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THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT (PART D): INFORMATION FOR CALIFORNIANS LIVING WITH HIV/AIDS

I. Overview of the New Medicare Prescription Drug Program

With the passage of the Medicare Modernization Act of 2003 (MMA), Congress created the first Medicare prescription drug benefit, which will take effect January 1st, 2006 and is called **Medicare Part D**. This represents the largest shift in public benefits in forty years and consequently it will have a substantial impact on the HIV/AIDS community. Nationally, there are 60,000 to 80,000 Medicare beneficiaries with AIDS, 70 to 85% of whom also qualify for Medicaid (dual eligibles). In California, there are roughly 13,500 dual eligibles.

Beginning November 15, 2005, beneficiaries can enroll in one of two types of private insurance policies to receive Medicare Part D prescription drug coverage. Beneficiaries will enroll in either a **prescription drug plan (PDP)**, providing only prescription drug services *or* a **managed health care plan (known in Medicare as Medicare Advantage plans)** with a prescription drug benefit (**MA-PD**). The **Centers for Medicaid and Medicare Services (CMS)**, the agency that administers Medicare and Medicaid, has required that there be a minimum of two plans to choose from in each region. However, it is likely that most beneficiaries will have a variety of plans from which to choose. People who do not enroll in a plan by May 15, 2006 face a financial penalty for late enrollment.

People who are dually eligible face a different situation than the "standard" beneficiary. They *must* enroll in a Medicare Part D plan because their Medi-Cal prescription drug coverage will end January 1, 2006. They will be auto-assigned to a random plan in October, 2005 but may review other plans and change to a more appropriate one prior to January 1, 2006. If no plan changes are made, dually eligible individuals will be automatically enrolled in the original plan to which they were assigned. After January 1, 2006, dual-eligibles will have the opportunity to switch plans once per month.

Each of the plans will create a **formulary** (list) of prescription drugs available to Medicare beneficiaries. CMS has issued guidance stating that plans should cover all or substantially all of six classes of drugs, including anti-retroviral drugs, antidepressants, anti-psychotics, anticonvulsants, anticancer agents, and immunosuppressants. CMS has further said that anti-HIV drugs should not be subject to prior authorization, with the exception of Fuzeon, which can be put on prior approval only for those not currently on the drug.

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Plans are only asked to fully cover anti-retrovirals; other drugs essential to HIV care such as medication management drugs, drugs for the treatment and prophylaxis of opportunistic infections or co-morbidities, will not necessarily be fully covered. Formularies are required to include at least two drugs from each Part D covered therapeutic class of drugs. There are some drugs that are often covered by Medicaid but have been excluded from Part D coverage including benzodiazepines, over the counter drugs, weight loss and weight gain drugs (not including anti-wasting drugs) and vitamins and minerals. Medicaid programs will decide if they will continue to cover these drugs for those who are dually eligible.

Plans will decide whether or not to approve all drugs, including those in the “protected classes,” that receive FDA approval after January 1, 2006. Plans are not required to provide reimbursement for the use of **off-label drugs**, although CMS is reviewing the process by which reimbursement is requested to ensure that it is not “burdensome.” Plans are allowed to “tier,” or charge higher co-pays for certain drugs. A prescription drug plan can also change its formulary at any time. It is required to provide 60 days notice, in writing, to individuals enrolled in the plan.

Below you will find information, much of it specific to Californians, about how Medicare Part D will affect **Medicare-only clients**, clients that are **Medicare and ADAP eligible** and clients who are **dually eligible for Medicare and Medi-Cal**. For each of these groups, you will find information about how much a client will have to pay for his or her prescription drugs under the new benefit, if and how a client can receive a low-income subsidy (known as extra help), some information about how a client’s Medi-Cal services may be affected, how the **AIDS Drug Assistance Program (ADAP)** may interact with Medicare Part D and other important information.

Many in the Medicare population, particularly the dual eligibles, may be hard to reach and could be confused by the benefit and the information intended to help them understand it. *Thus, it is essential to ensure that clients keep all paperwork received from CMS, SSA or California DHS related to their prescription drug coverage and, if possible, review it with a case manager, benefits counselor, or other health care advocate.*

It is important to note that all dollar amounts mentioned are estimated for plan year 2006 and it is therefore projected that these costs will rise each year. Additionally, some of the information included in this document, particularly the information regarding how ADAP may interact with Medicare Part D coverage, has not yet been completely decided and could change as more decisions are made about benefits coverage. Accordingly, the document will be updated as significant changes occur and will be posted at www.sfaf.org/policy.

