



Medicare Part D Prescription Drug Coverage 2012

Quick Consult Guide

to help answer your patients' questions

My Medicare Matters

AstraZeneca 

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September 2011

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11	12	13	14	15	16	17
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September 2011

- Mailing of *Medicare & You* handbook to current beneficiaries. Let your patients know they can sign up at www.mymedicare.gov to receive an electronic copy

October 2011

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- Current plan members receive their *Annual Notice of Change* and *Summary of Benefits* from current plan explaining how their current plan will change next year

November 2011

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October 2011

- Medicare Plan Finder has 2012 plan info available on www.medicare.gov.
- Companies begin marketing their 2012 plans

December 2011

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October 15, 2011 – December 7, 2011

- Annual Enrollment Period for 2012 prescription drug coverage. Beneficiaries should review current coverage and make any changes by December 7

January 2012

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January 1, 2012

- The drug plan your patients selected takes effect

What is covered by Medicare?

Each “part” of Medicare plays a different role in health coverage for people with Medicare.

Part A: Medicare Hospital Insurance (eg, acute hospital care, skilled nursing facilities, some home health care, hospice)

Part B: Medicare Medical Insurance (eg, physician office visits)

Part C: Private Medicare Advantage plans (eg, coordinated care plans, Medical Savings Accounts) that cover the same benefits as Parts A and B and may offer some additional benefits. Plans might have different costs for your patients.

Part D: Outpatient Prescription Drug Coverage

Who is eligible for Part D?

Your patients who have Medicare Part A and/or Part B can get Medicare’s prescription drug coverage.

How can my patients get Medicare Part D Coverage?

There are two ways

1. For those with Original Medicare, join a Medicare Prescription Drug Plan (PDP) that adds drug coverage to their Medicare Parts A and B coverage. (PDPs only offer drug benefits and do not offer medical benefits.)
2. Or, join a Medicare Advantage Plan (MA-PD). Many MA-PDs include prescription drug coverage as part of the plan. In these plans your patients get all their Medicare coverage, including medical and prescription.

Why do patients have so many plans from which to choose?

Congress wanted people with Medicare to be able to choose from a variety of plans depending on their needs. In each state many PDPs and MA-PDs are offered as choices.

What is the “standard” benefit?

In 2012, for a monthly premium of around \$30, in plans with the standard benefit your patients pay

- “Deductible” – \$320 for their covered medications
- “Initial Coverage Period” – 25% coinsurance until the patient’s out-of-pocket spending (including the deductible and coinsurance for drugs on his/her plan’s formulary) reaches \$972.50
- “Coverage Gap” – Begins once the patient spends \$972.50 out-of-pocket (deductible and coinsurance for plans on his/her plan’s formulary) and ends once the patient’s out-of-pocket expenses reach \$4,700

**In 2012, your patient gets a 50% discount on all brand-name drugs covered by the plan during the coverage gap. The discount will still apply to getting out of the gap. Your patient will also get a 14% discount on all generic drugs covered by the plan during the coverage gap.

- “Catastrophic Coverage Period” – Minimal copayments (greater of 5% coinsurance or \$2.60 for generic drugs, \$6.50 for brand-name and preferred drugs) once out-of-pocket costs exceed \$4,700

Most plans are not standard, however all plans are based on this standard design.

What other benefit designs are available?

- Some plans have no deductible and smaller copays for brand and generic drugs during the initial coverage period. Your patients should carefully consider their costs and coverage for the drugs you have prescribed in selecting a Part D plan.

What is included in TrOOP and why is it important?

TrOOP—true out-of-pocket costs—includes the deductible, copayments/coinsurance, and drug costs during the coverage gap, but does not include monthly plan premiums.

TrOOP is important because your patient must incur \$4,700 in TrOOP to reach the Part D catastrophic coverage period.

What is the difference between TrOOP and Total Annual Cost?

TrOOP is different from Total Annual Cost, which is the total amount your patient spends for his/her plan-covered outpatient medications and includes monthly premiums.

The patient should consider his/ her medication needs and Total Annual Cost in choosing the plan that is best for him/her.

TrOOP

Copays or Coinsurance
(Up to \$4,700)
+ Deductible

Total Annual Cost

Copays or Coinsurance
+ Deductible
+ **Monthly Premiums**

Does everyone reach the coverage gap and at the same time?

No, not everyone reaches the gap. Plans notify your patients of where they stand every month they use their benefit to fill prescriptions. Patients who reach the coverage gap enter at different points in the year depending on

- The number of medications they are taking—the more they take, the quicker they will likely reach the gap
- The costs of their medications—the higher the cost, the quicker they reach the gap

However, once the total drug spending between your patient and the plan reaches \$2,930, he or she enters the coverage gap – no matter when that is during the year.

Do my patients have to pay 100% for costs during the coverage gap?

No, not anymore. In 2012, people who enter the coverage gap will get certain discounts

- 50% discount on all covered brand-name drugs. The discount counts toward getting out of the gap in coverage.
- 14% discount on all covered generic drugs. This discount does not count toward TrOOP.

The discounts are automatically applied at the pharmacy.

How do my patients pay for drugs during the coverage gap?

Your patients are responsible for paying the balance beyond the discounts, plus a small dispensing fee, during the coverage gap until their TrOOP (true-out-of-pocket) costs reach \$4,700.

Once their TrOOP reaches \$4,700, they stay in the catastrophic coverage period for the remainder of the year. Their costs during the catastrophic coverage period are minimal – 5% coinsurance, or \$2.60 for generics, \$6.50 for brand-name and preferred drugs – whichever amount is greater.

