A Medicare Drug Benefit Glossary

(All ***italicized*** words used in the definitions also have definitions in this glossary)

Actuarial equivalence –Actuarial equivalence is an insurance term for a determination that the dollar value of drug coverage under one plan is equal to the dollar value of coverage under another plan. Two plans with different ***co-payments, deductibles, formularies*** and other features are ***"actuarially equivalent"*** if, at the end of the year, a person would have obtained the same total dollar benefit from either plan.

Appeals - If a person is dissatisfied with any part of a ***coverage determination*** (including an ***exception*** request), they may request a redetermination by their plan (and have the redetermination expedited under certain circumstances. If a redetermination fails to satisfy the beneficiary, they may request reconsideration by an independent review entity (IRE) contracted by Medicare.

Assets–***Assets*** include your bank accounts, stock accounts, real estate, homes and cars – but excluding your primary residence and one car. In determining whether you are a ***subsidy-eligible individual,*** your assets and those of your spouse (if you are married and live in the same household) will be added together.

Catastrophic coverage - catastrophic coverage refers to the much higher level of coverage (95% discount or better, depending on your income) you receive for all ***covered drugs*** after you have spent more than the ***TrOOP*** limit for your prescriptions in that year. For 2006, the ***TrOOP*** limit is $3,600.

Creditable coverage – includes a drug benefit through an employer, TriCare, or a union that is the ***actuarial equivalent*** of the ***Part D*** drug benefit. People who have creditable coverage do not have to pay the ***late enrollment penalty*** for failing to enroll in a ***Part D Plan*** as soon as they are eligible.

Co-insurance – a fixed percentage of the ***negotiated discount price*** of a ***covered drug*** paid by the patient. The ***coinsurance*** may be different for one drug than for another (depending on whether you have a generic drug or a ***non-preferred*** drug), and it may vary throughout the year, from 0 to 100% (depending on whether your total spending that year is still in the ***deductible*** period, or has reached the ***doughnut hole)***. Even with all of these differences, your total ***out-of-pocket*** payments for ***covered drugs*** in the year will not exceed ***TrOOP.***

Co-payment – a fixed dollar amount to be paid by the patient per prescription dispensed. For example, a ***subsidy eligible individual*** who has a very low income will pay no more than $3 to the pharmacy for each brand name prescription filled at the pharmacy, and $1 for each generic drug, regardless of the cost of the drug.

Coverage determination – A decision by a ***Part D plan*** that your prescription counts as a benefit under the plan, no matter how much the plan actually pays for the drug.

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Covered Drugs – prescription drugs that are on the plan's ***formulary;*** an individual's payments for ***covered drugs*** count toward the ***TrOOP*** limit.

Deductible – the amount of spending by the individual that is required before insurance benefits are paid by the ***Part D Plan***. For ***standard coverage***, you pay a $250 ***deductible*** before your plan begins to pay on your prescriptions.

Doughnut hole – Your prescription spending after you reach ***initial coverage limit*** and before you reach the ***TrOOP*** limit is sometimes referred to as ***doughnut hole.***

Dose restrictions - a ***formulary*** restriction that causes a particular drug not to be covered for the number of doses prescribed. A ***formulary*** with ***dose restrictions*** limits the number of tablets (or other dosage forms) that may be dispensed by a pharmacy to a beneficiary during a specific amount of time (typically per month).

Dual-eligible – ***also "duals"*** More than 7 million Americans qualify to receive benefits from both Medicare and Medicaid. If you are dual eligible, in the past, Medicaid paid for your drugs. Dual eligibles will now receive their prescriptions from a ***Part D Plan***, but they automatically qualify for a subsidy to help with their premiums, copayments, coinsurance and deductibles.

Enhanced alternative coverage – see *also supplemental benefits.* Includes ***standard prescription drug coverage*** and ***supplemental benefits.***

Enrollment period – ***more commonly, initial enrollment period*** The initial enrollment period will be the same for Medicare ***Part D*** drug coverage as for Medicare Part B. It is the seven-month period that begins three months before the month an individual first meets the eligibility requirements for Medicare and ends three months after that first month of eligibility. The ***initial enrollment period*** for those individuals who are already eligible for Medicare as of November 15, 2005, is from November 15, 2005, until May 15, 2006.

Exceptions process – ***also " exception." See also "appeals." See also "rights of Part D enrollees."*** A beneficiary denied coverage for a drug as being not on the plan ***formulary***, or wishing to have a ***non-preferred drug*** treated as a ***preferred drug*** under a ***tiered formulary***, or wishing to access a drug outside of the plan's ***step therapy*** requirements may request an ***exception.*** If the plan does not grant to ***exception*** and provide access to the drug, the individual may ***appeal.*** Typically, the beneficiary's physician must determine that the preferred drug, formulary drug, or first-tier drug is not effective for the beneficiary, harmful to the beneficiary, or both.

Formulary – a list of ***covered drugs*** available through the ***Part D plan***. Your plan is also using a ***formulary*** if they limit the number or size of dose you may receive ***(dose restriction)*** or require you to try another drug ***(step therapy)*** before letting you have access to the one selected by your physician. Money spent on medicines "on formulary" count towards ***TrOOP***; money spent on "non-formulary" drugs do not count towards ***TrOOP***. Tell your doctor or health professional if a medicine you need is not "on formulary," they may be able to help you obtain

an "***exception***" to have the medicine be covered, and have money spent counted towards ***TrOOP,*** or they may be able to prescribe another drug that is appropriate to meet your medical needs.

FPL – Federal Poverty Level, (officially: the HHS Federal Poverty Guidelines.) The federal poverty statistics, including the FPL, are published annually by the Census Bureau for statistics purposes. For 2004, FPL has been set at $9,310/single; $12,490/couple. 135% of FPL is $12,569/single; $16,862/couple, and 150% of FPL is $13,965/single; $14,710/couple.

Income: Income includes your earned wages, earnings from self-employment, royalties, annuity payments, pension payments, disability benefit payments, veterans compensation and pension, workmen's compensation payments, old age survivor and disability insurance benefit payments (including Social Security payments), unemployment insurance payments, prizes, support and alimony payments, inheritances, and earned rents or dividends. In determining whether you are a ***subsidy-eligible individual,*** your income and that of your spouse (if you are married and live in the same household) will be added together.

Initial coverage limit – In ***standard coverage,*** the level of total prescription costs where the 25% ***coinsurance*** ends, and you are required to pay 100% of the cost of Part D covered drugs, up to the ***TrOOP*** limit. The ***initial coverage limit*** for 2006 is $2,250 worth of prescriptions (including both what the beneficiary pays and what the plan pays, plus any subsidy).

Late enrollment penalty – A late penalty in the form of a 1%-per-month higher premium must be paid by an individual who has a continuous period of 63 days or longer without prescription drug coverage at any time after the end of their ***enrollment period.***

Medicare Advantage – a program under which a non-government entity arranges for all Medicare covered services, including physicians, labs and hospitals. Some ***Medicare Advantage*** plans may offer the ***Part D*** drug benefit to their enrollees.

Negotiated discount prices - prices for ***covered drugs*** that your ***Part D Plan*** must make available to you at participating pharmacies. For example, 25% ***coinsurance*** is 25% of the negotiated discount price. These prices take into account discounts, rebates, and other price concessions, given to your plan by manufacturers and pharmacies. Even when you paying for prescriptions during the ***deductible*** or the ***doughnut hole,*** you pay only the ***negotiated discount prices***.

Non-Preferred drug – a drug that a plan discourages access to, typically by requiring a larger ***co-payment,*** which may be up to 100% of the ***negotiated discount price*** of the drug.

Out-of-Pocket Payments – Payments by the beneficiary toward the total cost of covered prescriptions, including the ***deductible, coinsurance, co-payments, and*** the cost of prescriptions during the ***doughnut hole.***

Part D– Part D is the section of the Medicare program that provides prescription drug coverage. In general, Medicare Part A covers hospital services, Part B covers physician services, and Part C is Medicare Advantage, the comprehensive managed care program.

Part D Eligible Individual - means an individual who is entitled to Medicare Part A and/ or enrolled in Medicare Part B.

Part D Plan – Your Part D Plan may be either a ***Prescription Drug Plan (PDP)*** to add to traditional Medicare, or ***a Medicare Advantage*** plan that offers ***Part D*** coverage ***(MA-PD)***.

Preferred drug - a drug that a plan encourages physicians and patients to choose, typically by including it on a ***formulary*** or requiring a smaller ***co-payment*** or no ***co-payment.***

Prescription Drug Plan – ***also PDP***. A plan that offers coverage for prescription drugs only to beneficiaries who choose to receive their other Medicare benefits in the traditional way.

Premium – ***also monthly beneficiary premium*** The amount a beneficiary pays monthly for ***Part D*** coverage. Each beneficiary will pay a premium agreed to between Medicare and the ***Sponsor***, plus any ***late enrollment penalties*** or charges for ***supplemental coverage.***

Rights of Enrollees – Generally, enrollees have the right to have a ***grievance*** heard, the right to a timely ***coverage determination*** (expedited under certain circumstances), the right to an ***appeal*** – including coverage redetermination (expedited under certain conditions) and review by an independent review entity contracted my Medicare.

Sponsor – A non-governmental entity approved by Medicare to offer a ***Prescription Drug Plan.***

State Pharmaceutical Assistance Program – ***also SPAP*** A program (other than Medicaid) operated by a State (or under contract with a State) that provides financial assistance to Medicare beneficiaries to purchase prescription drugs. After 2006, SPAPs can provide enrollees assistance with their enrollee's premiums, deductibles and coinsurance, under a ***Part D Plan***.

Standard coverage – also ***"standard prescription drug coverage"*** is a fixed way to allocate the annual cost of drug coverage among the Medicare beneficiary, the ***Part D Plan*** and the federal Medicare program. Each ***Part D Plan*** must offer ***standard coverage*** to make it easier for potential enrollees to comparison shop between different ***sponsors'*** plans and their ***supplemental benefits*** options. In 2006, ***Standard coverage*** has a $250 ***deductible,*** 25% ***coinsurance*** on the next $2000 worth of drugs, and ***catastrophic coverage*** after the ***TrOOP*** limit.

Step therapy – Generally, a plan requirement that, with respect to a specific disease or condition, the patient must try one drug before having access to another, ***non-preferred*** drug if the preferred drug does not work for the patient.

Subsidy Eligible Individual: A Medicare beneficiary enrolled in a ***Part D Plan*** who qualifies for one of several levels of assistance to help with premiums and out-of-pocket payments for the purchase of prescription drugs. To qualify for one of the subsidies your ***income*** must be at or below the target and your ***assets*** must be at or below the target.

Supplemental benefits – Individuals may pay an additional premium to purchase supplemental benefits to enhance ***standard coverage*** by reducing the ***deductible,*** the ***coinsurance*** percentage or ***copayments,*** filling the ***doughnut hole,*** or having a different ***formulary.***

Tiered cost-sharing – ***also "tiered formulary"*** A ***formulary*** that has different levels of ***coinsurance*** or ***co-payments*** for different drugs that could be used to treat the same disease or condition. Different tiers typically include generic drugs, ***preferred*** drugs, and non-preferred drugs.

Transitional Assistance -- For beneficiaries with incomes below 135% of poverty ($12,569/single; $16,862/couple in 2004) who do not have private or Medicaid drug coverage, the government provides $600 per year for drug expenses in 2004 and 2005 and pays the annual enrollment fee for a Medicare drug discount card. These dollars must be used by December 31, 2005, before the ***Part D*** drug benefit goes into effect.

True Out-of-Pocket Spending – ***also TrOOP limit.*** The amount a beneficiary must spend on ***covered drugs*** to reach ***catastrophic coverage.*** An individual's payment of the ***deductible, coinsurance, copayments,*** and ***doughnut hole*** count toward ***TrOOP***. For 2006, ***TrOOP*** is $3,600. The Part D premium does <u>not</u> count toward ***TrOOP***.

FREQUENTLY ASKED QUESTIONS ABOUT THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT

Question #1. What is the new benefit?

***Answer*:** Beginning on January 1, 2006, individuals who are entitled to Medicare Part A or are enrolled in Medicare Part B will be able to get prescription drug coverage through the new Medicare Part D. If you sign up for it, this optional benefit will pay for portion of your prescription drug costs; lower income people receive higher payments that those with higher incomes.

Question #2. When do I need to sign up for the benefit?

***Answer*:** If you are eligible for Part D as of November 15, 2005, you can enroll between November 15, 2005 and May 15, 2006. After May 15, 2006, enrollment will only be allowed under special circumstances, and you will have to pay more for the same drug benefit because you have delayed signing up.

If you do not become eligible for Medicare until after November 15, 2005, the Medicare program will inform you of the dates of your a six month enrollment period.

Question #3. What if I just wait a year to see how this new program goes before I join?

***Answer*:** If you do not enroll during your six month enrollment period, you will have to pay a premium penalty. You will have to pay the premium penalty each month for the whole time that you are enrolled in Medicare Part D. The longer you wait to enroll, the higher the penalty will be.

Question #4. How do I sign up for the drug benefit?

***Answer*:** You can get information on how to sign up from the Medicare program at 1-800-MEDICARE (1-800-633-4227) or on the internet at www.medicare.gov.

Question #5. How much will it cost?