II. How Part D Will Affect Medicare-Only Clients (Standard Benefit)

Clients who currently receive their primary medical care through Medicare only and have no publicly financed prescription drug coverage can (but are not required to) enroll in a Medicare part D prescription drug plan or managed care health plan between November 15, 2005 and May 15, 2006. People who do not enroll during this period, but decide to

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subsequently enroll, are subject to a financial penalty. Once a Medicare only client enrolls in a plan, they can switch plans only once each year during an open enrollment period. While there are very few in the HIV/AIDS community who fall into this particular category, this information is important to provide context for the overall Medicare Part D benefit.

1. What will Medicare-only clients have to pay?

- Clients will pay an estimated average annual **premium** of \$444 or approximately \$37 monthly in 2006.
- Clients will also pay an annual \$250 **deductible** for all prescription drug costs in 2006.
- Between \$251 and \$2250 in prescription drug costs, beneficiaries will fall into the **initial benefit** level. Here, individuals will pay a **25% co-pay** for prescription drugs. For example, if a drug costs \$100, the individual will pay \$25.
- Between \$2251 and \$5100 in drug costs, individuals receive **NO** coverage. This is often referred to as the “**doughnut hole**.”
- Once a person meets \$3600 in **True Out Of Pocket expenditure (TrOOP)**, or the money they spend on their own, and overall drug costs are greater than \$5,100, individuals will pay a **5% co-pay**. In other words, if a drug costs \$100, the individual will pay \$5. This coverage is referred to as “**catastrophic coverage**.”

2. Medicare only clients may be eligible and can apply for “extra help” through Medicare Part D’s Low Income Subsidy (LIS)

- If Medicare-only clients earn below 135% of the **federal poverty level (FPL)**, \$12,919.50 for a single and \$17,320.50 for a couple, and have assets at or below \$6,000 for a single person and \$9,000 for a couple, they are eligible for the full Low-Income Subsidy (LIS). Additionally, Medicare beneficiaries in Medicare Savings Programs also automatically qualify for the full LIS.
 - With the full subsidy, clients will pay no premium and no deductible. They will have no gap in their coverage (doughnut hole).
 - Clients earning below 100% of the FPL (\$9,570 for singles, \$12,830 for couples) will pay a co-pay of \$1 for a generic and \$3 for a brand name drug.
 - Those earning above 100% of the FPL will pay a co-pay of \$2 for a generic and \$5 for a brand name drug.
- If Medicare-only clients earn below 150% FPL (\$14,355 for a single and \$19,245 for a couple) and have assets at or below \$10,000 for a single and \$20,000 for a couple, they are eligible to receive and should apply for a *partial* low-income subsidy.
 - With the partial subsidy, clients will pay a sliding scale premium (not higher than \$420 a year), a \$50 deductible, a 15% co-pay up to \$3,600 in TrOOP (out of pocket costs), and a co-pay of \$2 for a generic and \$5 for a brand name drug after reaching \$3,600 in out of pocket costs.
- Clients who would potentially qualify for either of the Low Income Subsidies should receive a letter and an application from the Social Security Administration (SSA) informing them that they may be eligible for “extra help” and instructing them on

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how to apply. A copy of this letter can be found in the packet of information distributed during the forum.

- *It is very important for everyone who might be eligible to apply for the benefit. It is also essential that the client keep the application and seek assistance with applying, if necessary.*
- Clients who are potentially eligible for LIS should also be screened for Medi-Cal or Medicare Savings Programs (MSP)

3. Other important information for Medicare-only clients

- Individuals should enroll in a prescription drug plan (PDP) or managed health care plan (MA-PD) by May 15, 2006. If they enroll after this date, they will likely be charged a 1% late enrollment fee per month. This fee will continue to accrue until they have enrolled. For example, if an individual enrolls in May, 2007 they will face a 12% increased premium.
- Once enrolled in a particular plan, beneficiaries in the Medicare only category can change plans only once per year, during an open enrollment period.
- If a particular drug is not covered, beneficiaries can file an exception with the PDP or MA-PD to get coverage. A standard exception takes 72 hours, while an expedited exception requires a physician's involvement and takes 24 hours to get back to the physician. If a plan denies an exception, the beneficiary may file an appeal, which has a much longer time frame. The plans are not required to dispense an emergency supply of drugs during the exceptions or appeals process.

