The New Medicare Drug Benefit: What Consumers Need to Know

Beginning January 1, 2006 there will be a new Medicare prescription drug benefit. This document includes important information for everyone who currently has Medicare or both Medicare and Medicaid. If you currently get your health care covered by Medicare, including those who have some Medicare costs paid through Medicaid, this prescription drug coverage will be a new benefit. If you currently have both Medicare and Medicaid, as of January 1, 2006, you will begin receiving your prescription drugs through Medicare only.

There are some important differences in how the prescription drug benefit will work for specific groups. This document is separated into two sections according to the two groups affected by the new drug benefit. These groups are:

1. Medicare beneficiaries with Part A or B coverage (see pages 1-6);

2. Individuals who currently have both Medicare and Medicaid (known as full benefit dual eligibles); individuals who have some of their Medicare costs covered through Medicaid, including Medicare Part B premiums, but do not have any Medicaid health benefits (known as partial benefit dual eligibles); and individuals with SSI only (no Medicaid) (see pages 6-9).

Find the section that applies to you and learn more about the Medicare prescription drug benefit.

Medicare Beneficiaries

What are the Basics of the Benefit?

The new Medicare drug benefit will offer insurance to help you pay for your prescription drugs. It will be available to everyone who is enrolled in Medicare. The new drug benefit begins January 1, 2006.

What Will the Basic Plan Look Like?

The new drug benefit will be offered through two types of insurance plans:

- Those offering only the Medicare drug benefit, called Prescription Drug Plans (PDPs)

- Medicare managed care plans (such as HMOs) that offer more comprehensive health care coverage (the new drug benefit will be added to the services these plans already offer), called Medicare Advantage Prescription Drug Plans (MA-PDs)

There will be a choice of at least two plans in your area. Each plan will have its own listing of drugs that will be covered under the plan (known as a formulary). Since plans may cover different drugs, it is important that you compare plans in your area before choosing a plan. You must fill your prescriptions at a pharmacy that is in your plan's network. Each plan will provide a list of pharmacies where you will be able to have your prescriptions filled.

A Plan Comparison Web Tool and Medicare Personal Plan Finder will be available at http://www.medicare.gov in late October 2005. These tools may help you in choosing a

prescription drug plan that is right for your needs. For help evaluating your plan choices you may contact:

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **Mental Health Associations (MHAs)**
  http://www.nmha.org/affiliates/directory/index.cfm

If you do not have Internet access and need help getting phone numbers for these organizations, you can call the NMHA Resource Center at 1-800-969-6642.

What Will the Benefit Cost Me?

Unless you have very little income (about $14,000/year for an individual and about $19,000/year for a couple.), your costs will include a monthly premium of about $37 and a $250 deductible. In addition, you will have to pay 25% of your prescription drug costs between $250 and $2,250. Once your drug costs reach $2,250, you will be responsible for paying the full cost for your medications until your drug costs reach $5,100, or you pay a total of $3,600 out-of-pocket. Once you reach this amount, you will only have to pay a co-payment (generally 5% of the medication cost or co-pays of $2-$5 per drug).

Extra Help with Costs For Medicare Participants With Limited Incomes

"Extra Help" will be available to Medicare participants who have low incomes and a small amount of assets. The amount of financial help you receive from the federal government will depend on which of the following two categories describes your financial situation.

1. If your income is below $12,920 a year for individuals and $17,321 a year for couples this year (in 2006, when the drug benefit begins, these income limits will be higher reflecting inflation) and you have assets below $6,000 for individuals and below $9,000 for couples (you do not count the value of the home you live in, your furniture or your car but do count all of the following: bank accounts including checking, savings, and certificates of deposit; stocks; bonds, including U.S. Savings Bonds; mutual funds; individual retirement accounts (IRAs); real estate (other than the house you live in); and cash at home or anywhere else), you can apply for the Extra Help.

   Extra Help will cover both your premium for the lowest cost drug plan or managed care plan in your area and will also cover your deductible. If you choose a higher cost drug plan, you will have to pay the extra premium amount yourself. You will have co-payments between $2 and $5 until you pay $3,600 in out-of-pocket drug costs; then, your medications will be covered in full with no co-pay.

