

Medicare Prescription Drug Coverage

“How to Get Extra Help Paying for Your Prescription Drugs”



A 2007 Guide Produced by the CHOICES Program

On January 1, 2006 Medicare began a new program to pay for prescription drugs for people who have Medicare Part A and/or Part B. The new program is known as “Medicare Rx.” It is also called “Medicare Part D.”

There are premium costs, deductibles and co-pays associated with the Medicare program. Medicare recipients with limited income and assets may qualify for Extra Help to pay for these costs. According to Social Security, this Extra Help may be worth up to \$3,700 in 2007. This Guide will help you understand how Extra Help works, and to see if you would qualify for Extra Help. If you are already enrolled in a Medicare prescription drug plan and already have Extra Help, this Guide will explain the Extra Help “redeeming” and “redetermination” processes that occurred in the fall of 2006. It also discusses the “benchmark” plans for 2007.

IMPORTANT! If you are on Medicaid (Title 19), Supplemental Security Income (SSI), or a Medicare Savings Program (QMB, SLMB, or ALMB), you automatically qualify for Extra Help! Instead of reading this Guide, please ask CHOICES for one of the special Guides written for people on these programs. If you have ConnPACE, ask CHOICES for a copy of the ConnPACE Guide.

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1. **What is Medicare prescription drug coverage?**

On January 1, 2006, Medicare began a new program to pay for most outpatient prescription drugs, insulin and insulin supplies, and “stop smoking” drugs. It is a program for everyone who has Medicare. It is also known as “Medicare Rx” and “Medicare Part D.”

2. **How is the program administered?**

Medicare doesn’t administer the program directly. Instead, it contracts with private companies to provide the coverage. You need to enroll in a Medicare-approved plan offered by one of these companies in order to have coverage. You may have enrolled in a plan on your own last year or, if you qualified for Extra Help in 2006, Medicare may have auto-enrolled you in a plan in May 2006.

In 2007, there will be 51 free-standing **PDPs** (prescription drug plans) offered in Connecticut. The PDPs just offer prescription drug coverage.

There are 24 **MA-PDs** (Medicare Advantage Prescription Drug Plans). MA-PDs, which may be HMOs or Private Fee For Service plans, offer hospital and medical coverage in addition to prescription drug coverage. MA-PDs are options for people who want to receive all of their health care under a single provider. Some of these plans only offer coverage in certain counties within Connecticut.

There are also 9 Medicare Special Needs Plans (**SNPs**). SNPs are MA-PD plans that have special rules for enrollment. They are all limited to people who have Medicare and Medicaid (“dual eligibles”). Some have other

requirements, such as living in an institution or having certain chronic or disabling conditions. Most SNPs only offer coverage in certain counties within Connecticut.

Ask CHOICES for the Enrollment Guide that describes all of the Connecticut PDPs, MA-PDs and SNPs in detail.

3. What drugs does Medicare cover?

Medicare covers most outpatient prescription drugs, insulin and insulin supplies, and “stop-smoking” drugs. Medicare-approved plans are required to offer a choice of at least two drugs in each of 146 categories of drugs. Medicare-approved plans are also required to cover substantially all drugs in the following six categories of drugs: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS.

Certain drugs are not covered by any of the Medicare prescription drug plans. These “excluded” drugs include: barbiturates, benzodiazepines, drugs exclusively for weight loss or gain, over-the-counter drugs, and drugs that are covered by Medicare Part A or Part B.

Each Medicare prescription drug plan offers its own selection of covered drugs, called a “formulary.” Each plan has a different formulary. **Your plan will only pay for Medicare-covered drugs that are on its formulary. Your plan will not pay for excluded drugs!**

4. **How do I pay for drugs that my plan doesn't cover?**

Some drugs are coverable by Medicare but may not be on your plan's formulary. These are referred to as "non-formulary" drugs. Other drugs are "excluded," i.e., Medicare won't pay for them, and so they won't be on any plan's formulary.

To get coverage of most non-formulary and excluded drugs, ask your CHOICES counselor if you might qualify for the Medicaid program or the ConnPACE program. Medicaid, which is also known as Title 19, is a state program that pays for medical care for low-income individuals and families. ConnPACE is a state program that helps eligible seniors and people with disabilities to pay for prescription drugs. Both Medicaid and ConnPACE pay for non-formulary and excluded drugs for their members, provided these drugs were covered by the State of Connecticut prior to January 1, 2006.

If you do not qualify for Medicaid or ConnPACE, you need to request an Exception to get coverage for your non-formulary drugs. You can ask for an Exception if your plan is denying a drug because of utilization management restrictions such as prior authorization, quantity limits or step therapy. You can also ask for an Exception to have a drug that you need reduced to a lower and less expensive tier. You will need your doctor's written support to obtain an Exception from your plan.