III. How Part D Will Affect Medicare-only Clients Who Use ADAP to obtain Prescription Drugs

In California, most Medicare-only beneficiaries use ADAP to obtain prescription drugs. All of the information above applies to Medicare only clients who use ADAP. These clients can and should apply for the LIS as well if they qualify. However, Medicare/ADAP eligible clients will be required to enroll in Medicare Part D and will receive a portion of their prescription drug coverage from both programs, as you will see below.

1. What will Medicare and ADAP eligible clients have to pay under the Part D prescription drug benefit?

- Medicare only clients will likely have to buy into their Medicare prescription drug benefit (Part D) before ADAP can cover expenses. This means that in order to continue receiving ADAP benefits, clients will have to enroll in and pay premiums under the Medicare Part D drug benefit.
- Currently, it appears that these clients will have to pay the premium for Medicare Part D out of pocket.
- Advocates are working to identify other sources of coverage to pay premiums.

2. What will ADAP pay for Medicare and ADAP eligible clients?

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- Under Medicare Part D, ADAP will likely pay the deductible for a Medicare-only client (\$50-\$250 in drug costs)
- ADAP will also likely pay the 25% co-pay, not covered by Medicare during the initial coverage period (between \$251 and \$2250 in drug costs).
- Once the client reaches \$2251 in drug costs (beginning of the doughnut hole) ADAP will provide the rest of the annual drug coverage. Because ADAP can't count toward out of pocket expenses, the individual will never reach the catastrophic level of coverage under Medicare Part D. Thus ADAP will provide continued coverage.

3. What will Medicare cover for Medicare and ADAP eligible clients?

- Medicare will cover 75% of drug costs during the **initial coverage period**, when the client has between \$251 and \$2250 in prescription drug costs. The remaining 25% co-pay will likely be covered by ADAP.

4. Other important information for Medicare and ADAP eligible clients

- Clients will have to use ADAP participating pharmacies in their Prescription Drug Plan to receive cost-sharing assistance.
- ADAP can only provide cost-sharing assistance for the drugs included on the ADAP formulary.

IV. How Part D Will Affect Dual-Eligible (Medicare/Medi-Cal) Clients

Individuals who are eligible for both Medicare and Medi-Cal are referred to as **dual eligibles**. These clients currently receive much of their primary medical care through Medicare and prescription drug coverage and some other health care services through Medi-Cal. As of December 31, 2006, dual eligibles will lose Medi-Cal drug coverage and will be *required* to enroll in the Medicare prescription drug program. They can continue to receive all other Medi-Cal services for which they are eligible.

1. What will dual eligible clients have to pay?

- People who are dually eligible are also deemed eligible for the full Low Income Subsidy.
- Clients earning below 100% of the FPL (\$9,570 for singles, \$12,830 for couples) will be required to pay a co-pay of \$1 for a generic and \$3 for a brand name drug. Those who are institutionalized (i.e., in a nursing home) however, will have no co-pays.
- Those earning above 100% of the FPL will be required to pay a co-pay of \$2 for a generic and \$5 for a brand name drug.
- Dual eligible clients are subsidized for "cost-average" plans. If they wish to enroll in a higher cost plan, they will have to pay the difference between the average premium, as deemed by CMS, and the premium cost of the more expensive plans.

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2. What dual eligibles will NOT have to pay:

- Premium (as long as plan is considered “**cost average**”)
- Deductible
- Gap in coverage (no doughnut hole)
- Co-pays, after \$5,100 in drug costs. (This has yet to be clarified by CMS.)

3. How will ADAP interact with Medicare Part D for dual eligibles?

- ADAP will pay co-pays for those drugs that are also on the ADAP formulary. ADAP may also cover a drug that is not covered under the client’s Prescription Drug Plan if it is also on the ADAP formulary. However, ADAP will require the client to exercise the PDP exceptions process to obtain these non-formulary medications.
- People will have to use a pharmacy that is in their plan and also participates with ADAP to access co-payment assistance.

4. What will people who are dually eligible and have a Share of Cost (SOC) under California’s Medically Needy program have to pay?

- People who are responsible for a SOC (the amount of income over Medi-Cal eligibility level that a client must spend down or pay to Medi-Cal before accessing benefits each month) must incur one monthly SOC to become eligible for the full LIS under Medicare for one full plan year.

