Medicare Part D Overview & Eligibility

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- Medicare Prescription Drug Coverage
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- Medicare Drug Plan Costs
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- Part D Eligibility Requirements
- Enrollment Periods
- Creditable Drug Coverage
- Medicare Part D Extra Help (LIS)
- Quiz
Session Objectives

• This session should help you
  – Differentiate Medicare Part A, Part B, and Part D drug coverage
  – Summarize Part D eligibility and enrollment requirements
  – Compare and choose drug plans
  – Describe Extra Help with drug plan costs
  – Explain coverage determinations and the appeals process
Medicare Prescription Drug Coverage

• Prescription drug coverage under Part A, Part B, or Part D depends on
  – Medical necessity
  – Health care setting
  – Medical indication (why you need it, like for cancer)
  – Any special drug coverage requirements
    • Such as immunosuppressive drugs following a transplant
Part A Prescription Drug Coverage

• Part A generally pays for all drugs during a covered inpatient stay
  – Received as part of treatment in a hospital or skilled nursing facility

• Drugs used in hospice care for symptom control and pain relief only
Part B Prescription Drug Coverage

• Part B covers limited outpatient drugs
  – Most injectable and infusible drugs given as part of a doctor’s service
  – Drugs used at home with some types of Part B-covered durable medical equipment (DME)
    • Such as nebulizers and infusion pumps
  – Some oral drugs with special coverage requirements such as
    • Certain oral anti-cancer and antiemetic drugs
    • Immunosuppressive drugs, under certain circumstances
Part B Immunization Coverage

• Part B covers certain immunizations as part of Medicare-covered preventive services
  – Flu shot
  – Pneumococcal shot (to prevent pneumonia)
  – Hepatitis B shot

• Part B may cover certain vaccines after exposure to a disease or after an injury
  – Tetanus shot
Self-Administered Drugs in Hospital Outpatient Settings

• Part B doesn’t cover self-administered drugs in a hospital outpatient setting
  – Unless needed for hospital services

• If enrolled in Part D, drugs may be covered
  – If not admitted to hospital
  – May have to pay and submit for reimbursement
Part D Covered Drugs

• Prescription brand-name and generic drugs
  – Approved by the U.S. Food and Drug Administration
  – Used and sold in the United States
  – Used for medically-accepted indications

• Includes drugs, biological products, and insulin
  – And supplies associated with injection of insulin

• Plans must cover a range of drugs in each category

• Coverage and rules vary by plan
Part D Medicare Prescription Drug Coverage

• Medicare drug plans
  – Approved by Medicare
  – Run by private companies
  – Available to everyone with Medicare

• You must join a plan to get coverage

• There are 2 ways to get coverage
  1. Medicare Prescription Drug Plans
  2. Medicare Health Plans with prescription drug coverage
Medicare Drug Plans

• Can be flexible in benefit design
• Must offer at least a standard level of coverage
• Vary in costs and drugs covered
  – Different tier and/or copayment levels
  – Deductible
  – Coverage for drugs not typically covered by Part D
• Benefits and costs may change each year
### Standard Part D Benefit Parameters

<table>
<thead>
<tr>
<th>Benefit Parameters</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$320</td>
<td>$360</td>
</tr>
<tr>
<td>Initial Coverage Limit</td>
<td>$2,960</td>
<td>$3,310</td>
</tr>
<tr>
<td>Out-of-Pocket Threshold</td>
<td>$4,700</td>
<td>$4,850</td>
</tr>
<tr>
<td>Total Covered Drug Spending at OOP Threshold</td>
<td>$6,680</td>
<td>$7,062.50</td>
</tr>
<tr>
<td>Minimum Cost-Sharing in Catastrophic Coverage</td>
<td>$2.65/$6.60</td>
<td>$2.95/$7.40</td>
</tr>
</tbody>
</table>

### Extra Help Copayments

<table>
<thead>
<tr>
<th>Extra Help Copayments</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Receiving Home and Community-Based Services</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Up to or at 100% Federal Poverty Level (FPL)</td>
<td>$1.20/$3.60</td>
<td>$1.20/$3.60</td>
</tr>
<tr>
<td>Full Extra Help</td>
<td>$2.65/$6.65</td>
<td>$2.95/$7.40</td>
</tr>
<tr>
<td>Partial Extra Help (Deductible/Cost-Sharing)</td>
<td>$66/15%</td>
<td>$74/15%</td>
</tr>
</tbody>
</table>
**Standard Structure in 2016**

