiums for the Medicare HMO in the future. Kaiser Senior Advantage has agreed not to charge a premium for 2006. In 2006, Secure Horizons charged a premium but did not disenroll beneficiaries for nonpayment.

ADAP (AIDS Drug Assistance Program) will no longer pay the Medi-Cal share of cost for ADAP beneficiaries who have a share of cost for Medi-Cal. ADAP will pay for Medicare Part D coverage.

Medi-Cal also has an emergency drug program if there are problems obtaining Medicare Part D coverage. Information can be found on the California Department of Health Services Medicare Part D website: http://files.medi-cal.ca.gov/pubsdoco/pubsframe.asp?hurl=/pubsdoco/whatsnew_7050.htm.

What happens if I am in long-term care?

If you are in long-term care and you have both Medicare and Medi-Cal, you will have to enroll in a Medicare Part D plan in order to continue drug coverage just like everyone else who has both Medicare and Medi-Cal.

You will not have to pay a copayment once you have been in long-term care for a full calendar month. Remember, you will keep your full income as well until you have been in long-term care for a full calendar month, so you will have copayments during this time.

A long-term care facility subject to the Nursing Home Reform Act (skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), other than ICFs for the developmentally disabled) must provide you with all medically necessary drugs whether or not the drugs are covered by a Medicare Part D plan, or Medi-Cal. The facility cannot collect the copayment if you cannot afford to pay it.

How do I enroll in a Medicare Part D plan?

Contact the plan. Telephone numbers for some plans are listed above.

If you enroll in a new plan, you will be automatically disenrolled from any other plan. Be sure that you do not enroll from your old plan before you enroll in the new plan. Otherwise, you could lose coverage.

PLEASE NOTE: If you enroll in a Medicare Part D plan, you could be disenrolled from all of your existing health insurance coverage or HMO. If you currently have drug coverage with your current health insurance or HMO, contact them before signing up for a Medicare Part D plan.

When can I change my enrollment in the plan?

If you receive Medi-Cal with zero share of cost, you can change plans as often as once a month. If you receive Medi-Cal with a share of cost, and you meet your share of cost at least four times during the year, you can also change plans as often as once a month.

If you do not receive Medi-Cal (or if you receive Medi-Cal with a share of cost, and you do not meet your share of cost at least four times during the year) you can generally change plans up to two times before June 30, 2006. After June 30, 2006, you can change plans once a year. You can change plans during the open enrollment period from November 15 through December 31. The change will be effective the following January 1. You can change plans more often under some circumstances, for example, if you move out of the plan area.

What should I do if I have Medi-Cal and I am not auto-enrolled in a Part D plan, or I don't know what plan I am enrolled in?

Contact your pharmacy after January 1. Give the pharmacist your Medicare Part D card, or the yellow notice you received in November telling you which plan you are enrolled in. If you don't have either of these, your pharmacist will take steps to find out what plan you are enrolled in, or to enroll you in a plan.

If you are enrolled in a Part D plan, but do not know what plan you are enrolled in, your pharmacist can find out that information. The pharmacist can do one of two things:

1. Call the Medicare Pharmacy Line at (866) 835-7595. CMS customer service representatives are available to help Pharmacists identify the beneficiary's plan by providing some basic information. Upon calling this number, pharmacists must identify themselves with their NCPDP Provider ID number. Pharmacists should also have most of the following information available to assist the call service representative with the search: HIC #, Date of Birth, Beneficiary Name, Zip Code, Part A or B Effective Date and Gender. Upon completion of the search, the CMS call service representative will identify the drug plan name and, if requested, the effective date of Medicare coverage.
2. Submit an E1 eligibility transaction to the TrOOP facilitator. This transaction will return the phone number of the plan to which the beneficiary has been assigned.

If you are not enrolled in a Part D plan, the pharmacist will access a national system (operated by Wellstone) to pay for your medications and sign you up with a Medicare Part D plan. A detailed description of the process that the pharmacist must follow can be found at these links:

<http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/POSFacilitatedEnrollmentSummary.pdf>; http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=6248.

You can change your Part D plan up to once a month no matter how you came to be enrolled in it.

What do I do if I am dissatisfied with any action of my Part D plan?

There is an appeal procedure. You can obtain information about the Medicare Part D appeals procedure from the Center for Medicare and Medicaid Services (CMS) website:

<http://www.cms.hhs.gov/Partnerships/MMAOP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS052192>.