5. How will ADAP interact with dual eligibles who currently have a share of cost under Medi-Cal?

- Currently, ADAP pays Medi-Cal share of cost for many who receive prescription drugs through Medi-Cal.
- As of January 2006, ADAP will no longer be permitted to pay Medi-Cal share of cost for dual eligibles.
- ADAP will cover the co-pay obligations for those drugs that are on its formulary if the client uses ADAP participating pharmacy, just as it may with full dual eligibles.

6. Other important information

- Dual eligible clients, clients on SSI and those in a Medicare Savings Program will receive a letter from CMS starting in June, 2005. This letter will state that they automatically qualify for the Low Income Subsidy (LIS) and do not need to apply.
- Dual eligible clients will receive another letter from CMS randomly assigning them to a drug plan starting in October, 2005. At this point, the client can review other plans and switch to a different “cost average” plan. If no change is made, they will be automatically enrolled in the originally assigned plan by January 1, 2006.
- Dual eligible clients can change plans every month.

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- Dual eligible clients will continue to receive all Medi-Cal services for which they are eligible with the exception of the prescription drugs that are covered by Medicare Part D. There are some drugs that have been excluded from Part D coverage and are covered under Medi-Cal. Medi-Cal will continue to provide those drugs to the dual eligibles.
- All dual eligibles who have a SOC and have incurred it in any ONE month from March 2005 – December 2005, will be eligible for the LIS for the plan year 2006.
- Most California dual eligibles living with HIV will qualify for LIS for the plan year 2006, as ADAP will have paid SOC in one of the qualifying months.
- In order to be eligible for LIS for plan year 2007, clients will have to incur a full SOC in one month of year 2006.
- Since SOC payment through ADAP for dual eligibles will end on January 1, 2006, clients who have a Share of Cost (SOC) that has previously been met by ADAP will have to be individually counseled about how to maintain access to any necessary Medi-Cal services.
- Other clients who have a SOC may want to consider moving to a Medicare Savings Program, which does not require SOC payments but provides coverage for Medicare premiums and makes one automatically eligible for the LIS under Medicare Part D. However, these clients would likely lose access to Medi-Cal services. Thus, such a move will require individual counseling and decision making.

****This document is a draft. We would appreciate any feedback to help make this document most helpful and useful for service providers. If you have comments or questions about the format or content of this document, please e-mail them to akasdan@sfaf.org Future updates of this document will be posted at sfaf.org/policy**

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Appendix

- I. Glossary of Terms
- II. Additional Resources
- III. Timeline of MMA implementation

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Appendix I: Glossary of Terms

ADAP (AIDS Drug Assistance Program): Program pays for some or all of the costs associated with medications that are included on its formulary for low-income people with HIV/AIDS who cannot otherwise afford them. ADAP is a discretionary program and its scope of benefits and eligibility are determined by how much money is allocated to the program from federal and state government each year. The ADAP formulary contains 153 drugs; both drugs used to treat HIV and associated diseases.

Catastrophic Coverage: The term CMS is using to describe the highest level of coverage provided under the Part D benefit. This level is reached once an individual has met \$3600 in out of pocket costs and overall annual prescription drug spending over \$5,100. At this level, individuals only pay the greater of 5% of their prescription drug costs or \$2 for a generic drug and \$5 for a brand name drug.

Co-Insurance: Percentage the beneficiary is required to pay towards an incurred healthcare expense.

Co-Payment: Mechanism whereby beneficiaries must pay a portion of the cost of their prescription drugs.

Cost-Average Plan: The term that CMS is using to describe plans that, after being analyzed by actuaries, fall within the average cost range of all the plans that have been submitted to CMS for approval to provide drugs under Medicare Part D. Dual Eligible beneficiaries will only be subsidized for the cost average and below plans. If they choose a plan with a higher premium, they will have to pay the difference between the average cost and the cost of the higher premium out of their own pocket.

Cost Sharing: The cost for medical care paid by beneficiary. Includes co-payments, premiums and deductibles.

Coverage Gap (Doughnut Hole): The terms that CMS and the general public are using to describe the period during which there is no coverage in the Part D benefit. This includes annual prescription drug spending from \$2,251 to \$5,100. At this level, prescription drug plans provide NO coverage and individuals must pay 100% of their drug costs.

CMS: The Centers for Medicaid and Medicare Services, the federal agency that administers both Medicaid and Medicare.

