Medicare Prescription Drug Coverage (Part D) Alaska - 2013

National Medicare
TRAINING PROGRAM

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Version 23

Session Objectives

This session will help you to

- Understand Medicare prescription drug coverage
  - Under Medicare Part A
  - Under Medicare Part B
  - Under Medicare Part D
- Summarize eligibility and enrollment
- Compare and choose plans
- Describe Extra Help with drug plan costs
- Review coverage determinations and appeals

Four Parts of Medicare

Part A
Hospital
Insurance

Part B
Medical
Insurance

Part C
Medicare
Advantage
Plans
Includes Part A & B and sometimes Part D coverage

not available in Alaska

Part D
Medicare
Prescription
Drug
Coverage

Medicare Prescription Drug Coverage

- Medicare Parts A, B and D cover prescription drugs
  - Drugs must be medically necessary
- Coverage by Parts A, B, or D depends on
  - Health care setting
  - Medical indication
  - Need for special coverage requirements

Part A Prescription Drug Coverage

- Part A generally pays for all drugs
  - During a covered inpatient stay
  - In hospital or skilled nursing facility (SNF)
    - Drugs received as part of treatment
  - Hospice
    - Drugs for symptom control and pain relief only

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
  - Injectable and infusible drugs that are
    - Not usually self-administered, and
    - Administered as part of a physician service
  - Administered through Part B-covered Durable Medicare Equipment (DME)
  - Some other types of drugs with special coverage requirements
  - Certain vaccines (e.g., flu shot)

Part B Prescription Drug Coverage

- Generally doesn't cover self-administered drugs in hospital outpatient setting
  - Unless required for hospital services you're receiving
- If enrolled in Part D, drugs may be covered
  - If not admitted to hospital
  - May have to pay and submit for reimbursement

Part B Prescription Drug Coverage

- Covers drugs administered through Part B-covered Durable Medical Equipment (DME)
  - Such as nebulizers and infusion pumps
  - Only when used with DME in your home
- Supplier must be accredited DME provider
  - In some areas must be contract provider (DMEPOS) *not currently in Alaska*

Part B Prescription Drug Coverage

- Covers oral drugs with special coverage requirements
  - Anti-cancer drugs (see Appendix A)
  - Anti-emetic drugs (see Appendix B)
  - Immunosuppressive drugs, under certain circumstances (Appendix C)

Exercise

Medicare Part B covers certain vaccines, including the influenza ("flu") and pneumococcal pneumonia vaccines.

1. True
2. False

Medicare Prescription Drug Coverage

- Also called Medicare Part D
- Prescription drug plans approved by Medicare
- Run by private companies
- Available to everyone with Medicare
- Must be enrolled in a plan to get coverage
- Two sources of coverage
  - Medicare Prescription Drug Plans (PDPs)
  - Medicare Advantage Plans with Rx coverage (MA-PDs)
    - And other Medicare health plans with Rx coverage

Medicare Drug Plans

- Can be flexible in benefit design
- Must offer at least standard level of coverage
- May offer different or enhanced benefits
- Benefits and costs may change each year

Medicare Drug Plan Costs

- Costs vary by plan
- In 2013, most people will pay
  - A monthly premium
  - A yearly deductible
  - Copayments or coinsurance
  - 47.5% for covered brand name drugs in coverage gap
  - 79% for generic drugs in coverage gap
  - Very little after spending $4,750 out-of-pocket

Improved Coverage in the Coverage Gap

Year	What You Pay for Brand Name Drugs in the Coverage Gap	What You Pay for Generic Drugs in the Coverage Gap
2013	47.5%	79%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Note: Dispensing fees are not discounted.

Standard Structure in 2013

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.			
Monthly Premium – Ms. Smith pays a monthly premium throughout the year.			
1. Yearly Deductible	**2. Copayment or Coinsurance**	**3. Coverage Gap**	**4. Catastrophic Coverage**
Ms. Smith pays the first $325 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their **combined** amount (plus deductible) reaches $2,970.	Once Ms. Smith and her plan have spent $2,970 for covered drugs, she is in the coverage gap. In 2013, she gets a 52.5% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2013, she also gets 21% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent $4,750 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each drug until the end of the year.

Which Payment Sources Count Toward TrOOP?

