

National Medicare Training Program Workbook



**Module 9:
Understanding Medicare
Prescription Drug Coverage**



*...helping people with Medicare
make informed health care decisions*

**National Medicare
TRAINING PROGRAM**

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Module 9: Understanding Medicare Prescription Drug Coverage



This module, Understanding Medicare Prescription Drug Coverage, contains basic information about Part D of the Medicare program. It is divided into five lessons.

NOTE TO INSTRUCTORS: This module is suitable for presenting to partners, trainers, and other information intermediaries, as well as to groups of people with Medicare who already have a basic understanding of Medicare Part D. The various lessons can be included and/or modified based on the audience and time limits for the presentation.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2009.

Slides with this symbol in your workbook are not included in the presentation, but are provided as a resource for more detail.

To check for an updated version of this training module, visit www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Notes:

SLIDE 2

Lesson Topics

1. Drug Coverage Basics
2. Eligibility and Enrollment
3. Extra Help with Drug Plan Costs
4. Comparing and Choosing Plans
5. Coverage Determinations and Appeals

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Notes:

SLIDE 3

Lesson 1

Drug Coverage Basics

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Notes:

SLIDE 4 *Speaker's Notes*

- As we discuss Medicare Part D, there are several important things to keep in mind.
- All people with Medicare are eligible to enroll in a Medicare drug plan. (People who live outside the U.S. or who are incarcerated are not eligible to enroll in a plan and therefore cannot get this coverage.)
- People must be enrolled in a plan to get Medicare drug coverage.
- Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. There are two types of Medicare drug plans:
- Medicare Prescription Drug Plans add coverage to Original Medicare and some other types of Medicare plans.
- Some Medicare Advantage Plans (like an HMO or PPO) and other Medicare plans also offer Medicare prescription drug coverage.

The term "Medicare drug plans" is used throughout this presentation to mean both Medicare Prescription Drug plans and Medicare Advantage or other Medicare plans with prescription drug coverage.

NOTE: Some Medicare Supplement Insurance, or Medigap policies offered prescription drug coverage prior to 1/1/2006; this however, is not Medicare prescription drug coverage.

Medicare Part D

- Available to all people with Medicare
- Must be enrolled in a plan to get coverage
- Coverage provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage and other Medicare plans
- People can choose a plan to meet their needs
 - Coverage, cost, convenience, customer service
- Extra help available to those who need it most

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Notes:

SLIDE 5 *Speaker's Notes*

Medicare Prescription Drug Plans are approved by Medicare and are run by private companies. They are sometimes referred to as “stand-alone” drug plans and PDPs.

Medicare Prescription Drug Plans add coverage to Original Medicare and some other types of Medicare plans, including some Medicare Private Fee-for-Service Plans, some Medicare Cost Plans, and Medicare Medical Savings Account Plans. Some Medicare Advantage Plans also include prescription drug coverage.

Medicare Prescription Drug Plans

- Drug plans approved by Medicare
 - Run by private companies
 - Sometimes called
 - “Stand-alone” drug plans or PDPs
 - Included in some MA plans
- Add coverage to
 - Original Medicare
 - Some other types of Medicare plans
 - Some Medicare Private Fee-for-Service Plans
 - Some Medicare Cost Plans
 - Medicare Medical Savings Account Plans

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Notes:

SLIDE 6 *Speaker's Notes*

All Medicare drug plans must offer at least the standard level of coverage. This standard benefit in 2009 includes a \$295 deductible, 25% cost-sharing until reaching \$2,700 in total drug costs, 100% cost-sharing (coverage gap) until reaching \$4,350 in total out-of-pocket costs, after which the plan pays all but 5% or a small copayment for the rest of the year.

At the same time, plans can be flexible in their benefit design, as long as what the plan offers is at least as good as the standard benefit. Most plans continue to offer different benefit structures, including tiers, copayments, and/or lower deductibles. Enhanced plans can even offer coverage for generic and/or brand-name medications in the coverage gap and may also cover non-Part D covered medications. Also, benefits and costs may change from year to year.

Medicare Drug Plans

- Can be flexible in benefit design
- Must offer at least standard level of coverage
 - \$295 deductible
 - 25% cost sharing until \$2,700 in total drug costs
 - 100% cost sharing until \$4,350 out-of-pocket costs
 - 5% copayment rest of year
- May offer different or enhanced benefits
- Benefits & costs may change from year to year

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Notes:

SLIDE 7 *Speaker's Notes*

Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically-accepted indication.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze, are also covered. CMS has also clarified that supplies associated with the inhalation of insulin may be covered by Part D plans.

Part D-covered Drugs

- Available only by prescription
 - Brand-name and generic
- Approved by FDA
- Used and sold in U.S.
- Used for medically-accepted indications
- Include
 - Drugs
 - Biologicals
 - Insulin
 - Supplies associated with injection or inhalation

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Notes:

SLIDE 8 *Speaker's Notes*

Drugs for the following conditions, or the following types of drugs are excluded by law from Medicare prescription drug coverage.

- Anorexia
- Weight loss or weight gain
- Erectile dysfunction
- Fertility
- Cosmetic or lifestyle purposes (e.g., hair growth)
- Symptomatic relief of coughs and colds
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs
- Barbiturates
- Benzodiazepines

However, plans may choose to cover them at their own cost or share the cost with their members.

Part D can only cover Medicare Part A or Part B covered drugs if the person does not meet the Part A or part B coverage requirements. Drugs covered under Part B include immunosuppressive drugs after an organ transplant, some oral anti-cancer drugs, hemophilia clotting factors, and drugs that are not selfadministered.

Drugs Not Covered by Part D

- Excluded by law from Medicare coverage
 - Plan may choose to cover
 - Own cost
 - Share cost with member
- Non-prescription drugs
- Covered under Medicare Part A or B

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Notes:

SLIDE 9 *Speaker's Notes*

CMS requires Medicare drug plans to cover “all or substantially all” medications in six categories:

- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

For more information about drugs covered under Part B and Part D, go to http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf

“All or Substantially All”

- Plans must cover most drugs to treat certain conditions
 - Cancer medications
 - HIV/AIDS treatments
 - Antidepressants
 - Antipsychotic medications
 - Anticonvulsive treatments for epilepsy and other conditions
 - Immunosuppressants

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Notes:

SLIDE 10 *Speaker's Notes*

All plans must cover the same categories of drugs, but plans can choose what specific drugs to cover in each category. Generally, not all Part D drugs are covered by each plan. Virtually all plans have a formulary or list of covered drugs. Plans' formularies must include a range of drugs in each prescribed category to make sure people with different medical conditions can get the treatment they need.

A plan's formulary may not include every drug a person takes. However, in most cases, a similar drug that is safe and effective will be available.

To have lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form its tiers in different ways. In some plans with these different cost levels or tiers, people can often save money by choosing a generic drug instead of the brand-name drug.

Medicare drug plans work to provide people with Medicare with the high-quality, cost-effective drug coverage they need. All Medicare drug plans must make sure their members can get medically-necessary drugs to treat their conditions.

Coverage Varies

- Plans have formularies
 - May not include every Part D drug
 - Similar drug usually covered
 - Safe and effective
 - May have different cost levels ("tiers")
- Must cover range of drugs in each category

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Notes:

SLIDE 11 *Speaker's Notes*

Some of the methods plans use to manage their members' access to drug coverage include:

- Formularies
- Prior authorization
- Step therapy
- Quantity limits

Becoming familiar with these terms will help people make choices about their coverage.

Access to Covered Drugs

- Plans can manage access to drug coverage through
 - Formularies
 - Prior authorization
 - Step therapy
 - Quantity limits

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Notes:

SLIDE 12 *Speaker's Notes*

We've already said that a plan's drug list or formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form its tiers in different ways.

Here is an example of how a plan might form its tiers:

Tier 1—Generic drugs. Tier 1 drugs will cost the least amount.