2. If your income is $14,355 a year for individuals and $19,245 a year for couples (in 2006, when the drug benefit begins, these income limits will be higher reflecting inflation) and you have assets below $10,000 for individuals and below $20,000 for couples (see description in Number 1 above for what assets are counted), you can also apply for Extra Help.

   "Extra Help" will cover your premium on a sliding scale (the exact amount of help with your premium will be based on your income and assets information). In addition, your deductible will be reduced to $50 and your co-pay will be 15% on your out-of-pocket drug costs up to $3,600. Once your out-of-pocket drug costs reach $3,600, you will only have to pay $2-$5 co-pays on each medication.

If you are unsure whether you qualify for "Extra Help" you should apply. If you do not qualify for this financial assistance, you can check with the following agencies to see if your state is providing any additional assistance with medication costs for Medicare beneficiaries:

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **State Medicaid agency**
  http://www.cms.gov/medicaid/statemap.asp

- **Partnership for Prescription Assistance**
  http://www.pparx.org and 1-888-477-2669

- **Local Mental Health Association office**
  http://www.nmha.org/affiliates/directory/index.cfm

If you do not have Internet access and need help getting phone numbers for these organizations, you can call the NMHA Resource Center at 1-800-969-6642.

How Do I Apply For the Extra Help?

If your income falls within the amounts described above, you should receive an application from the Social Security Administration to apply for the Extra Help. You will receive the application sometime between May and August 2005. If you do not receive this application, call 1-800- 772-1213 to request an application or go to http://www.socialsecurity.gov.

You can complete this application on-line http://www.socialsecurity.gov or fill out a paper application and mail it to the Social Security Administration or your state Medicaid office to apply for this help with your prescription drug costs. The Social Security Administration address should be on the paper application. Your state Medicaid office's address can be found at http://www.cms.gov/medicaid/statemap.asp.

For help completing this application, you can contact:

- **Local Social Security Administration office**
  http://s3abaca.ssa.gov/pro/fol/fol-home.html

- **Local Medicaid office**
  http://www.cms.gov/medicaid/statemap.asp

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **Local Mental Health Association office**
  http://www.nmha.org/affiliates/directory/index.cfm

If you need help finding telephone numbers for these organizations, please call the NMHA Resource Center at 1-800-969-6642.

Important Note: In addition to applying for this financial assistance, you will also need to sign up for a prescription drug plan beginning November 15, 2005.

How Do I Sign Up For A Medicare Prescription Drug Plan?

You can sign up for the new Medicare prescription drug benefit by submitting an application to the plan you choose. You will receive information from Medicare in October 2005 about the different plans available in your area. Since plans may cover different drugs, it is important that you compare available plans before choosing a plan. A Plan Comparison Web Tool and Medicare Personal Plan Finder will be available at http://www.medicare.gov in late October 2005. These tools may help you in choosing a prescription drug plan that is right for your needs.

For help evaluating your plan choices you may contact:

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **Mental Health Associations (MHAs)**
  http://www.nmha.org/affiliates/directory/index.cfm

If you do not have Internet access and need help getting phone numbers for these organizations, you can call the NMHA Resource Center at 1-800-969-6642.

The initial deadline for signing up is May 15, 2006. If you do not have comparable drug coverage (coverage that is as good as the Medicare prescription drug plan) through either an employer or past employer, TRICARE, the Veterans' Administration, or some other provider of prescription drug coverage (such as a MediGap policy) you must sign up by this deadline or you will have to pay a higher monthly premium for your drug plan when you do enroll. Your employer or other organization through which you have your drug coverage will provide you with written information that tells you if your drug coverage is as good or better than the Medicare drug coverage.

For more detailed information on enrolling into the new Medicare prescription drug benefit, call the NMHA Resource Center at 1-800-969-6642 to request a copy of NMHA's "Medicare Prescription Drug Coverage Getting Enrolled Consumer Workbook."

What Medications Will Be Covered By Plans?

