California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814
Phone (916) 445-5014
Fax (916) 327-6308

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

NOTICE OF MEETING and AGENDA
Communication and Public Education

Subcommittee on Medicare Drug Benefit Plans

Contact Person: Virginia Herold
(916) 445-5014 X 4005

Time: 1- 3:30 p.m.
Date: July 7, 2005
Place: Department of Consumer Affairs
400 R Street, Suite 4080, Sacramento, CA 95814

This committee meeting is open to the public and is held in a barrier-free facility in accordance with the Americans with Disabilities Act. Any person with a disability who requires a disability-related modification or accommodation in order to participate in the public meeting may make a request for such modification or accommodation by contacting Candy Place at (916) 445-5014, at least five working days before the meeting. Candy Place can also provide further information prior to the meeting and can be contacted at the telephone number and address set forth above. This notice is posted at *www.pharmacy.ca.gov*.

Opportunities are provided for public comment on each agenda item.

MEETING AGENDA

A.	Call to Order and Welcoming Remarks	*Board President Stan Goldenberg, RPh, and Vice President Bill Powers*	1:00 p.m.
B.	Overview of Medicare Part D	*Teri Miller, PharmD., California Department of Health Services*	
C.	Policy Implications for California	*Dr. Miller*	
D.	Public Information and Outreach Activities		
E.	CMS Provider Outreach Campaign	*Lucy Saldana, PharmD., Centers for Medicare & Medicaid Services*	
F.	Open Discussion on Focus for Future Subcommittee Meetings	*President Goldenberg*	
G.	Adjournment		3:30 p.m.

Meeting materials will be on the board's Web site by June 30, 2005

Background Materials

"California Pharmacists Association" <cpha@cpha.com>

06/29/2005 03:55 PM
Please respond to cpha

To: "Virgina Herold" <virginia_herold@dca.ca.gov>
cc:
Subject: CPhA Weekly Medicare Part D Update

[IMAGE]

June 29, 2005

Dear Virgina Herold,

The California Pharmacists Association has partnered with CMS to provide you with a regular update on the Medicare Drug Benefit program that will be implemented on January 1, 2006. The following update comes from Larry Kocot, Senior Advisor to the Administrator of CMS:

First... what will the customer need?

For the past few weeks we have been providing information about the Medicare drug benefit and Medicare beneficiaries who are entitled to extra help with their prescription drug costs through the limited income subsidy (LIS) (For more information, click here). Indeed, we now have tens of thousands of pharmacies across the country preparing to work with CMS and SSA to assist LIS eligible Medicare beneficiaries with their LIS applications... and we expect to begin seeing a lot of activity at pharmacies very soon.

In addition to applying for the LIS, these beneficiaries will have an opportunity to choose a prescription drug plan beginning November 15th. However, not all beneficiaries will have to make the same choices. In order to understand this 43 million Medicare population and the options they will consider, we offer the following breakdowns so you may begin to think about how to communicate with your customers to help them assess their needs.

1. Medicaid... locked and loaded

There are approximately 6.3 million Medicaid beneficiaries who are currently eligible for or receiving benefits through both Medicare and Medicaid. Medicaid will no longer be responsible for providing prescription drug coverage to these beneficiaries beginning January 1, 2006. These full-benefit dual eligibles will pay no premiums and pay only nominal copays ($1/3) for their prescription drugs. Moreover, CMS will pre-enroll these beneficiaries in a prescription drug plan so if they fail to proactively enroll, they will automatically be assigned to a Plan. This way, their prescription drug coverage will continue uninterrupted on January 1, 2006. Medicaid dual eligibles do not have to fill out an application for the LIS either... they automatically qualify for comprehensive assistance.

2. Limited Income seniors... coming to a pharmacy near you

Approximately 8.1 million Medicare beneficiaries will qualify for the LIS... in other words, their incomes fall below 150% of the federal poverty level and they meet certain other qualifications to receive subsidized premiums and nominal copays ($2/5) for their prescriptions. These beneficiaries must apply for assistance with SSA, or their state, in order to receive the LIS assistance. While pharmacies are helping with SSA applications now, these beneficiaries may need help selecting a prescription drug plan in November. Limited Income seniors have every incentive to enroll in a Plan quickly to take advantage of the LIS beginning January 1, 2006.

3. Employer/Union/Public Sector Employees… only choice is for better coverage

Estimates indicate that nearly 11.8 million Medicare beneficiaries will keep the retiree coverage that they currently have because it is as good as or better than the prescription drug coverage they could get through the Medicare program. Employers, unions and public sector employees will be sending a letter to those retirees to inform them if their coverage is "creditable", or as good as or better than that offered in the Medicare program click here). Obviously, beneficiaries who have great retiree coverage may have no choice to make… and it will be important to explain this to them because if they drop their employer coverage they could lose it permanently.

4. Medicare Advantage enrollees… most will stay with a deal that is hard to beat

There are currently 5.7 million Medicare beneficiaries in the Medicare Advantage program who will be able to access prescription drug coverage through their existing plans or new options available to them. These beneficiaries are availing themselves of full medical Medicare benefits through Medicare Advantage Plans…and with the addition of prescription drug coverage they will have added incentives to stay in the Program as this represents an incredible value for a full suite of benefits. Thus, it is likely that many if not most of the Medicare Advantage beneficiaries will select a prescription drug option that is offered by a Plan in which they are already enrolled.

5. Those without good drug coverage… shopping for value

That leaves around 11 million beneficiaries not eligible for LIS and without adequate prescription drug coverage who will be shopping for a prescription drug plan that represents the best value for them. We anticipate that these beneficiaries will enroll in the new benefit after they assess their options. Depending upon their circumstances, this may mean that some beneficiaries will wait to enroll until late in the initial enrollment period which ends on May 15th. It will be important to let these beneficiaries know that they must enroll in the benefit before the end of the open enrollment period to avoid a penalty for late enrollment. They need to be reminded that this is insurance and even if they don't think they need it now, it is likely they will in the future... and the longer they wait, the more it will cost them in premiums. (Click here for more on late enrollment penalties)

Playing by the numbers… and helping beneficiaries make choices

Understanding these population segments and beneficiary situations is key to helping beneficiaries decide what choices to make… and perhaps not make… when contemplating the new Medicare prescription drug benefit. Knowing what the customer needs is as important in this case as knowing what the customer wants.

Next week we will provide more information about the benefit. But please give us your feedback and let us know what we can tell you to help you prepare by sending an e-mail to Larry.Kocot.Pharmacy@cms.hhs.gov, we will provide an answer to your "question of the week".

Question of the Week:

"Have you clarified the policy on 90 days at retail?"

(click here for the answer)

If CPhA and/or The Pharmacy Foundation has provided protected health information in this communication to you, it is as a response to your request as a plan sponsor, health plan, medical provider, or business associate. CPhA is aware of your obligations under HIPAA and has provided this information at your request with the understanding that the information requested may not be secure, and is being released to the proper personnel and is limited to the proper scope and purpose in accordance with the HIPAA regulations. Thank you.

Swiginc@aol.com
06/26/2005 02:16 PM

To: Virginia_Herold@dca.ca.gov
cc:
Subject: Fwd: Are You Prepared to Answer Part D Questions?

[IMAGE]

June 3, 2005

Dear Stanley Goldenberg,

Consumers Look to Pharmacists for Answers about Medicare Prescription Drug Coverage
Are You Ready?

During the week of May 27, 2005, the Social Security Administration began sending letters to people with limited incomes and assets whom they believe may qualify for the extra help (sometimes called the low-income subsidy, or LIS) available through the new Medicare Prescription Drug Coverage (sometimes called Medicare Part D), which begins in January 2006. In addition, the Centers for Medicare and Medicaid Services (CMS) will soon be sending out a series of letters to Medicare beneficiaries to assist them with signing up for the new drug benefit. As this information reaches consumers, you can expect to field a wide variety of questions from your patients.

In an effort to ensure that you are prepared to answer these questions, the California Pharmacists Association (CPhA) is working to put timely information about the Medicare Prescription Drug Coverage into the hands of pharmacists throughout the state. It is hoped that this communication will be just the first of many about Medicare Part D over the coming months. For more information about Medicare Part D, visit www.cms.hhs.gov/medicarereform/pharmacy. If your patients need more information, you can have them visit www.medicare.gov, www.calmedicare.org, www.accesstobenefits.org/default.aspx, www.socialsecurity.gov, or call 1-800-Medicare or 1-800-434-0222.

What You Need to Know about the New Medicare Prescription Drug Coverage[1]

- **Who will benefit from this program?** Every person eligible for Medicare will have a chance to obtain the new Medicare Prescription Drug Coverage. This program can help people with Medicare regardless of their income level or current prescription drug coverage status. People with limited incomes and resources may be eligible for extra help for the costs associated with the new benefit (see table 2 below).
- **Who will administer the benefit?** The law authorizing the establishment of prescription drug coverage under Medicare dictates that the benefit is to be administered by private companies under contract with CMS. These companies will be called "Medicare Advantage-Prescription Drug plans" (i.e., Medicare Advantage Plans that are approved to administer a Medicare drug benefit to people enrolled in its health plan) and "Prescription Drug Plans" (i.e., PBMs that offer "stand-alone" Medicare drug benefits to eligibles within one or more designated regions - California has been identified as its own Part D region). Unfortunately CMS will not be announcing which Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug plans (MA-PDs) will be contracted to administer the Medicare prescription dug coverage until the fall, but CMS is working to assure that consumers in each region will have at least two plans to choose from.
- **What will the drug benefit design look like?** While the Medicare Modernization Act defines a "standard benefit" for Medicare Prescription Drug Coverage (see table 1 below), it is important to note that PDPs and MA-PDs have the flexibility to create and offer a wide variety of benefit designs provided the benefit design is at least "actuarially equivalent" to the standard benefit (i.e., consumers get the same overall value for their premium dollar). Consequently, it is quite possible that consumers within a region may not see a benefit design like what has been defined as the "standard benefit." Having said that, CMS will ensure that at least one option within each region will be no richer than the standard benefit, thereby keeping the premium for at least one of the plan options to a minimum.

Table 1: Medicare Prescription Drug Coverage -- Standard Benefit Design

~$37 monthly premium, then **Benefit Stages**	**Coverage Ranges From:**	**To:**	**% Covered by Benefit**	**TrOOP**[a]
Annual Deductible	$0	$250	0%	($250)
Initial Coverage	$250.01	$2,250	75%	($500)
Coverage Gap	$2,250.01	$5,100[b]	0%	($

				2,850)
Catastrophic	$5,100.01	No Maximum	95%[c]	($3,600)

[a] TrOOP = True Out-of-Pocket costs
[b] Catastrophic coverage begins when the beneficiary satisfies the $3,600 TrOOP requirement
[c] Medicare is liable for 80% and the PDP is liable for 15%

What is the timeline for implementation of Medicare Prescription Drug Coverage?