A generic drug:

- Is the same as a brand-name drug in active ingredients, dosage, safety, strength, how it is taken, how it works in the body, quality, performance and intended use.
- Is safe and effective.
- Has the same risks and benefits as the original brand-name drug.

Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the FDA. Today, almost half of all prescriptions in the U.S. are filled with generic drugs.

Tier 2—Preferred brand-name drugs. Tier 2 drugs will cost more than Tier 1 drugs.

Tier 3—Non-preferred brand-name drugs. Tier 3 drugs will cost more than Tier 2 drugs.

Formularies

- May have "tiers" that cost different amounts
- Example
 - Tier 1—generic drugs
 - Cost the least amount
 - Tier 2—preferred brand-name drugs
 - Cost more than Tier 1 drugs
 - Tier 3—non-preferred brand-name drugs
 - Cost more than Tier 1 and Tier 2 drugs

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Notes:

SLIDE 13 *Speaker's Notes*

Plans may have rules that require prior authorization. Prior authorization means before the plan will cover a prescription, the person's doctor must first contact the plan. The doctor has to show there is a medically-necessary reason why the person must use that particular drug for it to be covered. Plans do this to be sure these drugs are used correctly and only when medically necessary.

Current or prospective plan members or their representatives can request the plan's prior authorization requirements in order to understand what they will need to do to access a drug or to provide this information to their doctors. Prior authorization requirements are also available on Part D plans' (sponsors') websites.

Prior Authorization ☑

- Doctor must contact plan
 - Before prescription will be covered
 - Must show medical necessity
- Prior authorization requirements available from plan on request

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Notes:

SLIDE 14 *Speaker's Notes*

Step therapy is a type of prior authorization.

With step therapy, in most cases people must first try less expensive drugs that have been proven effective for most people with their condition. For example, some plans may require members to try a generic drug (if available), then a less expensive brand-name drug on their drug list before they will cover a more expensive brand-name drug.

However, if a member has already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of the person's medical condition it is medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), the member (with the doctor's help) can contact the plan to request an exception. If the request is approved, the originally prescribed step-therapy drug will be covered.

Step Therapy

- Type of prior authorization
- Person must try a similar, less-expensive drug that has proven effective
- Doctor can request an exception if
 - Tried similar, less expensive drug and it didn't work, or
 - Step-therapy drug is medically necessary

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Notes:

SLIDE 15 *Speaker's Notes*

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time.

For example, some people prescribed Nexium® should take 1 capsule per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of Nexium®. People who require more than this quantity of Nexium® may need their doctors' assistance in contacting the plan to request an exception if the member's doctor believes the additional amount is medically necessary. If the request is approved, the amount prescribed by the doctor will be covered.

Quantity Limits ☐

- Plans may limit quantity of drugs they cover
 - Over a certain period of time
 - For reasons of safety and cost

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Notes:

SLIDE 16 *Speaker's Notes*

If a member's doctor needs to change the person's prescription or prescribe a new drug, the person should give the doctor a copy of the formulary for his or her Medicare drug plan. This list and the prices for drugs can change. **People can get current information by calling the plan, or looking on the plan's website to find the most up-to-date drug list and prices.**

If the doctor needs to prescribe a drug that isn't on the Medicare drug plan's formulary and the person doesn't have any other health insurance that covers outpatient prescription drugs, he or she can request a coverage determination from the plan. We'll talk more about coverage determinations in a later lesson.

If the person's plan still won't cover a specific drug, the person may have to pay full price for the prescription.

Prescription Changes ☑

- Give doctor copy of plan's formulary
 - Get up-to-date information
 - Call plan
 - Look on plan's website
- New drug is not on plan's formulary
 - Can request a coverage determination
 - May have to pay full price
 - If plan still won't cover drug

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Notes:

SLIDE 17 *Speaker's Notes*

CMS has instructed Part D plans to not change their therapeutic categories and classes in a formulary other than at the beginning of each plan year, except to account for new therapeutic uses and newly approved Part D drugs. A plan year is a calendar year, January through December.

Part D plans can make maintenance changes to their formularies, such as replacing brand-name drugs with new generic drugs or modifying formularies as a result of new information on drug safety or effectiveness. Those changes must be made according to the prescribed approval procedures and following 60-days notice to CMS, SPAPs, prescribing physicians, network pharmacies, pharmacists, and affected members.

CMS has issued guidance to Medicare drug plans indicating that no plan members should be subject to a discontinuation or reduction in coverage of drugs they are currently using for the remainder of the plan year. However, this is not true in the case of drugs removed from the formulary due to Food and Drug Administration (FDA) or the manufacturer's withdrawal of the drug from the market. Part D plans are not required to obtain CMS approval or give 60-days notice when removing formulary drugs that have been withdrawn from the market by either the FDA or a product manufacturer.

Formulary Changes ☐

- Plan year is January through December
- Generally, plans may change categories and classes only at beginning of each plan year
- May make maintenance changes during year
- May remove drugs withdrawn from market

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Notes:

SLIDE 18 *Speaker's Notes*

Costs vary depending on the plan. For coverage in 2009, people will generally pay:

- A **monthly premium**, which is different from plan to plan. Some plans have \$0 premiums. Others have higher than average premiums but might cover more.
- An **annual deductible**. This is the amount plan members must pay for prescriptions each year before the plan starts to pay. These amounts can change every year. Some plans offer a \$0 deductible (usually for a higher premium). No plan can have a deductible higher than \$295 in 2009.
- **Copayments or coinsurance**. This is the amount plan members have to pay for each prescription after meeting the deductible, if any. In some plans, the copayment (a set amount) or coinsurance (a percentage of the cost) is the same for any prescription. In other plans, there might be different drug levels or "tiers" with different costs.

The amount people pay in some plans may vary depending on how much they have spent that year. Under the standard benefit, once the deductible is met, members pay 25% coinsurance until they reach the coverage gap. During the **coverage gap**, they will be paying 100% coinsurance. After the coverage gap, they will pay very little for each prescription for the rest of the calendar year. Some plans do not have a coverage gap or may pay for some drugs during the gap.

Medicare Drug Plan Costs

- Monthly premium
 - Varies by plan
 - Some plans have no premium
- Possible deductible
 - No more than \$295 in 2009
- Copayments or coinsurance
 - May depend on how much spent that year

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Notes:

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SLIDE 19 *Speaker's Notes*

People with Medicare enrolled in a standard prescription drug plan will generally pay a premium of about \$30 or less a month and will be responsible for a \$295 deductible in 2009. Once the deductible has been met, Medicare will pay 75% of drug costs up to \$2,700 in total expenditures, and you pay the other 25% of these costs. You will be responsible for 100% of drug costs between \$2,700 and \$6,153.75. This is called the coverage gap.

Once you have reached \$4,350 in out-of-pocket costs, Medicare will pay approximately 95% of your drug costs, and you will pay 5%, for the rest of that year. This is called catastrophic coverage. Keep in mind, this is on an annual basis, so these limits apply for each year.

Out-of-pocket expenditures include:

- Annual deductible
- Coinsurance and copayment amounts

Costs must be incurred by the person with Medicare, or another person such as a family member on his or her behalf, or under a State Prescription Assistance Program (SPAP), with no reimbursement from insurance, a group health plan, or other third party.

Premium	Generally less than \$30 monthly
Deductible	No more than \$295
Drug Costs \$295-\$2,700	Beneficiary pays 25%
Drug Costs \$2,700-6,153.75	Beneficiary pays 100%
After out-of-pocket costs reach \$4,350	Beneficiary pays 5%

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Notes:

SLIDE 20 *Speaker's Notes*

Under the defined standard benefit in 2009, the coverage gap—for plans that have one—begins after plan members reach \$2,700 in total drug costs. This is called the initial coverage limit. It is based on the total cost of the drugs, not just the person's costs.

After reaching the initial coverage limit, people pay 100% of their drug costs in the gap until their out-of-pocket costs total \$4,350. Out-of-pocket costs include the money the person has spent on drugs and do not include the amount of money the plan has paid.