Deductible: An initial specified amount that an enrollee has to pay before the insurer begins to contribute towards prescription drug costs. The Medicare Part D deductible for 2006 is \$250 and will increase every year.

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Dual Eligible: Beneficiaries who are eligible for both Medicare and Medi-Cal. Nationally, approximately 70 to 85% of Medicare beneficiaries with AIDS also qualify for Medi-Cal. In California there are approximately 13,500 dual eligible people with AIDS.

Extra-Help: The term CMS is using to describe the Low Income Subsidy (LIS) being provided to subsidize cost-sharing for those with incomes below 150% of the poverty level and all dual eligibles.

Formulary: A list of drugs that a particular plan will cover. Under Medicare Part D, all formularies must include at least two medications in each class of drugs, as defined by the US Pharmacopoeia model guidelines.

Initial Coverage Period: The term CMS uses to describe the first level of coverage in the Medicare Part D benefit. It includes drug spending from the \$251 to \$2,250 in one year. During this period, individuals must generally pay 25% of the costs of their prescription drugs.

Medicare: A federal health insurance program for retired workers and workers under age 65 who become disabled and cannot work. It doesn't cover those who did not work a sufficient amount of time to qualify. It has gaps in coverage including dental, vision and most long term care. Medicare is an entitlement program, meaning that all who qualify receive benefits.

Medicare and HIV/AIDS: In order to be eligible for Medicare, individuals must have qualified for disability under the Social Security Administration rules and completed an approximately two year waiting period. Medicare serves approximately 85,000 people with AIDS.

Medicare Advantage (managed health care plans) with a prescription drug plan (MA-PD): The term CMS uses to describe private managed care organizations that will provide both health care and prescription drugs under the Medicare Part D plan.

Medicare Savings Plan (MSP): Medi-Cal operates a program which allows people who meet income, asset and categorical eligibility requirements to use Medi-Cal to pay Medicare premiums and some cost sharing. They don't receive other Medi-Cal benefits.

Medi-Cal (California's Medicaid program): A federal-state program that provides health care for low-income children and families, seniors and people with disabilities in California. All Medicaid programs, including Medi-Cal have some flexibility in who they serve and what benefits they provide. Although prescription drugs are an optional service, Medicaid programs in all states, including Medi-Cal in California, provide prescription drug coverage. Medi-Cal is an entitlement program.

Medi-Medi: Another term used to describe individuals who are eligible for both Medi-Cal and Medicare.

Off-Label Prescription Drug: A drug that is used to treat a condition for which it was not approved by the Food and Drug Administration (FDA).

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Premium: An amount paid, often in installments, to purchase an insurance policy and to obtain drug coverage.

Premium Penalty: A term used by CMS to describe the financial penalty imposed on Medicare beneficiaries who enroll in a Medicare prescription drug plan after May 15, 2006. The penalty is likely to be a 1% increase in the standard premium for every month a beneficiary delays enrollment.

Share of Cost: Term used in California to refer to spend down. California is one of 36 states with a Medically Needy program under Medi-Cal. This program assists those who make more money than financial eligibility for Medi-Cal allows, but otherwise qualify for Medi-Cal and have medical expenses that are so high that once partially covered will allow them to meet Medi-Cal eligibility requirements. Share of cost clients must show that they have paid the difference between their income and the Medi-Cal maximum income requirement in medical expenses before accessing their Medi-Cal benefit. If you need further explanation of this, please see the “Medicaid Spenddown Tip Sheet” provided by the Department of Health and Human Services.

Share of Cost Dual Eligible—an individual that qualifies for Medicare and Medi-Cal because they fit one of the categories but makes too much income to qualify under income eligibility. Under California’s Medically Needy program, they are allowed to deduct medical expenses from their income each month until they meet the income eligibility level after which Medi-Cal pays their medical costs.

Stand Alone Prescription Drug Plans (PDPs): The term CMS uses to describe new private insurance policies providing prescription drug coverage only to Medicare beneficiaries under the Medicare Part D.

True Out Of Pocket cost (TrOOP): The term CMS is using to describe the amount of money an individual beneficiary must pay out of their own pocket. This can include premium, deductible, co-pays and doughnut-hole payments. The calculation is used to allow movement through the levels of coverage to reach catastrophic coverage. No federal or state program is allowed to make payments that would “count” toward this calculation with the exception of a State Prescription Assistance Program (SPAP). Most SPAPs serve only seniors. At this time, California doesn’t have one.