Ms. Smith joins a PDP. Her coverage begins on January 1, 2016. She doesn’t get Extra Help and uses her Part D plan when she buys prescriptions. She pays a monthly premium throughout the year.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Smith pays the first $360 of her drug costs before her plan starts to pay its share.</td>
<td>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $3,310.</td>
<td>Once Ms. Smith and her plan have spent $3,310 for covered drugs, she’s in the coverage gap. In 2016, she would get a 55% discount off brand name drugs and a 42% discount off generic drugs covered by her plan. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.</td>
<td>Once Ms. Smith’s drug costs have reached $7,062 the coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.</td>
</tr>
</tbody>
</table>
## Improved Coverage in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>Discounts off Brand Name Drugs in the Coverage Gap</th>
<th>Discounts off Generic Drugs in the Coverage Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>55%</td>
<td>42%</td>
</tr>
<tr>
<td>2017</td>
<td>60%</td>
<td>49%</td>
</tr>
<tr>
<td>2018</td>
<td>65%</td>
<td>56%</td>
</tr>
<tr>
<td>2019</td>
<td>70%</td>
<td>63%</td>
</tr>
<tr>
<td>2020</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Part D Premium and Income-Related Monthly Adjustment Amounts (IRMAA)

- Based on income above a certain limit
  - Fewer than 5% pay a higher premium
  - Uses same thresholds used to compute IRMAA for the Part B premium
  - Income as reported on your IRS tax return from 2 years ago

- Required to pay if you have Part D coverage
  - Failure to pay will result in disenrollment
Required Coverage

• All drugs in 6 protected categories
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants

• All commercially available vaccines
  – Except those covered under Part B (e.g., flu shot)
Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs
Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

**Tier Structure Example**

<table>
<thead>
<tr>
<th>Tier</th>
<th>You Pay</th>
<th>Prescription Drugs Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lowest copayment</td>
<td>Most generics</td>
</tr>
<tr>
<td>2</td>
<td>Medium copayment</td>
<td>Preferred, brand name</td>
</tr>
<tr>
<td>3</td>
<td>High copayment</td>
<td>Non-preferred, brand name</td>
</tr>
<tr>
<td>4 or Specialty</td>
<td>Highest copayment or coinsurance</td>
<td>Unique, very high cost</td>
</tr>
</tbody>
</table>
Formulary Changes

• Plans may only change categories and classes at the beginning of each plan year
  – May make maintenance changes during year
    • Such as replacing brand-name drug with new generic

• Plan usually must notify you 60 days before changes
  – You may be able to use drug until end of calendar year
  – May ask for exception if other drugs don’t work

• Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification
# How Plans Manage Access to Drugs

<table>
<thead>
<tr>
<th>Prior Authorization</th>
<th>▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered</th>
</tr>
</thead>
</table>

| Step Therapy | ▪ Must first try similar, less expensive drug  
▪ Doctor may request an exception if  
  • Similar, less expensive drug didn’t work,  
  or  
  • Step therapy drug is medically necessary |
|--------------|---------------------------------------------------------------------------------------------------|

| Quantity Limits | ▪ Plan may limit drug quantities over a period of time for safety and/or cost  
▪ Doctor may request an exception if additional amount is medically necessary |
|-----------------|---------------------------------------------------------------------------------------------------|
If Your Prescription Changes

• Get up-to-date formulary information from your plan’s
  – Website
  – Customer service center

• Give your doctor a copy of plan’s formulary

• If the new drug isn’t on the plan’s formulary
  – Can request an exemption from the plan
  – May have to pay full price if plan still won’t cover
Part D Eligibility Requirements

• You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
• You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
• You must live in the plan’s service area
  – You can’t be incarcerated
  – You can’t be unlawfully present in the U.S.
  – You can’t live outside the United States
• You must join a plan to get drug coverage

Effective 1/1/2016
Creditable Drug Coverage

• Current or past prescription drug coverage
  – For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, etc.
  – Creditable if it pays, on average, as much as Medicare’s standard drug coverage

• Plans inform yearly about whether creditable

• With creditable coverage you may not have to pay a late enrollment penalty
When You Can Join or Switch Plans

• Medicare’s Open Enrollment Period is **October 15–December 7** each year
  – coverage starts January 1

• You can leave a Medicare Advantage Plan and switch to Original Medicare from January 1–February 14 each year
  – You have until February 14 to also join a Part D plan
Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
  - 7-month IEP for Part D

<table>
<thead>
<tr>
<th>If You Join</th>
<th>Coverage Begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the 3 months before you turn 65</td>
<td>Date eligible for Medicare</td>
</tr>
<tr>
<td>During the month you turn 65</td>
<td>First day of the following month</td>
</tr>
<tr>
<td>During the 3 months after you turn 65</td>
<td>First day of the month after month you apply</td>
</tr>
</tbody>
</table>
Special Enrollment Period (SEP)

• Life events that allow an SEP include
  – You permanently move out of your plan’s service area
  – You lose other creditable prescription coverage
  – You weren’t properly told that your other coverage wasn’t creditable, or your other coverage was reduced and is no longer creditable
  – You enter, live at, or leave a long-term care facility
  – You have a continuous SEP if you qualify for Extra Help
Part D Late Enrollment Penalty

• Higher premium if you wait to enroll
  – Exceptions if you have
    • Creditable coverage
    • Extra Help
  – Pay penalty for as long as you have coverage
    – 1% of base beneficiary premium ($34.10 in 2016)
      • For each full month eligible and not enrolled
    – Amount changes every year
What Is Extra Help?