There are assistance programs that your patients may qualify for to get help with the costs in Part D (see next page).

What resources are available for additional information and/or assistance?

Tell your patients to see if they may qualify for help

- Part D Extra Help (or Low-Income Subsidy) pays some or all of the out-of-pocket costs of Part D:
 - To apply, contact the Social Security Administration (SSA) toll free at 1-800-772-1213 (TTY 1-800-325-0778), or go online at www.socialsecurity.gov/prescriptionhelp. SSA determines eligibility for Extra Help
- State Pharmaceutical Assistance Programs (SPAPs) — contact Medicare at 1-800-MEDICARE (1-800-633-4227) to find out if your state offers an SPAP
- Patient Assistance Programs (PAPs) — contact RxAssist at 401-729-3284 or visit their website at www.rxassist.org
- AIDS Drug Assistance Programs — contact Medicare at 1-800-MEDICARE (1-800-633-4227)
- Veterans Administration Assistance — 1-877-222-8387

Is there personal assistance available?

Your patients can get personalized help with applying for these assistance programs by contacting their state health insurance assistance program (SHIP). SHIPs provide free, personalized counseling to people with Medicare and their families.

To find out how to reach a SHIP counselor in your state, your patients can contact Medicare at 1-800-MEDICARE (1-800-633-4227), or use the online SHIP locator at <https://shipnpr.shiptalk.org/>.

How can I help my patients choose the right plan?

How often can patients change plans?

Most patients can only change plans once a year during the Annual Enrollment Period, which comes earlier this year, starting October 15 and running through December 7.

However, anyone who has the Part D Extra Help (or Low-Income Subsidy) can change plans as often as once per month.

Should my patients review plan choices every year?

Yes, your patients should always review their plan options every year, before the Annual Enrollment Period. They can do this by

- Using the online Medicare Plan Finder interactive tool www.medicare.gov/find-a-plan/questions/home.aspx. Your patients can begin to find 2012 plan information generally the week before the Annual Enrollment Period begins.
- Contacting their local SHIP (State Health Insurance Assistance Program). A SHIP counselor can help them review the Part D plan options available in their area. To find their local SHIP, your patients can contact Medicare at 1-800-MEDICARE (1-800-633-4227), or use the online SHIP locator at <https://shipnpr.shiptalk.org/>

What if my patient decides to stay in the same plan?

If a patient decides to stay in the same plan, he/she does not need to do anything; his/her coverage will continue automatically. But most plans change every year, so reviewing options is always important.

How do my patients switch or enroll in a plan during the Annual Enrollment Period?

If your patient does want to change plans, there are three ways to enroll or change plans during the Annual Enrollment Period (October 15 - December 7, 2011). Your patients can

- **Enroll Online through the Medicare Plan Finder**

1. Go online to www.medicare.gov/find-a-plan/questions/home.aspx. Your patients can follow the instructions online, or contact their local SHIP for assistance.
2. The Plan Finder will provide details on plans in your patients' area. They will be asked to select the type of search to conduct (personalized or general) and then will be prompted to enter all current prescription medications and dosages. They can compare information on different plans (up to three plans at one time).
3. They will decide which plan is right for them and enroll using the "enroll now" button.

- **Call 1-800-MEDICARE (1-800-633-4227):** Staff will walk your patients through the steps. They will need to have their Social Security number, Medicare number, and prescription list before making the call.

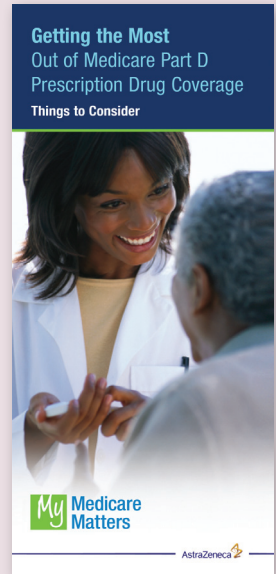
- **Contacting the Plan:** You can enroll by calling the plan directly, or through its website.

Any enrollment changes will take effect January 1, 2012.

Patient Information Brochure

Don't forget to provide your patients with the trifold brochure highlighting important things to know about Medicare prescription drug options including

- Key Dates, such as the *earlier* Annual Enrollment Period
- Understanding plan choices
- Ways to enroll



This quick consult guide and patient brochure is also available to print on www.mymedicarematters.org

Specific Medication Coverage

To find out formulary status and tier level for specific medications, visit

- www.Medicare.gov
- www.fingertipformulary.com

Compare Plans and Enroll

- **www.Medicare.gov**

Contact Medicare 24 hours a day, 7 days a week

Toll Free: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

Learn about Medicare Part D

- Visit the National Council on Aging, My Medicare Matters – www.mymedicarematters.org

Get Personalized Help

- Contact your local SHIP (State Health Insurance Assistance Program). For contact info, use the online SHIP locator at <https://shipnpr.shiptalk.org/>

Determine Eligibility and Apply for Extra Help

- Use Benefits Check Up online screening tool www.benefitscheckup.org
- Contact the Social Security Administration
Toll Free: 1-800-772-1213
TTY: 1-800-325-0778
www.socialsecurity.gov/prescriptionhelp

Find Out about State, Local, and Community-Based Organizations that Offer Assistance

- Call Eldercare locator for referrals
Toll Free: 1-800-677-1116
www.eldercare.gov



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