You cannot get an Exception for coverage of an excluded drug. You must pay for these drugs out-of-pocket.

5. **What is extra help?**

Extra Help is a subsidy administered by the Social Security Administration. It helps people to pay for their Medicare prescription drug costs. The amount of Extra Help people receive depends on their income and assets. There are “partial subsidies” and “full subsidies.” The table on page 8 shows how much help you can receive depending on the type of subsidy you have. **To understand the table you need to know how the Medicare prescription drug “standard benefit” works. See Question 6.**

If your countable income is below \$14,700 * (single) or \$19,800 * (couple), and your countable assets are below \$10,000 (single) or \$20,000 (couple), you may qualify for Extra Help. Some forms of income are not countable against the income limit. Similarly, not all assets are countable. For example, the home you live in, funds designated for funeral and burial expenses, and life insurance policies with less than \$1,500 face value are not counted as assets. Therefore, you may qualify for Extra Help even if your income and assets exceed the amounts shown above. It is better to apply for the Extra Help rather than assume you are not eligible.

* These amounts equal 150% of the 2006 Federal Poverty Level. They include an annual per person \$240 unearned income disregard. The 2007 amounts will be announced in early 2007.

6. **How does the “standard benefit” work?**

Different plans offer different benefit structures, but in general the standard benefit will work as follows. (For more detailed information about the standard benefit ask CHOICES for a General Information Guide.) **You will pay less than these amounts if you have Extra Help!**

- There is a monthly premium. In 2007, PDP premiums in Connecticut range from about \$13 to \$87 per month. MA-PD premiums range from \$0 to about \$159 per month.
- Some plans have an annual deductible (the amount you are responsible to pay before coverage starts). In 2007, the deductible cannot exceed **\$265** per year.
- After you have met your deductible, you enter the “Initial Benefit Period.” Medicare pays 75% of each prescription and you pay 25% of the next **\$2,135** in drug costs. (NOTE: most plans have tiered co-pays instead of 25% co-insurance during the Initial Benefit Period.)
- The next period is a Coverage Gap sometimes called the “donut hole.” If your chosen plan has a coverage gap, you pay 100% of all prescriptions until you have spent **\$3,051.25** out-of-pocket.
- Once you have spent a total of **\$3,850** in allowable “true out-of-pocket costs” (“TrOOP”), you will be eligible for “Catastrophic Coverage.” (Read more about “TrOOP” in the General Guide.) For the remainder of the calendar year, Medicare will pay 95% of your prescription drug costs and you will pay only 5% of each prescription, or a \$2.15 or \$5.35 co-pay, whichever is greater.

The table on the next page shows how much you will pay during the deductible period, the Initial Benefit Period, the “donut hole” and the Catastrophic Benefit Period if you have Extra Help.

Costs for People Who Receive Extra Help⁽¹⁾

Annual Income Limit ⁽²⁾	Asset Limit	Subsidy Level	Monthly Premium	Annual Deductible	Co-pays during the INITIAL BENEFIT PERIOD	Co-pays during the COVERAGE GAP (the "Donut hole")	Co-pays during the CATASTROPHIC BENEFIT PERIOD
\$13,230 (single) \$17,820 (couple) (135% FPL)	\$6,000 (single) \$9,000 (couple)	Full subsidy	\$0 ⁽³⁾	\$0	\$2.15 generic \$5.35 brand	\$2.15 generic \$5.35 brand	\$0
\$13,230 (single) \$17,820 (couple) (135% FPL)	\$10,000 (single) \$20,000 (couple)	Full subsidy	\$0 ⁽³⁾	\$53	15% cost of prescription	15% cost of prescription	\$2.15 generic \$5.35 brand
\$14,700 (single) \$19,800 (couple) (150% FPL)	\$10,000 (single) \$20,000 (couple)	Partial subsidy	Sliding scale	\$53	15% cost of prescription	15% cost of prescription	\$2.15 generic \$5.35 brand

(1) **Do not use this chart if you are on Medicaid, SSI, a Medicare Savings Program or ConnPACE.** You may pay less if you are on one of those programs. Ask CHOICES for more information.

(2) These income limits are based on the 2006 Federal Poverty Limits (FPL) and they include an annual \$240 per person unearned income deduction. These amounts will increase in early 2007.

(3) You will pay \$0 premium provided you enroll in a "benchmark" plan. Read more about benchmark plans at Question 12.