***Answer*:** Unless you qualify for low income assistance, you will need to pay a monthly premium, an annual deductible, and co-payments, which will vary according to the plan you choose and where you live. Under the standard plan, individuals will need to pay a premium of about $35 per month (or $420 per year) and a $250 deductible before Medicare starts helping with costs. After you have paid $3600 for your prescriptions for the year, you will receive a 95% discount or better for your prescriptions.

Question #6. Will all plans cost the same?

***Answer*:** No. The plans can set different premiums and co-payments as long as the total package of benefits is of equal value to the standard plan. But no matter which plan you choose your total payments for drugs during the year will be capped at $3600, after which you receive the 95% or better discount on your prescriptions. You also must pay your premiums.

Question #7. Will all plans offer the same benefits?

***Answer*:** No. The drugs covered may vary from plan to plan, so you will need to make sure that the plan you choose covers the drugs that you need.

Question #8. How much will I save?

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Answer: The amount you save will depend on your drug costs, your income, and the discounts that your drug benefit plan negotiates for the drugs that you take. If you spend more than $670 per year on drugs (which equals the estimated $420 yearly premium + $250 standard deductible), then you will likely save on your drug costs. It is important to keep in mind that your drug costs may increase as you grow older, or if you become sick, so even though it may not seem worthwhile to get the coverage now, you may want it later. If you enroll now, you won't have to pay penalties for delaying your enrollment.

Question #9. What if my plan charges me a different price for the same prescription each time I get a refill?

Answer: Your plan sets the negotiated discount price you pay for each drug based on the rebates it obtains from manufacturers, discounts from pharmacies, and the preferences it gives you for reducing the co-payment you make for preferred drugs. The amount you pay for the same drug throughout the year also will vary, depending on whether you are still counting up toward the deductible, or have exhausted the initial coverage, or have reached your True Out Of Pocket cap.

Question #10. Is there any additional assistance for low-income seniors?

Answer: Yes. About one-third of all seniors will qualify for additional assistance based on their income and assets. Low income assistance helps with premiums and reduces your copayments. If your income is less than about $14,000 (or less than about $18,800 for couples) and your assets are less than $10,000 ($20,000 for couples), then you may qualify for additional assistance. Assets that may be counted in determining whether you qualify for additional assistance include: savings accounts, stocks, bonds, real estate, a car, and life insurance, excluding your primary residence and a car.

Question #11. How can I find out if I qualify for low-income assistance?

Answer: If you think you may qualify, beginning in June, you can apply for assistance with your premiums and copayments by filing an application at your local Social Security Office.

Question #12. Can I keep my Medigap policy?

Answer: If you have a Medigap plan that includes prescription drug coverage and you keep that plan, you cannot enroll in Part D. If you would prefer to enroll in Part D, you may either continue your existing Medigap plan without the prescription drug coverage (with a lower premium) OR you may enroll in a new Medigap policy that does not offer prescription drug coverage. If you keep your current Medigap policy, you will be subject to premium penalties if you decide to enroll in Part D later, unless your Medigap benefit is at least equal in value to the Part D benefit. Your Medigap plan must tell you whether it is at least equal in value.

Question #13. What if I want additional coverage?

Answer: You may be able to supplement your Part D benefit by purchasing additional coverage from the same company that provides your basic drug benefit. Supplemental coverage will reduce the amount you must pay in coinsurance for each prescription, or provide access to a different formulary of covered drugs.

Question #14. I have Medicaid, can I stay with it?

***Answer*:** You will no longer be able to get your prescription drugs through Medicaid. Medicare will provide your prescription drug benefit beginning in 2006. Medicare will pay for all your prescription drug costs, except for co-payments that could range between $1 and $5, depending on your income and whether the drug is generic or brand name. You will not need to pay premiums or a deductible, and will not need to pay co-payments after your total drug expenses reach a about $5100. If you do not enroll in a plan by January 1, 2006, you will be assigned to a plan.

Question #15. I am enrolled in Tricare—will my military retiree or veterans' drug benefits change?

***Answer*:** No. Military retirees and their dependents can opt to stay in Tricare-for-Life, and veterans can get drugs through the Veterans Affairs health system if they are enrolled in it.

Question #16. If I participate in my state's pharmacy assistance program, can I continue to participate if I enroll in Medicare Part D?

***Answer*:** This will depend on your state. Before January 1, 2006, you should contact your state's pharmacy assistance program for information about how the program will be coordinated with the new Part D benefit.

Question #17. Can I get discounted drugs from a manufacturer-sponsored program if I sign up for the new benefit?

***Answer*:** This will depend on the manufacturer's policy. Many pharmaceutical companies limit their patient assistance programs to low income individuals that do not have access to drug coverage. Such programs may exclude Medicare beneficiaries starting in 2006. You should contact the company to find out how they are planning to respond to the new Part D benefit.

Question #18. I am a retiree covered by my former employer's plan—can I still get the Medicare drug benefit?

***Answer*:** Yes. You can choose to keep your retiree coverage or switch to Medicare Part D. If you keep your coverage and later lose it involuntarily, you will have about 2 months after your coverage stops to sign up for Part D without penalty, provided your coverage was as comprehensive as the Medicare benefit.

Question #19. I am a retiree with prescription drug coverage through my union—can I still get enroll in Part D?

***Answer*:** Yes. You can keep your union coverage or switch to Medicare Part D. If you keep your coverage and later lose it involuntarily, you will have about 2 months after your coverage stops to sign up for the Medicare drug benefit without penalty, provided your coverage was as comprehensive as the Medicare benefit.

Question #20. Do I have to change pharmacies?

***Answer*:** You may have to change pharmacies, depending on your Part D plan. Some plans may have a limited pharmacy network, so whether you need to change pharmacies will depend on whether your pharmacy is part of the plan's network.

Question #21. Can I switch Part D plans if I don't like the one I'm in?

Answer: You may switch plans once a year, between November 15 and December 31, beginning in 2006. If you switch plans, your new coverage will begin the following calendar year. For example, if you complete the paperwork to switch plans on November 29, 2006, you will be enrolled in a new plan as of January 1, 2007, and will remain in your old plan until then.

Question #22. Does Part D pay for all drugs?

Answer: Each Part D plan will have a list of drugs that are covered (called a "formulary"). Your plan will have a process for you to request an "exception" to obtain coverage for drugs not on the formulary.

Question #23. What if the drug my doctor prescribed is not on the formulary?

Answer: You or your doctor can request that your plan pay for a drug not on the plan's formulary, or drug list. If your plan refuses to pay, you can appeal. If your appeal is denied, you will be responsible for paying the full cost of any drug that is not on the formulary.

Question #24. I don't want to change my Medicare coverage, do I have to enroll in an HMO to get prescription drugs?

Answer: No. You can choose to enroll in a Medicare HMO (Medicare Advantage plan) or you can enroll in a private plan that offers only drug coverage while receiving the rest of your benefits through traditional Medicare.

Question #25. What is Medicare Advantage and how does the new benefit work with those plans?

Answer: Medicare Advantage is the new managed care program that is replacing Medicare+Choice. Most Medicare Advantage plans will likely offer a combination of health coverage and a drug benefit, and perhaps additional benefits not offered by traditional Medicare, such as dental or vision care. Most Medicare Advantage plans will require you to choose a doctor in the plan's network or pay more to go to an out-of-network doctor. Each year you can choose whether you want to stay in a Medicare Advantage plan, switch to a different Medicare Advantage plan, or return to traditional Medicare.

6 Things Each State Should Be Doing To Prepare For the MMA
January 2005

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) contains opportunities for States that prepare and consequences for those that don't. These changes will affect many state offices, including the Office of the Governor, the Secretary of Health, the Secretary of Mental Health, the Office of Personnel Management, the Insurance Commissioner/Secretary, the Attorney General, and the State Information Technology Coordinator (where applicable).

1) **Prevent coverage gaps among dual-eligibles**
   - The Center for Medicare and Medicaid Services has announced that dual-eligibles will be auto-enrolled prior to January 2006.

2) **Don't overpay the federal government**
   The oft-discussed "clawback" payment is a per beneficiary, per month calculation. States may have over-stated the number of dual-eligibles in 2003 and the length of actual service use; rebates from associated programs, (e.g., 340B) may also be overstated. States should obtain technical assistance to identify actual dual-eligible counts and service usage to avoid over-payment.

3) **Maximize federal assistance**
   - Provisions of the Act include subsidies to employers for employer or retiree drug coverage to Medicare-eligible beneficiaries, State Pharmaceutical Assistance Programs (SPAPs), and funds for educating beneficiaries.
   - State agencies are required to make low income subsidy application forms available by July 1, 2005 and be prepared for eligibility screening and determination.
   - States must attest to the value of retiree prescription drug coverage and apply for subsidy payment by September 30, 2005.

4) **Assess the cost-effectiveness and sustainability of managed Medicaid and disease management**
   Managed care and/or disease management may no longer be cost-effective options for dual-eligibles; providers may choose not to participate if auto-enrollment is not allowed. Actuarial assistance and decision-modeling can help predict the future value of these programs.

5) **Assess the effectiveness of current cost-containment strategies**
   - The MMA significantly reduces States' potential for savings from contemplated PDL cost containment initiatives. This is because the MMA shifts responsibility of prescription drug benefits for dual eligible patients from Medicaid to Medicare effective January 1, 2006. As a result, the potential savings for dually-eligible patients will accrue over a diminishing period of time and the number of prescriptions from which savings can be derived (subject to a PDL) will be greatly reduced.
   - The remaining Medicaid population will represent a new patient mix with different drug utilization patterns. Cost-containment of this population may be more sensitive to *utilization controls* and less sensitive to *deeply discounted prices* and *restrictive formularies.* States should re-think their cost-containment strategies to reflect the patient mix of the new Medicaid population.

6) **Assess the IT infrastructure**
   Many state Medicaid agencies are using outdated computer hardware with outdated software. States should be sure they have the necessary IT infrastructure and personnel for the new program.

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Medicare Modernization Act

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January 11, 2005

Medicare Modernization Act of 2003

- A widely-debated Act with optional misunderstood but oft-criticized and under-utilized benefits, to be administered by an agency under construction, guided by yet to be finalized rules, and implemented by private-sector organizations that either don't yet exist or are choosing to remain silent!
- The clock is already ticking!

Medicare Modernization Act of 2003

- Elderly constituents are interested in the benefit
- States administer Medicaid drug benefits currently provided to part D-eligible individuals
- States will pay a maintenance of effort payment to support part D for their "full benefit dual eligibles"
- Many states currently provide state-funded pharmacy assistance programs to part D-eligible individuals.
- States are employers who pay for retiree drug benefits

MMA Issues

I. Patient Access to drug benefits
   - Migration of duals
   - Enrollment and subsidies for low income

II. Patient Access to medicines
   - Choice of plans
   - Formularies vs. tiered cost-sharing

III. State budgets
   - Residual Medicaid
   - Clawback

I. Patient Access To Drug Benefits

Part D is a Private Sector Benefit

- The new stand part D drug benefit is available to all Medicare beneficiaries as of January 1, 2006, but enrollment is *optional* for each individual.
  - The process and options are no different than those faced by employees during an open enrollment.
  - No drug benefit for an individual who chooses not to participate
- No federal funds will be available to States to pay for dual eligibles' drugs in Medicaid.

How many Part D plans will there be?

- CMS contracts with entities to offer stand-alone "prescription drug plans" – PDPs – at least two plans everywhere, one of which can be an MA-PD.
- In order to receive drug coverage through an MA-PD, beneficiary must enroll in Medicare Advantage.
  - MA plans must modify drug benefits to conform to standard coverage or actuarial equivalent.
- CMS designates "regions" for bidding
  - 34 PDP regions (12/6/2004)
    - Upper Midwest and Northern Plains
    - (IA, MN, MT, NE, ND, SD, WY).
  - Same entity can bid in multiple regions.

How many Part D plans will there be?

- Declare – February 18, 2005
- Applications – mid-March, 2005
- Formularies – April 18, 2005
- CMS preliminary approval – May 16, 2005

Region 25

- Eligible Population. This region provides an adequate population of 1.9 million eligibles to assure PDP viability but is not too large to impair start-up and enrollment capacity in the first year.
- Beneficiary Considerations. This region combines seven states that are identical to the seven states in MA Region 19.
- Limited Variation in Prescription Drug Spending. Nationally, there is a 43% difference between the highest and lowest estimated average prescription drug spending in states by individuals age 65 and over in 2006. In this region, there is a 12% variation in drug spending across states within the region.

Choosing and Using a Plan

- Beneficiary has the option of selecting a part D Prescription Drug Plan "PDP" or an "MA-PD" annually
- Beneficiary may select a plan with standard coverage or alternative coverage or pay an additional premium for enhanced coverage.
- Beneficiary can change plans only at open enrollment; Plans can change drugs on formulary or preference status of drugs with 30 days notice.
- Beneficiary can file an exception request if a claim is denied or if he/she is charged a higher copayment. Can appeal denied requests for exceptions.