Sources That Count	Sources That Don't Count
• Your payments • Payments by family members or other individuals • Most state pharmacy assistance programs (SPAPs) • Extra Help • Charities (not if established/ controlled by employer/union) • Indian Health Services • AIDS drug assistance programs • Payments by manufacturers under coverage gap discount program	• Payments made by your Medicare drug plan • Group Health Plans (including employer and union retiree coverage) • Government-funded programs (including TRICARE and VA) • Manufacturer Patient Assistance Programs (PAPs) • Other third-party payment arrangements

Medicare Prescription Drug Coverage Premium (IRMAA)

- A small group may pay a higher premium
- Income-Related Monthly Adjustment Amount
  - Based on income
  - Fewer than 5% of all people with Medicare
  - Uses same thresholds used to compute income-related adjustments to Part B premium
    - As reported on your IRS tax return from 2 years ago
- Required to pay if have Part D coverage

Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2011 was		In 2013 You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
$85,000.01 – $107,000	$170,000.01 – $214,000	YPP + $11.60*
$107,000.01 – $160,000	$214,000.01 – $320,000	YPP + $29.90*
$160,000.01 – $214,000	$320,000.01 – $428,000	YPP + $48.10*
Above $214,000	Above $428,000	YPP + $66.40*
*per month		

Part D-Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by Food and Drug Administration (FDA)
  - Used and sold in United States
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - Supplies associated with injection or inhalation

Required Coverage

- "All or substantially all" drugs in 6 categories
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments
  - Immunosuppressants
- All commercially-available vaccines
  - Except those covered under Part B (e.g., flu shot)

Drugs Excluded By Law Under Part D

- Anorexia, weight loss or weight gain drugs
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth)
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs

Access to Covered Drugs

- Plans must cover range of drugs in each category
- Coverage and rules vary by plan
- Plans can manage access to drug coverage through
  - Formularies (list of covered drugs)
  - Prior authorization (doctor requests before service)
  - Step therapy (type of prior authorization)
  - Quantity limits (limits quantity over period of time)

Formulary

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

Tier Structure Example		
Tier	**You Pay**	**Prescription Drugs Covered**
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand-name
3	Highest copayment	Non-preferred, brand-name
Specialty	Highest copayment or coinsurance	Unique, very high-cost

Rules Plans Use to Manage Access to Drugs

Prior Authorization	▪ Doctor must contact plan for prior approval • Before prescription will be covered • Must show medical necessity for drug ▪ Process for requests may vary by plan
Step Therapy	▪ Type of prior authorization ▪ You 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

Formulary Changes

- Plans may change categories and classes
  - Only at beginning of each plan year
  - May make maintenance changes during year
    - E.g., replacing brand-name drug with new generic
- Plan usually must notify you 60 days before changes
  - 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 market
  - By manufacturer or FDA without 60 day notification

If Your Prescription Changes

- Get up-to-date information from plan
  - By phone or on plan's website
- Give doctor copy of plan's formulary
- If the new drug is not on plan's formulary
  - Can request a coverage determination from plan
  - May have to pay full price if plan still won't cover drug

Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
  - You must have Medicare Part A **or** Part B
- To be eligible to join a MA Plan with drug coverage
  - You must have Part A **and** Part B
- You must live in plan's service area
  - You cannot be incarcerated
  - You cannot live outside the United States
- You **must** be enrolled in a plan to get drug coverage

When You Can Join or Switch Plans

- When you become newly entitled to Medicare
  - 7-month Initial Enrollment Period (IEP) for Part D

If You Join	Coverage Begins
3 months before your month of eligibility	Date eligible for Medicare
Month of eligibility	First of the following month
3 months after your month of eligibility	First of the month after month you apply

When You Can Join or Switch Plans

Medicare's Open Enrollment Period ("Open Enrollment")	October 15 – December 7 each year Changes are effective January 1
January 1 – February 14	Between January 1–February 14, if you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch to Original Medicare during this period, you will have until February 14 to also join a Medicare drug plan to add drug coverage. Coverage begins the first of the month after the plan gets the enrollment form.