Wrap Around: Any assistance, usually when states use their own money, to help dual-eligibles pay for cost sharing obligations or drugs that are excluded from formularies. There are no requirements to provide this assistance and some limitations.

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Appendix II: Additional Resources

Government Agencies

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Medicaid: www.cms.hhs.gov/states/default.asp

Centers for Medicaid and Medicare Services: www.cms.gov

Social Security: www.socialsecurity.gov

ADAP/ Ramsell: www.ramsellcorp.com (not government agency, but company that administers ADAP), 1-888-575-ADAP (2373)

Advocacy and Research Groups

CalMedicare.org: www.CalMedicare.org (1-800-434-0222)

Medicare Rights Center: www.medicarerights.org

Health Insurance Counseling and Advocacy Program (HICAP): 1-800-434-0222

California Health Advocates: www.cahealthadvocates.org

California Medicare Information: www.CalMedicare.org

Disabilities Benefits 101: www.db101.org

National Senior Citizens Law Center: www.nslc.org

Henry J. Kaiser Family Foundation: www.kff.org

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Appendix III: Time Line for Implementation

June 20 – 30, 2005	CMS mails informational letter to dual eligibles regarding transition to Medicare plans
June 30, 2005	CMS distributes CY 2006 summary of benefits instructions to MA contractors
June 31, 2005	Deadline for CMS to pre-qualify bidders from eligible fallback entities for plans starting in 2006
July 2005	CMS launches “discussion” phase of message campaign
July 1, 2005	State Medicaid offices and local SSA offices begin accepting applications for low-income subsidies
July 1, 2005	Deadline for CMS to establish requirements and procedures for coordination between Part D plans and SPAPs and other insurers (Medicaid, group health plans, FEHBP, TRICARE)
August 3, 2005	CMS releases national average monthly bid amount and calls for reallocation of rebates for MA-PDs (if needed)
August 3 – September 30, 2005	CMS accepts retiree drug subsidy applications from employers and unions
September 30, 2005	Deadline for plan sponsors to apply for retiree drug subsidy payment for 2006
October 1, 2005	Approved Part D plans begin marketing
October 1, 2005	Deadline for transfer of Medicare appeals from SSA to DHHS
October 13, 2005	CMS begins disseminating information comparing available Part D coverage to beneficiaries via mail, 1-800-MEDICARE, and Plan Comparison Web Tool and Medicare Personal Plan Finder on Medicare.gov
October 15, 2005	Deadline for Secretary to notify states of their annual per capita drug payment amounts (“clawback”) for 2006
October 21, 2005	CMS announces decision on retiree drug subsidy applications
October 27 – November 10, 2005	CMS mails auto-enrollment information to dual eligibles
November 15, 2005 – May 15, 2006	Coordinated election period for 2006 Part D enrollment for all beneficiaries

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November 15, 2005 – May 15, 2006	States and entities offering drug coverage provide written disclosure to Part D eligible individuals regarding actuarial equivalence
December 31, 2005	Medicaid drug coverage ends for full benefit dual eligibles
December 31, 2005	Medicare drug discount card program ends
January 1, 2006	<ul style="list-style-type: none">• Part D coverage begins for all beneficiaries enrolled in a plan B• Low-income subsidies for Part D coverage begin• Secretary implements system for billing and benefit coordination for determining beneficiaries' true out-of-pocket (TrOOP) costs States begin making monthly "clawback" payments to federal government for dual eligibles Medigap insurers prohibited from selling new policies with drug coverage
January 1, 2006 – December 2007	Moratorium on formation of new local Medicare PPOs
January 1 – June 30, 2006	Open enrollment period for MA-eligible individuals (during which they can change plans once)
January 1-June 30, 2006	CMS launches "urgency" phase of message campaign
February 28, 2006	Retiree drug subsidy payments begin
March 2006	CMS identifies all beneficiaries not enrolled in Part D
April 2006	CMS mails spring enrollment reminder to beneficiaries
May 16, 2006	Late enrollment penalty begins
October 15, 2006	Deadline for Secretary to notify states of their annual per capita drug payment amounts ("clawback") for 2007
November 15, 2006	States and entities offering drug coverage provide written disclosures to Part D eligible individuals regarding actuarial equivalence
November 15 – December 31, 2006	Annual coordinated election period for 2007 Part D enrollment for all beneficiaries

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