Area Agency on Aging 1-B
Advocacy • Action • Answers on Aging

Medicare Prescription Drug Improvement and Modernization Act of 2003:
Frequently Asked Questions

The following provides answers to many of the questions frequently asked about the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Is it necessary to enroll in the Medicare prescription drug benefit?

No. The Medicare drug benefit is voluntary. However, if a beneficiary does not enroll during the initial seven-month enrollment period, upon qualifying for Medicare, or was eligible for Medicare Part D during the first enrollment period of the program from November 15, 2005 through May 15, 2006, and the beneficiary enrolls at a later date, they may be required to pay a premium penalty. If a beneficiary already has prescription drug coverage at least as good as Medicare's, they will not be required to pay a premium penalty if they later enroll in the Medicare drug benefit. The premium penalty is 1 percent for every month the beneficiary delays enrollment. For example, if enrollment is delayed 24 months and the premium at that time is $50, the monthly premium would increase by 24 percent, or $12, and total premium would be $62. The premium penalty will be assessed as long as the beneficiary is enrolled in the Medicare drug benefit.

If beneficiaries have prescription drug coverage through a former employer, will they be required to pay the premium penalty if they lose their coverage?

Probably not. If beneficiaries have prescription drug coverage that is **at least as good as the Medicare drug benefit, or "creditable coverage,"** they will not be required to pay a premium penalty if they lose coverage. However, they will be required to choose a Medicare drug plan within 63 days if their coverage is cancelled to avoid paying a penalty. Beneficiaries with coverage through a former employer need to obtain written information explaining whether their retiree plan is creditable. It is critical that beneficiaries read this information before making any decisions about their prescription coverage, and keep the information as proof of creditable coverage for the future.

What will happen to current retiree plans as a result of the MMA?

Under MMA, qualified retiree plans will have the option of receiving a 28 percent tax-exempt payment if they continue to provide a retiree prescription drug benefit that is considered creditable coverage.

Does the MMA limit the costs a drug company can charge beneficiaries?

No. The bill does nothing to lower drug costs. The legislation actually prohibits Medicare from using its purchasing power to negotiate lower drug prices for beneficiaries.

Will all private plans offering the prescription drug benefit cost the same?

No. Private plans can charge different premiums and deductibles. They can also charge different co-pay or co-insurance amounts, as long as the plan is equal in value to the standard plan outlined by Medicare. Therefore, it will again be necessary for beneficiaries to compare plans.

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Will the Medicare prescription drug plan cover all medications?

No. Each private plan offering the prescription drug benefit has a formulary, or list of covered drugs. The plans decide independently which drugs will be included in their formulary. Plans are required to cover a minimum of two drugs from each therapeutic class – but not all drugs. For example, a plan may cover two drugs for high blood pressure – which may not be either of the medications prescribed. If a drug is not on the list of covered medications, the beneficiary is required to pay for the full cost, ask her/his physician to rewrite their prescription for the covered drug, or ask the plan for a coverage determination. Additionally, the cost of drugs not on a plan's formulary **does not count** towards out-of-pocket prescription drug expenses to qualify for levels of drug coverage. Therefore, beneficiaries are advised to carefully compare plans in order to find the one best suited to their drug needs.

What if the medication needed is not covered by the Medicare private drug plan?

If a medically necessary drug is removed from a Medicare private drug plan formulary, for reasons other than safety, a beneficiary has the right to request that the plan cover the drug. Also, a beneficiary can request that the plan cover a drug not on the formulary if their doctor believes the drugs on the plan's formulary will not work for them. The beneficiary or doctor should contact the plan to request an exception when notified that the drug is not covered. Oral or written supporting statements from the doctor are needed to demonstrate need for the drug. Generally, plans must grant an exception when they determine that it is medically appropriate to do so. If a plan denies an exceptions request, beneficiaries can appeal.

If beneficiaries have Medigap policies that contain prescription drug coverage, will they be able to continue with this plan?

Beneficiaries are allowed to continue with this coverage. However, if beneficiaries decide to drop a Medigap policy that has drug coverage – Medigap plans H, I, or J – and enroll in the new Medicare prescription drug benefit after the initial enrollment period of November 15, 2006 to December 31, 2006, they will be charged a premium penalty. These plans are not considered creditable coverage. Additionally, no new Medigap policies containing prescription drug coverage will be sold or issued after January 1, 2006.

If beneficiaries are receiving their medications through Medicaid, will they be able to continue with this coverage?

No. All Medicare beneficiaries, including those enrolled in Medicaid, are required to enroll in the Medicare drug benefit to receive prescription drug coverage. Medicaid will only pay for drugs that are not covered by MMA law, and those drugs are benzodiazepines, barbiturates, certain over-the-counter drugs, select vitamins and mineral products, and agents used to promote smoking cessation.

How can beneficiaries learn more about the Medicare prescription drug plans that will be offered?

Beneficiaries can obtain the "Medicare & You: 2008" books from Medicare, which will contain basic information on the prescription drug benefit. Plan information is also available on the Medicare website, ***www.medicare.gov***. Beneficiaries may contact Medicare at 1-800-MEDICARE or the Area Agency on

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Aging 1-B's Medicare Medicaid Assistance Program at 1-800-803-7174 for help in choosing a plan that best meets their needs.

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Once I am enrolled in a Medicare prescription drug plan, when can I change plans?
Medicare beneficiaries have the opportunity to change plans during the open enrollment period held each year between November 15 and December 31st. Other times when beneficiaries can change plans include moving out of your current plan's service area and transitioning into a nursing home.

Each year, by October 31, Medicare Part D plans are required to send participants an Annual Notice of Change which includes information on any changes in the cost of the plan's deductible, copays, coverage gap and formulary. Participants should carefully review the Annual Notice of Change.

How do Medicare beneficiaries change plans?
During the open enrollment period, if a beneficiary wishes to change plans, the beneficiary must enroll in the new plan. Beneficiaries are only allowed one change during the enrollment period, and calling their current plan to disenroll is considered a change.

Is there a local agency a Medicare Beneficiary or family member can call for more assistance?
The Medicare Medicaid Assistance Program (MMAP) is a local Michigan program, funded through a grant from the Centers for Medicare and Medicaid Services that provides local, trained counselors that can address questions on Medicare Part D, and other parts of Medicare and Medicaid. To speak with a MMAP counselor call 1-800-852-7795.

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