7. **The Extra Help “Redeeming” Process**

If you were on Medicaid (Title 19), SSI or a Medicare Savings Program in 2005, you were “deemed” eligible (automatically qualified) for Extra Help in 2006. This means you did not need to apply for it separately. **Your Extra Help will continue in 2007 if you are still on one of these programs.** If you are no longer on one of these programs, or if you had certain types of changes in your situation, you probably received a letter saying that you lost your eligibility for Extra Help or that the amount of your Extra Help will change in 2007.

If you lost your eligibility for Extra Help and think you may still qualify, you should reapply immediately. If you don’t reapply and qualify for Extra Help, you may have to pay premiums, deductibles and co-pays for your prescription drugs 2007. **NOTE:** Because people who lose their Extra Help may face an increased premium, Medicare will allow them to switch to a lower cost plan through March 31, 2007. This limited opportunity to change plans is called a Special Election Period (SEP).

If the amount of your Extra Help has changed, you may have to pay something toward your monthly premium and the amount of your co-pays may change. Be sure to follow instructions in your letter if you think this change is incorrect. Ask CHOICES if you need help with this.

8. **The Extra Help “Redetermination” Process**

If you applied for and were granted Extra Help prior to May 1, 2006, Medicare probably sent you a letter this fall to “redetermine” your eligibility. Only respond to this letter if you have had significant changes in your situation, as described in the letter. If you have had changes, please

follow the instructions in the letter and be sure to return the redetermination form on time or you may lose your Extra Help and will have to reapply.

9. If I have Extra Help can I change plans?

Yes. You can change plans during the Annual Coordinated Enrollment Period, which is from November 15 – December 31, 2006. **However, you will need to select a benchmark plan in order to avoid paying a portion of your premium.** (Read more about benchmark plans at Question 12.) Your change will be effective the first day of the month following the month you made the change.

NOTE: People who have Medicaid (Title 19) or ConnPACE can change plans more often. Ask CHOICES if you would qualify for one of these programs.

10. How do I change my plan?

To change plans, you just need to enroll in the new plan that you want. You don't need to disenroll from your existing plan! Your enrollment in the new plan will automatically cancel your enrollment in your former plan. **To avoid delays or problems with enrollment, it is strongly advised that you enroll in your new plan before the 8th of the month.** For example, if you want to be in your new plan by January 1, 2007, you should enroll by December 8, 2006.

You can enroll in your new plan by calling the plan directly, calling 1-800-MEDICARE, or by calling CHOICES at 1-800-994-9422.

Medicare recently mailed you the "Medicare & You 2007" handbook, which lists all of the plans in Connecticut. You should also get a copy of the CHOICES Enrollment Guide. It gives you information about the plans in Connecticut, including benchmark plans, and suggests what to do to be sure you get into a plan that meets your needs.

11. Do I have to do anything if I am happy with my existing plan?

Before you decide whether to stay with your existing plan you need to find out if your plan will change in 2007. The way to find out is to study the information your plan sent you at the end of October in its Annual Notice of Change (ANOC).

The ANOC includes information about changes to premium and deductible amounts, changes in "donut hole" coverage, and changes to formularies, including the addition of utilization management tools such as prior authorization, quantity limits and step therapy on any of its formulary drugs. The ANOC also includes information about changes to tiered co-pay amounts, including the placement of some drugs on a different tier.

People who are limited to a "benchmark" plan should check to be sure their plan still qualifies as a benchmark plan in 2007. Read more about benchmark plans at Question 12.

<p>IMPORTANT: If a plan granted an indefinite Exception in 2006 that it does not intend to continue in 2007, the plan must notify the member of this</p>

change. This notice may be included in the ANOC or it may be sent in a separate notice mailed by the end of October.

If you remain satisfied with your plan after reading the ANOC you do not need to do anything. In most cases, your membership in the plan will automatically continue into 2007. **The exception to this is if you were auto-enrolled in a benchmark plan that is no longer a benchmark plan in 2007. If this is the case, Medicare will reassign you to another plan.** Read more about this below.

12. **What is a benchmark plan?**

A benchmark plan is one that offers standard (rather than enhanced) benefits and has a monthly premium at or below the regional average monthly premium. The 2007 regional average monthly premium is \$27.35. Fifteen (15) of the 51 PDPs in Connecticut are benchmark plans in 2007. You can get a list of these from CHOICES. If you have Extra Help you must be enrolled in a benchmark plan in order to have your premium covered in full. If you are not in a benchmark plan you will be billed for the difference between the regional average premium and the premium of your chosen plan.

You may already be enrolled in a benchmark plan. You may have been auto-enrolled into this plan by Medicare or you may have enrolled on your own. If your plan no longer qualifies as a benchmark plan in 2007, you will be allowed to remain in the same plan if the new premium is no more than \$2 over the benchmark, i.e., no more than \$29.35.