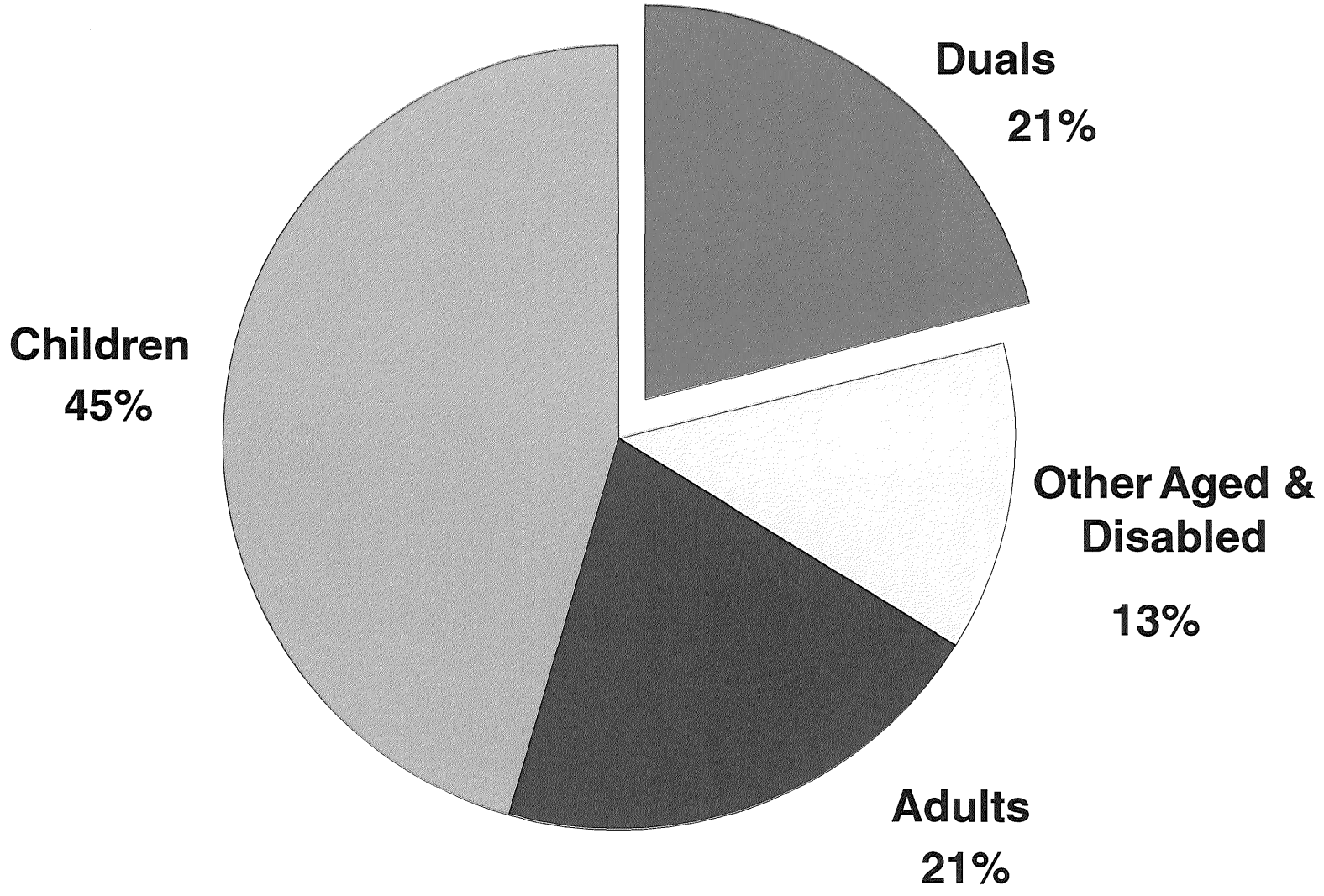
Medicaid Impact

- As of 1/1/06, the following categories of Medicaid beneficiaries *must* obtain their prescriptions through Medicare—
  - All Medicaid beneficiaries over age 65 who are entitled to Medicare part A or enrolled in part B.
  - Medicare-eligible disabled persons
  - Medicare beneficiaries who spend down to Medicaid eligibility.

  These are the "DUAL ELIGIBLES"

Medicaid Recipients

Source: Kaiser Family Foundation 2002 MMIS Data



Distribution of Eligibles in Oklahoma Medicaid and Dual Eligibles by Age

Age	% of Total	% Dual Eligible	% of Dual Total
< 21	65.7%	0.1%	0.1%
21-49	14.8%	21.5%	22.2%
50-64	6.1%	44.4%	18.8%
65 +	10.8%	78.1%	59.0%
Unknown	2.6%	0.0%	0.0%
Total	100%	14.3%	100%

Source: Dr. Elgene Jacobs, University of Oklahoma

How Will The Duals' Access Be Protected?

- If a full benefit dual eligible does not select a plan, the Secretary of HHS will "auto-enroll" each person in a plan
- Premiums for full benefit duals are fully paid by the federal government at the federal subsidy level
- Individuals have the right to disenroll from a plan to which they have been assigned and choose another.
- HELP THEM GET AND STAY ENROLLED!

Subsidies For Full-Benefit Duals

- Institutionalized Dual Eligibles

  never pay anything – premiums, deductibles, copay

- Dual Eligibles under 100% FPL –
  - Income must be less than $9,310 for an individual; $12,490 for a couple; and
  - Eligible for Medicaid in their state

  pay no premium
  never pay more than $1 generic/$3 brand

- Dual Eligibles over 100% FPL (Eligible for Medicaid in their state)

  pay no premium
  never pay more than $2 generic/$5 brand

Premiums

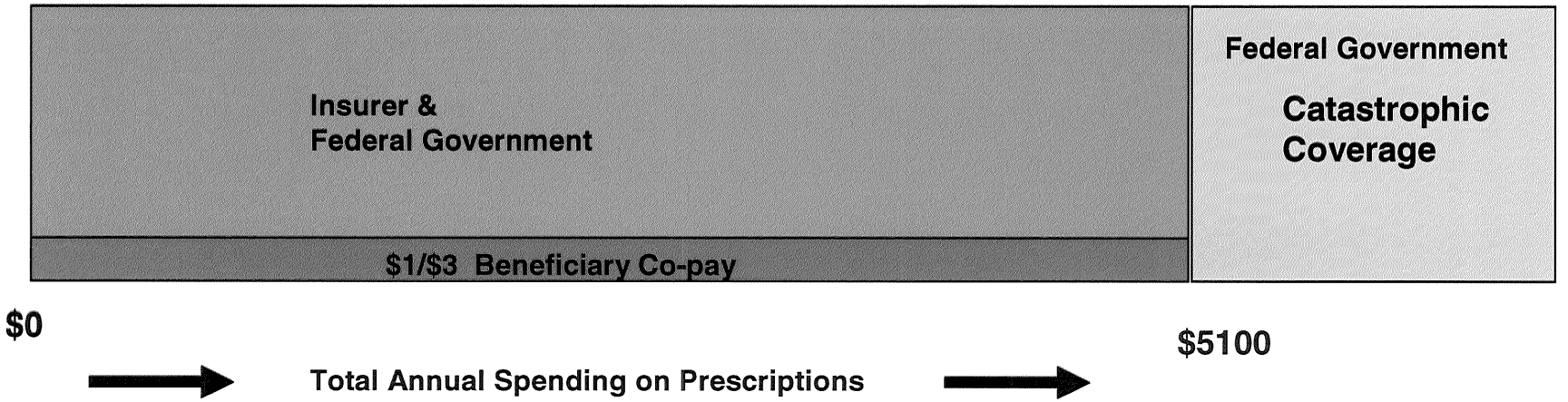
- CMS determines the basic premium for standard coverage in each region based on the bids of the plans awarded.
  - The federal premium subsidy for low income enrollees is for the basic premium.
  - At least one basic plan in each region must be available for the subsidized premium.
- Different plans may have different premiums, but every enrollee that has maintained continuous coverage will pay the same premium as every other enrollee in a plan.
- The beneficiary pays a 1% penalty for each month there is a lapse in standard coverage.

Low Income, Non-Medicaid

- Income under 135% FPL – (pay no premium)
  never pay more than $2 generic/$5 brand
  - Income must be < $12,569 / $16,862 for a couple.
  - Liquid assets <$6,000/$9,000 for a couple.
- Income under 150% FPL – (pay a sliding scale premium)
  never pay more than 15% after a $50 deductible
  - Income must be < $13,965 / $18,735 for a couple.
  - liquid assets <$10,000/ $20,000 for a couple.
- Income over 150% (or excess assets) – standard coverage and standard premiums

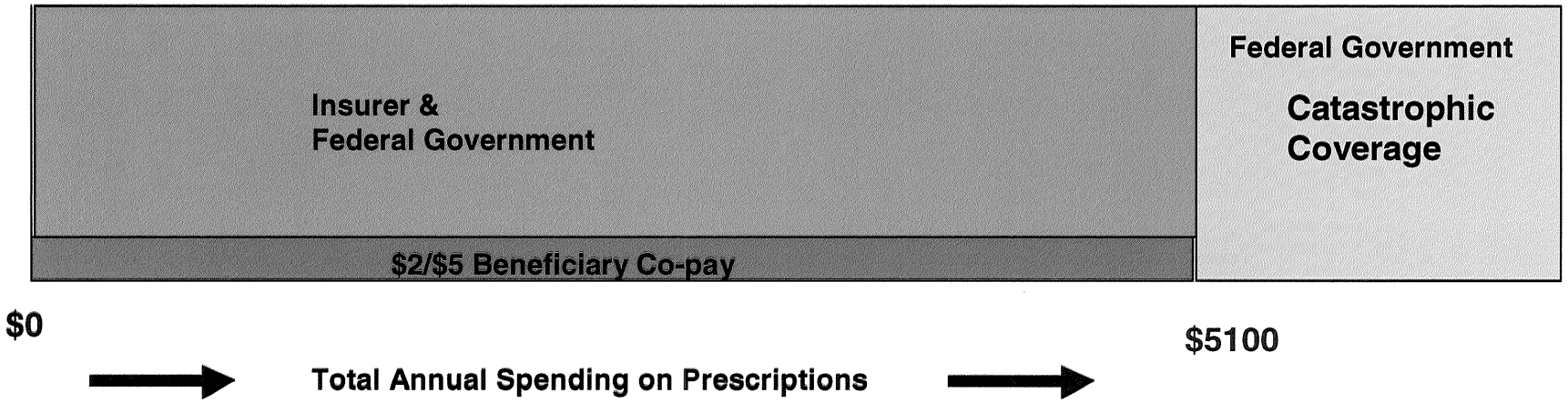
Dual Eligible Enrollees up to 100% FPL...

- Only the area in red must be paid by the individual.
- The $1 or $3 copay until prescription costs for the year reach $5100 would be the maximum cost for even the most medically needy beneficiary.



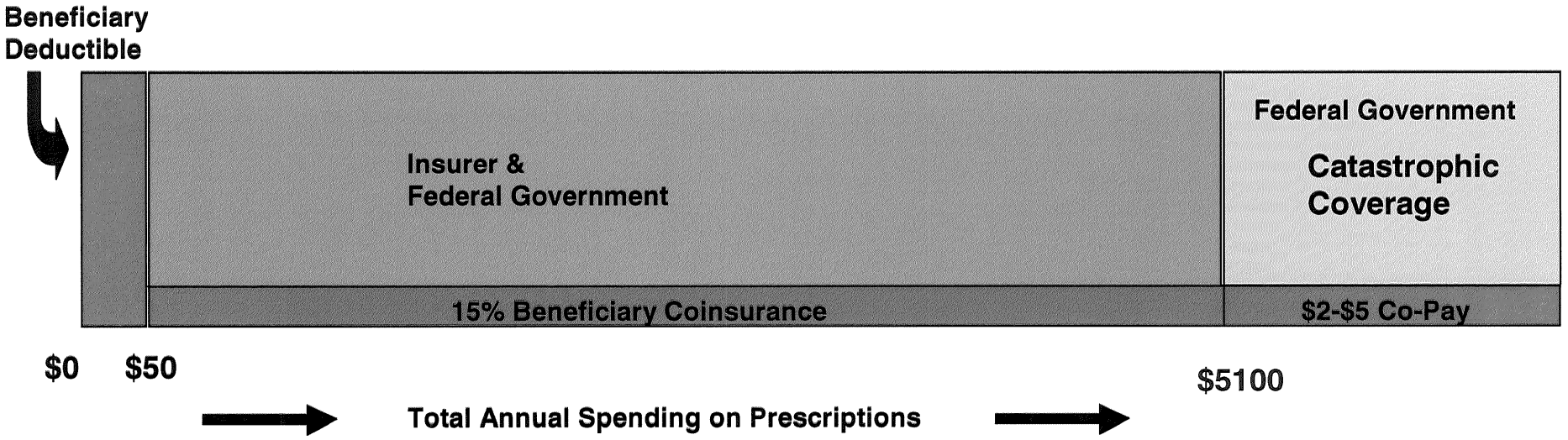
Dual Eligibles above 100% and *Non-* Dual Eligibles up to 135% FPL...