It is important to review the plans available in your region to see which drugs they will pay for since plans can choose to cover different medications. If possible, you should choose a plan that covers all of your medications. You are only allowed to change plans once a year during the open enrollment period between November 15th and December 31st unless you have both Medicaid and Medicare coverage (see pages 5-9).

A **Plan Comparison Web Tool** will be available in October 2005 at http://www.medicare.gov. The tool will help you pick the drug plan that's right for you.

CMS requires that each plan cover at least two drugs in each drug category. They are strongly encouraging plans to cover a majority of medications in the following categories: anti-psychotics, anti-depressants, and anti-convulsants.

Some drugs are not included in the new Medicare prescription drug benefit. These include: benzodiazepines (e.g. Ativan, Klonopin, Valium, Xanax), barbiturates, and drugs to treat eating disorders. If you take these medications, you should:

(1) find other private manufacturer patient assistance programs to see whether they might cover your prescription, by contacting the Partnership for Prescription Assistance at 1-888-477-2669 or http://www.pparx.org; and
(2) talk with your doctor about other medications that might work for you.

Plans are allowed to make changes to their approved drug list at any time. However, they must give 60 days notice of these changes to enrollees who are taking that medication or provide enrollees with a 60-day supply of the medication they are removing from the approved drug list. The plan must also notify prescribing physicians and the Centers for Medicare and Medicaid Services.

What Do I Do If My Medication Isn't Covered?

If your plan does not cover your medication or your plan requires a higher co-payment for your medication than for other similar medications, you may seek an exception to your plan's approved drug list (formulary). An exception is a formal decision by the plan to cover your medication or reduce your co-payment. If an exception is granted, it will last one year and will need to be requested again.

To file an exception, first call the plan to find out whether they will cover your medication. If they say no, request that they send you that decision in writing and follow the steps in your plan documents to file an exception. Your doctor will have to give a statement in writing or by phone (depending on the plan's process) to the plan that the medication you are seeking coverage for is medically necessary and that other similar medications on your drug plan or managed care plan's list of covered drugs will not be effective or will be harmful to you. Plans are required to make decisions on exception requests within 72 hours or within 24 hours in emergency situations.

If your exception request is denied, you may appeal that decision. Since this can take a long time, it is important to talk with your doctor about other medications that you can take while you are going through the appeals process. For more detailed information about appealing a plan's decision, call the NMHA Resource Center at 1-800-969-6642 to request a copy of NMHA's "Medicare Part D: The New Prescription Drug Benefit Getting Enrolled Consumer Workbook."

While your appeal is pending, you may also contact an organization that helps consumers apply for state or pharmaceutical industry-sponsored pharmacy assistance programs that provide medications or cost-sharing assistance directly to consumers: Partnership for Prescription Assistance http://www.pparx.org and 1-888-477-2669. You can also contact your local Mental Health Association office http://www.nmha.org/affiliates/directory/index.cfm for information about pharmacy assistance programs available in your state.

Need Further Help Understanding Your Benefit?

- **Federal Medicare Program (Centers for Medicare and Medicaid Services)**
  1-800-MEDICARE (633-4227) or http://www.medicare.gov

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **State Ombudsman offices**
  http://www.ltcombudsman.org/static_pages/ombudsmen.cfm

- **Mental Health Associations (MHAs)**
  http://www.nmha.org/affiliates/directory/index.cfm

- **NMHA Resource Center**
  1-800-969-6642 or http://www.nmha.org/medicare

- **Medicare Rights Center**
  http://www.medicarerights.org

- **Protection & Advocacy organizations**
  http://www.napas.org

Full Benefit and Partial Benefit Dual Eligibles

This section gives information for individuals who have both Medicare and Medicaid (known as full benefit dual eligibles) and individuals who have some of their Medicare costs covered through Medicaid, including Medicare Part B premiums, but do not have any Medicaid health benefits (known as partial benefit dual eligibles). Individuals with SSI only (and no Medicaid) are also included in this section.

What are the Basics of the Benefit?

Beginning January 1, 2006, if you are a full benefit dual eligible (an individual who currently has both Medicare and Medicaid) you will begin receiving your prescription drugs through the new Medicare prescription drug benefit. You will receive a letter from the Centers for Medicare and Medicaid Services (CMS) in May or June 2005 telling you about this change. Your prescription drug coverage through Medicaid will end as of December 31, 2005. However, Medicaid will continue to pay for your doctors' visits and other healthcare services, if the program pays for them now.