Once a person has spent \$4,350 out-of-pocket for covered drug costs during 2009, the plan will pay all but 5% or a small copayment for the rest of the year. This is called **catastrophic coverage**, and it could start even sooner in some plans. All plans must offer this catastrophic coverage.

Coverage Gap in 2009

- When member pays 100% of drug costs
- Begins after \$2,700 in total drug costs
 - Initial coverage limit
- Continues until out-of-pocket costs total \$4,350
 - May start earlier in some plans
- After gap, pay 5% or small copayment
 - Catastrophic coverage

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Notes:

SLIDE 21 *Speaker's Notes*

Payments that count toward a person's out-of-pocket costs include payments for drugs on the plan's formulary made by

- The plan member
- The person's family members or other individuals
- Most State Pharmacy Assistance Programs (SPAPs)
- Extra help (low-income subsidy)
- Charities, unless established, run, or controlled by a current or former employer or union

NOTE: Sometimes you may hear Part D out-of-pocket costs referred to as "TrOOP" or "true out-of-pocket" costs.

Out-of-Pocket Costs ☑

- Payment sources that count
 - Plan member
 - Family members or other individuals
 - Most State Pharmacy Assistance Programs (SPAPs)
 - Extra help (low-income subsidy)
 - Charities
 - Unless established or controlled by current or former employer or union

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Notes:

SLIDE 22 *Speaker's Notes*

The following payments don't count toward out-of-pocket costs:

- Group health plans, including employer or union retiree coverage
- Government-funded programs, including TRICARE or VA
- Manufacturer-sponsored Patient Assistance Programs (PAPs) that provide free or significantly reduced-price products. People with Medicare prescription drug coverage can still take advantage of these programs, but the amount of this in-kind assistance will not count toward TrOOP. PAPs may charge a small copayment when providing this in-kind assistance, and this amount may count toward TrOOP. The person with Medicare will need to submit a paper claim to the prescription drug plan, along with documentation of the copayment. (A list of PAPs is available at www.rxassist.org on the Internet. Click on "More Resources" and then "Patient Assistance Program Directory.")
- Other third-party payment arrangements

For coverage gap and TrOOP question, you can:

- Call the plan
- Call the pharmacist
- Visit www.cms.hhs.gov (Chapter 14 in the Medicare Prescription Drug Benefit Manual)
- Call 1-800-MEDICARE (1-800-633-4227)
- Call the state Medical Assistance office

For more drug plan cost information, visit <http://www.cms.hhs.gov/partnerships/downloads/11245-P.pdf>.

Out-of-Pocket Costs ☑

- Payment sources that don't count
 - Group health plans
 - Including employer or union retiree coverage
 - Government-funded programs
 - Including TRICARE and VA
 - Manufacturer Patient Assistance Programs
 - Other third-party payment arrangements

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Notes:

SLIDE 23

Exercise

A. You must have Medicare Part A and Medicare Part B to enroll in a Medicare Prescription Drug Plan.

1. True
2. False

Exercise

- A. You must have Medicare Part A and Medicare Part B to enroll in a Medicare Prescription Drug Plan.
1. True
 2. False

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Notes:

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Exercise

B. All Medicare Prescription Drug Plans must offer at least a standard level of coverage.

1. True
2. False

Exercise

B. All Medicare Prescription Drug Plans must offer at least a standard level of coverage.

1. True
2. False

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Notes:

SLIDE 25

Exercise

- C. Companies that offer Medicare Prescription Drug Plans may decide to cover only generic drugs.
1. True
 2. False

Exercise

- C. Companies that offer Medicare Prescription Drug Plans may decide to cover only generic drugs.
1. True
 2. False

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Notes:

SLIDE 26

Lesson 2

Eligibility and Enrollment

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Notes:

SLIDE 27 *Speaker's Notes*

Anyone who has Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), or both Part A and Part B, and who lives in the plan's service area is eligible to join a Medicare Prescription Drug Plan. To get prescription drug coverage through a Medicare Advantage Plan, generally the person must have both Part A and Part B of Medicare.

Each plan has its own service area, and people must live in a plan's service area to enroll. People in the U.S. territories, including the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Marianas, can enroll. As we said earlier, people who live outside the U.S. and its territories or who are incarcerated are not eligible to enroll in a plan and therefore cannot get this coverage.

It's important to understand that Medicare prescription drug coverage is not automatic. A person must enroll in a Medicare drug plan to get Medicare prescription drug coverage. So while all people with Medicare can have this coverage, most must take action to get it. Later on in this module, we will discuss the auto and facilitated enrollment processes for people eligible for extra help.

A person can only be a member of one Medicare drug plan at a time.

Part D Eligibility Requirements

- Medicare Part A and/or Part B
 - Part A and Part B to join Medicare Advantage plan with drug coverage
- Live in plan's service area
- Enroll in a plan

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Notes:

SLIDE 28 *Speaker's Notes*

Generally there are three times when people can sign up for Medicare prescription drug coverage.

The **Initial Enrollment Period (IEP)** is 7 months long, starting 3 months before the month people become entitled to Medicare.

There is an **Annual Coordinated Election Period (AEP)** sometimes called the Part D "Fall Open Enrollment." The AEP is November 15 – December 31 each year. During the AEP people can join, change, or drop prescription drug coverage. The change will be effective January 1 of the following year.

There are special situations that give a person a **Special Enrollment Period (SEP)**, such as a permanent move out of the plan's service area, being eligible for extra help (low-income subsidy), or moving into, residing in, or leaving a long-term care facility (like a nursing home). The time period of the SEP depends on the reason for the Special Enrollment Period.

Enrollment periods give a person the opportunity to join, switch, or drop Medicare drug plans. However, some people with Medicare have a continuous Special Enrollment Period, including those who qualify for extra help and those who live in a long-term care facility. They can change plans at any time, with the new plan coverage starting the first day of the next month. We will talk more about extra help in a few minutes.

For more information about eligibility and enrollment go to www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPErollmentGuidanceUpdate.pdf

When Can People Join?

- Initial Enrollment Period (IEP)
- Annual Coordinated Election Period (AEP)
 - Sometimes called "Fall Open Enrollment"
- Special Enrollment Periods (SEP)

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Notes:

SLIDE 29 *Speaker's Notes*

All people who become entitled to Medicare have a 7-month **Initial Enrollment Period (IEP)** for Part D:

- They can apply 3 months before their month of Medicare eligibility. Coverage will begin on the date they become eligible.
- They apply in their month of eligibility, in which case their Part D coverage will begin on the first of the following month.
- Or they can also apply during the 3 months after their month of eligibility, with coverage beginning the first of the month after the month they apply.

Some groups of people who become entitled to Medicare will be enrolled in a Part D plan by CMS unless they join a plan on their own. We will discuss these groups later.

Initial Enrollment Period (IEP) ☐

- All people newly entitled to Medicare
 - 7-month IEP for Part D

If You Join	Coverage Begins
3 months before month of eligibility	Date eligible
Month of eligibility	First of the following month
3 months after month of eligibility	First of the month after month of application

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Notes:

SLIDE 30 *Speaker's Notes*

After the IEP is over, people are generally in their chosen plan for the rest of that calendar year.

There is an **Annual Coordinated Election Period** from November 15 – December 31 each year. During the Annual Coordinated Election period, people who are not enrolled in a Medicare drug plan can enroll, and people who are in a Medicare drug plan can drop or switch plans. The change will be effective January 1 of the following year.

Unless they have a capacity limit waiver, Medicare Advantage Plans must accept eligible new members between November 15 and December 31 of each year. A capacity limit waiver means that the plan has been authorized to close enrollment because it has already reached a certain number of members. There is also a Medicare Advantage Open Enrollment Period January 1 through March 31 each year, which we'll discuss in a later lesson.

Annual Coordinated Election Period (AEP)

- November 15 – December 31 every year
- Can enroll, switch, or drop coverage
 - Medicare Prescription Drug Plan
 - Original Medicare
 - Medicare Advantage Plan
- New plan starts January 1

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Notes:

SLIDE 31 *Speaker's Notes*

There are a number of situations, some shown here, when people have a Special Enrollment Period and can add, change, or drop Medicare drug coverage. We have already mentioned a few of them.