If Medicare assigned you to a plan that is no longer a benchmark plan in 2007, Medicare will send you a notice of reassignment in November. **The notice of reassignment will be on blue paper.** If the company that sponsors your current plan has another plan that qualifies as a benchmark plan, you will be reassigned to that plan. If the sponsor does not have a qualifying benchmark plan in your area, Medicare will randomly assign you to another benchmark plan. **Remember, if you have a Medicare Savings Program you can change plans if you do not like the plan you have been reassigned to.**

NOTE: Pacificare merged with United Health Care and continues to offer plans under this new company. If you were randomly assigned to a Pacificare benchmark plan in 2006, Medicare will reassign you to a United Health Care benchmark plan so you continue to have coverage in 2007.

IMPORTANT!

To respect individual choice, Medicare won't reassign people who:

1. Joined a plan on their own in 2006, rather than being auto-enrolled by Medicare, or
2. Switched to another plan after Medicare auto-enrolled them in a plan in 2006, or
3. Were enrolled in a plan by ConnPACE.

13. **What if I have Extra Help but did not enroll in a Medicare prescription drug plan in 2006?**

Most people who failed to enroll in a plan before May 15, 2006 will have a late-enrollment penalty if they decide to enroll later on. However, if you have Extra Help you are eligible for a Special Enrollment Period (SEP). You may enroll in a plan any time up to December 31, 2006 and will not have a late-enrollment penalty.

14. **Important dates in late 2006 and early 2007.**

Mid-October 2006 - Medicare's on-line Plan Finder tool, which allows people to identify and compare PDPs and MA-PDs in their area, is updated with 2007 plan information. It also allows people to enroll in a plan on-line. To access the Plan Finder go to: www.medicare.gov.

End of October 2006 - Plans mail out their Annual Notice of Change (ANOC) informing members of any changes to premiums, formularies, cost-sharing, Extra Help subsidy status, and continuing exceptions for the coverage of non-formulary drugs.

Late October - early November 2006 - Medicare mails out the "Medicare & You 2007" Handbooks. The handbook provides general information about Medicare, including services covered by Medicare and the rights of Medicare beneficiaries. It also contains detailed information about PDPs, MA-PDs and SNPs available in your geographic area.

November - Medicare notifies people who were randomly assigned to a plan in 2006 if they are being reassigned to another benchmark plan in 2007.

Mid-November 2006 - Employers and unions that provide benefits to Medicare-eligible individuals and dependents must provide members with notice, before November 15, whether the prescription drug coverage they offer is "creditable," i.e., whether it is at least as good as the Medicare prescription drug program.

November 15, 2006 – December 31, 2006 - The Annual Coordinated Enrollment Period. Medicare-eligible individuals can enroll in or change their PDP. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their PDP for the rest of the calendar year.

December 8, 2006 – The date by which people who wish to change plans should enroll in their new plan in order to ensure coverage by January 1, 2006.

January 1, 2007 - New Medicare prescription coverage begins for 2007.

January 1, 2007 – March 31, 2007 - The MA Open Enrollment Period. Medicare-eligible individuals can change their MA or MA-PD plan. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their MA or MA-PD plans for the rest of the calendar year. People cannot add or drop prescription drug coverage during this period.

March 31, 2007 – The end of the Special Election period for beneficiaries notified that they no longer qualify for Extra Help.

15. Where can I get more information?

Call CHOICES at **1-800-994-9422** to speak to a counselor at the Area Agency on Aging serving your area of the state. CHOICES counselors are trained and certified to assist you with your Medicare issues and concerns. They can also help with comparing and enrolling in a Medicare prescription drug plan and getting Extra Help to pay for your premiums, deductibles, and co-pays.

You can also get more information from these on-line sources:

- State of CT, Department of Social Services: www.ct.gov/Medicarerx
- Medicare: www.medicare.gov
- Social Security: www.socialsecurity.gov
- Center for Medicare Advocacy: www.medicareadvocacy.org
- Department of Social Services, Aging Services Division:
www.ct.gov/agingservices

CHOICES is a program of the State of Connecticut Department of Social Services, Aging Services Division, and serves as Connecticut's State Health Insurance Assistance Program (SHIP), as designated by the Centers for Medicare and Medicaid Services. CHOICES is administered in partnership with the Area Agencies on Aging and the Center for Medicare Advocacy, Inc.



DSS Publication 2005 - 5, REV **November 17, 2006**

This publication is not a legal document. The official Medicare provisions are contained in the relevant laws, regulations and rulings.

This information is available in alternative formats. Call 1-800-994-9422. TDD/TTY users call 1-800-842-4524.