- Only the area in red must be paid by the individual.
- Total out-of-pocket is the sum of the $2/$5 copays for up to $5100 worth of prescriptions



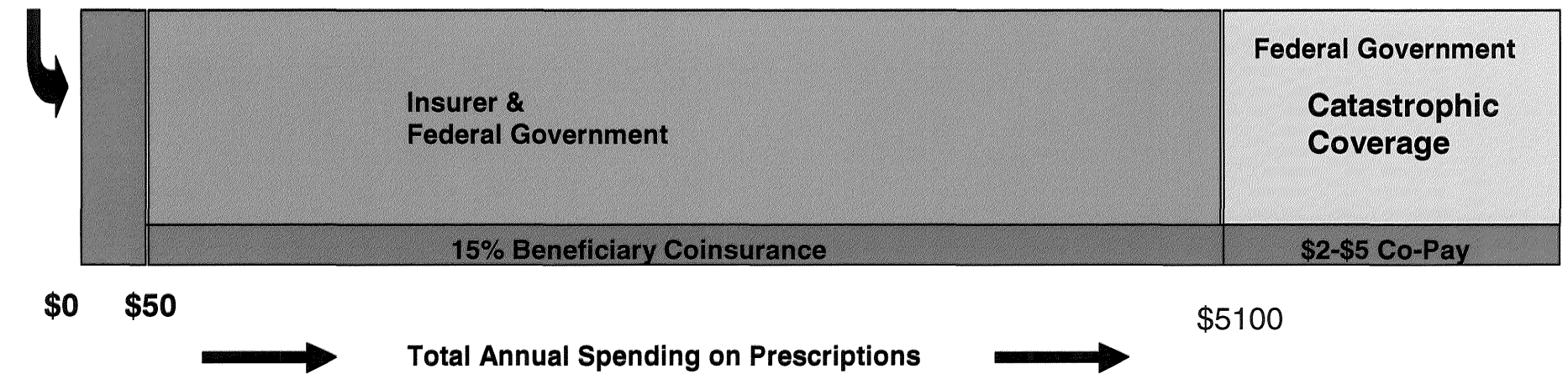
Enrollees 135 to 150% FPL...

- A sliding scale monthly **premium** and the areas in red are what must be paid by the individual.

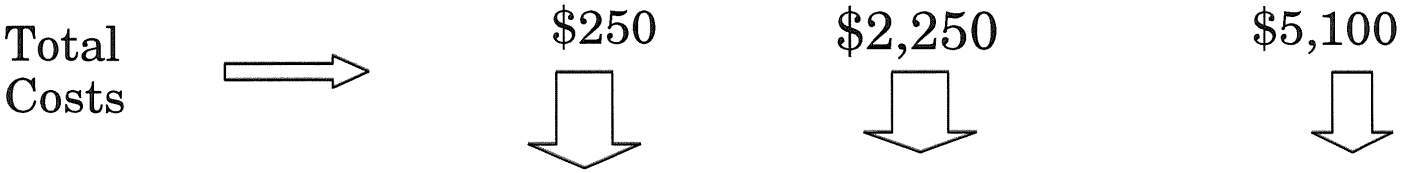


No Coverage Gaps for Enrollees With Incomes Under 150% FPL...

- A sliding scale monthly premium and the areas in red are what must be paid by the individual.
- For people under 135% FPL, no premium, no deductible, and copayments at $2 generic/ $5 brand or lower



Drug Benefit's Standard Coverage



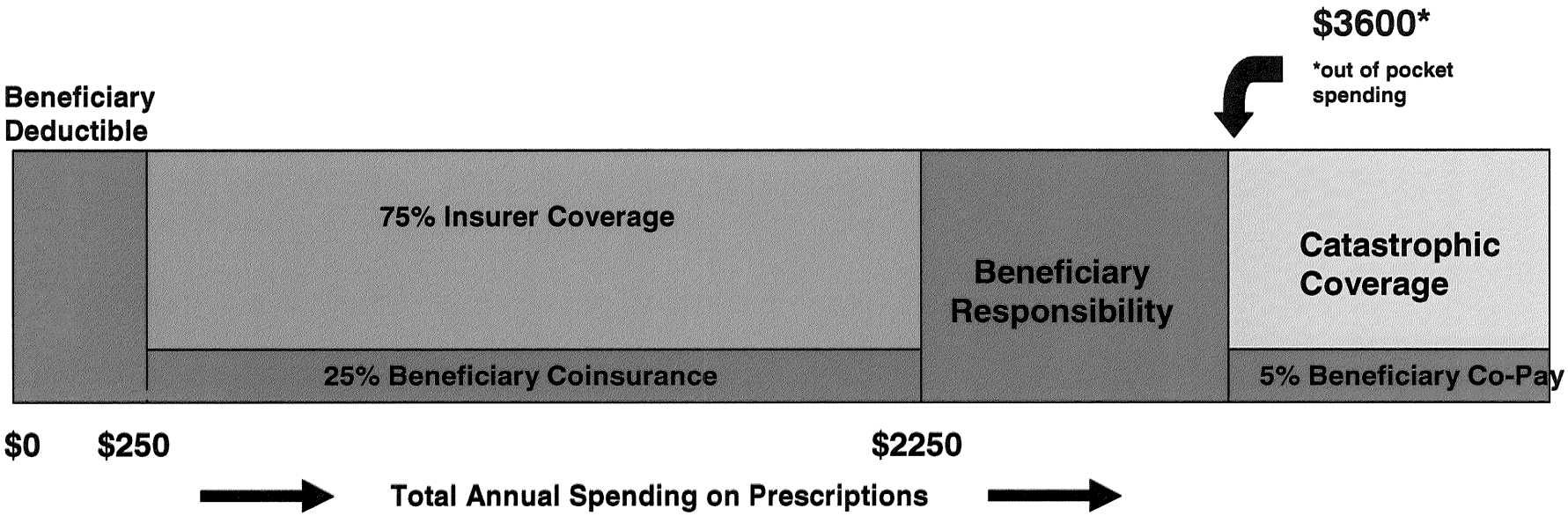
	Deductible	Next $2,000 in drug expenses	Next $2,850 in drug expenses	Any additional drug expenses
Beneficiary Pays	$250	25% (as much as $500)	Up to $2,850	5% or $2/$5 copay
Medicare Pays	$0	75% (as much as $1,500)	$0	95% or drug cost minus copay

Why/What is Standard Coverage?

- Think of it as a high deductible catastrophic coverage policy plus some earlier payments to encourage compliance with maintenance medications.
- No lifetime or annual cap on prescriptions; no monthly limit on the number of scripts
- Community rated premiums – no age or health underwriting.
- Predictable budgeting for moderate income people
  - Catastrophic coverage after $3600 out of pocket.
  - Premiums known in advance.

Enrollees over 150% FPL receive unsubsidized "standard coverage"

- The monthly premium and the areas in red are what must be paid by the individual.

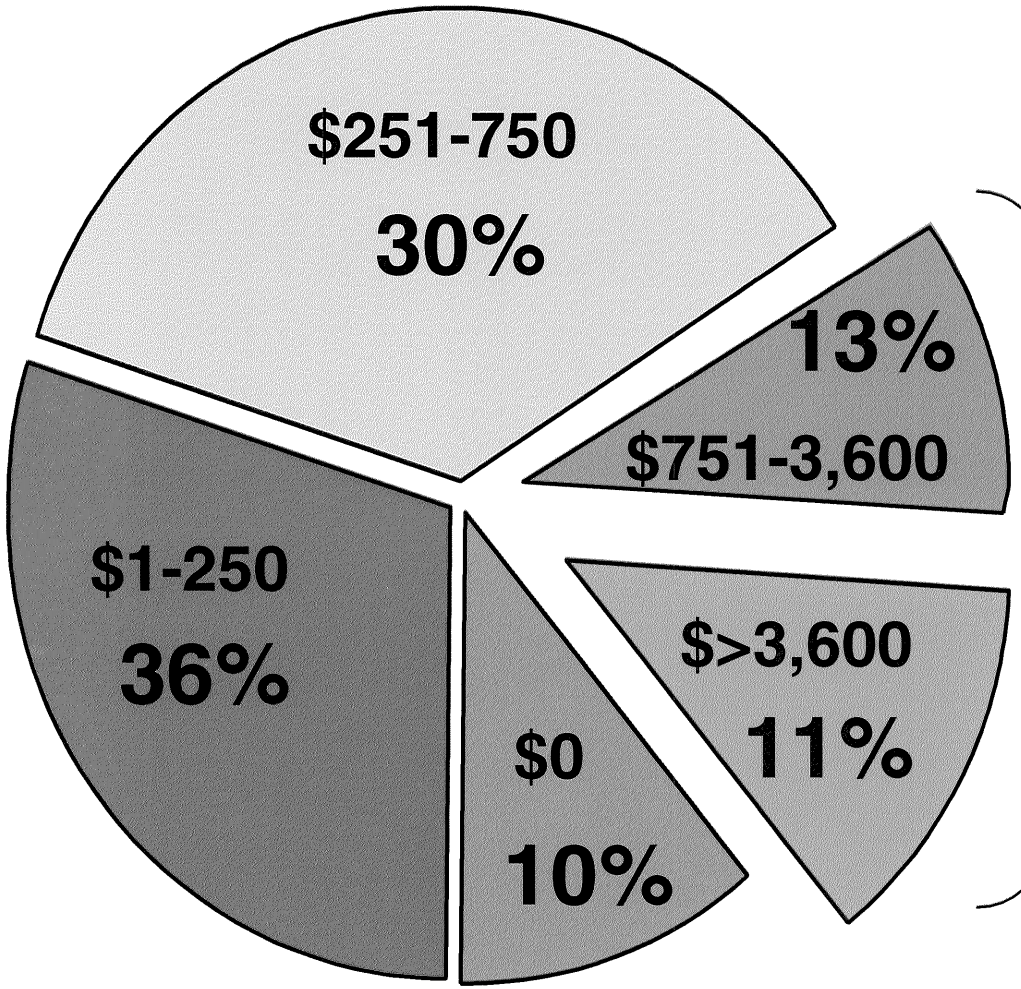


II. Patient Access To Medicines

Benefits for Beneficiaries in Region 25

- 1.9 million beneficiaries to get Medicare prescription drug benefit beginning in January 2006.
- 558,000 Medicare beneficiaries will have access to drug coverage they would not otherwise have; improves coverage for many more.
- About 559,000 beneficiaries with incomes below 135% FPL who have limited savings will pay no premium and will be responsible for no more than $2 for generic drugs or $5 for brand name drugs).
- About 157,000 beneficiaries with incomes below 150% FPL will pay reduced premiums, a $50 deductible, 15% coinsurance, and have no gaps in coverage.
- Medicare will assume the prescription drug costs of about 242,000 Medicaid beneficiaries in Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming. These seniors generally will pay $1 for generic drugs or $3 for brand name drugs. Seniors in nursing homes will pay nothing.

Estimates of Part D Out-of-Pocket Spending



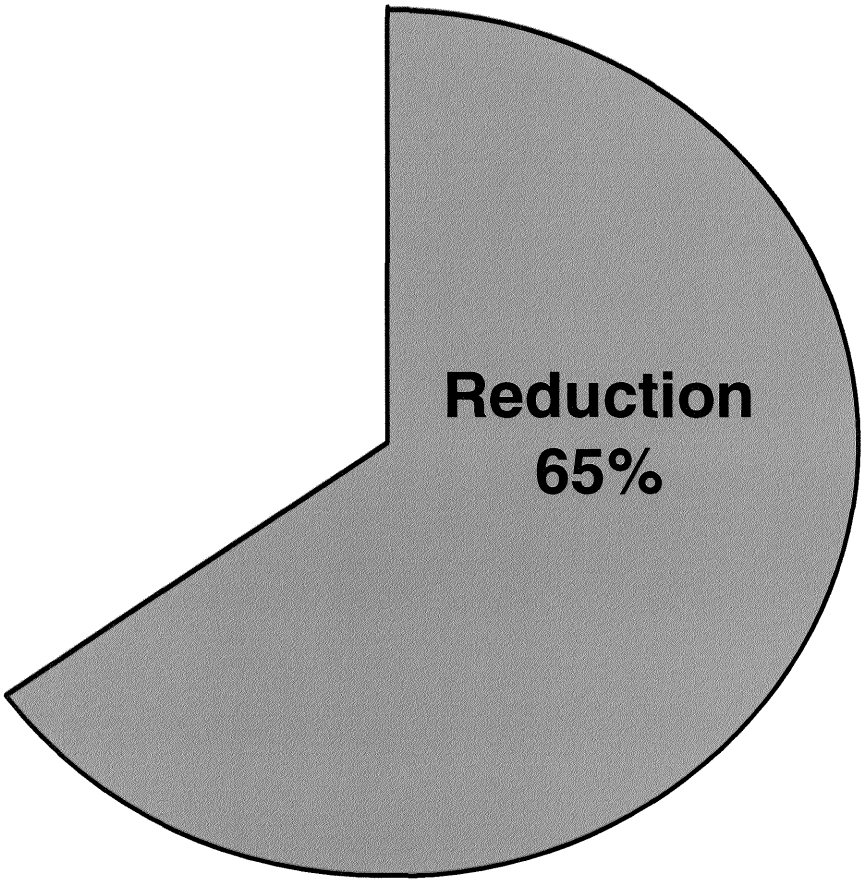
Less than 25% reach the "donut hole"

11% exceed it and benefit from a 37% reduction in spending due to catastrophic coverage

23%

Source: Kaiser Family Foundation/Actuarial Research Corporation; Excludes premiums and assumes no supplemental coverage