Click on the link for: Medicare Prescription Drug Coverage: How to File a Complaint, Coverage Determination, or Appeal. You can also open the document directly by clicking on:

<http://www.medicare.gov/Publications/Pubs/pdf/11112.pdf>

What questions should I ask when looking for a plan?

First you should make a list with all of the following information:

1. The drugs you take
2. The formulation (e.g. tablets, caplets, liquid, timed release)
3. The dosage strength (mg for each tablet)
4. The number of times per day that you take the drug
5. The name and location of your local pharmacy

The World Institute on Disability has a useful planning tool that you can use for this purpose. It can be found at:

http://www.disabilitybenefits101.org/ca/news/news_1642.htm.

Once you have made a list with your drug and pharmacy information, you are ready to start comparing various prescription drug plans. Here are some questions you should ask:

1. Are the drugs I take covered by the plan?
2. Does my local pharmacy participate in the plan?
3. If my local pharmacy does not participate, are the drugs available by mail?
4. Will the plan provide the particular formulations of the drugs that I take (e.g., tablets, caplets, liquid, timed release)?
5. Will the plan provide the particular dosage strengths of the drugs that I take?
6. Are there quantity limits for the drugs I take? If so, is this a limit on the amount of medication I can receive at one time, or is it a limit on the length of time I can receive the drug without my doctor seeking additional approval?
7. What formulary tier is the drug on? (I.e., if I am not a Medi-Cal or other LIS beneficiary, what will I have to pay out of pocket for the drug?)

You should also consider whether there are other utilization controls, for example:

1. Is there a prior authorization (“pre-certification”) requirement for the drugs I need?
2. Is step therapy required before I can take certain drugs (i.e., do I have to try a particular drug first before I can get the drug I want)?
3. Are there substitution requirements for the drugs I need?
4. Are there other utilization controls, such as therapy management, for certain drugs?

If you do not receive Medi-Cal, or you are not a low income subsidy beneficiary, you should also consider the following:

1. What is the plan’s monthly premium?
2. What is the plan’s annual deductible?
3. Are my drugs on the plan formulary?
4. Is my local pharmacy a preferred pharmacy? (i.e., do the drugs at my pharmacy cost less than the drugs at other pharmacies in the plan network?)
5. What will the drugs I take cost me? Are the drugs I take preferred drugs? If not, what tier are the drugs on and what will they cost?
6. What will I pay for drugs in the donut hole? (If the drugs are covered by your plan, you will pay the same price for drugs that your plan pays.)
7. What is the estimated cost of this plan for one year?

How do I find a plan?

You can call the various plans and obtain information from them. Ask them to send you information such as a copy of their formulary and enrollment form.

You can also use the plan finders at www.medicare.gov. You can use the “Formulary Finder” to determine what plans in your area cover the drugs you take. You can input the drugs you take to find out this information. You can also use the “Prescription Drug Plan Finder” to determine if a particular plan covers the drugs you take. First find a plan, then input the drugs you take. You can also use the Formulary Finder to enroll in a plan.

Where can I find additional information?

More information about the Medicare Part D program can be found in the excellent publication: “Understanding Changes in Prescription Drug Coverage for People with Disabilities,” published by the Health Policy Institute at Georgetown University. The publication contains general information about the basic structure of the Medicare and Medicaid programs, which is helpful in understanding Medicare Part D. It is available at: <http://hpi.georgetown.edu/rxchanges.html>.

Information about the Medicare prescription drug program can be found at www.medicare.gov. That website includes tools for finding a Part D plan. That website also includes the online version of Medicare & You, the Medicare handbook, which contains general information about Medicare, and specific information about Part D plans available in each state. It can be found at: <http://www.medicare.gov/spotlights.asp#medicare2006>.

More information about Medicare Part D is posted on www.calmedicare.org, and on the main page and California page of the National Senior Citizens' Law Center (NSCLC) website, which you can view at www.nsclc.org. Other helpful websites: Center for Medicare Advocacy at www.medicareadvocacy.org; Health Consumer Alliance at www.healthconsumer.org; Families USA at www.familiesusa.org; Medicare Rights Center at www.medicarerights.org; California Health Advocates at www.cahealthadvocates.org; California HealthCare Foundation at www.chcf.org/topics/healthinsurance/drugbenefit; Health Assistance Partnership at www.healthassistancepartnership.org; and Kaiser Family Foundation at www.kff.org/medicare.