- People who involuntarily lose their creditable prescription drug coverage have 2 months from the date of the loss or notice of the loss, whichever is later, to enroll in a Medicare drug plan. Creditable drug coverage is coverage that is as good as Medicare prescription drug coverage.
- People who qualify for extra help from Medicare may enroll in a Part D plan or switch plans at any time, with the new plan effective the first day of the following month.
NOTE: Before June 20, 2007, only people who had Medicaid or were in a Medicare Savings Program qualified for this continuous SEP.)
- People who permanently move out of their plan's service area have up to 2 months after moving to enroll in a new Part D plan.
- People who move into a long-term care facility, like a nursing home, can enroll in or change plans at any time, with the new plan effective the first day of the following month. They also have 2 months after moving out to enroll in or change plans.

For more information about SEPs, including eligibility and timeframes, see the PDP enrollment guidance at www.cms.hhs.gov/MedicarePresDrugEligEnrol/ on the CMS website.

Special Enrollment Periods (SEP)

- Involuntary loss of creditable coverage
 - Loss of other creditable drug coverage
- Continuous SEP for people who
 - Receiving extra help (low-income subsidy/LIS)
 - Move to, live in, or move from a long-term care facility
- Change in residence
 - Move out of plan's service area
- Others
 - See CMS PDP enrollment guidance

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Notes:

SLIDE 32 *Speaker's Notes*

Most people who don't join a Medicare drug plan during their Initial Enrollment Period may have to pay a premium penalty for every month they wait to enroll, unless they have other prescription drug coverage that meets Medicare's minimum standards, called "creditable" coverage. To avoid a penalty, a beneficiary must not go for a period of 63 consecutive days or more without creditable prescription drug coverage.

People with this penalty will have to pay it as long as they have Medicare prescription drug coverage. People with extra help pay no penalty.

Late Enrollment Penalty

- Pay penalty
 - Most people who enroll after IEP
 - 63 days or more without creditable coverage
 - Pay penalty as long as enrolled in drug plan
- No penalty
 - People with extra help

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 33 *Speaker's Notes*

As mentioned earlier, people will incur a penalty if they join a Medicare drug plan after their Initial Enrollment Period and they don't have other creditable prescription drug coverage or they have a gap in creditable prescription drug coverage of 63 or more days. The penalty is added to the premium payment amount. It is calculated by multiplying 1% of the national base beneficiary premium

by the number of full months the person was eligible but not enrolled in a plan and did not have other creditable drug coverage. The penalty calculation is not based on the premium of the plan the individual is enrolled in. The base beneficiary premium (\$30.36 in 2009) is a national number and can change each year.

NOTE: In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. The base beneficiary premium is different from the average beneficiary premium. The average member premium reflects the specific plan-by-plan premiums and the actual number of people who are enrolled in each plan.

Example: Mr. Smith did not enroll in a Medicare prescription drug plan by May 31, 2008, the end of his IEP. He did not have creditable prescription drug coverage and first enrolled in a Part D plan in December 2008, during the AEP. His penalty is 7% because he had 7 months without creditable coverage, starting with the first month he would have been covered if he had joined a plan by May 31. We count June through December of 2008 (7 months). Since the national base beneficiary premium in 2009 is \$30.36, the penalty would be \$2.10 per month. ($\$30.36 \times .07 = \2.12 , rounded to the nearest 10 cents = \$2.10). In general, the penalty will be added to his premium payment, and assessed for as long as he has Medicare prescription drug coverage. It is recalculated each year that the national base beneficiary premium changes.

Penalty Calculation

- National base beneficiary premium
 - \$30.36 in 2009
 - Can change each year
- Pay 1% for every month eligible but not enrolled
 - Unless person has creditable coverage
 - Penalty added to premium payment

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 34 *Speaker's Notes*

If people have other prescription drug coverage, they will get information each year from their plan that tells them if the plan meets Medicare's minimum standards. This is referred to as "creditable coverage." The plan will also notify them if their coverage changes and no longer meets Medicare's minimum standards.

Creditable Drug Coverage

- Prescription drug coverage that meets Medicare's minimum standards
- Will get information from other plan each year
 - Employer group plans
 - Retiree plans
 - VA
 - TRICARE
 - FEHB

4/14/2009

Understanding Medicare Prescription Drug Coverage

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If people have other drug coverage that meets Medicare's minimum standards, they may keep that coverage and won't have to pay a penalty if they decide to enroll in a Medicare prescription drug plan later, as long as they join within 63 days after their other drug coverage ends.

Some examples of coverage that meets Medicare's minimum standards include:

- Some group health plans
- Employer or union retiree drug coverage

VA coverage, military coverage including TRICARE, and the Federal Employees Health Benefits Program are all currently considered creditable coverage.

Most Medigap (Medicare Supplement Insurance) policies do not provide drug coverage that meets Medicare's minimum standards. If people have a Medigap policy that covers drugs, they can keep their policy, but may have to pay a penalty if they wait to join a Medicare drug plan. If they decide to join a Medicare drug plan, they will need to tell their Medigap insurer when their coverage starts, so the prescription drug coverage can be removed from their Medigap policy.

Notes:

SLIDE 35

Exercise

- A. You must have Medicare Part A and Medicare Part B to join Medicare Advantage plan with drug coverage.
1. True
 2. False

Exercise

- A. You must have Medicare Part A and Medicare Part B to join Medicare Advantage plan with drug coverage.
1. True
 2. False

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Notes:

SLIDE 36 *Exercise*

B. The Annual Coordinated Election Period runs from November 1 through December 15 each year.

1. True
2. False

Exercise

- B. The Annual Coordinated Election Period runs from November 1 through December 15 each year.
1. True
 2. False

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 37

Exercise

- C. People receiving extra help (LIS) have a continuous Special Enrollment Period.
1. True
 2. False

Exercise

- C. People receiving extra help (LIS) have a continuous Special Enrollment Period.
1. True
 2. False

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 38

Lesson 3

Extra Help with Drug Plan Costs

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Notes:

SLIDE 39 *Speaker's Notes*

We've already noted that all people with Medicare can get Medicare prescription drug coverage. This is true regardless of their income or health status or how they pay for prescriptions now. In addition, many people with limited income and resources will get **extra help** paying for prescription drugs. Extra help is sometimes referred to as the low-income subsidy.

People with the lowest income and resources will pay no premiums or deductibles and have small or no copayments.

Those with slightly higher incomes will have a reduced deductible and pay a little more out of pocket.

There is no coverage gap for people who qualify for extra help. We'll talk more about eligibility for extra help in a few minutes.

Extra Help With Drug Costs

- Sometimes called Low Income Subsidy (LIS)
- People with lowest income and resources
 - Pay no premiums or deductibles
 - Have small or no copayments
- Those with slightly higher income and resources
 - Have a reduced deductible
 - Pay a little more out of pocket
- No coverage gap for people who qualify for LIS

4/14/2009

Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 40 *Speaker's Notes*

Some people automatically qualify for extra help. People automatically qualify for extra help and don't need to apply if they:

- Have Medicare and full Medicaid benefits (including prescription drug coverage)
- Have Medicare and get Supplemental Security Income (SSI) benefits but not Medicaid
- Get help from Medicaid paying their Medicare premiums (belong to a Medicare Savings Program)

People with Medicare who are eligible for Medicaid benefits during the year (either full Medicaid benefits or help from Medicaid paying their Medicare premiums and/or cost-sharing, i.e., people in a Medicare Savings Program) are **deemed** by CMS to be eligible for extra help based on information received from the state. People who receive SSI benefits are deemed eligible based on information CMS receives from Social Security. When people qualify automatically for the first time, they will be notified in a letter from Medicare.

All other people with Medicare must file an application to get extra help. People who think they qualify but aren't sure should still apply. They should contact Social Security or their state Medicaid office for more information on the requirements and how to apply.