Nearly 2/3 of Part D Beneficiaries to spend less



65% to spend an average of $919 less

16% to have increased spending ≤ $250, due to $250 deductible or loss of "free" Medicaid coverage

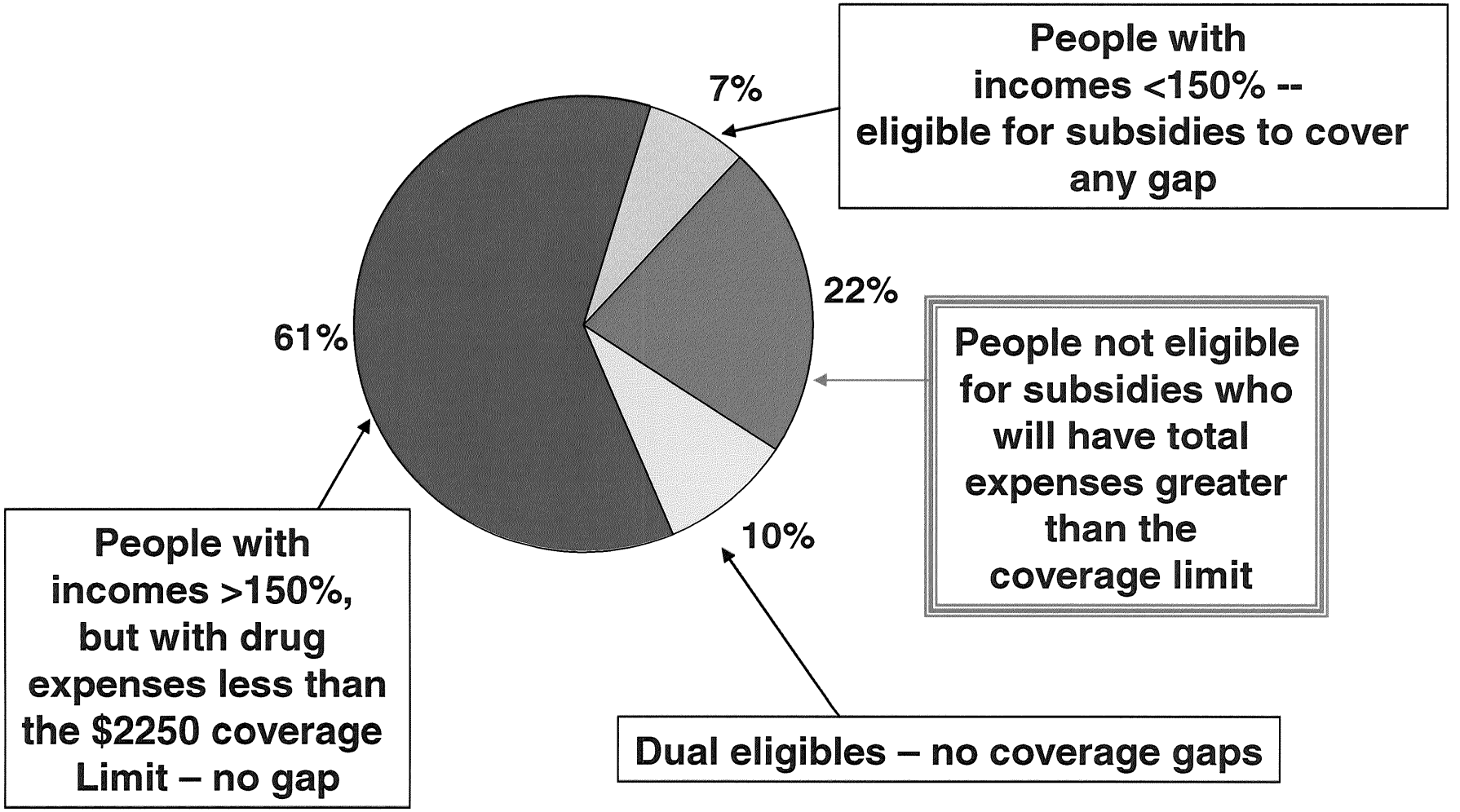
10% to have no change OOP spending

8% to spend more, IF they lose employer coverage

Source: Kaiser Family Foundation/Actuarial Research Corporation; Excludes premiums and assumes no supplemental coverage

MINNESOTA

Estimated Percentage of Medicare Part D Eligibles in Minnesota For Whom "Standard Coverage" Will Leave A Gap



Reductions in OOP Spending Benefit Low-Income Beneficiaries receiving subsidies

- 5 million beneficiaries < 100% FPL to spend 84% less
- 1.4 million between 100-134% FPL to spend 85% less
- 400,000 between 135-150% FPL to spend 77% less
- 700,000 duals >150% FPL to spend 65% less
- Those not receiving low-income subsidies to spend 28% less; average reduction 37%

Source: Kaiser Family Foundation/Actuarial Research Corporation; 150% group includes dual-eligibles

Projected Part D OOP Spending

- Dual-eligibles, $94
- Low-income subsidy < 135% FPL, $153
- Low-income subsidy 135-149% FPL, $406
- Part D, no low-income subsidy, $1,081
- Non Part D employer subsidy, $1,309
- Non-participants, $1,416

Source: Kaiser Family Foundation/Actuarial Research Corporation

True Out-Of-Pocket (TrOOP)

- Each beneficiary's out of pocket payment is capped at $3600 -- TrOOP.
- PDP must track TrOOP for each beneficiary.
- TrOOP includes—
  - Deductible
  - Coinsurance
  - Donut hole
  - And the amounts paid in cost-sharing subsidies on behalf of beneficiaries with SPAP or federal subsidies.
- TrOOP does NOT include payments for drugs *excluded* from a plan's formulary.

A PDP formulary must --

- Be developed by a P&T Committee
- Include drugs in each therapeutic category and class, but need not include all drugs within each
- Give 30 days notice before removing drug or changing preferred or tiered cost-sharing
- Make changes in therapeutic classification only at beginning of plan year
- Provide an appeal process for non-preferred drugs
- Have a process for suggesting generic or lower cost products.

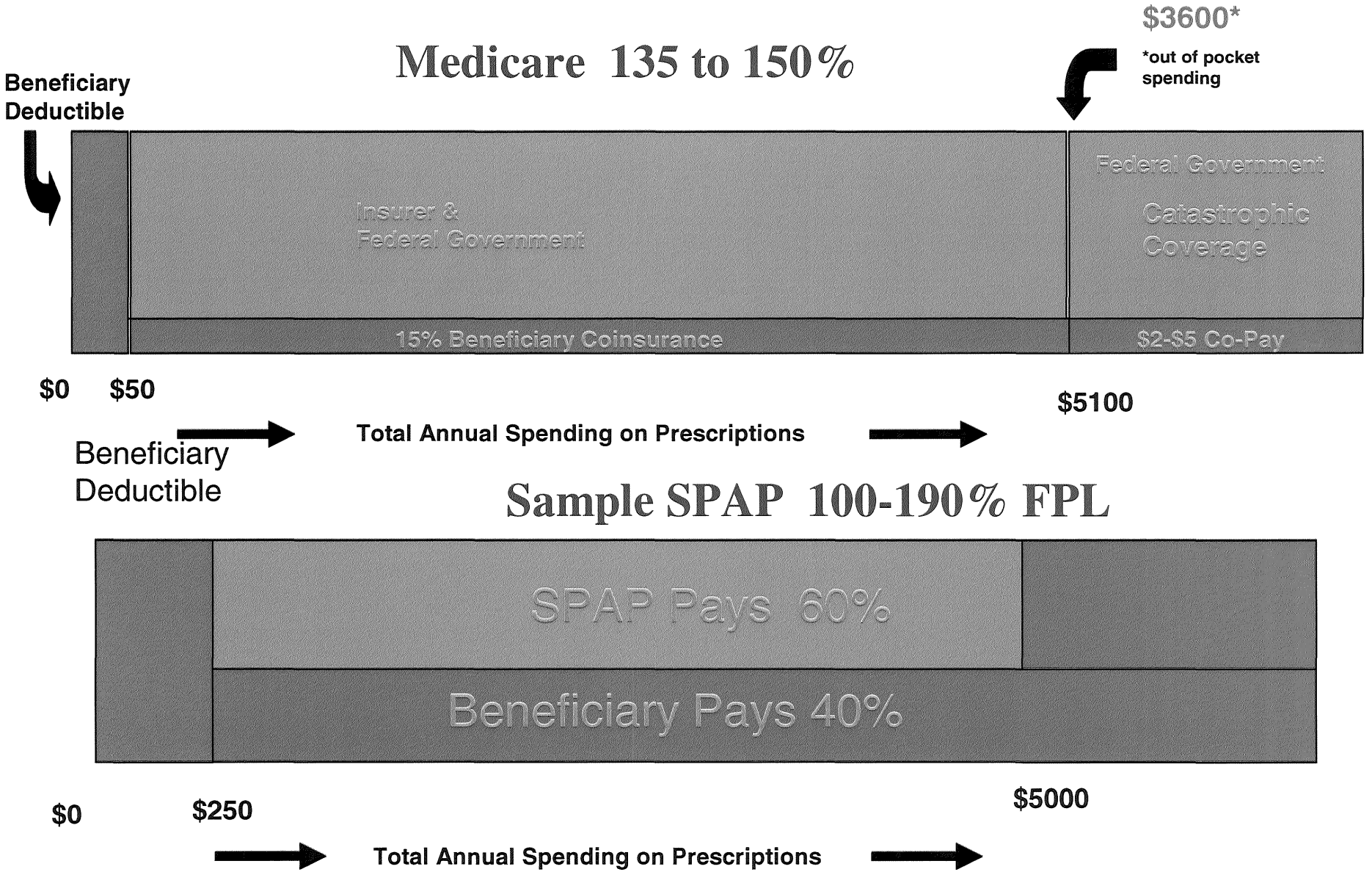
CMS Review of Formularies

- PDP Formulary may not create disincentives for enrollment by special medical populations.
- Categories and Classes (only *one* component)
  - USP safe harbor for categories and classes
  - *At least* two drug(s) per class
- Some drugs "on" formulary may have 100% coinsurance (counts toward TrOOP)
- Beneficiaries with federal subsidies are not exposed to formulary tiers; have flat copays for brand/generic.

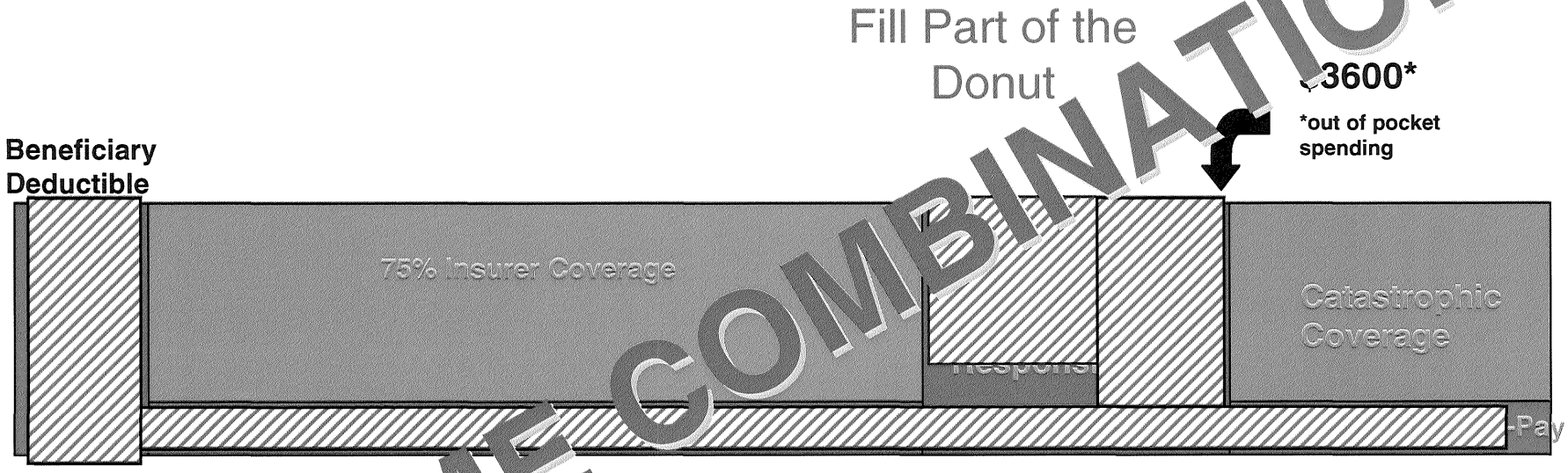
Enriching Standard Coverage

- Medicare plans are allowed to offer "ehanced coverage" to improve on standard coverage
- State Pharmacy Assistance Programs -- SPAPs – but not retiree or Medi-Gap plans -- are allowed to stand in the individual's shoes and pay cost-sharing
- Current SPAPs largely duplicate part D coverage for non-Medicaid low-income beneficiaries but generally are not as good, because of limits on catastrophic coverage.
- Opportunity for SPAPs to "wrap around" part D standard coverage for low income beneficiaries who cannot afford enhanced coverage.