When You Can Join or Switch Plans

Special Enrollment Periods (SEP)	▪ You permanently move out of your plan's service area ▪ You lose other creditable prescription coverage ▪ You weren't adequately informed your other coverage was not creditable or was reduced and is no longer creditable ▪ You enter, live in or leave a long-term care facility ▪ You have a continuous SEP if you qualify for Extra Help ▪ You belong to a State Pharmaceutical Assistance Program (SPAP) ▪ Or in other exceptional circumstances

5-Star Special Enrollment Period (SEP)

- Can enroll in 5-Star Medicare Advantage (MA), Prescription Drug Plan (PDP), or MA-PD
- Enroll at any point during the year
  - Once per year
- New plan starts first of month after enrolled
- Plan ratings granted on calendar basis
  - Ratings assigned in October of the preceding year
  - Use Medicare Plan Finder to view plan ratings
    - Look at Overall Plan Rating to identify eligible plans

Creditable Drug Coverage

- Current or prior prescription drug coverage
- Creditable if it meets or exceeds Medicare's minimum standards
- With creditable coverage
  - May not have to pay a late enrollment penalty
- Plans inform yearly about whether creditable
  - For example, employer group health plans (EGHPs), retiree plans, VA, TRICARE and Federal Employee Health Benefits (FEHB)

Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Additional 1% of base beneficiary premium
    - For each month eligible and not enrolled
    - For as long as you have Medicare drug coverage
  - Except if you had creditable drug coverage
  - National base beneficiary premium
    - $31.17 in 2013
    - Can change each year

Exercise

To be eligible to join a stand-alone Medicare Prescription Drug Plan (PDP), you must have:

1. Medicare Part A
2. Medicare Part B
3. Medicare Part A **or** Part B
4. Medicare Part A **and** Part B

What is Extra Help?

- Program to help people pay for Medicare prescription drug costs
  - Also called the Low-Income Subsidy (LIS)
- If you have lowest income and resources
  - Pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources
  - Pay reduced deductible and a little more out-of-pocket
- No coverage gap if you qualify for Extra Help

Qualifying for Extra Help

- You automatically qualify for Extra Help if you
  - Have full Medicaid coverage
  - Receive Supplemental Security Income (SSI)
  - Get help from Medicaid paying your Medicare premiums (aka MSP/"Buy-in")
- All others must apply
  - Online at www.benefitscheckup.org/alaska
  - Apply with the Alaska SHIP 1-800-478-6065
  - Call SSA at **1-800-772-1213** (TTY 1-800-325-0778)
    - Ask for "Application for Help with Medicare Prescription Drug Plan Costs" (SSA-1020)

2013 Alaska Income and Resource Limits

- Income
  - Below 150% of the Federal poverty level (FPL)
    - $1,793.75 per month for an individual, or
    - $2,422.00 per month for a married couple
    - Based on family size
- Resources
  - Up to $13,300 for an individual, or
  - Up to $26,580 for a married couple
    - Includes $1,500/person for funeral or burial expenses
    - Counts savings and investments
    - Does not count home you live in

Medicare and Full Medicaid

- You are auto-enrolled in a plan unless you
  - Are already in a Medicare drug plan
  - Choose and join a plan on your own
  - Are enrolled in employer/union plan receiving subsidy
  - Call the plan or 1-800-MEDICARE to “opt out”
- You are covered 1st month you are covered by
  - Medicaid and are entitled to Medicare
- Will get auto-enrollment letter (yellow paper)
- You have a continuous Special Enrollment Period

Others Qualified for Extra Help

- You are facilitated into a plan unless you
  - Are already in a Medicare drug plan
  - Choose and join a plan on your own
  - Are enrolled in employer/union plan receiving subsidy
  - Call the plan or 1-800-MEDICARE to “opt out”
- Coverage is effective 2 months after CMS notifies
- Will get facilitated enrollment letter (green paper)
- You have a continuous Special Enrollment Period

Medicare's Limited Income Newly Eligible Transition (LINET) Program

- Designed to eliminate gaps in coverage for low-income individuals transitioning to Part D coverage
- Provides 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
  - Requires no prior authorization
  - Has no network pharmacy restrictions
  - Includes standard safety and abuse edits
  - Humana currently administers LINET http://www.humana.com/pharmacists/pharmacy_resources/information.aspx

How Do You Access Medicare's Limited Income NET Program?