May 2005	Social Security Administration (SSA) begins mailing letters and applications to individuals who are likely to be eligible for the limited-income subsidy (LIS). These mailings will go out in 10 "waves" between late May and mid-August; the "waves" are based on the last two digits of a person's Social Security number.
June 2005	PBMs and Medicare Advantage plans begin negotiating with CMS for contracts to offer Medicare Prescription Drug Coverage
July 2005	SSA and Medi-Cal offices begin processing LIS applications and online applications become available in 14 different languages at www.socialsecurity.gov. Potential LIS recipients will also have the option of applying over the telephone.
Sept. 2005	CMS awards bids to PDPs and MA-PDs.
Fall 2005	California Medi-Cal offices will send notices to dual eligibles that they will be losing their Medi-Cal prescription drug coverage and will be automatically enrolled in a Medicare Prescription Drug Coverage plan.
Oct. 2005	PDPs and MA-PDs begin marketing to consumers. Part D plan comparison tool becomes available on www.medicare.gov. CMS sends information to Medicare beneficiaries describing their PDP and MA-PD options.
Nov. 15, 2005	Enrollment for Medicare Prescription Drug Coverage begins.
Jan. 1, 2006	Medicare Prescription Drug Coverage begins, and Medi-Cal prescription drug coverage ends for patients who are enrolled in both Medi-Cal and Medicare
May 15, 2006	Deadline for individuals who enrolled in Medicare before January 1, 2006 to sign up for Medicare Prescription Drug Coverage without incurring a penalty. (Penalty = 1% of monthly Part D premium for each month that the beneficiary was not enrolled in Part D ***and*** did not have prescription drug coverage at least as good as the standard benefit within the 63 day period prior to their enrollment in Part D).

Table 2: Extra Help for People with Limited Incomes and Resources

For Individuals who have:	And whose assets are:	They will pay:
Medi-Cal and an income below 100% of the federal poverty level (FPL): $9,570 a year for an individual; and $12,830 a year for a couple in 2005	Below $2,000 for individuals and $3,000 for couples	No monthly premium*^ No deductible $1/generic and $3/brand-name co-pays (no co-pays after $3,600 in total annual drug costs)*
Medi-Cal and an income above 100% of the FPL: $9,570 a year for an individual; and $12,830 a year for a couple in 2005	Below $2,000 for individuals and $3,000 for couples	No monthly premium*^ No deductible $2/generic and $5/brand-name co-pays (no co-pays after $3,600 in total annual drug costs)
Do NOT have Medi-Cal and have an income below 135% of the FPL: $12,920 a year for an individual; and $17,321 a year for a couple in 2005	Below $7,500 for individuals and $12,000 for couples	No monthly premium* No deductible $2/generic and $5/brand-name co-pays (no co-pays after $3,600 in total annual drug costs)
Do NOT have Medi-Cal and have an income below 150% of the FPL: $14,355 a year for an individual; and $19,245 a year for a couple in 2005	Below $11,500 for individuals and $23,000 for couples	Sliding scale monthly premiums $50 deductible 15% coinsurance ($2/generic and $5/brand-name co-pays after $3,600 in total annual drug costs)

*** Only if the plan's monthly premium is equal to or less than the premium amount covered by the low-income subsidy**
^ Those with Medicare and Medi-Cal who live in an institution pay no premiums, no deductibles, and no co-pays.

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Call (916) 779-1400 now to become a CPhA member!

[1] Some information adapted with permission from California Health Advocates website – www.calmedicare.org

Los Angeles Times
latimes.com

http://www.latimes.com/news/nationworld/nation/la-na-bush17jun17,1,4970743.story?ctrack=1&cset=true

Medicare Plan's No. 1 Promoter

Bush goes on a publicity drive to educate beneficiaries about the new prescription drug benefit. Critics remain worried about the cost.

By Edwin Chen
Times Staff Writer

June 17, 2005

WASHINGTON — President Bush began a two-day campaign Thursday to publicize Medicare's new prescription drug benefit, which takes effect in 2006.

"This great and trusted program is about to become even better," Bush said. "Starting this November, every American on Medicare can sign up to get help paying for their prescription drugs. This new law is bringing preventive medicine, better healthcare choices and prescription drugs to every American receiving Medicare."

The drug coverage, which beneficiaries must choose to purchase, represents a landmark shift in the program's emphasis from covering medical treatments almost exclusively to including preventive measures such as screenings for cancer, diabetes and heart disease and immunizations against pneumonia and the flu.

In a speech promoting the benefit, the president contended that preventive measures would save taxpayers money by dealing with ailments when they were less severe, thus averting the need for costlier treatments.

He derided as "the medicine of the 1960s" the Medicare policy of paying $28,000 for ulcer surgery "but not $500 for prescription drugs that eliminate the cause of most ulcers."

Similarly, Bush said, "Medicare would pay $100,000 to treat the effects of a stroke but not $1,000 for blood-thinning drugs that could prevent strokes."

Today, Bush is scheduled to take his publicity drive to Maple Grove, Minn., a suburb of Minneapolis, where he plans to meet with workers being trained to help seniors sign up for the benefit.

Behind the nationwide outreach campaign, which will include all levels of government as well as consumer groups, is a concern among experts that low-income seniors may not hear about the drug benefit. They noted that about 25% of those eligible initially signed up for food stamps when the program started four decades ago.

Bush spoke Thursday at the Department of Health and Human Services, the agency that oversees Medicare.

Although the drug coverage benefit appears to be popular among seniors, who in recent years have faced soaring prices for medications, its projected price tag seems certain to erode Medicare's financial viability.

Even before Congress added the drug benefit, Medicare was confronting $27.7 trillion in unfunded liabilities over 75 years, the congressional Government Accountability Office said. The new benefit will add $8.1 trillion over the same period to the program's unfunded promises — making Medicare more likely to go bankrupt than Social Security, which faces a $3.7-trillion liability over the same time frame.

"Medicare is by far a more serious problem than Social Security," said Michael Cannon, director of health policy studies at the Cato Institute, a libertarian think tank. "It's hard to understand why an administration that's been so responsible on Social Security is so irresponsible in dealing with Medicare."

He said the price tag was likely to grow. "As with all entitlements, the cost is going to vastly exceed projections," Cannon said. "Costs always outpace projections."

When Congress passed the Medicare bill in late 2003, the Congressional Budget Office estimated its cost at $395 billion over 10 years. Weeks later, the Bush administration upped the projection to $534 billion. The current figure is $724 billion.

The publicity campaign will call on the Social Security Administration and the departments of Labor, Housing and Urban Development, Transportation and Veterans Affairs to disseminate information.

Transportation, for instance, will work with cities and states to post information on buses and at highway rest stops, and the Social Security Administration will send out millions of letters to people likely to be eligible for help in enrolling.

To simplify the process, the signup form has been whittled to four pages and 16 questions, down from the 20-plus pages required of a typical Medicaid enrollment application, said Mark McClellan, administrator of the Centers for Medicare and Medicaid Services.

His agency has established a hotline — (800) MEDICARE — and, starting this fall, will mail to every Medicare beneficiary a booklet with information about the drug benefit.

Premiums will vary depending on the plan but are expected to average about $35 a month, a White House fact sheet said.

Beneficiaries will be protected against the highest out-of-pocket costs, with Medicare covering 95% of all drug costs above $5,100 a year. But no coverage will be provided for expenditures from

$2,250 to $5,100, a gap known as the "doughnut hole."

Low-income seniors, who make up about a third of Medicare's 42 million beneficiaries, will not be required to pay a premium or a deductible and will have co-payments of $2 for generic or $5 for brand-name drugs.

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PARTNERS: ktla Hoy

CALIFORNIA HEALTHCARE FOUNDATION

The Medicare Drug Benefit: Implications for California

ISSUE BRIEF

Introduction

On January 1, 2006, the federal Medicare program will offer, for the first time, an outpatient prescription drug benefit to all Medicare beneficiaries. The new benefit, established as Part D of the Medicare program by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is designed to lower the cost of prescription drugs for most senior and disabled Medicare beneficiaries.[1]

The Medicare drug benefit will present a wide, and potentially confusing, array of new options to California's four million Medicare beneficiaries. It will change the structure and delivery of drug coverage for nearly one million low-income beneficiaries in California who have existing drug coverage through Medi-Cal. Moreover, it will create significant operational and financial challenges for the state and county government agencies responsible for implementing key elements of the new drug benefit for low-income residents.

California lawmakers and program officials must soon make important decisions relating to the new drug benefit. These decisions will affect not only seniors and disabled persons covered by Medicare but also the state budget. Making these decisions even more difficult is that the new drug benefit is being rapidly implemented under very tight deadlines, while many questions regarding the new benefit still await answers from the federal Centers for Medicare and Medicaid Services (CMS). In addition, several unique attributes of California and its Medicare population contribute to the challenges state lawmakers and program officials face.

This issue brief provides an overview of the new Medicare drug benefit and a timeline for its implementation. In addition, it highlights the special characteristics of California that will affect introduction of the benefit and identifies and organizes numerous policy issues that state lawmakers and program officials must consider.

Overview

The Medicare drug benefit is designed to provide Medicare beneficiaries with affordable drug coverage. The benefit is expected to reduce out-of-pocket drug spending for about 65 percent of Medicare beneficiaries in 2006.[2] Individual savings will vary greatly depending on income, prescription drug use, and other factors.

Under the standard Medicare drug benefit, a minimum of two drugs in each of 146 therapeutic classes must be covered by participating insurance plans.[3] For this standard coverage, beneficiaries will pay in 2006:

- A premium, which will vary by plan, estimated to average $37 per month nationally;[4]
- A $250 deductible;

APRIL 2005

- Twenty-five percent cost-sharing, up to an initial coverage limit of $2,250 in total drug spending;
- One hundred percent of their costs from $2,250 to $5,100 in total drug spending (a gap in coverage referred to as the "donut hole"); and
- Five percent cost-sharing thereafter.

For most Medicare beneficiaries, participation in the drug benefit is voluntary. For dual-eligibles, however, participation is mandatory if they are to continue receiving drug coverage. Federal matching funds will no longer be available for Medicaid expenditures for prescription drugs provided to dual-eligible beneficiaries except for drugs excluded from the Medicare drug benefit.

To begin receiving the new drug benefit, beneficiaries will have to enroll in a private Medicare insurance plan. There will be two types of Medicare drug plans: Medicare Advantage managed care plans that will provide all services covered by Medicare, including drug coverage (MA-PDs); and stand-alone prescription drug plans (PDPs) for beneficiaries who remain in the Medicare fee-for-service delivery system.

Medicare drug plans will be required to offer enrollees the standard benefit or an actuarially equivalent benefit with modified cost-sharing requirements. For example, plans may require higher cost-sharing with a smaller gap in coverage; or, they may charge tiered copayments in lieu of percentage cost-sharing. Drug plans may also offer more comprehensive coverage with higher premiums. In addition, the plans will establish formularies, subject to federal approval, which will limit the specific drugs covered.