Example: SPAP Dollars Are In The Wrong Place



Options for Enhancement



OR SOME COMBINATION

Lower the Deductible

Lower the Coinsurance

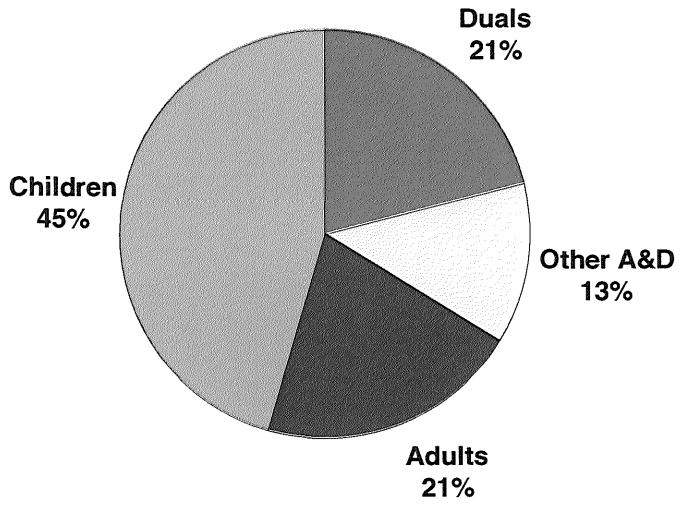
Lower the Stop Loss

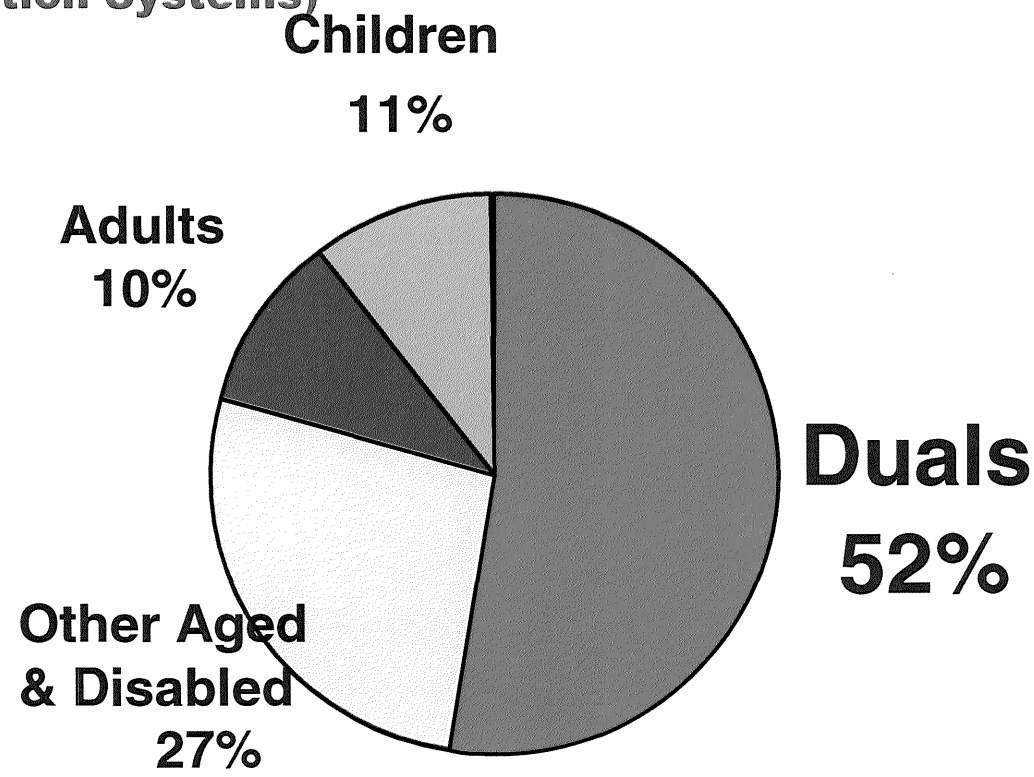
Premium Subsidy Up to Some Poverty Level

III. State Budgets

National Data from KFF
(2002 Medicaid State Information Systems)

Medicaid *Recipients*





Prescription Drug *Expenditures*

National Medicaid Expenditures (from Kaiser Family Foundation 2002 data)

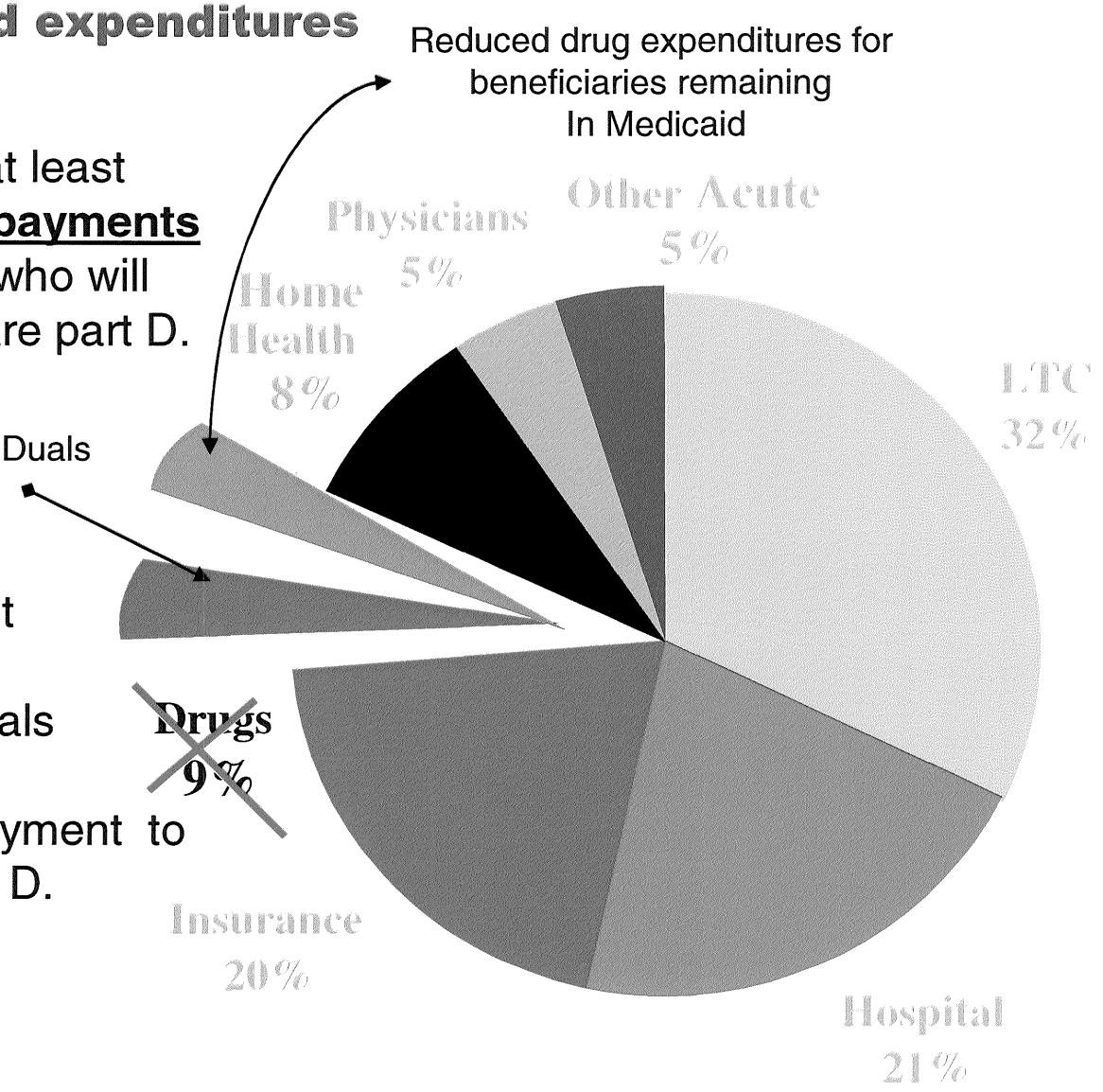
- Total Medicaid expenditures = $248,722 MM
  - $23,398 MM (9.4%) on prescription drugs (net of manufacturer rebates)
  - $13,177 MM of the $23,398 MM is drugs for duals -- ***56% of drug payments are drugs for duals***
- State only funds – net per capita drug spend on duals = $918 national average)
- KFF says the US had 6,126,000 full benefit duals in 2002

2006: Clawback Payment

- Base Amount: Net weighted average monthly per capita expenditure by your State for a dual eligible's drugs (including dispensing fees but net of manufacturer rebates) in 2003
- 2006 Monthly Payment = The base amount –
  - increased by the health expenditure growth factor
  - Multiplied by the number of the state's "full benefit" Medicaid Beneficiaries enrolled in part D in that month
  - Multiplied by the clawback percentage -- 90% in 2006, down to 75% in 2015 and thereafter.

2006: Clawback changes the distribution of State-Only Medicaid expenditures

- Of the 2003 drug slice, at least **56% of Medicaid drug payments** were for "dual eligibles" who will be transferred to Medicare part D.
- Assuming that the state has the same number of dual eligibles in 2006, 90% of the amount spent by the state Medicaid program on drugs for duals in 2003 will be paid as a maintenance of effort payment to Medicare to finance part D.



Five things every state should be doing

- Prevent dual-eligible coverage gaps
  - Enrollment begins 11/05
  - Medicaid payments cease 1/06
  - ~~Auto-enrollment not scheduled until 5/05~~
- Communicating the value of the benefit
- Avoid overpaying the federal government
- Maximize federal assistance
- Assess cost-containment approaches
  - Will PDLs, Managed Care, and/or Disease Management be effective?

Distribution of Eligibles in Oklahoma Medicaid and Dual Eligibles by Age

Age	% of Total	% Dual Eligible	% of Dual Total
< 21	65.7%	0.1%	0.1%
21-49	14.8%	21.5%	22.2%
50-64	6.1%	44.4%	18.8%
65 +	10.8%	78.1%	59.0%
Unknown	2.6%	0.0%	0.0%
Total	100%	14.3%	100%

Source: Dr. Elgene Jacobs, University of Oklahoma

Medicaid Data by Drug Type and Dual Eligible Status

	Percent of Medicaid Expenditures	
AHFS 2 digit	% Dual Eligible	% Non Dual Eligible
Central Nervous System Drugs	36%	39%
Cardiovascular Drugs	15%	7%
Gastrointestinal Drugs	12%	8%
Anti-Infective Agents	6%	14%

Percent Growth of Medicaid Prescription Drug Expenditures- 2002-2004*

	Total	Population	Price	Utilization
Total	17.5%	2.5%	7.0%	8.0%
Dual Eligibles	19.5%	2.0%	10.0%	7.5%
Non Dual Eligibles	15.0%	3.0%	4.0%	8.0%

* Muse & Associates estimate based on CMS data

2006 – Retiree benefits

- Employer plan (including states) may receive a subsidy by offering:
  - Retiree coverage that is the actuarial equivalent of standard coverage, or
  - Enhanced coverage (coverage that is better than standard coverage)
- Subsidy is available for each retiree who is eligible for part D but who is instead enrolled in a group health plan
  - a federal refund equal to 28% of each person's allowable prescription drug costs between $250 and $5000 (indexed in future years)
  - approximately $1330 maximum refund per retiree in 2006
  - Must certify and apply by September 30, 2005!

A Framework For (r)Evolution

- A step on the road to ensuring that government-financed health care systems work more like the best employer-financed health care systems
- Near term challenges will include rearranging existing funding relationships; establishing the logistics of how the system will work; and informing everyone – patients, providers, plans, systems vendors.
- In the longer term, the challenge will be creating incentives for assuring each patient's access to the standard of care for his or her unique medical needs.