Auto-Enrollment by CMS

- CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits

Point of Sale (POS) Use

- You may use Medicare's Limited Income NET Program at the pharmacy counter (point-of-sale)

Submit a Receipt

- You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out-of-pocket during periods you're eligible

Re-establishing Eligibility for People Who Automatically Qualify

- CMS re-establishes eligibility each fall for next calendar year
  - If you no longer automatically qualify
    - CMS sends letter in September (gray paper)
      - Includes SSA application
  - If you automatically qualify, but your copayment changed
    - CMS sends letter in early October (orange paper)

Continuing Eligibility for Extra Help

- People who applied and qualified for Extra Help
  - Four types of redetermination processes
    - Initial
    - Cyclical or recurring
    - Subsidy-changing event (SCE)
    - Other event (change other than SCE)

Exercise

To be eligible for Extra Help, you must have limited resources and income below:

1. 125% FPL
2. 150% FPL
3. 175% FPL
4. 200% FPL

Exercise

If you receive Extra Help, you have a continuous Special Enrollment Period (SEP).

1. True
2. False

Things to Consider Before Joining a Plan

- Important questions to ask
  - Do you have other current health insurance coverage?
  - What about current prescription drug coverage?
    - Is any prescription drug coverage you might have as good as Medicare drug coverage?
  - How does your current coverage work with Medicare?
    - Could joining a plan affect your current coverage?
      - Or affect a family member's coverage?

Step 1: Collect Information

- Collect information
  - Current prescription drug coverage
  - Prescription drugs, dosages, and quantities
  - Preferred pharmacy
  - Medicare card
  - ZIP code

Step 2: Use the Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more
- Enroll in a plan

Step 3: Decide and Enroll

- Decide which plan is best for you and enroll
  - Mail or fax paper application to plan
  - Online
    - www.medicare.gov
    - Plan's website
  - Telephone
    - 1-800-MEDICARE (TTY 1-877-486-2048)
    - The plan
    - AK SHIP 1-800-478-6065 or (907) 269-3680

What New Members Can Expect

- You will receive
  - An enrollment letter
  - Membership materials, including card
  - Customer service contact information
- If your current drug is not covered by plan
  - You can get transition supply (generally 30-days)
  - Work with prescriber to find a drug that is covered
  - Request exception if no acceptable alternative drug is on the list

Annual Notice of Change (ANOC)

- All Medicare drug plans must send to members by September 30th
  - May arrive with Evidence of Coverage
- Will include information for upcoming year
  - Summary of Benefits
  - Formulary
  - Changes
    - New premium
    - Copayments/coinsurance

Exercise

Joining a Medicare drug plan may affect your current health and/or prescription drug coverage.

1. True
2. False

Coverage Determination Request

- Initial decision by plan
  - Which benefits you are entitled to receive
  - How much you are required to pay for a benefit
  - Can be requested by you, your prescriber, or your appointed representative
- Timeframes for coverage determination request
  - May be standard (decision within 72 hours)
  - May be expedited (decision within 24 hours)
    - If life or health is seriously jeopardized

Part D Exception Requests

- Two types of exceptions
  - Tier exceptions
    - e.g., getting Tier 2 drug at Tier 1 cost
  - Formulary exceptions
    - Drug not on plan's formulary or
    - Access requirements (e.g., step therapy)
- Requests can be made by you, your appointed representative, or prescriber
- Requires supporting statement from doctor
- Exception may be valid for remainder of year

Requesting Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, appeal requests must be written
  - Plans must accept expedited requests orally
- An appeal can be requested by
  - You
  - Your doctor
  - Your appointed representative
- There are 5 levels of appeals
  - https://medicare.gov/claims-and-appeals/file-an-appeal/appeals.html

Medicare Prescription Drug Coverage Resource Guide

Resources

www.medicare.gov
1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-466-2048)

Prescription Drug Benefit Manual
www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp

PDP Enrollment and Disenrollment Guidance
http://www.cms.gov/MedicarePresDrugEligEnrol/01_Overview.asp

Local State Health Insurance Programs
www.medicare.gov/contacts

Centers for Medicare & Medicaid Services
www.cms.gov

Social Security
1-800-772-1213
www.socialsecurity.gov

LI NET Program
1-800-783-1307
1-877-801-0369 (TTY)
e-mail : MedicareLINET@cms.hhs.gov

Affordable Care Act
www.healthcare.gov/law/full/index.htm

RxAssist
www.rxassist.org

Medicare Part D Appeals
www.medicarepartdappeals.com

Determining the Part B income-related premium – SSA publication 10161 available at http://www.socialsecurity.gov/pubs/10536.pdf.