Terms Defined

Dual-eligible: Someone enrolled in both Medicare and Medicaid (which covers Medicare cost-sharing, prescription drugs, long-term care, and other services not covered by Medicare). Compared to other Medicare beneficiaries, dual-eligibles are more likely to reside in nursing facilities and to suffer from cognitive impairment and mental disorders.

Medi-Cal: California's version of Medicaid, it provides health and long-term care coverage for many low-income individuals, including seniors and people with disabilities. Medi-Cal is funded jointly by federal and state governments and administered by the state.

Medi-Cal Managed Care: California's unique system of managed care includes three different models operating in 22 counties. In any of eight counties, all Medi-Cal beneficiaries must enroll in a single plan (County Organized Health Systems); in 12 other counties, they have a choice of two plans (Two Plan Model); and in two counties they can choose among three or more plans (Geographic Managed Care).

Medicare: The federally funded and administered program that provides health care coverage for individuals age 65 and older and many individuals under age 65 with long-term disabilities.

Medicare Advantage: Medicare's managed care program (formerly Medicare+Choice).

Medicare Part D: The name given to the new Medicare drug benefit. Medicare Part A covers inpatient hospital services and post-acute care, Part B covers physician and other outpatient services, and Part C is the Medicare Advantage program.

Drug Coverage for Low-Income Beneficiaries

The Medicare drug benefit includes significant federal subsidies to reduce cost sharing for low-income beneficiaries (see Figure 1). Many low-income beneficiaries will receive coverage for the standard benefit with much lower or no monthly premiums. In California, the federal government will set the subsidy based on the average premium in the state. Low-income beneficiaries who enroll in a drug plan that charges a premium high-

Figure 1: Cost-Sharing and Enrollment for Medicare Drug Benefit Eligibles in 2006

ELIGIBILITY LEVEL*	Premium	Deductible	Copay	Copay After Catastrophic Limit§	Coverage Gap	Enrollment
Dual-eligible (Medi-Cal) individual regardless of assets†	None	None	$1/$3‡ (generic/brand)	None	None	Auto-enrolled
Income below $12,920 ($17,321 for couples) meeting asset test	None	None	$2/$5 (generic/brand)	None	None	Facilitated by CMS
Income between $12,920 ($17,321) and $14,355 ($19,245) meeting asset test	25 to 75% of full premium, depending on income	$50	15% of drug cost	$2/$5 (generic/brand)	None	Facilitated by CMS
Income above $14,355 ($19,245)	$37 per month average	$250	25% of drug cost	5% of drug cost	$2,250 to $5,100	Up to individual

* Income limits are tied to federal poverty guidelines, which are updated annually. Values shown reflect guidelines published in February 2005.

† Institutionalized dual-eligibles will have no cost-sharing responsibilities. However, beneficiaries receiving home and community-based waiver services or residing in assisted living facilities will be responsible for copayments.

‡ Dual-eligible beneficiaries with incomes above $9,570 ($12,830 couple) will have co-pays of $2 (generic) and $5 (brand).

§ Set at $5,100 in total drug spending for 2006.

er than the state average will have to pay the difference between the plan's premium and the federal subsidy. At least one prescription drug plan will be available without a premium to all low-income beneficiaries with incomes below 135 percent of poverty.

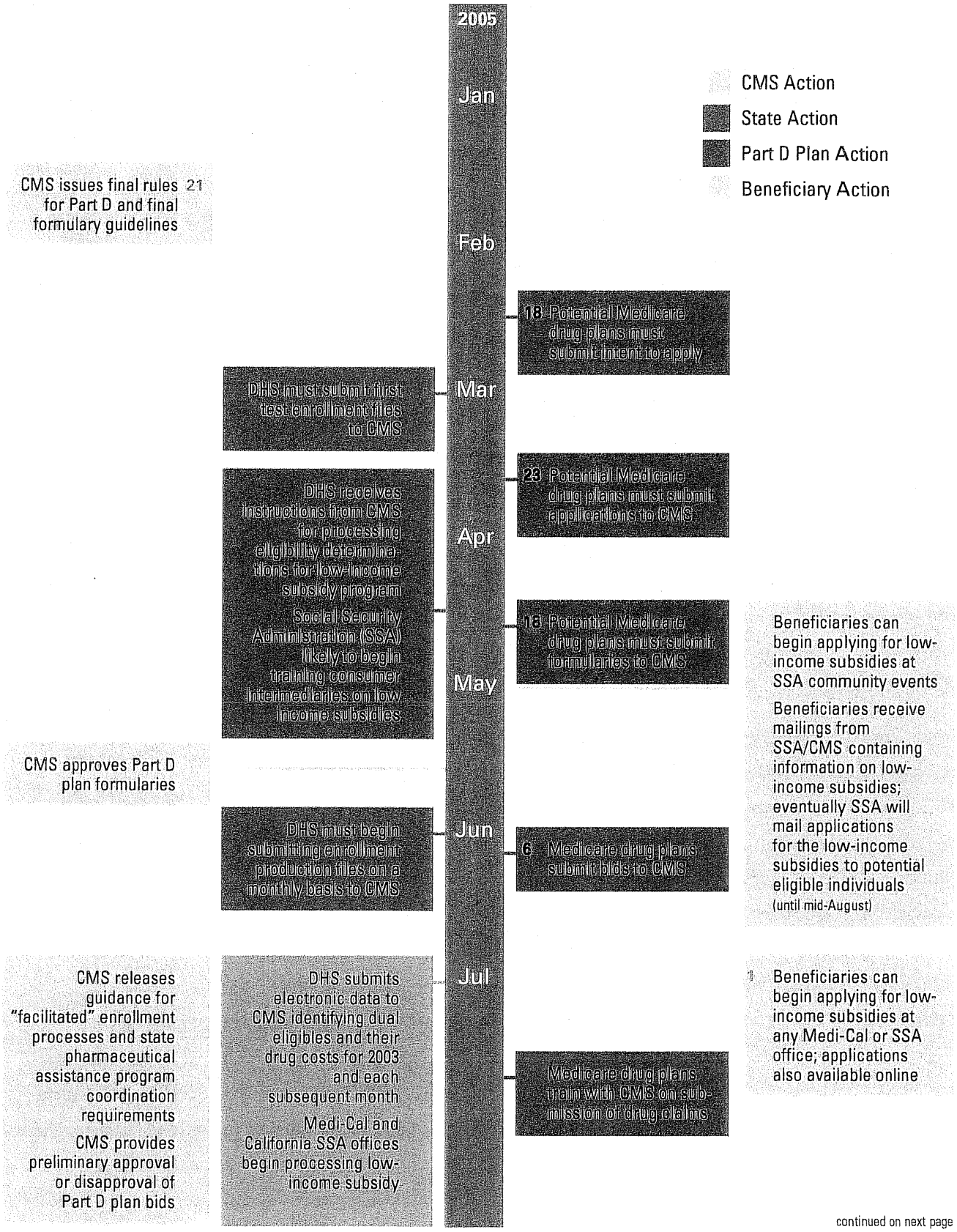
As of January 1, 2006, dual-eligible beneficiaries will no longer receive drug coverage through Medi-Cal. To continue receiving drug coverage, they must enroll in a Medicare drug plan. CMS plans to automatically enroll dual-eligible beneficiaries into plans starting in October 2005, completed by January 1, 2006. As part of this process, dual-eligible beneficiaries will be enrolled randomly into stand-alone PDPs that offer a premium priced at or below the average for all plans offered in the state. Dual-eligible beneficiaries may select a different plan before or after they are automatically enrolled. Even if they fail to exercise a choice before January 1, 2006, they will be permitted to switch plans thereafter on a monthly basis.

To encourage broad participation in the new drug benefit, CMS will also facilitate enrollment for low-income Medicare beneficiaries who are not dual-eligibles beginning in May 2006. Although details of this facilitated enrollment are not yet available, CMS has indicated that it may use a default system whereby CMS will inform low-income Medicare beneficiaries that they will be enrolled in a CMS-selected plan. If the beneficiary does not choose a different plan, or does not formally reject enrollment by a certain date, the beneficiary will become enrolled in that CMS-selected plan.

Timeline for Implementation

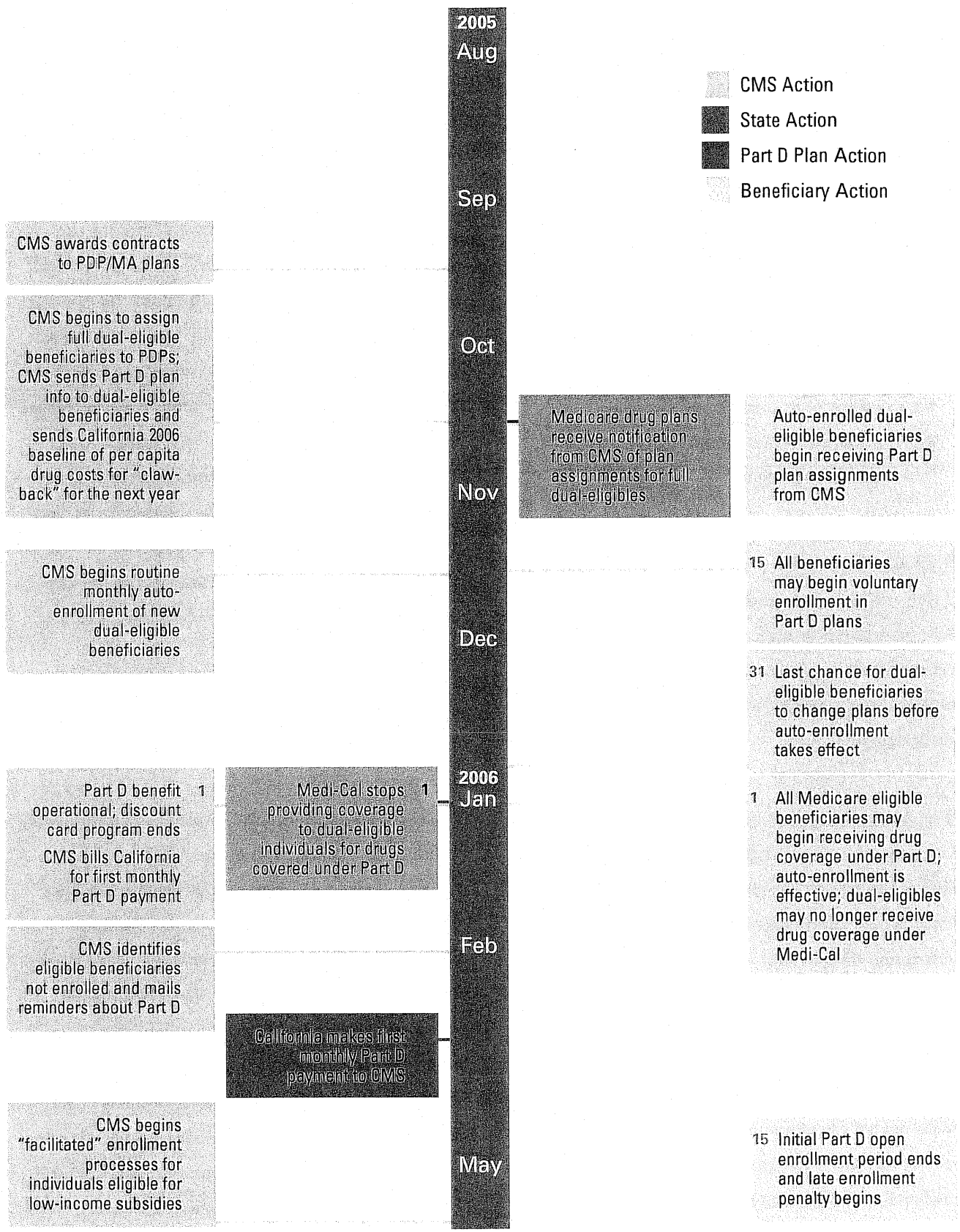
During 2005 and early 2006, numerous important and complex tasks must be accomplished by federal and state officials, drug plans, and Medicare beneficiaries, as the new benefit is implemented (Figure 2 on the following pages). Actions required of the California