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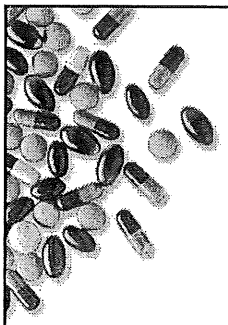
* Muse & Associates estimate based on CMS data

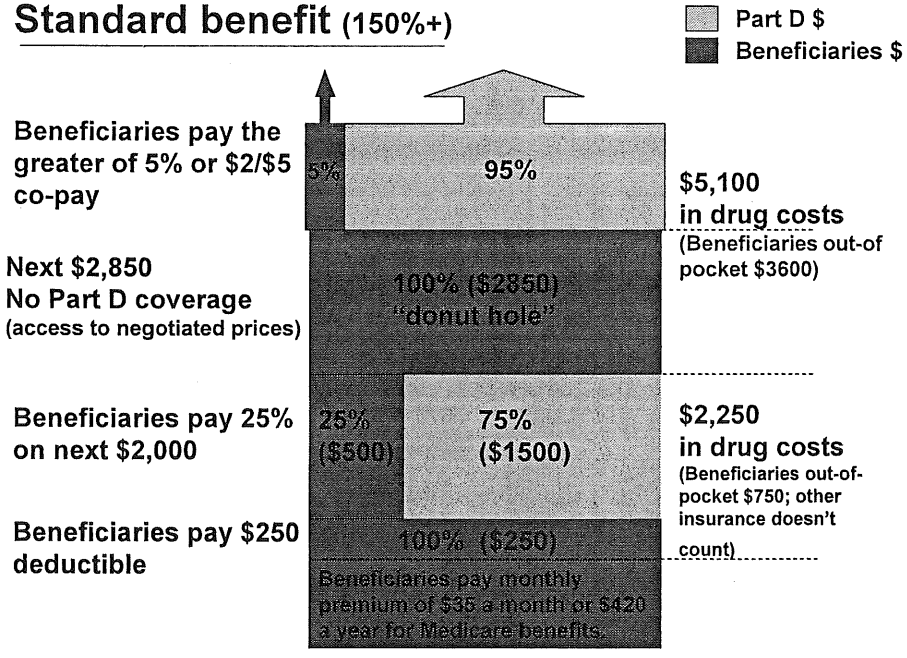
Christine Brouson

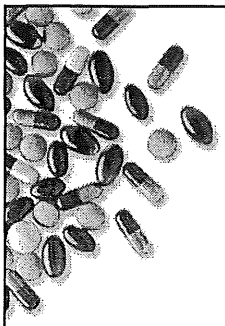


Part D standard benefit

- Voluntary
- Standard benefit is what most Minnesota beneficiaries would qualify for
- Income above 150% FPG
- Choice per region of at least one Prescription Drug Plan, and one integrated plan (Medicare Advantage) or a second PDP
- $35 per month premium/$420 annually
- Other cost sharing shown on accompanying chart
- Cost sharing amounts in later years adjusted upward
- NOTE: Plans may design "actuarially" equivalent options and alter cost sharing

Standard benefit (150%+)



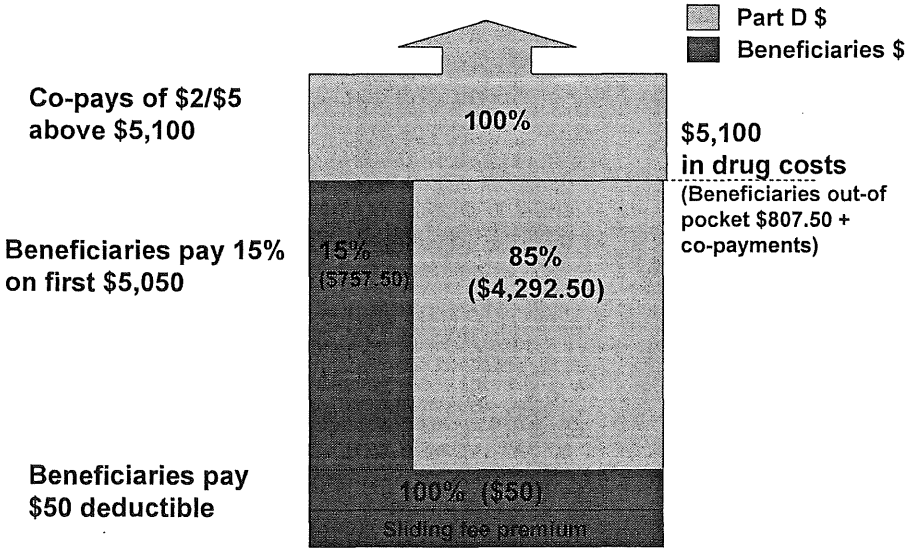


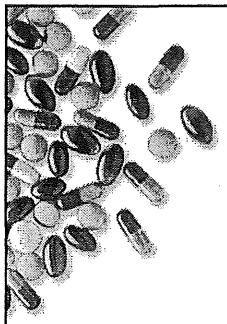
Low-income beneficiaries:

Non-Medicaid and non-SSI with income between 135%-150% FPG

- Assets no more than $10,000/$20,000
- Premium on sliding-fee scale (not defined)
- Choice of at least one Prescription Drug Plan and one integrated plan (Medicare Advantage)
- $50 deductible
- 15% coinsurance on costs up to $5,100
- $2-$5 co-payments on prescriptions *above* the catastrophic threshold of $5,100

Non-Medicaid and non-SSI 135% - 150% FPG



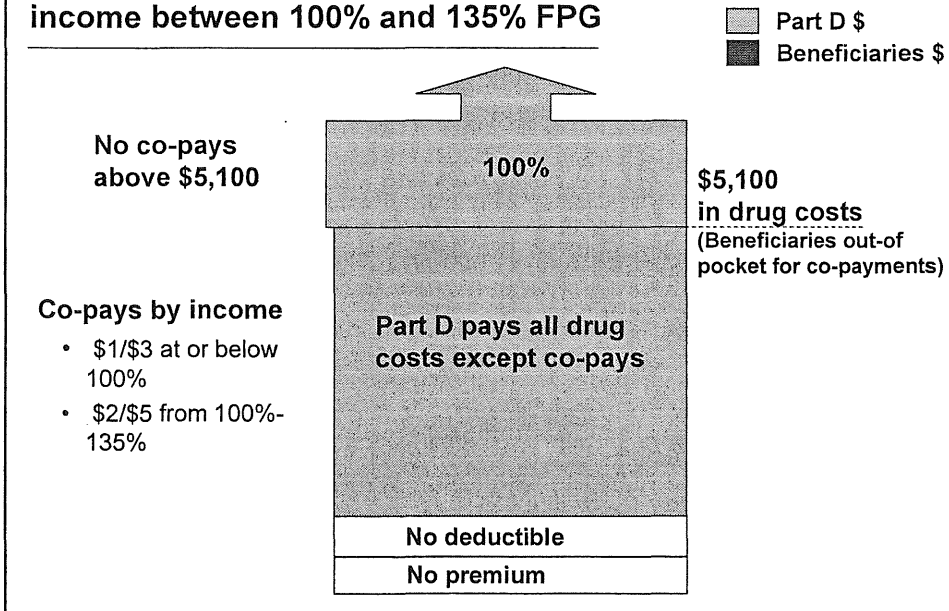


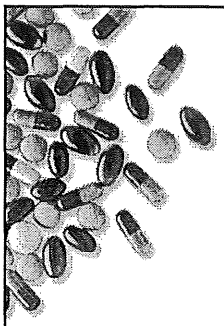
Low-income beneficiaries:

Non-Medicaid and non-SSI with income below 135% FPG

- Assets no more than $6,000/$9,000
- Choice of at least one Prescription Drug Plan and one integrated plan (Medicare Advantage)
- No premiums
- No deductible
- Co-payments below catastrophic threshold (i.e. $5,100)
  - $1/$3 for incomes at or below 100%
  - $2/$5 for incomes between 100%-135%
- No co-payments above $5,100

Non-Medicaid and non-SSI with income between 100% and 135% FPG



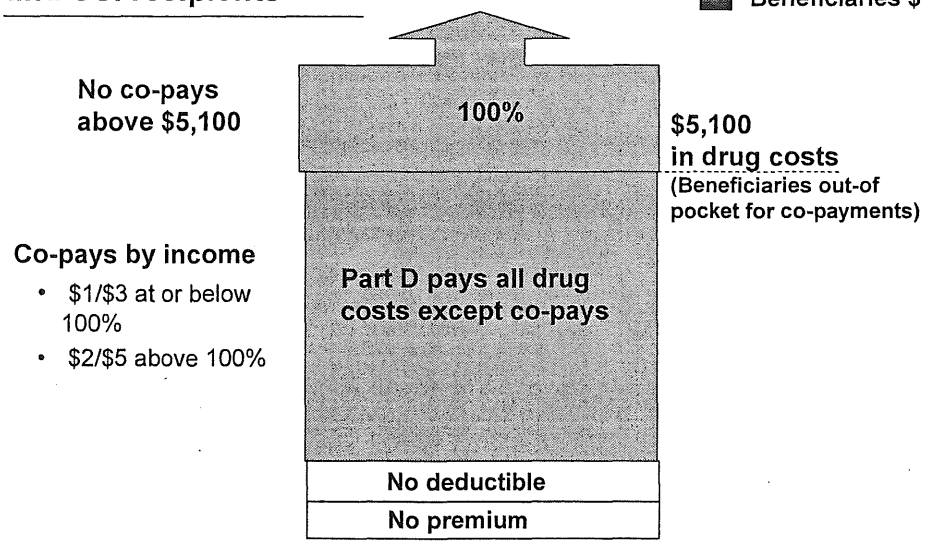


Low-income beneficiaries:

Medicaid full-benefit duals, Medicare Savings Program-only and SSI recipients

- Automatically eligible for subsidy (this will include Minnesota's Prescription Drug Program enrollees)
- Choice of at least one Prescription Drug Plan and one integrated plan (Medicare Advantage)
- No premiums
- No deductible
- Co-payments below catastrophic threshold (i.e. $5,100)
    - $1/$3 for incomes at or below 100%
    - $2/$5 for incomes above 100%
- No co-payments above $5,100
- No co-payments for full-benefit dual eligibles in nursing homes or other long-term care facilities

Medicaid full-benefit duals, Medicare Savings Program-only and SSI recipients



Christine Bronson

Impacts of Medicare Part D and MMA on Minnesota

Christine Bronson
Minnesota Medicaid Director
January 11, 2005

Minnesota's Medicare Population

Each of the 660,000 Medicare beneficiaries in Minnesota will have to make a decision about Medicare Part D.

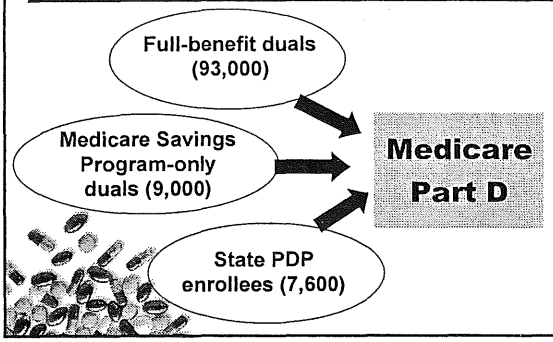
Minnesota's Medicare Population

Of the 660,000 beneficiaries in Minnesota:

- 50% (330,000) have no drug coverage[1]
- 230,000 have income below 150% FPG
- 93,000 are dually eligible for full benefits from Medicare and Medicaid
- 7,600 are enrolled in the state's PDP program (Nov. '04)

[1] Minnesota Department of Health, "Prescription Drug Coverage and Spending in Minnesota," April 2003.

Migration on 1/1/06



Part D Low-Income Subsidy

Full-benefit duals

- Deemed eligible for Part D subsidy.

Medicare Savings Programs (QMB, SLMB, QI) and Minnesota Prescription Drug Program enrollees

- Deemed eligible for Part D subsidy.

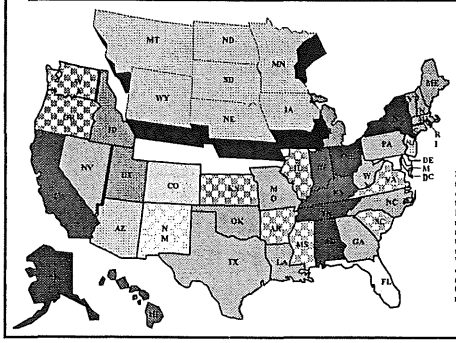
Others under 150% FPG

- May apply for low-income subsidy.

Part D Timeline

Spring 2005	Beneficiary Mailings
July 1, 2005	SSA's Low-Income Subsidy Application Process Begins
September 2005	CMS announces approved plans
November 15, 2005	Part D Plan Enrollment Begins
Fall 2005	*Auto Assignment Begins*
December 31, 2005	Medicaid Drug Coverage for Dual Eligibles Ends
January 1, 2006	Medicare Part D Coverage Begins

Medicare Advantage and Prescription Drug Plan Regions



Impact on Full-Benefit Dual Eligibles

Positives

- Continued no premiums
- Continued no deductible
- Not subject to "donut hole"
- *Auto-assignment before January 1, 2006 would ensure no gap in drug coverage*

Impact on Full-Benefit Dual Eligibles (con't)

Potential negative impacts

- Loss of $20 monthly cap on co-pays
- Co-pays will apply to antipsychotics
- Possibly more limited formulary than Medical Assistance
- Possibly smaller pharmacy network than Medical Assistance
- Program is complex & confusing

Impact on Minnesota PDP Enrollees

Positives

- **Continued no premium**
- **Elimination of $35 deductible**
- **Not subject to "donut hole"**

Potential negatives

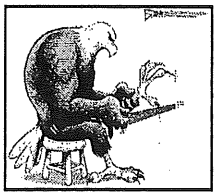
- **Unlikely to be able to auto-assign PDP-only enrollees**
- **Cost-sharing could exceed $35 per month**
- **Possibly more limited formulary than PDP**
- **Possibly a smaller pharmacy network than PDP**
- **Pharmacy charges will no longer count toward Medical Assistance spenddown**

The "Clawback" of Medicaid Savings

The "clawback" is a continued state contribution to the cost of providing benefits for full-benefit dual eligibles through a monthly payment to the federal government.

- State contribution will be determined by October 15, 2005
- Monthly payments start January 1, 2006

The "Clawback" 10-year Phase Down

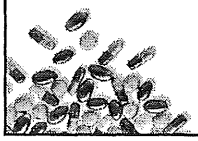


2006	**90%**
2007	**88.33%**
2008	**86.66%**
2009	**85%**
2010	**83.33%**
2011	**81.66%**
2012	**80%**
2013	**78.33%**
2014	**76.33%**
2015	**and 75% thereafter**

"Clawback" impact on Minnesota

Estimated clawback payments will be:
$ 67 million in FY 2006
$147 million in FY 2007

Expected to be budget neutral because of other costs.