Information about drugs covered under Parts B & D
www.cms.gov/PrescriptionDrugCovContra/

Medicare Products

Medicare & You Handbook
CMS (Product No. 10050)

Your Guide to Medicare Prescription Drug Coverage
(CMS Product no. 11109)

Your Medicare Benefits
(CMS Product No. 10116)

Understanding True Out-of-Pocket (TrOOP) Costs
(CMS Product No. 11223)

To access these products:
View and order single copies:
www.medicare.gov

Order multiple copies (partners only):
productordering.cms.hhs.gov
(You must register your organization.)

Appendix A: Part B Covered Oral Anticancer Drugs*

- Busulfan
- Capecitabine
- Cyclophosphamide
- Etoposide
- Melphalan
- Methotrexate
- Temozolomide

*List is subject to change

Appendix B: Part B Covered Oral Anti-Emetics for Use Within 48 Hours of Chemotherapy*

- 3 oral drug combination of
  - Aprepitant
  - A 5-HT3 Antagonist
  - Dexamethasone
- Chlorpromazine Hydrochloride
- Diphenhydramine Hydrochloride
- Dolasetron Mesylate (within 24 hours)
- Dronabinol
- Granisetron Hydrochloride (within 24 hours)
- Hydroxyzine Pamoate
- Ondansetron Hydrochloride
- Nabilone
- Perphenazine
- Prochlorperazine Maleate
- Promethazine Hydrochloride
- Trimethobenzamide Hydrochloride

*List is subject to change

Appendix C: Part B Covered Immunosuppressive Drugs*

- Azathioprine-oral
- Azathioprine-parenteral
- Cyclophosphamide-Oral
- Cyclosporine-Oral
- Cyclosporine-Parenteral
- Daclizumab-Parenteral
- Lymphocyte Immune Globulin,
- Antithymocyte Globulin-Parenteral
- Methotrexate-Oral
- Methylprednisolone-Oral
- Methylprednisolone Sodium Succinate Injection
- Muromonab-Cd3-Parenteral
- Mycophenolate Acid-Oral
- Mycophenolate Mofetil-Oral
- Prednisolone-Oral
- Prednisone-Oral
- Sirolimus-Oral
- Tacrolimus-Oral
- Tacrolimus-Parenteral

*List is subject to change

Appendix D: 2013 Standard Drug Benefit

Benefit Parameters	2012	2013
Deductible	$320	$325
Initial Coverage Limit	$2,930.00	$2,970.00
Out-of-Pocket Threshold	$4,700.00	$4,750.00
Total Covered Drug Spending at OOP Threshold	$6,730.39	$6,954.52
Minimum Cost-Sharing in Catastrophic Coverage	$2.60/$6.50	$2.65/$6.60
Extra Help Copayments	**2012**	**2013**
Institutionalized	$0	$0
Receiving Home and Community-Based Services (under waiver only)	$0	$0
Up to or at 100% Federal Poverty Level (FPL)	$1.10/$3.30	$1.15/$3.50
Full Extra Help	$2.60/$6.50	$2.65/$6.60
Partial Extra Help (Deductible/Cost-Sharing)	$65/15%	$66/15%

Appendix F: Guide to Consumer Mailings

- http://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2012Mailings.pdf

Appendix G: Medicare's Limited Income Newly Eligible Transition (NET) Program

- Resources
  - Program Help Desk: 1-800-783-1307
  - Address: The Medicare Limited Income NET Program
    P.O. Box 14310
    Lexington, KY 40512-4310
  - Websites
    - http://www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLimitedIncomeNET.asp
    - http://www.humana.com/pharmacists/resources/li_net.asp
  - CMS Mailbox: MedicareLINET@cms.hhs.gov

Questions?

Contact the Alaska SHIP/SMP

Judith Bendersky, Jeanne Larson, Nila Morgan or Elizabeth Kish

Medicare Information Office

State of Alaska, DHSS/SDS

1-800-478-6065 or in Anchorage (907) 269-3680

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