If you are a partial benefit dual eligible (someone who has their Medicare Part B premiums and other Medicare cost-sharing amounts paid for by Medicaid, but does not have any Medicaid health benefits), you will be eligible to receive prescription drug coverage through Medicare as of January 1, 2006.

What Will the Basic Plan Look Like?

The new drug benefit will be offered through two types of insurance plans:

- Those offering only the Medicare drug benefit, called Prescription Drug Plans (PDPs)
- Medicare managed care plans (such as HMOs) that offer more comprehensive health care coverage (the new drug benefit will be added to the services these plans already offer), called Medicare Advantage Prescription Drug Plans (MA-PDs)

If you are a full benefit dual eligible, this Fall you will be automatically enrolled in the lowest cost plan available in your area unless you choose to enroll in a different plan (for more information see the section "How Do I Sign Up For A Medicare Plan?"). Each plan will have its own listing of which drugs will be covered (known as a formulary). You must fill your prescriptions at a pharmacy that is in your plan network. Each plan will provide a list of pharmacies where you will be able to have your prescriptions filled. Once the drug benefit program begins on January 1, 2006, you are allowed to change plans up to once a month.

If you are a partial benefit dual eligible, you can choose a plan by May 15, 2006, or Medicare will enroll you into a plan randomly chosen for you beginning June 1, 2006. You will also be able to change plans up to once a month after the drug benefit begins on January 1, 2006.

Individuals with SSI only (no Medicaid) will only be able to switch plans once a year, during open enrollment period.

What Will the Benefit Cost Me?

Both full benefit and partial benefit dual eligibles, and individuals who receive SSI-only, automatically qualify for financial assistance called "Extra Help" to help cover your drug benefit costs. As a full or partial benefit dual eligible, you will be required to pay the following costs:

- Small co-pay of $1-$3 per medication if you are a full benefit dual eligible; $2-$5 co-pay per medication if you are a partial benefit dual eligible
- No monthly premium (unless you choose a plan with a higher than average premium)
- No deductible

If paying your co-pay is a financial hardship, you can ask your pharmacist whether they will waive the co-pay. However, unlike prescription drug coverage under the Medicaid program, pharmacists are not required to waive the co-pay and can refuse to fill your prescription if you cannot pay it.

If you need help obtaining your medications because you cannot afford your co-pay, you may contact the following organizations for information about State Pharmacy Assistance Programs (SPAPs) or private manufacturer patient assistance programs:

- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **Partnership for Prescription Assistance**
  http://www.pparx.org or 1-800-477-2669

If you do not have Internet access and need help getting phone numbers for these organizations, call the NMHA Resource Center at 1-800-969-6642.

How Do I Sign Up For A Medicare Prescription Drug Plan?

1. Full Benefit Dual Eligibles (Beneficiaries with both Medicare and Medicaid)
CMS will automatically enroll you into the regional plan that has the lowest monthly premium. Medicare will pay the full premium amount for this plan. In October 2005, you will receive a letter from CMS letting you know into which plan you will be auto-enrolled. If you wish, you can choose to enroll in a higher cost plan before the deadline of January 1, 2006; however, you will be responsible for paying the additional premium amount (the difference in cost between the lowest cost plan and the plan you choose). Information on all the prescription drug plans available in your area will be sent out in October 2005.

After January 1, 2006, you will be able to change plans once a month if you need to.

2. Partial Benefit Dual Eligibles (individuals who are Medicare beneficiaries, but Medicaid pays for Medicare Part B premiums and cost-sharing) and individuals with SSI only
You can sign up for the new drug benefit by sending in an application to one of the prescription drug plans. You will receive information from Medicare in October 2005 about the different plans available in your region.

The initial deadline for signing up is May 15, 2006. If you do not sign up for a plan by the May 15, 2006 deadline, Medicare will enroll you into a plan they choose for you beginning on June 1, 2006.