Figure 2: Key Dates for Implementation of the Medicare Part D Drug Benefit (as of April 2005)[5]



continued on next page

Figure 2: Key Dates for Implementation of the Medicare Part D Drug Benefit (as of April 2005), continued



Department of Health Services (DHS) include:

- Ensure that its staff is able to answer questions from consumers about the new Medicare prescription drug benefit and how it interacts with other sources of coverage.
- Provide enrollment files to the federal government that identify the state's dual-eligible beneficiaries to ensure that they are enrolled in a Part D plan.
- Determine eligibility for the Medicare drug benefit's low-income subsidies.
- Provide payment to the federal government for a portion of its dual-eligible beneficiaries' prescription drug costs (known as the "clawback" requirement).

The timeline provides an overview of the tasks that DHS must accomplish for successful implementation of the new Medicare benefit, as well as the dates these tasks are to be undertaken or completed. Also included are major milestones and deadlines for CMS, for insurers who will offer the drug benefit, and for Medicare beneficiaries.

The Uniqueness of California and Its Impact on Implementation

While all states will face many challenges and new financial obligations associated with the new Medicare prescription drug benefit, implementation in California is particularly complex due to several unique characteristics of the state and its Medicare population.

Size and Diversity of Medicare Population

California has the largest Medicare population of any state, as well as the largest number of dual-eligible beneficiaries.[6] California's Medicare population is not only large, it is also extraordinarily diverse. Compared to the Medicare population nationally, a greater proportion of California's Medicare population is Hispanic (12 percent vs. 5 percent nationally) and Asian/Other (11 percent vs. 4 percent nationally); a smaller proportion is African American (5 percent vs. 8 percent nationally).[7] California's dual-eligible population is even more likely to be non-white: 22 percent are Hispanic, 20 percent are Asian/Pacific Islander, and 10 percent are African American.[8] Even these comparisons, which (for example) lump numerous distinct Asian ethnic groups into one category, do not capture the extent of the multi-lingual, multi-cultural characteristics of California's Medicare population. Such diversity adds significantly to the already daunting challenges DHS staff, consumer intermediaries, and advocates face in conducting outreach and educating beneficiaries about the change in prescription drug benefits and the need to enroll in a private plan.

Participation in Medicare Managed Care

California has more Medicare beneficiaries enrolled in Medicare Advantage plans than any other state — twice as many as in Florida or New York.[9] California's 1.3 million Medicare Advantage enrollees account for one-fourth of all Medicare Advantage enrollees in the country. About 32 percent of Medicare beneficiaries in California are enrolled in Medicare Advantage plans, compared to 13 percent nationwide. This difference is due in large part to the greater selection of private health plans in California than in other states. In an urban county such as Los Angeles, beneficiaries can select among 11 different Medicare Advantage plans offering 21 plan options. Even in less populated counties, such as Sonoma or Stanislaus, beneficiaries can select among three different Medicare Advantage plans.[10]

The existence of a vibrant Medicare Advantage market may mean that many beneficiaries are accustomed to making health care coverage choices. On the other hand, the large number of existing Medicare Advantage plans is likely to result in a greater number of drug plan offerings in California, which will contribute to the complexity of the decision-making process.

Dual-Eligible Beneficiaries and Managed Care

California also has a large number of dual-eligible beneficiaries enrolled in managed care. There are 87,000 dual-eligible beneficiaries enrolled in Medicare Advantage plans,[11] and over 94,000 who are enrolled in Medicaid managed care plans (mostly in the five County Organized Health Systems).[12] This presents two challenges:

- CMS will not automatically enroll in a Medicare drug plan those dual-eligibles who currently receive care through a Medicare Advantage plan. In its final regulations, CMS asserts that it does not have legislative authority to automatically enroll dual-eligible beneficiaries in drug plans if they are currently enrolled in Medicare managed care. Instead, CMS will "facilitate" enrollment for these beneficiaries; in this process, beneficiaries may be assigned to plans that offer premiums above the low-income subsidy levels. Such beneficiaries would be personally responsible for the difference in premium costs.
- When the new Medicare drug benefit is implemented, a Medi-Cal managed care plan will no longer manage prescription drug benefits for its dual-eligibles, unless that plan chooses to offer MA-PD or PDP coverage and the beneficiary chooses that coverage. This scenario is likely to have the most affect on the state's five County Organized Health Systems, in which enrollment is mandatory for all Medi-Cal beneficiaries, including dual-eligibles, in the eight counties in which they operate.

County-Based Eligibility Determination Process

The MMA requires the Social Security Administration and states to perform the eligibility determinations for low-income subsidies. In California, eligibility determination for Medi-Cal is determined by county social services staff. SSA and DHS are considering permitting county eligibility workers to collect low-income subsidy applications and forward them to SSA for processing. However, the MMA requires that states themselves be equipped to process a beneficiary's application, so each county may be responsible for training its staff and making the information technology system changes necessary to perform eligibility determinations for low-income subsidies. This requirement places new staffing and cost burdens on counties, and may lead to inconsistencies in how eligibility for the low-income subsidies is determined in different counties.

Medi-Cal Drug Rebates

All states participate in a federal program through which they receive quarterly rebates directly from drug manufacturers to help offset what they pay for prescription drugs. California also uses its substantial purchasing power to negotiate supplemental rebates. A drug manufacturer must sign a supplemental rebate contract to have its drugs included in Medi-Cal's formulary. In fiscal 2003–04, California collected nearly $1.5 billion in drug rebates, including $481 million through the state supplemental rebate program.

Dual-eligible beneficiaries account for 55 percent of Medi-Cal's fee-for-service prescription drug expenditures.[13] Because the new Medicare drug coverage will remove the dual-eligibles from Medi-Cal's drug purchase management, California's purchasing power is expected to drop, as will the value of the supplemental rebates it receives. This loss of purchasing power may lead to higher per capita net drug expenditures for Medi-Cal beneficiaries who are not dual-eligible.

The magnitude of California's supplemental rebates from drug manufacturers is also important in the context of the clawback provision of the Medicare drug benefit. In calculating the clawback amount, CMS has indicated that it will consider the value of drug rebates collected in 2003 regardless of when the drugs were provided and paid for. In other words, rebates collected in 2004 for drug purchases made in 2003 are not considered. The state's Legislative Analyst's Office estimates that the combined impact of the Medicare drug benefit — including reduction in Medi-Cal drug expenditures for dual-eligibles, the clawback, and loss of drug rebates — will result in additional state General Fund expenditures of $758 million from 2005–06 through 2008–09.[14]

SB 393

In 1999, California adopted a law which allows all Medicare beneficiaries in the state to purchase prescription drugs at a price that is no greater than what Medi-Cal pays. It is not yet clear how the new Medicare drug benefit will affect this law (commonly referred to as the "Prescription Drug Discount Program for Medicare Recipients") and the prices beneficiaries pay for drugs not covered by their drug plan.

Major Issues and Considerations for the State of California

The new Medicare prescription drug benefit will have a significant impact on California's health care programs and the residents they serve. However, even as program implementation gets underway, CMS is still in the process of developing guidance to states on how they are to administer the program's low-income subsidies. And some provisions that significantly affect California's Medi-Cal beneficiaries will be carried out without any involvement or oversight by the state, including CMS administration of the auto-enrollment process for dual-eligible beneficiaries.

Despite these contingencies, California faces imminent decisions on several key matters. These include how the state will:

- Fulfill federal requirements in implementing the legislation;
- Modify its Medi-Cal and possibly other health and human services programs to coordinate with the new benefit;
- Notify beneficiaries of changes to existing state coverage, of new opportunities for assistance, and of the steps they must take in order to participate; and
- Modify current state budgets to reflect changes.

Figure 3 provides summaries of some of the most important challenges over the next year. It describes what actions must be taken within California, as well as who must take them: state lawmakers (the governor and legislature); program officials within Medi-Cal and the Department of Health Services, and in other departments, such as aging, mental health, and development services; and county eligibility workers.

Figure 3. Four Major Issues, the Challenges Posed and Actions Required

Issue 1: Beneficiary Outreach and Enrollment

Dual-eligible beneficiaries must enroll in a Medicare private plan by January 1, 2006 in order to continue to receive prescription drug benefits. CMS will auto-enroll those dual-eligible beneficiaries who are not in a managed care plan and who fail to select a drug coverage plan on their own.

CHALLENGE	ACTION REQUIRED
State officials must provide CMS with a complete list of dual-eligible beneficiaries by July 1, 2005. CMS will notify these dual-eligible beneficiaries that they qualify for the low-income subsidy and must choose a Medicare drug benefit plan to continue their drug coverage.	Program officials must ensure that they can identify all dual-eligible beneficiaries. State lawmakers must decide whether to create safeguards to prevent coverage gaps for those dual-eligible beneficiaries who are not properly identified.
States and the Social Security Administration will administer eligibility determinations for the low-income subsidies. In California, counties have traditionally determined eligibility for Medi-Cal.	County eligibility workers must be trained about the new benefit and low-income subsidy program, prepared to determine eligibility for the low-income subsidies, and be capable of transmitting this information to CMS. Program officials must decide how best to ensure that eligibility determination for the low-income subsidies is performed uniformly across all 58 counties. State lawmakers must decide whether to provide funding for these new administrative responsibilities.
Dual-eligible beneficiaries must enroll in a Medicare drug plan by December 31, 2005 to continue to receive drug coverage. CMS will randomly assign dual-eligibles to a drug benefit plan in mid-October: those who do not select a different plan will be auto-enrolled into assigned plans on January 1, 2006.	State lawmakers must decide whether to allocate funding to assist dual-eligible beneficiaries in learning about their options and selecting the Medicare drug benefit plan which best meets their individual needs.
Dual-eligible beneficiaries may not understand transition requirements or how to navigate within the new Medicare drug plan they join.	Program officials must be prepared to answer questions from dual-eligible beneficiaries about changes to their coverage.