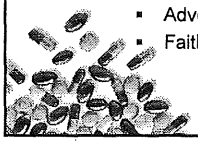
Other Impacts of Part D to Minnesota

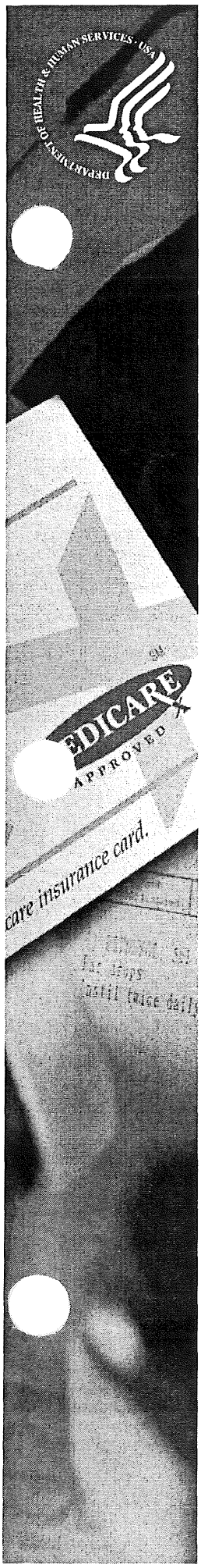
- **Current spending on state Prescription Drug Program will now be duplicative.**
- **Costs of any outreach, assistance, eligibility determinations the State undertakes.**
- **More complex administration of MSHO/MnDHO**

Help for Consumers

The Senior LinkAge Line® (RxConnect™)

- 1-800-333-2433
- www.MinnesotaHelp.info
- Coordinated outreach
  - Health Care Providers (Doctors, Clinics, Pharmacies, Health Plans)
  - Advocacy Groups
  - Faith-Based Organizations





The Facts about Upcoming New Benefits in Medicare

Medicare Modernization Act of 2003

Medicare is an essential health care program for people age 65 and older, people with certain disabilities, and people with End-Stage Renal Disease.

Recently, President Bush and Congress worked together to pass a new law to bring people with Medicare more choices in health care coverage and better health care benefits.

This new law preserves and strengthens the current Medicare program, adds important new prescription drug and preventive benefits, and provides extra help to people with low incomes. You will still be able to choose doctors, hospitals and pharmacies.

If you are happy with the Medicare coverage you have, you can keep it. Or, you can choose to enroll in new options described below. No matter what you decide, you are still in the Medicare program.

Drug Discount Cards Start in 2004

Medicare-Approved Drug Discount Cards will be available in 2004 to help you save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help you save 10–25% on prescription drugs.

You can enroll beginning as early as May 2004 and continuing through December 31, 2005. Enrolling is your choice. Medicare will send you information soon with details about how to enroll.

People in the greatest need will have the greatest help available to them. If your income is no more than $12,569 for a single person, or no more than $16,862 for a married couple, you might qualify for a $600 credit on your discount card to help pay for your prescription drugs. These income limits change every year. Different rules may apply if you live in Puerto Rico or a U.S. territory. (You can't qualify for the $600 if you already have drug coverage from Medicaid, TRICARE for Life or an employer group health plan.)

Also new in 2004, Medicare Advantage is the new name for Medicare + Choice plans. Medicare Advantage rules and payments are improved to give you more health plan choices and better benefits. Plan choices might have improved already in your area. To find out more, call 1-800-MEDICARE (1-800-633-4227).

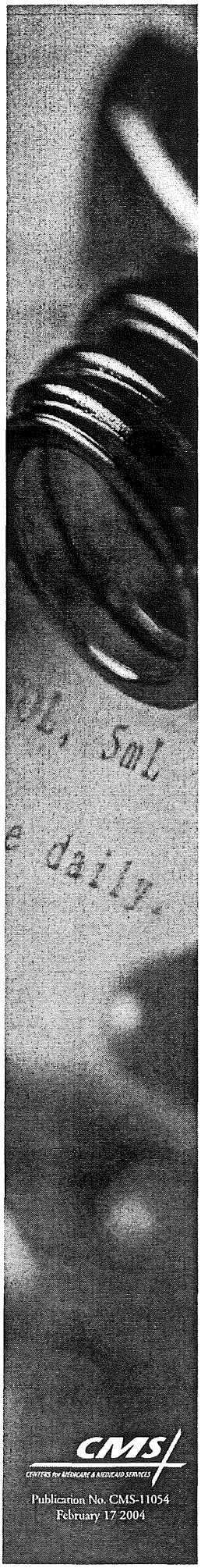
New and Improved Preventive Benefits Start in 2005

New Preventive Benefits will be covered, including:

- A one-time initial wellness physical exam within 6 months of the day you first enroll in Medicare Part B.
- Screening blood tests for early detection of cardiovascular (heart) diseases.
- Diabetes screening tests for people with Medicare at risk of getting diabetes.

These benefits add to the preventive services that Medicare already covers, such as cancer screenings, bone mass measurements and vaccinations.

John Gross



Prescription Drug Plans Start in 2006

Prescription Drug Benefits will be added to Medicare in 2006. All people with Medicare will be able to enroll in plans that cover prescription drugs. Plans might vary, but in general, this is how they will work:

- You will choose a prescription drug plan and pay a premium of about $35 a month.
- You will pay the first $250 (called a "deductible").
- Medicare then will pay 75% of costs between $250 and $2,250 in drug spending. You will pay only 25% of these costs.
- You will pay 100% of the drug costs above $2,250 until you reach $3,600 in out-of-pocket spending.
- Medicare will pay about 95% of the costs after you have spent $3,600.

Some prescription drug plans may have additional options to help you pay the out-of-pocket costs.

Extra Help Will be Available for people with low incomes and limited assets. Most significantly, people with Medicare in the greatest need, who have incomes below a certain limit won't have to pay the premiums or deductible for prescription drugs. The income limits will be set in 2005. If you qualify, you will only pay a small co-payment for each prescription you need.

Other people with low incomes and limited assets will get help paying the premiums and deductible. The amount they pay for each prescription will be limited.

Medicare Advantage plan choices will be expanded to include regional preferred provider organization plans (PPOs). Regional PPOs will help more people with Medicare have multiple choices for Medicare health coverage, no matter where they live. PPOs can help you save money by choosing from doctors and providers on a plan's "preferred" list, but usually don't require you to get a referral. PPOs are among the most common and popular plans right now for working Americans.

All of these options are voluntary. You can choose to remain in the traditional Medicare plan you have today.

Questions about Medicare?

For the latest information about Medicare, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

To get a copy of this information in Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Para una copia en español, llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

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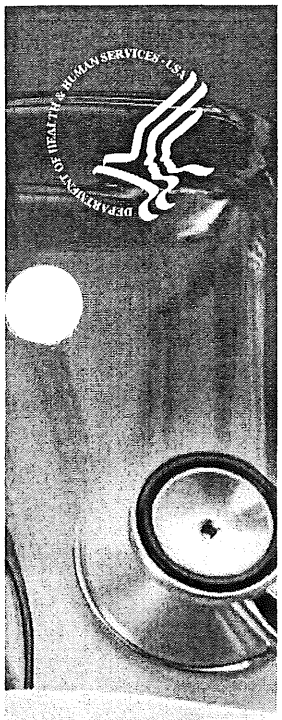
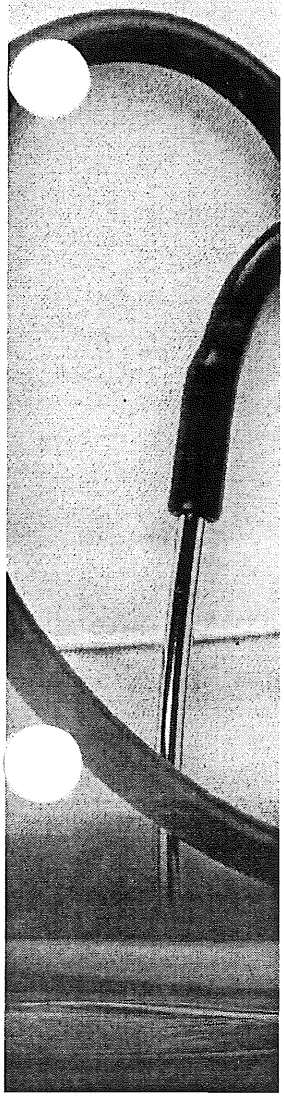




The Facts About Medicare Prescription Drug Plans

Coming in 2006

MEDICARE MODERNIZATION ACT

What are Medicare prescription drug plans?

Beginning January 1, 2006, new Medicare prescription drug plans will be available to people with Medicare. Insurance companies and other private companies will work with Medicare to offer these drug plans. They will negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards, which phase out by May 15, 2006, or when your enrollment in a Medicare prescription drug plan takes effect, if earlier.

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join you will pay a monthly premium (generally around $35 in 2006) and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose.

Drug plans may vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans will have to provide at least a standard level of coverage, which Medicare will set. However, some plans might offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it is important for you to choose one that meets your prescription drug needs.

When can I join a Medicare prescription drug plan?

If you currently have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), you can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. If you join by December 31, 2005, your Medicare prescription drug plan coverage will begin on January 1, 2006. If you join after that, your coverage will be effective the first day of the month after the month you join. In general, you can join or change plans once each year between November 15 and December 31.

Even if you don't use a lot of prescription drugs now, you still should consider joining a plan. If you don't join a plan by May 15, 2006, and you don't have a drug plan that covers as much or more than a Medicare prescription drug plan, you will have to pay more each month (a surcharge) to join later.

What if I can't pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including your savings and stocks, but not counting your home) will qualify for extra help. The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions. The type of extra help will be based on your income and assets.

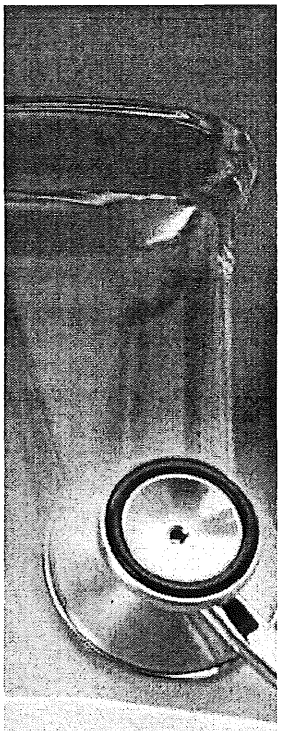
Look for details in the mail from Medicare and the Social Security Administration (SSA). If you think you qualify for extra help, you can sign up with SSA or your local Medicaid office as early as the summer of 2005.

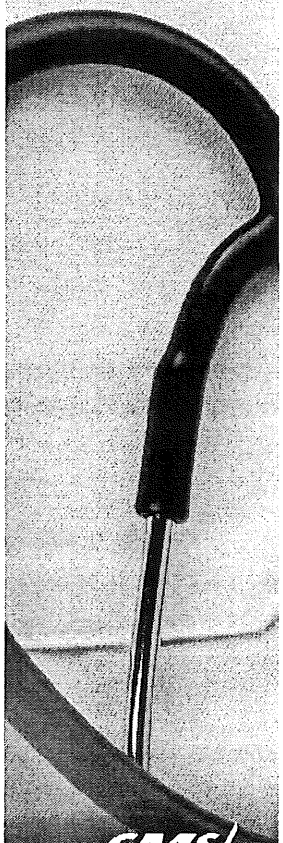
Do Medicare prescription drug plans work with all types of Medicare health plans?

Yes. There will be Medicare prescription drug plans that add coverage to the Original Medicare Plan. These plans will be offered by insurance companies and other private companies.

There will also be other drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

John Gross





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What if I already have prescription drug coverage from a Medigap (Supplemental Insurance) Policy?

If you have a Medigap policy with drug coverage, you will get a detailed notice from your insurance company telling you whether or not your policy covers as much or more than a Medicare prescription drug plan. This notice will explain your rights and choices.

What if I have prescription drug coverage from an employer or union?

If you have prescription drug coverage from an employer or union, you will get a notice from your employer or union that tells you if your plan covers as much or more than a Medicare prescription drug plan.

If your employer or union plan covers as much as or more than a Medicare prescription drug plan you can...

- keep your current drug plan. If you join a Medicare prescription drug plan later your monthly premium won't be higher (no surcharge), or
- drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

If your employer or union plan covers less than a Medicare prescription drug plan you can...

- keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage, or
- just keep your current drug plan. But, if you join a Medicare prescription drug plan later, you will have to pay more for the monthly premium (a surcharge), or
- drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

When will I get more information?

Throughout 2005, Medicare will provide you more information about Medicare prescription drug plans, including how to choose and join a drug plan that best meets your needs. In the fall of 2005, the "Medicare & You 2006" handbook will list the Medicare prescription drug plans available in your area.

In mid-2005, SSA will send people with certain incomes information about how to apply for extra help paying their prescription drug costs.

How can I get help choosing a Medicare prescription drug plan?

In the fall of 2005, you will be able to get personalized information at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227) to help you make your best choice. TTY users should call 1-877-486-2048. Your State Health Insurance Assistance Program (SHIP), and other local and community-based organizations, will also provide you with free health insurance counseling.