Qualifying for Extra Help

- Some people automatically qualify for extra help
 - Get full Medicaid benefits
 - Get Supplemental Security Income (SSI) or
 - Medicaid helps pay their Medicare premiums
- All others must apply
 - Apply online at www.socialsecurity.gov or
 - Call 1-800-772-1213 (TTY 1-800-325-0778)
 - Ask for "Application for Help with Medicare Prescription Drug Plan Costs" (SSA-1020)

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 41 *Speaker's Notes*

Extra help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources. Let's talk about how income and resources are counted.

Medicare counts the income of you and your spouse (living in the same household), regardless of whether or not your spouse

is applying for extra help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Resources also are counted for you and a spouse (living with you). Only two types of resources are considered:

- Liquid resources (i.e., savings accounts, stocks, bonds, and other assets that could be cashed in within 20 days) and
- Real estate, not including your home or the land on which your home is located.

Items such as wedding rings and family heirlooms are not considered resources for the purposes of qualifying for extra help.

NOTE: This extra help isn't available to people in the U.S. territories. The territories have their own rules for providing help with Medicare drug plan costs to their residents.

Income and Resource Limits

- **Income**
 - Below 150% Federal poverty level

2009 amounts {

- \$1,353.75 per month for an individual* or
- \$1,821.25 per month for a married couple*
- Based on family size

- **Resources**

2009 amounts {

- Up to \$12,510 (individual)
- Up to \$25,010 (married couple)
- Includes \$1,500/person funeral or burial expenses
- Counts savings and stocks
- Does not count home you live in

*Higher amounts for Alaska and Hawaii

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Notes:

SLIDE 42 *Speaker's Notes*

When people first qualify for extra help, CMS will enroll them in a Medicare drug plan to be sure they have coverage if they don't join a plan on their own. This applies to people who qualify automatically and people who apply and qualify.

When people who have full Medicaid benefits, including drug coverage, become entitled to Medicare, Medicaid will no longer pay for their drugs that Medicare will cover. CMS uses data submitted by state Medicaid agencies to identify people with Medicare who have full Medicaid benefits. These individuals are called **full-benefit dual eligibles**, and they automatically qualify for extra help.

If people with Medicare and full Medicaid benefits don't choose and join a Medicare drug plan on their own, CMS will automatically enroll them in a plan effective the first day they have both Medicare and Medicaid. They will get a yellow auto-enrollment notice with the name of the plan assigned to them.

If they don't wish to be in any Medicare drug plan, they can call 1-800-MEDICARE (1-800-633-4227) or the plan in which CMS auto-enrolled them and ask to opt out of Medicare drug coverage. However, Medicaid still will not pay for their drugs that Medicare would have covered.

As we mentioned earlier in Lesson 2, people who qualify for extra help have a continuous Special Enrollment Period or SEP and can change drug plans at any time, with changes effective the first day of the following month.

Medicare and Full Medicaid

- Auto-enrolled in a plan unless
 - Already in a Part D plan
 - Choose and join own plan
 - Call plan or 1-800-MEDICARE to opt out
- Coverage first month person has both Medicare and Medicaid
- Will get auto-enrollment letter on yellow paper
- Have a continuous SEP

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 43 *Speaker's Notes*

Other people who qualify for extra help are facilitated into a Part D plan. CMS uses data submitted by state Medicaid agencies to identify people with Medicare who are in a Medicare Savings Program. CMS uses data submitted by Social Security to identify people who have Medicare and are entitled to Supplemental Security Income (SSI) but not Medicaid, or who applied and qualify for extra help.

CMS will facilitate these individuals into a plan unless:

- They are already in a Medicare drug plan.
- They choose their own plan.
- They are enrolled in an employer or union plan receiving the employer subsidy (sometimes called the retiree drug subsidy or RDS).
- They call 1-800-MEDICARE or the plan CMS assigned them and ask to opt out of enrolling in Part D.

The plan will be effective 2 months after the month CMS receives notice of their eligibility (for SSI recipients, enrollment is retroactive to the month beneficiary had both Medicare and SSI benefits). When they receive the notice of plan assignment from CMS on green paper, they have the option to choose their own plan instead of the facilitated enrollment plan. Like full-benefit dual eligibles, they can switch plans at any time, with the new plan effective the first of the following month.

Others Qualified for Extra Help

- Facilitated into a plan unless
 - Already in a Part D plan
 - Choose and join own plan
 - Enrolled in employer/union plan receiving subsidy
 - Call plan or 1-800-MEDICARE to opt out
- Coverage effective 2 months after CMS notified
- Will get facilitated enrollment letter on green paper
- Have continuous SEP

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 44 *Speaker's Notes*

People with Medicare can apply for extra help at any time. They can also reapply if their circumstances change.

When people with Medicare who are already enrolled in a Medicare drug plan are found eligible for extra help, the plan is notified. The plan will refund the deductibles, premiums and cost-sharing assistance the members would have received, back to the month they were found to be eligible.

People New to Extra Help

- People can apply for extra help any time
 - Can reapply if circumstances change
- People in a Medicare drug plan who later qualify for extra help
 - Plan is notified
 - Plan will refund costs back to effective date of extra help
 - Deductibles/Premiums
 - Cost-sharing assistance

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 45 *Speaker's Notes*

This slide summarizes the process CMS uses to assign plans for auto- and facilitated enrollment. New enrollments are identified and processed every month.

Plans are randomly chosen from those with premiums at or below the regional low-income premium subsidy amount. CMS chooses plans with premiums at or below that amount so that people who are entitled to the full extra help subsidy pay no premium. Those entitled to a partial subsidy will pay a reduced or no premium. People who are already in a Medicare Advantage Plan will be enrolled in the same plan with prescription drug coverage (MA-PD), if offered by the MA organization.

Auto- and Facilitated Enrollment

- CMS identifies and enrolls people each month
 - Plans are randomly assigned
 - From those with premiums at/below regional low-income premium subsidy amount
 - May join MA plan meeting special needs
- People already in MA plan
 - Enrolled in MA-PD, if offered

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 46 *Speaker's Notes*

CMS will notify people who will be enrolled in a Medicare Prescription Drug Plan. People who are being auto-enrolled receive a letter on yellow paper.

Those being facilitated receive a letter on green paper, in one of two versions—full subsidy or partial subsidy, depending on the subsidy level of extra help. Both versions of the facilitated enrollment letter include a list of the plans in that region that are at or below the regional low-income premium subsidy amount, so people can look for other plans that meet their needs.

Medicare Advantage Plans send the notice when they will be enrolling one of their members in an MA-PD.

Enrollment Notices

- CMS notifies people of enrollment in a PDP
 - Auto-enrollment letter on yellow paper
 - Facilitated enrollment letter on green paper
 - Two versions
 - Full subsidy
 - Partial subsidy
 - Includes list of plans in that region at/below regional low-income premium subsidy amount
- MA plan sends notice if enrollment in MA-PD

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 47 *Speaker's Notes*

In August 2008, CMS re-established eligibility for calendar year 2009 for people who automatically qualified for extra help in 2008. Extra help was continued or changed based on their continued eligibility as a full or partial dual eligible or SSI recipient. Any changes were effective January 1, 2009.

People who were automatically eligible for 2009 continued to qualify for extra help through December 2009. If they were no longer eligible, their automatic status ended on December 31, 2008.

People who no longer automatically qualified for extra help in 2009 received a letter from Medicare on gray paper with an extra help application from SSA.

Other people continued to automatically qualify for extra help in 2009, but their copayment levels may have changed. The change in copayment level could have resulted in a change from one of the following categories to another: institutionalized with Medicare and Medicaid, have Medicare and Medicaid, get help from Medicaid paying Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits but not Medicaid. People who had a change in their copayment level between 2008 and 2009 received a letter from Medicare in October on orange paper.

If people who no longer automatically qualified in 2009 regain their eligibility for Medicaid, a Medicare Savings Program, or SSI, CMS will mail them a new letter informing them that they now automatically qualify for extra help.

