



Overview of MMA

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) gives Medicare beneficiaries access to prescription drug coverage beginning January 1, 2006.

This prescription drug benefit is commonly referred to as Medicare Part D. All Medicare beneficiaries - no matter how they get their health care today or whether they have existing drug coverage - will be eligible for drug coverage under a Medicare prescription drug plan.*

Medicare Part D Plan Design

The Medicare Part D program provides a prescription drug benefit primarily through one of two sources: (1) a fee-for-service option known as a prescription drug plan (PDP) or (2) a managed care plan with a drug benefit (i.e., Medicare Advantage (MA)). These are referred to as "Part D plans."

In order to provide a choice of plans in all areas of the United States, the Center for Medicare and Medicaid Services (CMS) divided the country into 34 regions. In each region, beneficiaries must have at least two Part D plans to choose from and at least one plan must be a "stand alone" (PDP) plan.

As outlined by CMS, all plans are expected to create a formulary that makes available medically necessary drugs for seniors.

Medicare Part D Prescription Drug Benefit

The MMA defines a standard benefit design for Medicare Part D, which is subject to variation by Part D plans. For this defined standard coverage, most beneficiaries will pay a monthly premium, estimated to be \$35 per month in 2006, an annual deductible of \$250, and 25% co-insurance for costs above the deductible up to the initial limit, which is \$2,250 in 2006.

Once the initial coverage limit is reached, the enrollee must pay all drug costs until the enrollee has \$3,600 in out-of-pocket expenses for covered drugs, which equates to \$5,100 in total expenditures. This gap between \$2,250 and \$5,100 is being called the "coverage gap" or "doughnut hole." After a beneficiary has spent \$3,600 in out-of-pocket expenses, catastrophic coverage begins and the Medicare Part D plan will pick up approximately 95% of future costs.

* Drug coverage for residents on Medicare Part A covered days will not be affected by Medicare Part D.

Drug Costs	What Beneficiaries Pay	What Medicare Pays	Cost for Beneficiary (Total)
First \$250 (deductible)	100%	Nothing	\$250 (\$250)
\$251 to \$2,250	25%	75%	\$500 (\$750)
\$2,251 to \$5,100	100%	Nothing	\$2850 (\$3600)
Above \$5,100	\$2 for generic drugs, \$5 for brand name, or 5% of the drug cost (whichever is greater)	95%	\$3,600 plus \$2 for generic drugs, \$5 for brand name, or 5% of the drug cost (whichever is greater)

Plans can offer a different benefit that is equal to or “actuarially equivalent” to this standard coverage, and plans can also offer an enhanced benefit design (that might include coverage in the doughnut hole or no deductible) for an additional premium. This means that some PDPs may offer plans that look like the benefits outlined above, but others could offer plans with:

- Different premiums
- Different deductibles
- Different co-payment amounts
- Different out-of-pocket maximums
- Different drug formularies
- Supplemental benefits

Eligibility

To be eligible to participate in Medicare's prescription drug benefit, individuals must be enrolled in or entitled to receive benefits from Medicare Part A or B.

Dual Eligibles

Individuals who qualify for both Medicaid and Medicare are “full-benefit, dual eligibles.” *Nursing home residents who are dual eligibles will not be required to pay any premiums, deductibles or prescription co-pays.*

If these beneficiaries do not choose a PDP or MA plan, CMS will auto-enroll dual eligible individuals in a randomly selected, standard PDP benefit plan in the region where they reside. However, if the beneficiary is already enrolled in an MA plan for medical benefits, the individual will be automatically enrolled in the Part D plan offered by that MA plan.

Enrollment

Enrollment in Medicare Part D plans is voluntary (except for dual eligibles, as noted above). The initial enrollment period for the new Part D prescription drug benefit runs from November 15, 2005 through May 15, 2006 for people who already have Medicare and for those people who become eligible to enroll in Medicare in January 2006. People who become eligible for Medicare in February 2006 have an enrollment period that runs from November 25, 2005 through May 31, 2006. Individuals who become eligible for Medicare after February 2006 have the same seven-month initial enrollment period as the initial enrollment period for Part B of Medicare.

Medicare beneficiaries will generally only be able to change plans during the annual election period between November 15 and December 31 of each year. The change becomes effective in the following year on January 1.

Individuals who delay enrollment after their initial eligibility enrollment period will pay a lifetime premium penalty equal to 1% of the base premium for each month they delay enrollment.