Issue 2: Coverage and Cost-Sharing

Coverage of specific prescription drugs for dual-eligible beneficiaries, and the amounts some dual-eligible beneficiaries must pay, will vary depending on plan choice.

CHALLENGE	ACTION REQUIRED
The Medicare drug plans available to dual-eligible beneficiaries without a premium (i.e., those priced at or below average premium in California) may not cover the same drugs that Medi-Cal covers. Medicare drug plans are prohibited from covering certain drug classes (e.g., benzodiazepines) commonly prescribed to dual-eligible beneficiaries.	State lawmakers and program officials must decide what safeguards are needed to ensure that dual-eligible beneficiaries do not experience adverse effects as a result of changes in their formulary. They must also decide if Medi-Cal will cover Medicare-excluded drug classes.
If dual-eligible beneficiaries select a Medicare drug plan with a premium above the state average, they must pay the difference in premiums and full copayments in order to obtain better coverage.	State lawmakers must decide whether they want to ensure that dual-eligible beneficiaries have access to the same drugs as other Medi-Cal beneficiaries. If so, they must either provide state-only funded coverage that wraps-around the Medicare drug benefit, or they must subsidize the premiums of certain higher-cost Medicare prescription drug plans.
Under Medicare's new drug benefit, the $3 copayments for brand-name prescription drugs is higher than the $1 copayment under Medi-Cal, and pharmacies can refuse to dispense a drug if a beneficiary does not pay the full copayment.	State lawmakers must decide whether to create a pool of funding to ensure that these higher copayments are not a barrier to drug access for dual-eligible beneficiaries.

Figure 3. Four Major Issues, the Challenges Posed and Actions Required, continued

Issue 3: Coordination of Care

The addition of a new insurance plan for drug coverage may exacerbate problems with coordination of care for dual-eligible beneficiaries, particularly those residing in institutional settings or receiving mental health services.

CHALLENGE	ACTION REQUIRED
Dual-eligible beneficiaries may have health care coverage from three or more sources: Medicare (FFS or managed care); a Medicare private drug plan; Medi-Cal (FFS or managed care); and other state programs. This will increase opportunities for confusion and fragmentation, and making disease management and care coordination more difficult.	Program officials must set up systems to ensure that care is coordinated.
Residents of the same nursing home or state developmental center may be enrolled in different Medicare drug benefit plans, requiring the long-term care provider to manage multiple formularies instead of only one.	Program officials must take steps to ensure that nursing homes and state developmental centers understand and prepare for these changes to the current delivery system.
Dual-eligible beneficiaries residing in nursing homes will pay no share of cost for their drug coverage, whereas dual-eligible beneficiaries residing at home or in a community-based setting will have copayments.	State lawmakers must decide whether to take action to ensure that the Medicare drug benefit does not exacerbate the existing Medi-Cal bias toward nursing home care over community-based, long-term care options.

Issue 4: State Financing

Implementation of the benefit has implications for the Medi-Cal program and administrative expenditures.

CHALLENGE	ACTION REQUIRED
As Medicare beneficiaries are screened for the low-income subsidies, Medi-Cal enrollment is expected to increase as some of those screened are determined to be eligible for Medi-Cal.	Program officials and state lawmakers must decide how much to budget for increased Medi-Cal enrollment due to this "woodwork effect."
The amount California must contribute (the "clawback") to the Medicare drug benefit is based on Medi-Cal spending in 2003. However, supplemental rebates collected from manufacturers in 2004 for drugs purchased in 2003 are not counted. Also, clawback payments are linked to per capita growth in Medicare drug spending.	Program officials and state lawmakers must decide how much to budget for potentially higher Medi-Cal expenditures as a result of the clawback formula.
The state contribution under the clawback formula will decrease from 90 percent of projected drug expenditures for dual-eligible beneficiaries in 2005 to 75 percent of projected expenditures in 2015 and beyond.	State lawmakers must decide whether any long-term savings that materialize from the new Medicare drug benefit are to be reinvested in Medi-Cal.
Medi-Cal managed care plans will no longer have financial responsibility for drug coverage for their residents/members who are dual-eligible beneficiaries.	Program officials must determine how much to reduce payments to health plans for dual-eligible beneficiaries, based on this reduction in their financial responsibility.
Medi-Cal will lose purchasing power associated with the nearly one million dual-eligible beneficiaries. Thus, revenues from supplemental drug rebates may fall.	Program officials must develop new negotiating strategies to offset this reduction in purchasing power.

Conclusion

The impact of the new Medicare drug benefit will be felt throughout the health care system in California. The Medicare drug benefit is expected to reduce beneficiaries' out-of-pocket costs for prescription drugs, but it will also create many challenges for beneficiaries, particularly dual-eligibles who have existing drug coverage through Medi-Cal. Implementation of the new benefit also creates numerous challenges for state and county program officials, and raises numerous policy questions for California lawmakers. The process will be complicated by the fact that certain characteristics of the health care marketplace and the Medicare population in California present unique challenges to implementation of the new drug benefit.

The new benefit and its impact will begin to take shape as insurance companies and managed care plans submit applications to participate in the new program, as CMS awards contracts to drug plans, and as CMS addresses the many questions about the program that remain unanswered. However, implementation timing is such that state lawmakers and program officials will have to make decisions on many issues in the absence of perfect information. And when new information becomes available, decisions will have to be made quickly in order to make the transition to the new benefit as successful as possible and to minimize adverse consequences, particularly for dual-eligible beneficiaries.

Authors

Prepared by Chiquita White, Jonathan Blum, Ryan Padrez of The Health Strategies Consultancy, LLC

ENDNOTES

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The Medicare drug benefit, which starts Jan. 1, offers extra help for people on limited incomes. But you may need to act soon to find out if you're eligible.

MEDICARE

The first in a series on what you need to know about the new coverage

Do You Qualify?

WHO'S ELIGIBLE	Level 1	Level 2	Level 3	Level 4
In addition to being on Medicare, in 2005 you must be receiving the following:	Full Medicaid benefits and income no higher than $9,570 (single) or $12,830 (couple)*	Medicaid (but with income higher than level 1)*; **or** SSI (without Medicaid); **or** Medicare premiums paid by your state	Income no higher than $12,919 (single) or $17,320 (couple)*	Income no higher than $14,355 (single) or $19,245 (couple)*
Value of assets (not including your home, vehicles, burial plot or personal possessions)	Not applicable	Not applicable	No more than $7,500 (single) or $12,000 (couple)	No more than $11,500 (single) or $23,000 (couple)
To find out eligibility	Automatically enrolled	Automatically enrolled	Must apply	Must apply
WHAT YOU GET				
Drug coverage	Full (no gap)	Full (no gap)	Full (no gap)	Full (no gap)
Monthly premium	$0	$0	$0	Reduced on sliding scale based on income
Annual deductible	$0	$0	$0	$50
Copayment per prescription	$1 for generics, $3 for brands ($0 if you're in a nursing home)	$2 for generics $5 for brands	$2 for generics $5 for brands	15 percent of cost of each prescription
Copayment under catastrophic coverage**	$0	$0	$0	$2 for generics $5 for brands

* If your income is higher, you may still qualify in certain circumstances—for example, if you live in Alaska or Hawaii, or have certain earnings that don't count, or if you or your spouse pays at least half the support of relatives living with you.
** After you've spent $3,600 out of pocket in a year.

SOURCES: CENTERS FOR MEDICARE & MEDICAID SERVICES; SOCIAL SECURITY ADMINISTRATION; AARP PUBLIC POLICY INSTITUTE

By Patricia Barry

Medicare beneficiaries with limited incomes will soon be able to find out whether they qualify for substantial extra help in paying for prescription drugs after the new drug benefit goes into effect on Jan. 1.

As that date approaches, all beneficiaries—except those with good retiree drug coverage—will have to start making decisions about signing up for the benefit. (Information on coverage options will be available in October. Open enrollment runs from Nov. 15, 2005, to May 15, 2006.)

But for people with limited incomes, the first part of that process begins now, so they'll know well in advance if they qualify for the extra help.

From late this month through August, the Social Security Administration (SSA) will be sending application forms (in English or Spanish) to millions of people who may be eligible for this assistance.

AARP and other consumer groups urge all those who receive the form—or others who can act on their behalf—to fill it out and return it because, if eligible, the applicants can save a great deal of money on their prescriptions.

"This is a very valuable part of the drug benefit," says Paul Cotton, of AARP's legislative health team. "It allows people who have the greatest difficulty affording drugs to receive the most help. For many people, it will be worth thousands of dollars a year."

Those who qualify will pay no or reduced premiums and deductibles, and low copayments for prescriptions, depending on their incomes and circumstances. [See chart.] All will receive continuous coverage throughout the year. They will thus avoid the "doughnut hole," the gap in the standard drug benefit that leaves up to $2,850 of annual drug costs uncovered.

Who should apply for extra help? If you think you may be eligible, it is worth applying, even if your income seems over the limit. For some people—for example, those who have dependents, or live in Alaska or

Hawaii, or have certain earnings or expenses that don't count—the limits are higher.

However, if you have a very limited income (levels 1 and 2 on the chart), you need not apply because *you are automatically eligible.* The Centers for Medicare & Medicaid Services (CMS) will send a letter telling you this. In late fall you will still be asked to enroll in a drug plan of your choice. If you don't, CMS will enroll you in one.

What if my drugs are already paid for? People now receiving drugs from Medicaid will get them instead from Medicare after Dec. 31. People in some state Medicaid programs who now get free drugs will pay small copays for the first time next year.

Some states that run other drug assistance programs are still deciding how to fit in with the new Medicare benefit. Contact the program you're enrolled in for information.

What counts as "income" and "assets"? People who are automatically enrolled do not have to bother with these, since their income and assets have already been deemed below the limits. For others who must apply, income means any money from work, Social Security, retirement benefits, alimony, rental property, workers' compensation, etc. Assets are resources like bank accounts, investments, life insurance policies and extra real estate. They do *not* include your home, the land it stands on, vehicles, burial plots or personal possessions.

The asset limits—the maximum monetary amount allowed—include $1,500 per person for funeral or burial expenses. The application form asks if you expect to use any of your savings, investments or life insurance for this purpose. If you answer "no," the asset limit will be reduced by $1,500 (or $3,000 for a couple).

What do I need to know to fill out an application? You'll need your Social Security number and financial information. If you have life insurance, you may need to ask your insurer how much money you'd receive if you cashed it in right now. A married couple living together makes a joint application.

How do I apply? You can fill out and return the application form sent by the SSA. Or you can apply by phone at (800) 772-1213, or in person at a local SSA office or at one of your state SHIP (state health insurance program) offices. Or, from early July, you can apply online at **www.socialsecurity.gov.**

Can anyone help me apply? Trained SHIP counselors offer help at no charge. To find your nearest office, call the Medicare hotline at (800) 633-4227 or go to **www.shiptalk.org.**

Can someone else apply for me? Yes. Anyone—including a family member, friend, caregiver, legal representative, social worker or SHIP counselor—can complete a printed or online application and even sign on your behalf.

