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KLRD FACT SHEET

Medicare Part D
The New Medicare Prescription Drug Benefit

What is Medicare Part D?

Medicare Part D is one component of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Public Law 108-173) which includes the most significant changes to Medicare since its inception in 1965. This new "Part" of the federal Medicare health insurance program requires that every Medicare beneficiary have access to prescription drug coverage. Passage of Part D was prompted by the rising cost of prescription drugs and by the growing concern about seniors lacking prescription drug coverage.

Who's Eligible?

Medicare Part D is available to all Medicare beneficiaries. According to the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, **Kansas** has approximately 397,000 Medicare beneficiaries. An estimated 117,000 of these beneficiaries do not have prescription drug coverage from other sources such as retiree insurance, Medigap coverage or health plan benefits.

For Medicare beneficiaries who also participate in the Medicaid program (dual eligibles), participation is mandatory because Medicaid prescription drug coverage for dual eligibles ends on December 31, 2005. Part D participation is voluntary for all other Medicare beneficiaries.

When will the Benefit Start?

The Medicare Part D prescription drug benefit will become effective on January 1, 2006. Beneficiaries should receive enrollment information no later than October 15, 2005. The enrollment period begins on November 15, 2005 and ends on May 15, 2006. Unless the beneficiary is changing from comparable drug coverage, there will be a premium penalty for late enrollment. In 2006 and 2007, the late enrollment penalty will equal one percent of the base premium for each uncovered month in the period.

What Part D Prescription Drug Plans will be Available?

Medicare will contract with private insurance companies to provide the Part D prescription drug benefit. Coverage will be available through private prescription drug plans (PSPs) that offer drug-only coverage or through Medicare Advantage (formerly Medicare+Choice) local and regional managed care plans. Beneficiaries may remain in the traditional fee-for-service program and enroll in a separate private prescription drug plan or they may enroll in an integrated Medicare Advantage plan which will include prescription drug coverage as well as the other covered Medicare benefits.

The Centers for Medicare and Medicaid Services must establish the regions for the private prescription drug and Medicare Advantage plans by January 1, 2005. Between ten and 50 regions which ensure coverage for all 50 states and the District of Columbia must be established. However, the regions for the two types of plans do not have to be the same if access is improved by having them defined differently. At least two plans, one of which is to be a private plan, must be available in each region. If less than two plans are available in a region, the Centers for Medicare and Medicaid Services will be responsible for arranging the offering of one "fallback" plan in the region.

What Prescription Drugs will be Covered?

The prescription drugs that will be covered will vary based on the prescription drug plan the beneficiary chooses. Drug plans are required to include in their formularies (list of drugs that can be dispensed without prior authorization), at least two drugs in each therapeutic category and class of covered Medicare Part D drugs. There is no requirement to cover every drug in a class.

Model guidelines are being developed by U.S. Pharmacopeia, a nongovernmental organization that establishes drug standards, to help plan sponsors structure formulary categories and classes. However, the Medicare Prescription Drug, Improvement and Modernization Act does not require plan sponsors to follow the model guidelines. Plan sponsors are required to have a formal reconsideration and appeal process in place that allows plan enrollees to request reconsideration of drug coverage decisions.

How Much will the Part D Benefit Cost?

The cost of Medicare Part D will vary. Beneficiaries not eligible for low-income assistance will pay a monthly premium, an annual deductible and a varying percentage of their drug costs. In 2006, at the start of the Part D program, the monthly premium is estimated to be $35 and the deductible has been set at $250. When the $250 deductible has been met, the beneficiary will become responsible for the following portion of their drug costs:

- 25 percent of drug costs between $250 and $2,250 ($500).
- 100 percent of drug costs between $2,250 and $5,100 ($2,850). This gap in coverage is referred to as the 'doughnut hole' and the beneficiary is responsible for all drug costs.
- Five percent, or $2 for generic drugs and $5 for brand-name drugs, whichever is greater, for drug costs above $5,100. This is the point at which the beneficiary becomes eligible for catastrophic coverage.

Only the cost of drugs covered by the beneficiary's Medicare plan will count toward the deductible and out-of-pocket limits. In 2006, a Medicare beneficiary will incur $420 in premium costs and $3,600 in out-of-pocket covered drug costs before catastrophic coverage becomes effective. The deductible, benefit limits, and catastrophic threshold will change each year based on the increase in Medicare spending for Part D.

Is Low-Income Assistance Available to Help Pay for Part D Costs?

Various levels of assistance are available for low-income Medicare beneficiaries to help meet the cost of Part D premiums, deductibles, and co-insurance. As shown in the insert below, assistance is based on income and assets.

Additional Help with Rx Drug Costs for Low-Income People on Medicare

People on Medicare Who Also Have Full Medicaid Benefits (Dual Eligibles) will pay in 2006:

- No premium
- No deductible
- Copayments as follows:
  Nursing home residents: No copayments
  Individuals below poverty level: $1/generic; $3/brand name drug
  Individuals above poverty level: $2/generic; $5/brand name drug
  No copayments after individual spends $3,600 out-of-pocket on drugs

People on Medicare with Incomes Below 135% of Poverty (about $13,000/individual; 17,000/couple) and Assets Below $6,000 per individual/$9,000 per couple will pay:

- No premium
- No deductible
- Copayments of $2/generic and $5/brand name drug
- No copayments after individual spends $3,600 out-of-pocket on drugs

People on Medicare with Incomes Below 150% of Poverty (about $14,000/individual; $19,000/couple) and Assets Below $10,000 per individual/$20,000 per couple will pay:

- Sliding-scale premium
- $50 deductible
- 15% coinsurance up to $5,100 in total drug spending (= $3,600 out-of-pocket drug spending)
- Copayments of $2/generic; $5/brand name drug after individual spends $3,600 out-of-pocket on drugs

Source: Kaiser Family Foundation (KFF)

Low-income assistance is provided for three groups of Medicare beneficiaries—Medicare beneficiaries who receive full Medicaid benefits (dual eligibles); Medicare beneficiaries who are not eligible for Medicaid benefits but have incomes below 135 percent of poverty and meet Part D asset tests; and, Medicare beneficiaries who have incomes below 150 percent of poverty and meet Part D asset tests. The dual eligibles are further categorized into those beneficiaries with incomes at or below 100 percent of poverty as defined by the federal government and those with incomes above 100 percent of the federal poverty level. In 2004, the federal poverty level for an individual is $9,310 and for a couple is $12,490.

The low-income assistance will range from no premium and deductible costs to a maximum $50 deductible. Some beneficiaries will have no co-payments while others will have a 15 percent co-pay.