After January 1, 2006, partial benefit dual eligibles will be able to change plans once a month. However, people with SSI only (no Medicaid) will only be able to change plans once a year during open enrollment period.

Plans may cover different drugs, so it is a good idea to look at all plans in your area before deciding to stay with the lowest cost plan or to sign up for another plan. If a higher cost plan covers more of your medications than a lower cost plan, it may be worth the additional costs to avoid changing your medications or the need to go through a lengthy appeals process.

A Plan Comparison Web Tool and Medicare Personal Plan Finder will be available at http://www.medicare.gov in late October 2005. These tools may help you in choosing a prescription drug plan that is right for your needs. For help evaluating your plan choices you may contact:

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If you do not have Internet access and need help getting phone numbers for these organizations, you can call the NMHA Resource Center at 1-800-969-6642.

What Medications Will Be Covered by Plans?

It is important to review the plans available in your area to see which drugs they will pay for since plans can choose to cover different medications. If you cannot afford a higher cost plan that covers all your medications, you should talk with your doctor to develop a safe plan to switch to another medication that your plan does cover or seek an exception.

The Centers for Medicare and Medicaid Services (CMS) require that each plan cover at least two drugs in each drug category. They are strongly encouraging plans to cover a majority of medications in the following categories: anti-psychotics, anti-depressants, and anti-convulsants.

Some drugs are not included in the new Medicare prescription drug benefit. These include: benzodiazepines (e.g. Ativan, Klonopin, Valium, Xanax), barbiturates, and drugs to treat eating disorders. If you take these medications, you should:

(1) find other private manufacturer patient assistance programs to see whether they might cover your prescription, by contacting the Partnership for Prescription Assistance at 1-888-477-2669 or http://www.pparx.org; and
(2) talk with your doctor about other medications that may work for you.

If you are a full benefit dual eligible and you are taking a medication that Medicare will not cover, you can contact your state Medicaid program (http://www.cms.gov/medicaid/statemap.asp) to find out if they will continue to pay for that specific medication. If you do not have Internet access and need help finding the phone number for your state Medicaid office, please call the NMHA Resource Center at 1-800-969-6642.

Plans are allowed to make changes to their approved drug list at any time. However, they must give 60 days notice of these changes to enrollees who are taking that medication or provide enrollees with a 60-day supply of the medication they are removing from the approved drug list. The plan must also notify prescribing physicians and the Centers for Medicare and Medicaid Services.

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To file an exception, first call the plan to find out whether they will cover your medication. If they say no, request that they send you that decision in writing and follow the steps in your plan documents to file an exception. Your doctor will have to give a statement in writing or by phone (depending on the plan's process) to the plan that the medication you are seeking coverage for is medically necessary and that other similar medications on your drug plan or managed care plan's list of covered drugs will not be effective or will be harmful to you. Plans are required to make decisions on exception requests within 72 hours or within 24 hours in emergency situations.

If your exception request is denied, you may appeal that decision. Since this can take a long time, it is important to talk with your doctor about other medications that you can take while you are going through the appeals process. For more detailed information about appealing a plan's decision, call the NMHA Resource Center at 1-800-969-6642 to request a copy of NMHA's "Medicare Prescription Drug Coverage Getting Enrolled Consumer Workbook."

While your appeal is pending, or if you decide you do not want to appeal, you may also contact a organization that helps consumers apply for state or pharmaceutical industry-sponsored pharmacy assistance programs that provide medications or cost-sharing assistance directly to consumers: Partnership for Prescription Assistance http://www.pparx.org and 1-888-477-2669. You can also contact your local Mental Health Association office http://www.nmha.org/affiliates/directory/index.cfm for information about pharmacy assistance programs available in your state.

Need Further Help Understanding Your Benefit?

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- **State Health Insurance Assistance Programs (SHIPs)**
  https://www.shiptalk.org or 1-800-MEDICARE (633-4227)

- **State Medicaid agencies**
  http://www.cms.gov/medicaid/statemap.asp

- **State Ombudsman offices**
  http://www.ltcombudsman.org/static_pages/ombudsmen.cfm

- **Mental Health Associations (MHAs)**
  http://www.nmha.org/affiliates/directory/index.cfm

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