What if I'm turned down? You may still qualify for extra help from your state. Some state programs have higher income limits or may not require asset tests. A SHIP counselor can advise you. ■

What's the Difference?

- **Medicare drug discount cards** offer reduced prices on some prescriptions. This temporary program ends Dec. 31.
- **Medicare's standard drug benefit** offers drug coverage to all who sign up. Enrollment begins Nov. 15. Coverage starts Jan. 1.
- **Limited-income assistance** in the drug benefit offers low-cost coverage to those who qualify. Applications begin late May. Coverage starts Jan. 1.

FOR MORE INFORMATION, go to **www.socialsecurity.gov, www.medicareinteractive.org/aarp, www.medicare.gov** or **www.aarp.org/bulletin.**

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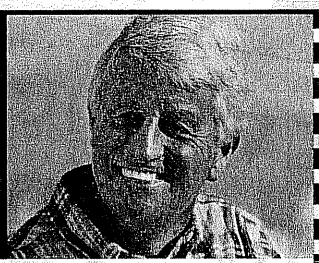

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Medicare drug program: Brace for challenge

By Lawrence M. O'Rourke
BEE WASHINGTON BUREAU

WASHINGTON – With critical deadlines looming, millions of elderly and disabled Americans on Medicare can anticipate tough and complicated choices in enrolling in the new federal drug program that begins next year.

"It will be a challenge," said Mark McClellan, the federal official in charge of getting the $720 billion, 10-year program off to a smooth start.

Robert Hayes, president of the Medicare Rights Center, an advocacy group in New York, is even more ominous.

"Only the savviest consumers will be able to navigate it on their own and even with assistance," he said. "Millions of elderly and disabled people face a bewildering range of options that will cause anxiety and a significant risk of exploitation and intimidation."

But Gary Karr, spokesman for the Centers for Medicaid and Medicare Services, insisted the selection process will be "a lot easier than it seems."

About half the 43 million people eligible for the new benefit will be assigned automatically into drug insurance programs. The others might seek help from family, pharmacists and advocacy groups getting up for the kickoff of the program.

"Most seniors will not have to wade through a bewildering list of choices," Karr said.

For those not automatically enrolled, crunch time will begin Oct. 1, when private insurance companies, including sponsors of health maintenance organizations, are permitted to start their sales pitches through newspaper, radio and TV ads, and direct

▶ MEDICARE, Page A10

mailings.

Oct. 1 will open a period of about six weeks in which Medicare beneficiaries are expected to start analyzing and digesting competing plans to see which works best for them.

The window for signing up opens Nov. 15. While there's no prize for an instant decision, the quicker the better so that people can be enrolled and claim the benefit from the outset.

The window that opens Nov. 15 will shut on May 15, 2006. After that, beneficiaries face a 1 percent-a-month penalty on their premium when they do sign up.

McClellan said the schedule provides enough time for beneficiaries to review their choices and make them, drawing if needed on the advice of family, pharmacists and others.

The vast majority of the nation's nearly 200,000 pharmacists are bracing for an onslaught of questions from customers, said Mary Ann Wagner, vice president of the National Association of Chain Drugstores.

Beneficiaries will "probably be a little confused by the choices and they'll turn for advice to the pharmacists who regularly dispense their drugs," she said.

The pharmacists, in turn, may rely heavily on a drug price scorecard developed by Gold Standard Multimedia Inc., a private health information technology company in Tampa, Fla.

Gold Standard's president, Russ Thomas, said in a telephone interview that pharmacists, consumers and advocates are testing software that could make it easier to figure out the best choice for each patient.

Such a system would go a long way toward alleviating a beneficiary's confusion and anxiety, Thomas said.

Once obstacles are overcome, the benefit could offer considerable help to millions who rely heavily on drugs to ease pain and control illness. Rising drug prices have driven some Medicare beneficiaries to choose between buying medicine and food, patient advocates contend.

McClellan said the plan could save the typical beneficiary $100 a month in drug costs, and thousands of dollars a year for people who have big drug expenses.

About 43 million people are eligible for the new benefit, approved by Congress and signed into law by President Bush in 2003. Medicare covers about 36 million elderly and 7 million under 65 with permanent disabilities.

McClellan's agency already has encountered a bump in getting information out to one group of beneficiaries – about 6.3 million low-income people eligible for Medicare and Medicaid.

The agency wrote a letter to each telling of the impending Medicare drug benefit, but "a few of them," said Karr, got empty envelopes because of a technical glitch. Karr said those who got the empty envelopes can call to get the information over the phone or to request a letter.

The first wave of Medicare beneficiaries with annual income below $15,000 a year and $11,000 in assets is now being mailed a seven-page questionnaire by the Social Security Administration. It asks questions about their possessions to determine eligibility. Some advocates expect many of the letters to go unanswered.

Another concern is that the new drug benefit seems to be putting at risk health insurance plans with drug benefits offered by companies and unions to 12 million retired people. The Kaiser Family Foundation said 2.4 million retirees face higher drug costs each year because they are being shifted from business and union plans to the Medicare plan.

McClellan insisted in a speech to business representatives at the U.S. Chamber of Commerce that the federal program is on course to begin operations on Jan. 1, and that some of the concerns are unwarranted.

But advocates say McClellan underestimates the nervousness many senior citizens display as they calculate advantages and disadvantages of complicated choices.

"Every plan will be different, a mixture of premiums, deductibles and co-insurance. A lot of people are going to say, 'It's all too much for me,' " said Deane Beebe of the Medicare Rights Center.

Though the choices will ideally be made as soon after Nov. 15 as feasible, it's not yet possible for beneficiaries to start plowing through the options.

That's because information about the number of drug insurance companies that will compete for the premiums of elderly and disabled in different parts of the country is still incomplete.

And, even more importantly, what the individual drug companies will offer on their list of covered drugs – called a formulary – is still unknown. While all companies are expected to cover the most commonly used drugs, not all will cover lesser used drugs that are vital to some patients.

As a consequence, a patient might see desired drugs covered on one formulary but not another, prompting astute beneficiaries to tote up each plan's relative advantages to them.

McClellan said every beneficiary in the United States and its territories will have access to at least one plan. Many, though, will have just one option.

But federal officials say Medicare beneficiaries in California, Florida and New York, some of the hotter markets, will be pressured to look at dozens of plans, perhaps as many as 50.

"We've had a very robust response from the insurance industry," McClellan said. That's what the Bush administration promoted as a step toward increasing competition and lowering prescription drug costs.

The starting premium per Medicare enrollee – the initial out-of-pocket price of signing up – is expected to average $37 a month, with the precise amount calculated on regional costs.

■ ■ ■

The Bee's Lawrence M. O'Rourke can be reached at (202) 383-0012 or lorourke@mcclatchydc.com.

MEDICARE DRUG TIMETABLE

Here are key dates for the benefit that will offer typical Medicare-covered retirees and those on disability a $100-a-month subsidy on drug costs up to $3,600 out-of-pocket per year and a 95 percent subsidy when individual drug costs rise above $5,100:

Now: Insurance companies, including managed-care organizations, are submitting plans for evaluation to the federal government.

Now through August: 20 million low-income individuals not on Medicaid should be receiving a seven-page application from the Social Security Administration that must be completed, returned and approved to qualify each for the Medicare drug subsidy.

Now: Individuals on Medicaid as well as Medicare, known as dual eligibles, should be receiving letters advising them that on Dec. 31 their drug coverage will switch automatically to Medicare. They will be randomly assigned to a plan but have the option to switch to another.

Oct. 1: The government will have completed its review of the plans submitted by the insurers. The companies may begin to market the approved plans.

Nov. 15: The 43 million beneficiaries can start deciding which plan they will pick.

Jan. 1 , 2006: Medicare starts covering prescription drugs.

May 15, 2006: The first window for choosing a plan closes.

June 1, 2006: The plan may begin to impose a 1 percent penalty per month on premiums of those who were eligible to enroll from the outset but failed to do so.

Nov. 15, 2006: The second window for enrollment opens and stays open through Dec. 31, 2006. A Nov. 15-Dec. 31 open enrollment period will be in effect in 2007 and thereafter.

IF YOU WANT TO KNOW MORE

Medicare Prescription Drug Coverage

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Beginning January 1, 2006, Medicare will offer prescription drug coverage. Most people will be able to get this coverage through Medicare prescription drug plans. Medicare will also work with employers and unions to ensure that people who currently receive drug coverage through their former employer or union can continue to do so.

Starting November 15, 2005, all people with Medicare can enroll in a plan that covers prescription drugs. Medicare will work with insurance companies and other private companies to offer these drug plans. The companies will negotiate discounts on drug prices on behalf of the people who enroll. Every person with Medicare will have a choice of at least two drug plans that cover both brand-name and generic drugs. There will be extra help for those who need it most.

MEDICARE PRESCRIPTION DRUG COVERAGE

Basics

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join, you will pay a monthly premium, generally about $37, plus a share of the cost of your prescriptions. Costs may be different depending on the drug plan you choose.

Drug plans may vary in the prescription drugs covered, how much you have to pay, and the 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 may offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it's important for you to choose one that meets your needs. Some employers or other third parties may offer coverage that supplements the standard coverage.

If you are in fee-for-service Medicare and want Medicare prescription drug coverage, you will need to sign up for a prescription drug plan. These plans may vary in coverage. Generally, standard coverage works like this:

- You pay a $250 deductible
- You pay 25% of drug costs from $250 to $2,250; Medicare will pay 75 percent
- You pay 100% of drug costs from $2,250 to $5,100
- After your total drug costs reach $5,100 and you have paid $3,600 in out-of-pocket costs, you pay only 5% of any costs above $5,100; Medicare will pay the other 95 percent

In most cases, if you are enrolled in a **Medicare Advantage Plan**, (like an HMO or PPO), you will receive your Medicare prescription drug coverage through that plan.

Medicare will provide information about Medicare prescription drug plans, including how to choose and join a plan. In the fall of 2005, Medicare will mail you the ***Medicare & You 2006*** handbook, which will list the Medicare prescription drug plans available in your area.

Extra Help for Those Who Need it Most

If you have a limited income and resources, which includes your savings and stocks, but not your home, you may be able to get extra help. If you qualify, you will get help paying the monthly premium for your drug plan and/or some of the other costs for your prescriptions. The type of extra help will be based on the amounts of your income and resources.

In the summer of 2005, the Social Security Administration will send people with limited incomes information about how to apply for this extra help. If you think you qualify, you can apply with Social Security as early as summer 2005.

Eligibility and Enrollment

If you have Medicare Part A and/or Part B, 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 coverage will begin on January 1, 2006. If you join after that, your coverage will begin the first day of the month after the month you join.