Special Enrollment

Under special circumstances, people with Medicare Part D can change to another PDP or MA plan outside the annual enrollment period. *Nursing home residents qualify for such a special enrollment, and consequently may change from one Part D plan to another during the course of a calendar year.*

Part D for Low-Income Beneficiaries

To help low-income individuals afford the prescription drug benefit, the MMA provides a premium subsidy, eliminates the deductible and/or reduces co-payments depending on the income and assets of the individuals and whether they receive Medicaid benefits.

Individuals whose incomes are below 150% of the federal poverty line and who have liquid assets below \$10,000 (\$20,000 for a married couple) will:

- Receive a premium subsidy on a sliding scale.
- Pay a \$50 deductible.
- Receive coverage after the \$50 deductible that continues through the “doughnut hole,” subject to 15% co-insurance.
- Pay \$2 and \$5 co-pays in the catastrophic benefit (i.e., higher coinsurance of 5% does not apply).

Individuals whose incomes are below 135% of the federal poverty line and who have liquid assets below \$6,000 (\$9,000 for a married couple), or who are dual eligible, will:

- Receive a premium subsidy equal to the average premium for standard coverage in the region.
- Pay no deductible.
- Receive coverage that continues through the “doughnut hole,” subject to co-pays of \$1 and \$3 respectively for generic and brand-name drugs if their incomes are below 100% of the federal poverty line, co-pays of \$2 and \$5 if their incomes are higher, and no co-pays if they are nursing home residents.
- Pay no co-pays for covered drugs in the catastrophic benefit.

IMPORTANT DATES

September **2005**

September 14 — Tentative date for CMS approval of benefit packages

October

October 1 — First date permitted to market 2006 benefits to Medicare beneficiaries with CMS-approved marketing materials

October 7-19 — 2006 health plan benefit and cost information mailed to beneficiaries

November

November 15 — Open enrollment begins (closes May 16, 2006)

January **2006**

January 1 — Effective date for 2006 plan benefits

FREQUENTLY ASKED QUESTIONS

Questions From Our Customers

Omnicare understands the importance of MMA to our customers. We are committed to providing you with important information about Medicare Part D so you can continue to deliver the best care to the residents you serve. Below are some of the most frequently asked questions we are receiving from our customers.

Can you briefly summarize how this new plan will differ from the current drug benefits in long-term care?

The biggest change will be how drug costs are paid. Approximately 60-70% of nursing home residents currently receive prescription drug benefits through the Medicaid program. Under the new plan, the cost of this benefit will shift to Medicare Part D and the newly formed PDPs and MAs. Whereas one program was providing the benefit, there may now be several PDPs and MAs within each region.

Private pay residents may elect to enroll for the benefits and will be responsible for out-of-pocket costs such as premiums, deductibles, the doughnut hole, and medication co-payments.

There will be no change for residents on Medicare Part A covered days. They will continue to receive Medicare Part A reimbursement.

Will this new benefit change my relationship with Omnicare?

No, your relationship with Omnicare will not be affected. CMS has laid out a plan that will require PDPs to demonstrate that they have sufficient contracts with long-term care pharmacies to provide convenient access for residents of long-term care facilities.

CMS also has provided guidance concerning the specific services required for long-term care residents, such as special packaging, routine and emergency delivery and emergency supplies of medications. Omnicare meets or exceeds all CMS requirements.

Are all my Medicare residents required to enroll in a drug benefit plan?

For residents who are not dual eligibles, the Medicare Part D drug benefit is optional. However, beneficiaries who do not enroll in Part D during the initial enrollment period and later decide to enroll will pay a 1% penalty for each month that an eligible person delays enrollment unless they have comparable coverage from another source (usually private and group health plans). The enrollment period begins November 1, 2005 and runs through May 15, 2006 for current Medicare beneficiaries.

Dual eligible residents will be randomly assigned to a plan in their region, beginning this fall. Dual eligible residents may elect to enroll in a different Part D plan, but if they do not do so they will be auto-enrolled by CMS, effective January 1, 2006.

I work in an assisted living facility. How will Medicare Part D coverage differ for individuals living in assisted living facilities?

Although currently the subject of much discussion, assisted living facilities were not included in the initial classification of a long-term care facility, as defined by CMS. Individuals living in an assisted living facility will have access to the same prescription drug benefits as any Medicare-eligible beneficiary. However, they will be responsible for out-of-pocket costs such as the premium, deductible, the doughnut hole, and medication co-payments. There is no special enrollment period for residents of assisted living facilities.



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