• Program to help people pay for Medicare prescription drug costs
  – Also called the Low-Income Subsidy (LIS)

• For people with limited income and resources
  – Lower cost sharing (premiums, copays, etc.)

• No coverage gap or late enrollment penalty if you qualify

• Continuous Special Enrollment Period
  – Can enroll/change plans anytime
Extra Help
2016* Extra Help
Income and Resource Limits

• Income limits
  – Below 150% of the federal poverty level
    • $1,471 per month for an individual
    • $1,991 per month for a couple
  – Based on family size

• Resources limits
  – Up to $13,640 for an individual, or $27,250 for a married couple
    • Counts savings and investments
    • Real estate (except your home)
Qualifying for Extra Help

• You automatically qualify for Extra Help if you get
  – Full Medicaid coverage
  – Supplemental Security Income
  – Help from Medicaid paying your Part B premium (Medicare Savings Program)

• All others must apply
  – Online at socialsecurity.gov/medicare/prescriptionhelp/
  – Call SSA at 1-800-772-1213 (TTY 1-800-325-0778)

• Ask for “Application for Help With Medicare Prescription Drug Plan Costs”
Changes in Qualifying for Extra Help

• Medicare reestablishes eligibility each fall for next year
  – If you no longer automatically qualify
    ○ Includes Social Security application to reapply
  – If your status changes and you again automatically qualify
  – If you automatically qualify, but your copayment changed
Medicare’s Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare’s Limited Income NET Program
  - Has an open formulary
  - Doesn’t require prior authorization
  - Has no network pharmacy restrictions
Annual Notice of Change (ANOC)

• All Medicare drug plans must send an ANOC to members by September 30
  – May be sent with Evidence of Coverage (EOC)

• Will include information for upcoming year
  – Summary of Benefits
  – Formulary
  – Changes to monthly premium and/or cost sharing

• Read ANOC carefully and compare your plan with other plan options
Coverage Determination Request

• Initial decision by plan
  – Which benefits you’re entitled to get
  – How much you have to pay for a benefit
  – You, your prescriber, or your appointed representative can request it

• Time frames for coverage determination request
  – May be standard (decision within 72 hours)
  – May be expedited (decision within 24 hours) if life or health may be seriously jeopardized
Exception Requests

• Two types of exceptions
  1. Formulary exceptions
     • Drug not on plan’s formulary, or
     • Access requirements (for example, step therapy)
  2. Tier exceptions
     • For example, getting a tier 4 drug at tier 3 cost

• Need supporting statement from prescriber
• You, your appointed representative, or
  prescriber can make requests
• Exception may be valid for rest of year
Requesting Appeals

• If your coverage determination or exception is denied, you can appeal the plan’s decision

• In general, you must make your appeal requests in writing
  – Plans must accept oral (spoken) expedited requests

• An appeal can be requested by
  – You or your appointed representative
  – Your doctor or other prescriber

• There are 5 levels of appeals
Which of the following is NOT a way to get Part D coverage?

A) Prescription Drug Plan (PDP)
B) Medicare Advantage Plan
C) Ohio Medicaid
Medicare Part D enrollment is automatic for most people

A) True

B) False
Where should someone compare Medicare Part D plans?

A) www.insurance.ohio.gov
B) www.medicare.gov
C) www.cms.gov
D) www.medicare.com
When is Medicare Part D's Annual Coordinated Election Period (Open Enrollment)?

A) Oct 15th-Dec 31st
B) Nov. 15th-Dec. 31st
C) Oct 15th-Dec. 7th
D) Anytime
What is not an example of a Special Election Period?

A) Moving out of a plan's service area
B) Being eligible for Extra Help
C) Losing creditable coverage from a previous employer
D) Forgetting to sign up during Open Enrollment
You can apply for Extra Help (LIS) at www.ssa.gov

A) True

B) False
Most people can sign up for a Medicare Part D Plan anytime throughout the year

A) True

B) False
The late enrollment penalty imposed on those delaying Part D coverage is

A) 10% per year
B) 1% per month
C) 10% per month
D) 20% per year
All Part D plans cover the same drugs at the same prices

A) True

B) False
Someone should compare Part D plans every year

A) True

B) False