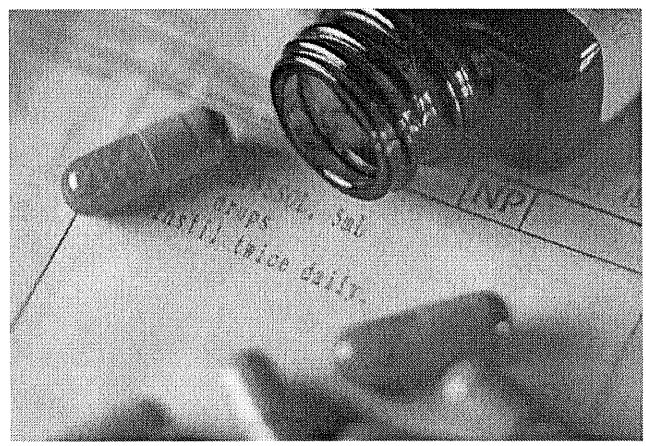
To enroll in a plan, you must live in the plan's service area. You can enroll directly in a plan, or someone else can help you enroll. The plan will notify you if your application is accepted or not.

It is important that you join a Medicare prescription drug plan when you are first eligible. Medical practice has come to rely more and more on new drug therapies to treat chronic conditions, and out-of-pocket spending on drugs has increased dramatically. Most people with Medicare currently need or will come to need prescription drugs to stay healthy. Medicare prescription drug coverage will protect you from high out-of-pocket costs. For most people, joining when you are first eligible means that you will pay a lower monthly premium than if you wait to join later.

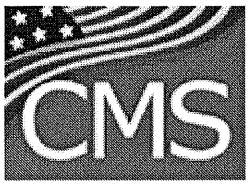
After May 15, 2006, you can enroll in a plan, drop a plan, or change plans only during the period November 15 through December 31 each year, except in certain situations. If you want to stay in the plan you are currently enrolled in for the next year, you don't have to do anything.

You May Need to Know

- As of January 2006, if you have both Medicare and full Medicaid benefits, you will no longer receive drug coverage through Medicaid. Medicare will provide your prescription drug coverage instead of Medicaid. If you have Medicare and full Medicaid benefits and do not choose a plan by December 31, 2005, Medicare will enroll you in one. However, you will be able to change plans at any time.
- Medicare prescription drug plans are different from the Medicare-approved drug discount cards that were available in 2004 and 2005. You can use your Medicare-approved drug discount card until May 15, 2006, or until you join a Medicare prescription drug plan—whichever is first.
- If you have a **Medigap (Medicare Supplement)** policy with drug coverage, you will get a notice from your insurance company telling you whether or not your policy is as good as or better than Medicare prescription drug coverage. This notice will explain your rights and choices.
- If you have prescription drug coverage from an employer or union, your employer or union will notify you about whether your current drug coverage is as good as or better than Medicare prescription drug coverage. If it is, you can keep your current drug coverage, and if you decide to join a Medicare prescription drug plan later, your monthly premium won't be higher. If you drop your current drug coverage and join a Medicare prescription drug plan, you may not be able to get your employer or union drug coverage back.
- If you live in a U.S. territory and have a limited income and limited resources, you may get extra help paying for your prescription drug costs.
- If you are in a nursing home, you may get your prescription drugs from a long-term care pharmacy that contracts with a Medicare prescription drug plan.
- Your Medicare prescription drug plan must notify you 60 days before taking one of your prescriptions off its list of covered drugs.
- In the fall of 2005 you will be able to get personalized information to help you find a plan that meets your needs by visiting **www.medicare.gov** or by calling **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048. Your **State Health Insurance Assistance Program (SHIP)** and other local organizations will also be able to help you with your drug coverage decisions.



These materials were prepared in March 2005 by the Centers for Medicare & Medicaid Services. They are intended for training purposes only and are not legal documents.



Medicare Prescription Drug Coverage Information for Providers

Quick-navigate to an area of interest

Basic Information | Beneficiary-focused Information | MMA Information

Congress mandated a new prescription drug benefit for people with Medicare through passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Beginning January 1, 2006, new Medicare prescription drug plans will be available to people with Medicare. CMS is preparing a variety of educational products to assist providers, beneficiaries and their advocates to understand the new benefit.

Basic Information for Health Care Professionals

This new benefit requires every Medicare beneficiary to make a decision. As a trusted source, patients may ask their healthcare providers for information about the new drug coverage. Because of this, CMS is looking to the provider community to take advantage of this "teachable moment" and help Medicare patients. Helping can be as simple as referring patients to beneficiary educational resources such as 1-800-Medicare and www.medicare.gov.

CMS is creating a series of Medlearn Matters articles to keep the provider community informed about drug coverage, as information becomes available.

Medlearn Matters Drug Coverage Series:

- Article 1 - SE0501: MMA - Coming Soon - The New Medicare Prescription Drug Program (293KB)
- Article 2 - SE0502: MMA - The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006 (270KB)
- Article 3 - SE0520: MMA - Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage (316KB)
- Article 4 - SE0537: New Educational Products Available (270KB) **New**

Bookmark this website as it will continue to be updated with articles and other educational materials, as they become available. To receive email notification of new Medlearn Matters articles visit: /mailinglists/

Beneficiary-focused Information and Materials for Beneficiaries, Their Advocates and Providers Who Want to Take a More Active Role in Educating or Counseling Beneficiaries

Limited Income? SSA Can Help - Posters: (Limited Supply. Orders will be filled with remaining supply.)
Limited income Medicare beneficiaries are directed to where they can call to find out if they are eligible for help with prescription drug costs. Posters are suitable for display in a physician's, provider's or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. Flat posters are suitable for wall display. Easel posters are suitable for counter display. Order the size and style (wall/easel) appropriate for your use. Artwork can not be specified as posters will be sent based on availability at the time the order is received. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

View Posters:

1. Poster 1 (837KB)
2. Poster 2 (270KB)
3. Poster 3 (562KB)
4. Poster 4 (577KB)

The Outreach Toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance to their clients on the Medicare prescription drug coverage. The toolkit is developed with basic, straightforward information that can be easily conveyed to beneficiaries. You can view and download this kit online, as well as order a copy to be shipped to your office.

These resources on Medicare Prescription Drug Coverage are available at www.medicare.gov.

Patient Publications: Health care professionals may download and photocopy these materials from www.medicare.gov (updated regularly) to distribute to their patients, or call 1-800-MEDICARE to order a limited number of free copies (publication number follows title):

- **The Facts About Medicare Prescription Drug Plans** - (126KB) 11065 This fact sheet gives a brief overview of the new Medicare prescription drug plans that begin on January 1, 2006. (2 pages) *Versión en Español*

- **Introducing Medicare's New Coverage for Prescription Drugs** - (624KB) 11103 This bifold provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, what are the costs, and when more information will be available. (4 pages) *Versión en Español*

State Health Insurance Assistance Programs (SHIPS):
Beneficiaries may also contact their SHIP counselor for information on prescription drug coverage. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE or visit www.medicare.gov/Contacts/Related/Ships.asp.

MMA Information for Health Care Professionals

For Health Care Professionals who want to know more about all aspects of the new legislation, visit http://www.cms.hhs.gov/medicarereform/. Information on this website is updated routinely.

Back to the Medlearn Home Page

Note: Some of the files on this page are available only in Adobe Acrobat - Portable Document Format (PDF). To view PDF files, you must have the Adobe Acrobat Reader (minimum version 5, version 6 suggested). You can check here to see if you have the Acrobat Reader installed on your computer. If you do not already have the Acrobat Reader installed, please go to Adobe's Acrobat download page now.

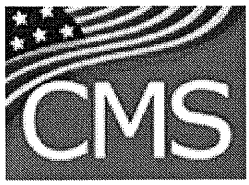
Last Modified on Tuesday, June 21, 2005

www3

Privacy & Security | Accessibility | FOIA | Help | Email Updates | CMS Careers
Health and Human Services | Medicare.gov | FirstGov
Equal Employment Opportunity Data Posted Pursuant to the No Fear Act

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Baltimore MD 21244-1850
CMS Telephone Numbers



Medicare Modernization Act

Fact Sheets

- Fact Sheets
  - Quick Facts about Medicare's New Coverage for Prescription Drugs for People with limited income and resources
  - Quick Facts about Medicare's New Coverage for Prescritpion Drug If You Applied for Extra Help
  - Medicaid Spend Down -Tip Sheet
  - Food Stamps -Tip Sheet
  - Quick Facts about Medicare's New Coverage for Prescription Drugs
  - Quick Facts about Medicare's New Coverage for Prescription Drugs (en Espanol)
  - Important Information from Medicare about Paying for Prescription Drugs- Medicare Savings Progam (MSP)
  - Important Information from Medicare about Paying for Prescription Drugs- Suplemental Security Income (SSI)
  - Important Information from Medicare about Paying for Prescription Drugs (Duals)
  - Quick Facts about Medicare's New Coverage for Prescription Drugs for people who get Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums
  - Quick Facts about Medicare's New Coverage for Prescription Drugs for people with Medicare and Medicaid, and Medicaid now pays for their prescription drugs
  - Quick Facts about Medicare's New Coverage for Prescription Drugs for people who get help from their state pharmacy program to pay for their prescriptions.

Note: Some of the files on this page are available only in Adobe Acrobat - Portable Document Format (PDF). To view PDF files, you must have the Adobe Acrobat Reader (minimum version 5, version 6 suggested). You can check here to see if you have the Acrobat Reader installed on your computer. If you do not already have the Acrobat Reader installed, please go to Adobe's Acrobat download page now.

Last Modified on Thursday, June 02, 2005

www3

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore MD 21244-1850
CMS Telephone Numbers

Social Security Administration
Important Information

THIS COVER LETTER IS FOR INFORMATION ONLY.
DO NOT COMPLETE THE FOLLOWING PAGES.
THIS IS NOT AN APPLICATION.

Our records show you may be eligible to get extra help paying for your prescription drugs.

Soon, a new Medicare Prescription Drug program will take effect. The new program will give you a choice of prescription plans that offer various types of coverage.

You may be able to get extra help to pay for the annual deductible, premiums and co-payments related to the new Medicare Prescription Drug program—an average of $2,100 in extra help.

But before we can help you, **you must fill out the application, put it in the enclosed envelope, and mail it today.** Or you may complete an online application at **www.socialsecurity.gov** beginning July 1, 2005. We will review your application and send you a letter to let you know if you qualify for extra help. We also will send you information about the Medicare Prescription Drug program and tell you what you should do next.

If you need help completing the application, call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). You can find more information at **www.socialsecurity.gov**.

If you need information about the new Medicare Prescription Drug program, call 1-800-MEDICARE (TTY 1-877-486-2048) or visit **www.medicare.gov**.

Mailing your application today will allow us to give you a quicker decision about whether you qualify for the extra help.