Continuing Eligibility

- People Who Automatically Qualify
 - CMS re-establishes eligibility each fall for next calendar year
 - People will receive letter from Medicare
 - In September on gray paper
 - Those who no longer automatically qualify
 - Includes SSA application
 - In early October on orange paper
 - Those who will continue to automatically qualify but with a different copayment level

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Notes:

SLIDE 48 *Speaker's Notes*

Social Security has modified its redetermination processes for people who applied with Social Security and qualified for the low-income subsidy or extra help.

There are four types of redetermination processes:

- Initial
- Cyclical or recurring
- Subsidy-changing event (SCE)
- Other events

Continuing Eligibility

- People who applied with Social Security
 - Four types of redetermination processes
 - Initial
 - Cyclical or recurring
 - Subsidy-changing event (SCE)
 - Other event
 - Any change other than SCE

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Notes:

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SLIDE 49 *Speaker's Notes*

Group 1, people with both Medicare and full Medicaid benefits (sometimes referred to as full-benefit dual eligibles) with incomes at or below 100% of Federal Poverty Level (FPL), pay no monthly premium or annual deductible. They are only responsible for small copayments, up to \$1.10 for generic drugs and \$3.20 for brand-name drugs. If extra help combined with these small copayments reaches \$4,350, the person would not be responsible for any copayments for the rest of the year.

Group 2, full-benefit dual eligibles above 100% of FPL; people who belong to a Medicare Savings Program—Qualified Medicare Beneficiaries (QMB), Specified Low-income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI); Supplemental Security Income (SSI)-only beneficiaries; and non-dual eligible beneficiaries with incomes below 135% FPL and limited resources (\$8,100/individual and \$12,910/married couple), are not responsible for the monthly premium or the deductible. They have up to a \$2.40 copayment for generic drugs and a \$6.00 copayment for brand-name drugs. Here again, if extra help and copayments total \$4,350, the person would not have any copayments for the rest of the year.

Group 3, those with incomes below 150% FPL and limited resources (\$12,510/ individual and \$25,010/married couple), the premium is based on a sliding scale depending on the person's income. They are responsible for a reduced deductible of \$60 per year, and they will be responsible for 15% of the cost of their prescriptions up to the \$4,350 out-of-pocket maximum. Once they have reached the maximum, they will have up to a \$2.40 copayment for generic drugs and a \$6.00 copayment for brand-name drugs for the rest of the year. There is no coverage gap (with 100% cost-sharing) for these groups. Institutionalized full-benefit dual eligibles will not be responsible for any out-of-pocket costs.

NOTE: The premium for Groups 1 and 2 will only be \$0 if the person enrolls in a basic plan with a premium at or below the regional low-income premium subsidy amount. People who choose an enhanced plan or a plan with a premium greater than the amount of premium assistance available will be liable for the difference.

	Group 1	Group 2	Group 3
Premium	\$0	\$0	Sliding scale based on income
Deductible \$295/year	\$0	\$0	\$60
Coinsurance up to \$4,350 out of pocket	\$1.10/\$3.20 copay	\$2.40/\$6.00 copay	Up to 15% coinsurance
Catastrophic coverage	\$0	\$0	\$2.40/\$6.00 copay

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Notes:

SLIDE 50

Exercise

A. People with the lowest income and resources will pay no premiums or deductibles and have small or no co-payments for Part D coverage.

1. True
2. False

Exercise

- A. People with the lowest income and resources will pay no premiums or deductibles and have small or no co-payments for Part D coverage.
1. True
 2. False

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Notes:

SLIDE 51

Exercise

B. If you are auto-enrolled in a Part D plan, you will receive a letter on blue paper.

- 1. True
- 2. False

Exercise

- 2. If you are auto-enrolled in a Part D plan, you will receive a letter on blue paper.
 - A. True
 - B. False

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Notes:

SLIDE 52

Exercise

C. People who were automatically eligible for extra help for 2009 continue to qualify for extra help through December 2009.

- 1. True
- 2. False

Exercise

3. People who were automatically eligible for extra help for 2009 continue to qualify for extra help through December 2009.
- A. True
 - B. False

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Notes:

SLIDE 53

Lesson 4

Comparing and Choosing Plans

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Notes:

SLIDE 54 *Speaker's Notes*

There are several questions people with Medicare should consider when joining a Medicare prescription drug plan. The most important consideration in deciding if Medicare drug coverage is right for them is the type of health insurance coverage they currently have and how that affects their choices.

Things to Consider

- Current health insurance coverage
- Current prescription drug coverage
 - As good as Medicare drug coverage?
- How does current coverage work with Medicare?
 - Will joining a Medicare drug plan affect current coverage of person or his/her family?

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If people have current prescription drug coverage, they will receive information each year from their plan telling them whether or not the coverage is considered creditable coverage. If they did not receive that information, they should call the benefits administrator for their plan. It is important to find out how Medicare coverage affects their current health insurance plan, to be sure they don't lose doctor or hospital coverage for themselves or their family members.

Information on how different types of current coverage work with Medicare prescription drug coverage is available on www.medicare.gov and by calling 1-800-MEDICARE (1-800-633-4227).

Notes:

SLIDE 55 *Speaker's Notes*

As we said earlier, Medicare drug plans are not all the same. Plans vary based on cost, which drugs are covered, and which pharmacies people can use.

- Cost—The monthly premium, deductible, and share of the cost people pay for their prescriptions (coinsurance and/or copayments) will be different depending on which plan they choose.
- Coverage—Most plans have a formulary, which is a list of drugs the plan covers. Plans may have rules about how they provide coverage for different drugs on their formularies.
- Convenience—Drug plans work with some but not necessarily all pharmacies in every area. They may have a list of preferred pharmacies where plan members can obtain the lowest cost for their drugs. Some plans also have a mail-order option.

Like other insurance, Medicare prescription drug coverage will be there for people when they need it to help with drug costs. Even if they don't take a lot of prescription drugs now, they still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy. Every year people can switch to a different plan if their needs change.

Medicare Drug Plans

- Medicare drug plans vary
 - Cost — How much a member has to pay
 - Coverage — What drugs they cover
 - Convenience — Which pharmacies they use

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Notes:

SLIDE 56 *Speaker's Notes*

People with Medicare can choose how to get their prescription drug coverage. Medicare drug coverage is provided through the following.

- Medicare Prescription Drug Plans
- Some Medicare Advantage and other Medicare plans
- Some employers and unions

Drug Plan Options

- Medicare Part D provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage and other Medicare plans
 - Some employers and unions

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Notes:

SLIDE 57 *Speaker's Notes*

There are three steps people can take to choose a Medicare drug plan.

Step 1: Collect information about their current prescription drug coverage and needs. Include information about any prescription drug coverage they may currently have as well as a list of the prescription drugs they currently take, the dosages, and how often they take them.

Step 2: Compare Medicare drug plans. Check for plans that cover the prescriptions they take and that use the pharmacies they prefer. For a list of the drug plans available in their area, they can:

- Use the Medicare Prescription Drug Plan Finder tool at www.medicare.gov to get personalized information about plans that meets their needs.
- Call 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.)
- Call the State Health Insurance Assistance Program (SHIP) in their state for help comparing Medicare drug plans.

Step 3: Choose the plan they want and call the plan with any questions.

Choosing a Medicare Drug Plan

- Step 1: Collect information
 - Any current prescription drug coverage
 - Prescription drugs, strengths, and dosages
- Step 2: Compare Medicare drug plans
 - www.medicare.gov
 - 1-800-MEDICARE (1-800-633-4227)
 - State Health Insurance Assistance Program (SHIP)
- Step 3: Call plan with any questions

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Notes:

Module 9: Understanding Medicare Prescription Drug Coverage

SLIDE 58 *Speaker's Notes*

The Medicare Prescription Drug Plan Finder is an online resource available at www.medicare.gov to help people:

- Learn about Medicare prescription drug coverage
- View current plan
- Find and compare plans available in their area
- Enroll in a plan

Note: Keep in mind that people can only enroll in a Medicare drug plan, using the plan finder tool or other means, during an established enrollment period for which they are eligible. Examples include the IEP, the AEP, and SEP.