Jo Anne B. Barnhart
Commissioner

General Instructions for Completing the Application for Help with Medicare Prescription Drug Plan Costs

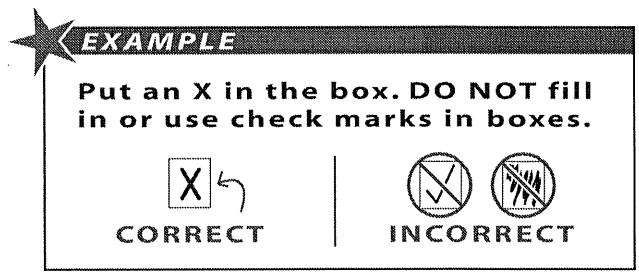
To Provide Extra Help in Paying for Your Drug Expenses

Do you (or the person you are helping apply) have Medicare and Supplemental Security Income (SSI) or Medicare and Medicaid or does your state pay your Medicare premiums?

If the answer is **YES, do not complete this application because you automatically will get the extra help**. You will receive another letter about how you will receive the extra help. If the answer is NO or NOT SURE, please complete this application. Please read the following instructions and guidelines before completing this application. Complete all questions unless otherwise noted.

How To Complete This Application

- Use **BLACK INK** or a **#2 pencil**;
- Keep your numbers, letters and Xs inside the boxes;
- Do not use dollar signs when entering money amounts. The dollar sign is preprinted; and
- Cents can be rounded to the nearest whole dollar.



If You Are Assisting Someone Else With This Application

Answer the questions as if that person were completing the application. You must know that person's Social Security number and financial information. Also, complete Section B on page 6.

Completing Your Application

You may complete the online application at **www.socialsecurity.gov** or use the enclosed pre-addressed stamped envelope to return your completed and signed application to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1020
Wilkes-Barre, PA 18767-9910

Return the entire package in the enclosed envelope. Do not include any attachments. If we need more information, such as statements from financial institutions, we will contact you.

If You Have Questions Or Need Help Completing This Application

You may call us toll-free at **1-800-772-1213**, or if you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**.

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

Application for Help with Medicare Prescription Drug Plan Costs

THIS DOES NOT ENROLL YOU IN THE MEDICARE PRESCRIPTION DRUG PROGRAM.

EXAMPLE

Use capital letters when entering answers | A | B | C | D |

1. Applicant's Name (Print each letter in a separate box.)

FIRST NAME MI

LAST NAME SUFFIX (Jr., Sr., etc.)

Applicant's Social Security Number

— —

SOCIAL SECURITY NUMBER EXAMPLE

— —

2. **If you are single, divorced, a widow(er) or your spouse does not live with you, skip to question 3.** If you are married and living with your spouse, please put an ☒ in one of the boxes below to indicate who is applying:

☐ Only you are applying. ☐ Both you and your spouse have Medicare and are applying on this application.

Even if your spouse is not applying, we need all of the questions answered and signatures for both of you if you live together.

Spouse's Name (if you are married and living together)

FIRST NAME MI

LAST NAME SUFFIX (Jr., Sr., etc.)

Spouse's Social Security Number

— —

3. If you are single, a widow(er) or your spouse does not live with you, are your savings, investments and real estate (other than your home) worth more than $11,500? If you are married and living together, are they worth more than $23,000? (These limits will be higher after 2006.) Include the things you own by yourself, with your spouse or with someone else. **Do not include your home, vehicles, burial plots or personal possessions.**

☐ **YES** ☐ **NO** ☐ **NOT SURE**

If you put an ☒ in the **YES** box, you are not eligible for the extra help and you do not need to complete the rest of this application. You may still be eligible through your state Medicaid agency. However, if you want a decision, put an ☒ in the **NOT SURE** box. If you put an ☒ in either the **NO** or **NOT SURE** box, complete the rest of this application.

4. Please enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own in the boxes below. Include items that either of you own with another person. (Include only the dollar figures, not the account number.) If you or your spouse (if married and living together) do not own an item listed, either separately, jointly or with another person, place an ☒ in the **NONE** box.

• Bank accounts (checking, savings and certificates of deposit)	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐
• Any other cash at home or anywhere else	☐ **NONE**	$ ☐☐ , ☐☐☐ . ☐☐

5. Do you (or your spouse, if married and living together) own life insurance policies with a total face value of $1,500 or more? Answer for you and for your spouse if your spouse lives with you. If you answered **NO** for both you and your spouse, go to question 6.

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

If the answer for either you or your spouse is **YES**, how much money would you get if you turned in your insurance policies for cash right now? (This is not the face value of your policies. You may need to call your insurance company to help answer this question.) Enter the amount.

$ ☐☐ , ☐☐☐ . ☐☐

6. Do you expect to use money from any of the sources listed in questions 4 or 5 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU: ☐ **YES** ☐ **NO**

SPOUSE (if living together): ☐ **YES** ☐ **NO**

7. Other than your home and the property on which it is located, do you (or your spouse, if married and living together) own any real estate?

☐ **YES** ☐ **NO**

8. Your living situation may affect the amount of help you can get. Therefore, we need to know how many relatives who live with you (and your spouse, if married and living together) depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least one-half of their financial support? **Do not include yourself or your spouse in this number.** (Place an ☒ in only one box.)

NONE	1	2	3	4	5	6	7	8	9 or more

9. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total monthly income**. **If the amount changes from month to month, enter the average monthly income for the past year for each type** in the appropriate boxes. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. If you or your spouse do not receive income from any of the sources listed below, place an ☒ in the **NONE** box.

• Social Security	We will use the amount in our records.	
• Railroad Retirement	NONE	$, .
• Veterans	NONE	$, .
• Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	NONE	$, .
• Other income not listed above, including alimony, net rental income, workers' compensation (Specify):_____ _____	NONE	$, .

10. Have any of the amounts you included in question 9 decreased during the last two years?

YES NO

11. Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, or help with medical treatment and drugs.)

YES NO

If you put an ☒ in the **YES** box, enter the monthly amount, or if the amount changes from month to month, enter the average monthly amount for the past year.

$, .

- **If you are single, divorced, separated or a widow(er) and have not worked in the last two years, skip questions 12 – 16 and go to page 6.**
- **If you are married and living with your spouse and neither of you have worked in the last two years, skip questions 12 – 16 and go to page 6.**

12. What do you expect to earn in wages before taxes **this year**?

YOU: ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

SPOUSE (if living together): ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

13. If self-employed, what do you expect your net earnings or loss to be **this year**?

YOU: ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

SPOUSE (if living together): ☐ **NONE** $ ☐☐ , ☐☐☐ . ☐☐

Put an ☒ here if you or your spouse expect a net loss. **YOU:** ☐ **SPOUSE (if living together):** ☐

14. Have the amounts you included in questions 12 or 13 decreased in the last two years?

☐ **YES** ☐ **NO**

15. If you (or your spouse, if married and living together) recently stopped working or plan to stop working, enter the month and year.

EXAMPLE

For January – September, put a zero (0) in the first box. May 2006 should read: 0 5 (M M) 2 0 0 6 (Y Y Y Y)

YOU: ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

SPOUSE : (if living together) ☐☐ (M M) 2 0 ☐☐ (Y Y Y Y)

- **If you are single, divorced, separated or a widow(er) and 65 or older, skip question 16 and go to page 6.**
- **If you are married and living with your spouse and both you and your spouse are 65 or older, skip question 16 and go to page 6.**

16. Do you (or your spouse, if married and living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression, or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU: ☐ **YES** ☐ **NO** **SPOUSE (if living together):** ☐ **YES** ☐ **NO**

DO NOT COMPLETE. THIS IS NOT AN APPLICATION.

Signatures

I/We understand that by submitting this application I am/we are declaring under penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge. I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service to make sure the determination is correct. By submitting this application I am/we are authorizing SSA to obtain and disclose information related to my/our income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my/our wages, account balances, investments, insurance policies, benefits, and pensions. **Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.**

SECTION A

Your Signature:	Your Spouse's Signature:	Phone Number: ( ) –

Your Home Street Address:	Apt. #:

City:	State:	Zip Code:

Your Mailing Street Address (if different from home address):	Apt. #:

City:	State:	Zip Code:

If you recently changed your address, put an ☒ here: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: ( ) –

SECTION B

If you are assisting someone else, place an ☒ in the box that describes who you are and provide your daytime phone number and address.

☐ Family Member ☐ Attorney ☐ Other Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: ( ) –

Street Address:	Apt. #:

City:	State:	Zip Code:

Coming January 1, 2006

Medicare Prescription Drug Coverage

Important Dates for People with Medicare during 2005 and 2006

MAY 2005

- Social Security Administration (SSA) begins mailing out and accepting applications for those who need extra help (low income subsidy) and begins holding local events in communities across the country.
- Medicare will mail letters to people who are automatically eligible for extra help with drug plan costs.

JUNE 2005

- Local community events continue through December.
- SSA begins processing applications for extra help. Help is available at 1-800-772-1213 or www.socialsecurity.gov.

JULY 2005

- *"Your Guide to Medicare Prescription Drug Plans" is available by calling 1-800-MEDICARE or by visiting www.medicare.gov.*
- SSA begins sending letters informing those who applied for extra help whether they qualify.

AUGUST 2005

- SSA continues sending letters informing those who applied for extra help whether they qualify.

SEPTEMBER 2005

- Medigap (supplemental) insurance companies send notices to policyholders with drug coverage informing them of their options.
- Employers/unions who provide prescription drug coverage to their retirees will directly notify them about their new prescription drug coverage choices.

OCTOBER 2005

- Comparative information about Medicare prescription drug plans will be available at www.medicare.gov, 1-800-MEDICARE, or through State Health Insurance Assistance Programs and other local organizations.
- Medicare & You 2006 Handbook containing all the necessary information is mailed to all Medicare households.
- Medicare Advantage plans notify plan enrollees about enhanced drug plan coverage options via "Notification of Change."
- People with Medicare and Medicaid will get information about how they will be automatically enrolled in a plan if they do not choose one on their own.

NOVEMBER 2005

- **Enrollment for Medicare prescription drug plans begin November 15. People must call the company offering the plan to enroll or enroll through 1-800-MEDICARE.**

DECEMBER 2005

People should enroll in a Medicare prescription drug plan now to pay lower premiums and to receive prescription drug coverage when it begins January 1, 2006.

Enrollment Begins November 15, 2005

JANUARY 2006

- Medicare prescription drug coverage begins January 1 for those who enrolled in a plan by December 31, 2005.
- Medicare begins to provide prescription drug coverage for those who have Medicare and full Medicaid coverage.

FEBRUARY 2006

MARCH 2006

Enrollment continues. Medicare prescription drug coverage begins in the following month.

APRIL-MAY 2006

- Medicare will send a reminder to those who have not enrolled in a Medicare prescription drug plan.
- May 15 is the last day to enroll in a Medicare prescription drug plan and pay lower premiums.
- Facilitated enrollment of those who qualify for extra help and have not yet chosen a plan; coverage effective June 1.

**Online qualifier tools available at www.medicare.gov and www.socialsecurity.gov allow people to determine whether they may be eligible to receive extra help before they apply. Online applications for extra help is available July 1 on the Social Security Web site.* People can call 1-800-Medicare (1-800-633-4227) to find out about local State Health Insurance Assistance Programs*