To access the Drug Plan Finder, click "Compare Medicare Prescription Drug Plans."

Medicare health plan information is also available by clicking "Compare Health Plans and Medigap Policies in Your Area."

Online Comparison Tools

- Online resource to help people
 - Learn about Medicare prescription drug coverage
 - View current plan
 - Find and compare plans available in their area
 - Enroll in a plan
- www.medicare.gov
 - Compare Medicare Prescription Drug Plans
 - Compare Health Plans and Medigap Policies

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Notes:

SLIDE 59 *Speaker's Notes*

Using the Plan Finder to do a personalized search will show all plans available in the person's ZIP Code, and will compare those plans by

- Annual cost
- Monthly premium
- Annual deductibles
- Coverage in the gap
- Pharmacies

Personalized Plan List ☐

- Shows all plans available in ZIP Code
- Compare by
 - Annual cost
 - Monthly premium
 - Annual deductibles
 - Coverage in the gap
 - Pharmacies

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Notes:

Module 9: Understanding Medicare Prescription Drug Coverage

SLIDE 60 *Speaker's Notes*

Before beginning to use the Drug Plan Finder, it is helpful to have certain information at hand. Entering personal information in the Drug Plan Finder will provide the most accurate, personalized information, including estimates of plan costs.

It is helpful to have a person's:

- Medicare card
- ZIP Code
- List of prescription drugs, including dosage and monthly amount

It is important to note that all of the information entered into the Drug Plan Finder is kept confidential.

A worksheet is available to help gather the information needed to use the Drug Plan Finder. It is located at www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp.

Getting Started

- Helpful information to gather
 - Medicare card
 - ZIP Code
 - List of prescription drugs
 - Including dosage and amount
 - Personal drug list can be saved online

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Notes:

SLIDE 61 *Speaker's Notes*

People can join the plan directly. All plans must offer paper enrollment applications. In addition, plans have the option to offer enrollment through their website or over the telephone. Most plans also participate and offer enrollment through Medicare's www.medicare.gov website.

Plans must process applications in a timely manner, and after people apply, the plan must notify them that it has accepted or denied their application.

It is a good idea for people to keep a copy of their application, confirmation number, any other papers they sign, and letters or materials they receive.

Joining a Plan

- Enroll directly with the plan
 - Mail or fax paper application to plan
 - Internet
 - Plan's website
 - www.medicare.gov
 - Telephone
 - 1-800-MEDICARE
 - TTY 1-877-486-2048
 - The plan

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Notes:

SLIDE 62 *Speaker's Notes*

People who join a plan, or who are enrolled in a plan by CMS, can expect to receive an enrollment letter and membership materials from the plan. The materials will contain an identification card and customer service information including a toll-free phone number and website address.

Plans will also have a transition process in place for enrollees who are new to the plan and taking a non-formulary drug. The plan will provide a 30-day temporary supply of the prescription (a 90-day supply if the enrollee is a resident of a long-term care facility). This gives people time to work with their prescribing physician to find a different drug that is on the plan's formulary. If an acceptable alternative drug is not available, they or their physician can request an exception from the plan, and denied requests can be appealed.

What New Members Can Expect

- Member will receive
 - Enrollment letter
 - Membership materials, including card
 - Customer service contact information
- Member can get transition supply
 - If drug not covered by plan
 - Generally 30-day supply
 - Work with physician to find a drug that is covered
 - Can request exception if no acceptable alternative drug is available

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 63 *Speaker's Notes*

Each year, both stand-alone Medicare Prescription Drug Plans (PDPs) and Medicare Advantage plans with prescription drug coverage (MA-PDs) are required to send an *Annual Notice of Change* (ANOC) to all plan members. The letter must be sent, along with a Summary of Benefits and a copy of the formulary for the upcoming year, in time to arrive no later than October 31. The

letter will explain any changes to the current plan, including changes to the monthly premium and cost-sharing information such as copayments or coinsurance.

Plans must send an *Evidence of Coverage* to all members no later than January 31 each year. It provides details about the plan's service area, benefits, and formulary; how to get information, benefits, and extra help; and how to file an appeal. The plan may choose to send the Evidence of Coverage with the ANOC.

Annual Notice of Change

- All Part D plans send to all members
 - By October 31
 - May arrive with Evidence of Coverage
- Will include information for upcoming year
 - Summary of Benefits
 - Formulary
 - Any changes
 - Premium
 - Copayment/coinsurance

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Notes:

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Special Populations

- State Pharmacy Assistance Program (SPAP) participants
- People in long-term care facilities
- Residents of U.S. territories

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Notes:

SLIDE 65 *Speaker's Notes*

State Pharmacy Assistance Programs (SPAPs) can provide wraparound coverage to help their members who have Medicare with their prescription drug costs. Therefore, SPAPs will be able to provide the same or better coverage for their members at a lower cost per member to the state. These savings can then be used to help reduce state budget costs or to expand the population served by their program. In most cases, costs incurred by SPAPs can count toward a person's out-of-pocket costs.

State Pharmacy Assistance Programs

- SPAP can provide wraparound coverage
 - Reduce state costs or expand population served
- Costs incurred by SPAP can count toward out-of-pocket limit
 - In most cases

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Understanding Medicare Prescription Drug Coverage

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Notes:

SLIDE 66 *Speaker's Notes*

Generally, long-term care facilities (i.e., nursing homes and skilled nursing facilities) contract with one long-term care pharmacy to supply the prescription drugs needed by their residents. With the implementation of Medicare Prescription Drug Plans, long-term care pharmacies have to contract with both the facility and the Medicare Prescription Drug Plans serving the region.

CMS requires that all Medicare Prescription Drug Plans have contracts with a sufficient number of long-term care pharmacies to ensure convenient access to prescription drugs for long-term care residents who have Medicare.

People with Medicare living in long-term care facilities have a continuous Special Enrollment Period. They can change plans at any time, with the new plan coverage starting the first day of the next month. In general, people who have Medicare prescription drug coverage and full Medicaid benefits and are living in long-term care facilities won't pay anything for their prescription drugs.

Long-Term Care Facilities

- Residents
 - Obtain drugs from pharmacy chosen by facility
 - Will have convenient access
 - Can change plans at any time
 - With Medicare and full Medicaid benefits have no deductible and no copayments

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Notes:

SLIDE 67 *Speaker's Notes*

Medicare prescription drug coverage is also available in each of the five U.S. territories—U.S. Virgin Islands, Guam, American Samoa, Commonwealth of Puerto Rico, and the Commonwealth of Northern Marianas.

However, territory residents are not eligible for the Part D low-income subsidy (LIS).

Each of the territories provides help for its residents with Medicare drug costs. This help is generally for the residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as extra help provided elsewhere in the United States.

Each territory has an Enhanced Allotment Plan (EAP) and receives a grant through the Medicaid program to cover Part D costs for its residents with both Medicare and Medicaid. Each territory can develop a plan for how it will use EAP funds. Territories may choose to pay for Medicare drug plan premiums, coinsurance, copayments and/or deductibles for individuals with Medicare and Medicaid. They may also decide to provide supplemental coverage, sometimes referred to as wraparound coverage.

To find out more about these rules, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

U.S. Territories

- Part D program is the same
 - Except residents are not eligible for extra help
- Each territory provides help for residents with Medicare and Medicaid
 - Different from extra help
 - Enhanced Allotment Plan (EAP)
 - Funded through Medicaid program grant
 - May pay for plan premiums, coinsurance, copayments, and/or deductibles
 - May provide supplemental coverage

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Notes:

SLIDE 68

Exercise

A. Your *Annual Notice of Change* for your Part D plan may be sent with your *Evidence of Coverage*.

1. True
2. False

Exercise

- A. Your *Annual Notice of Change* for your Part D plan may be sent with your *Evidence of Coverage*.
1. True
 2. False

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Notes:

SLIDE 69

Exercise

B. In most cases, costs incurred by an SPAP will not count toward out-of-pocket limit.

1. True
2. False

Exercise

B. In most cases, costs incurred by an SPAP will not count toward out-of-pocket limit.

1. True
2. False

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Notes:

SLIDE 70

Exercise

C. In the U.S. Territories, each territory provides help for residents with Medicare and Medicaid.

1. True
2. False

Exercise

- C. In the U.S. Territories, each territory provides help for residents with Medicare and Medicaid.
1. True
 2. False

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Notes:

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Lesson 5

**Coverage Determinations
and Appeals**

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Notes:

SLIDE 72 *Speaker's Notes*

A coverage determination is the initial decision made by a plan about the benefits a plan member is entitled to receive, the amount (if any) a member is required to pay for a benefit, or the amount a plan reimburses a member for Part D drugs he or she has already purchased. In addition, a plan's decision on an exception request is a coverage determination.

Coverage Determination

- Initial decision by plan
 - Benefits a member is entitled to receive
 - Amount member is required to pay for a benefit
- Exception request
- May be standard or expedited if health risk

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A plan also makes a coverage determination when it decides whether or not a member:

- Has satisfied a prior authorization requirement—such as having a certain level of functioning or a specific diagnosis for a drug to be covered, or
- Has met a step-therapy requirement to have a more expensive drug covered by trying the generic alternative first.

NOTE: A member can obtain a drug subject to a plan's coverage rules by either (1) satisfying the coverage rule criteria, or (2) requesting and obtaining an exception to the rule based on medical necessity. The member's prescribing physician can request a coverage determination on his or her behalf.

Coverage determinations can be standard or expedited. The request will be expedited if the plan determines, or if the doctor tells the plan, that the person's life or health will be seriously jeopardized by waiting for a standard request.

Notes:

SLIDE 73 *Speaker's Notes*

If a Medicare drug plan doesn't cover a Part D drug a member needs, or it covers a drug at a higher cost-sharing level than a member believes he or she is required to pay, the member has the right to request an exception from the plan. A member may also request an exception if the plan requires him or her to meet a coverage rule that the person can't meet for a medical reason.

Remember, an exception is a type of coverage determination.

There are two types of exceptions—tiering exceptions and formulary exceptions.

Exception requests require a supporting statement from the physician. In general, the statement must indicate the medical reason for the exception. The physician may submit the statement orally or in writing.

Exception Requests

- Two types of exceptions
 - Tiering (cost level of drug)
 - Formulary
 - Drug not on plan's formulary or
 - Access requirements
- Require supporting statement from physician

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Notes:

SLIDE 74 *Speaker's Notes*

If an exception request is approved, the exception is valid for refills for the remainder of the plan year, so long as

- The member remains enrolled in the plan,
- The physician continues to prescribe the drug, **and**
- The drug remains safe for treating the person's condition.

A plan may choose to extend coverage into a new plan year. If it does not, it must provide written notice to the member either at the time the exception is approved, or at least 60 days before the plan year ends. If coverage isn't extended, the member should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during the Annual Coordinated Election Period.

Approved Exceptions

- Exception valid for refills for remainder of year if
 - Person remains enrolled and
 - Physician continues to prescribe drug, and
 - Drug stays safe to treat person's condition
- Plan may extend coverage into the new plan year
 - Must provide written notice if not
 - At least 60 days before plan year ends

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Notes:

SLIDE 75 *Speaker's Notes*

A plan must notify a member of its coverage determination decision as quickly as the member's health condition requires, but no later than 72 hours (standard requests) or 24 hours (expedited requests) after receiving the member's request.

If a coverage determination request involves an exception, the clock starts when the plan receives the physician's supporting statement.

If a plan fails to meet these timeframes, it must automatically forward the request and case file to the Independent Review Entity (IRE) for review, and the request will skip over the first level of appeal (redetermination by the plan). The IRE is MAXIMUS. Their contact information is at www.medicarepartdappeals.com on the web.

A job aid is provided to outline the appeal process including timelines.

Coverage Determination Timeframe

- Must notify of coverage determination
 - Standard request - within 72 hours
 - Expedited request - within 24 hours
 - If exception involved, period starts with receipt of physician statement
 - If timeframe missed, goes to independent review entity (IRE)
 - Skip 1st level of appeal

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Notes:

SLIDE 76 *Speaker's Notes*

If a member receives an unfavorable decision, she or he has the right to appeal the decision. There are 5 levels of appeal:

1. Redetermination with the Part D plan (sponsor)
2. Reconsideration with the independent review entity
3. Hearing with an administrative law judge
4. Review by the Medicare Appeals Council
5. Review by a federal district court

In general, appeal requests must be made in writing. However, plans must accept expedited redetermination requests that are submitted orally and in writing. In addition, plans may choose to accept standard redetermination requests orally. Members should consult plan materials or contact their plans to determine if standard redetermination requests can be submitted orally.

A plan member, or a member's representative, may request any level of appeal. A member's physician can request an expedited redetermination on a member's behalf.

NOTE: See the copy of the Comparison of the Parts A, B, C, and D Appeal Processes provided in your materials, or view it on your CD Suite under "Job Aids."

Requesting Appeals

- 5 levels of appeals
- In general, appeal requests must be written
 - Plans must accept expedited requests orally
- An appeal can be requested by
 - Plan member
 - Appointed representative

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Notes:

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Exercise

- A. If an exception request is approved, the exception is valid for refills for the remainder of the plan year, so long as the member remains enrolled in the plan, the physician continues to prescribe the drug, and the drug remains safe for treating the person's condition.
1. True
 2. False

Exercise

- A. If an exception request is approved, the exception is valid for refills for the remainder of the plan year, so long as the member remains enrolled in the plan, the physician continues to prescribe the drug, and the drug remains safe for treating the person's condition.
1. True
 2. False

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Notes:

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Exercise

B. If a coverage determination request involves an exception, the clock starts when the plan receives the physician's supporting statement.

1. True
2. False

Exercise

- B. If a coverage determination request involves an exception, the clock starts when the plan receives the physician's supporting statement.
1. True
 2. False

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Notes:

SLIDE 79

Exercise

- B. An appeal can only be requested by a plan member.
1. True
 2. False

Exercise

- C. An appeal can only be requested by a plan member.
1. True
 2. False

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Notes:

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Lessons

- ✓ Drug Coverage Basics
- ✓ Eligibility and Enrollment
- ✓ Extra Help with Drug Plan Costs
- ✓ Comparing and Choosing Plans
- ✓ Coverage Determinations and Appeals

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Notes:

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SLIDE 81 *Speaker's Notes*

There are a number of sources where you can get more information about Medicare prescription drug coverage, including:

- Medicare's website for people with Medicare, **www.medicare.gov**
- Medicare's website for partners, **www.cms.hhs.gov**
- Social Security's website **www.socialsecurity.gov**
- Publications such as the *Medicare & You* handbook (CMS Pub. No. 10050) or *Your Guide to Medicare Prescription Drug Coverage* (CMS Pub. No. 11109)
- They can be ordered from the **www.medicare.gov** website or by calling 1-800-MEDICARE
- Toll-free number for Medicare, 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 for TTY users
- Toll-free number for Social Security, 1-800-772-1213 or 1-800-325-0778 for TTY users
- Your local State Health Insurance Assistance Program (SHIP). You can get the telephone number by visiting **www.medicare.gov** on the web, by calling 1-800-MEDICARE, or by looking at the back cover of your *Medicare & You* handbook.

For More Information

- Websites
 - www.medicare.gov
 - www.cms.hhs.gov
 - www.socialsecurity.gov
- Publications
 - *Medicare & You* handbook
 - *Your Guide to Medicare Prescription Drug Coverage*
- 1-800-MEDICARE (1-800-633-4227)
- Social Security at 1-800-772-1213
- State Health Insurance Assistance Program

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Notes:
