

DEPARTMENT OF HEALTH & HUMAN SERVICES

 **National Medicare**

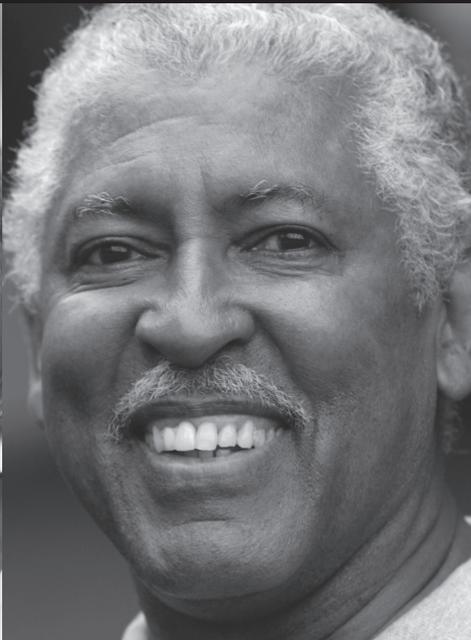
TRAINING PROGRAM

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Prescription Drug Coverage Module 9



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



2011 Workbook

Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet: Module 9 – Understanding Prescription Drug Coverage

Module Description

This module will help you understand how Medicare prescription drug coverage (Part D) works.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included. The Health Reform icon is used to highlight changes based on the Affordable Care Act.



The following sections are included in this module:

- Slides 1-37 Medicare Prescription Drug Coverage Basics
- Slides 38-50 Eligibility and Enrollment
- Slides 51-69 Extra Help
- Slides 70-84 Comparing and Choosing Prescription Drug Coverage
- Slides 85-94 Coverage Determinations and Appeals
- Slides 95-110 Information Resources

Objectives

- Understand Medicare Prescription Drug Coverage
- Know where to find additional sources of information

Target Audience

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Learning Activities

This module contains ten interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

Handouts

There are eight appendices included in this training module, as well as a resource guide that provides sources for additional information on Medicare prescription drug coverage. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 94 PowerPoint slides with corresponding speaker's notes. It can be presented in about 1½ hours. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

References

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

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

Medicare & You Handbook
CMS (Product No. 10050)

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

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

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

Medicare Prescription Drug Coverage: Module 9

This training module explains Medicare prescription drug coverage.

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 2011.



To check for updates on the new health care legislation, visit www.healthcare.gov.



To view the Affordable Care Act visit

healthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf



To check for an updated version of this training module, visit

www.cms.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.

Session Objectives

This session will help you to

- Recognize 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

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 - Under Medicare Part D
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- Compare and Choose Plans
- Describe Extra Help with Drug Plan Costs
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Lessons

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

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Understanding Medicare Prescription Drug Coverage explains the following:

- Medicare Prescription Drug Coverage Basics
- Medicare Part D
- Eligibility and Enrollment
- Comparing and Choosing Plans
- Extra Help with Drug Plan Costs
- Coverage Determinations and Appeals

Lesson 1 - Medicare Prescription Drug Coverage Basics

- Medicare Overview – Parts A, B, & D
- Medicare Prescription Drug Coverage
- Coverage in Health Care Settings

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This lesson provides information on:

- Medicare overview – Parts A, B, & D
- Medicare prescription drug coverage
- Coverage in various health care settings

Medicare has Four Parts	
Part A – Hospital Insurance	Helps cover inpatient care in hospitals and skilled nursing facilities, hospice and home health care.
Part B – Medical Insurance	Helps cover doctors’ services, outpatient care, home health care and some preventive services.
Part C – Medicare Advantage Plans	Another way to get Medicare benefits. Combines Parts A and B. Often includes Part D coverage. Run by private insurance companies approved by and under contract with Medicare.
Part D – Medicare Prescription Drug Coverage	Helps cover the cost of prescription drugs. Run by private insurance companies approved by and under contract with Medicare.
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- Medicare covers many types of services, and people have options for how they can get their Medicare coverage. Medicare has four parts.
 - **Part A (Hospital Insurance)** helps pay for inpatient hospital stays but also helps cover skilled nursing care, home health care, and hospice care.
 - **Part B (Medical Insurance)** helps cover medically-necessary services like doctor visits and outpatient care. Part B also covers some preventive services including screening tests and shots, diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers.
 - **Part C (Medicare Advantage)** is another way to get your Medicare benefits. It often combines Parts A and B, and sometimes Part D (prescription drug coverage). Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically-necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services.
 - **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs and may help lower your prescription drug costs and help protect against higher costs in the future.

Medicare Prescription Drug Coverage

- Coverage by Medicare Parts A, B, or D depends on
 - Health care setting
 - e.g., home, inpatient hospital, outpatient hospital, surgery center or institution
 - Medical indication
 - e.g., to treat cancer
 - Need for special coverage requirements
 - e.g., those for immunosuppressive drugs
- Drugs must be medically necessary

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- Prescription drug coverage under Medicare Part A, B, or D depends on several factors, including:
 - The health care setting (e.g., home, hospital (as inpatient or outpatient), surgery center or institution) where the health care will be provided,
 - The medical indication or reason why the person needs the medication (e.g., cancer),
 - Any special coverage requirements, such as those for immunosuppressive drugs.

This information relates to people in Original Medicare. People who have a Medicare Advantage (MA) Plan (like an HMO or PPO) with prescription drug coverage get all of their Medicare-covered health care from the plan, including covered prescription drugs. The cost of the drug under the MA plan may vary depending upon whether it is covered under Medicare Part A, B, or D.

Part A Drug Coverage

- Generally covers all drugs during a covered stay
 - Hospital or skilled nursing facility (SNF)
 - Receiving drugs as part of treatment
- Part B can pay for some Part B covered drugs in hospitals and SNFs
 - If you don't have Part A or your coverage has run out
 - The stay is not covered by Part A

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Medicare Drug Coverage

- People with Medicare who are hospital or skilled nursing facility (SNF) inpatients during covered stays may receive drugs as part of their treatment.
- Medicare Part A payments made to hospitals and SNFs generally cover all drugs provided during an inpatient stay.
- Part B can pay hospitals and SNFs for certain categories of Part B covered drugs if you don't have Part A coverage, if the Part A coverage for the stay has run out, or if the stay is not covered by Part A.

Part B Drug Coverage

- Part B covers a limited set of outpatient drugs
 - Injectable and infusible drugs
 - Not usually self-administered
 - Furnished/ administered as part of a physician service
 - Administered through Part B-covered Durable Medical Equipment (DME)
 - Some other types of drugs

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Part B—Medical Insurance

- Medicare Part B covers a limited set of drugs, including:
 - Injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., Imitrex® for migraines) or is not furnished and administered as part of a physician service, it is not covered by Part B.
 - A limited number of other types of outpatient drugs. Regional differences in local Part B drug coverage policies can occur in the absence of a national coverage decision.
- For more information view the publication How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings, CMS publication number 11333.



For more information on local and national Medicare Part B coverage determinations, please visit the web-based Medicare National Coverage Determination Manual at http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf

Part B Coverage- Outpatient Setting

- Part D may pay for formulary drugs
 - If not admitted
 - May have to pay and submit for reimbursement

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Part B Coverage in Outpatient Settings

- Sometimes people with Medicare need “self-administered drugs” (drugs you would normally take on your own) while in hospital outpatient settings. Part B generally doesn’t pay for self-administered drugs unless they are required for the hospital outpatient services you’re getting. If you get self-administered drugs that aren’t covered by Medicare Part B while in a hospital outpatient setting, the hospital may bill you for the drug. However, if you are enrolled in a Medicare drug plan (Part D), these drugs may be covered.
 - Generally, your Medicare drug plan only covers prescription drugs and won’t pay for over-the-counter drugs you get, like Tylenol® or Milk-of-Magnesia®
 - The drug you need must be on your drug plan’s formulary (or covered by an exception)
 - You can’t get your self-administered drugs in an outpatient or emergency department setting on a regular basis
 - Your Medicare drug plan will check to see if you could have gotten these self-administered drugs from an in-network pharmacy.
 - If the hospital pharmacy doesn’t participate in Medicare Part D, you may need to pay up front and out-of-pocket for these drugs and submit the claim to your Medicare drug plan.



For more information view the publication How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings, Publication number 11333.

Part B Drug Coverage DME Drugs

- Drugs administered through Part B-covered DME
 - Such as nebulizers and pumps
 - Only when used with DME in patient's home
- Supplier must be accredited DME provider
 - In some areas must be contract provider

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- Medicare Part B only covers drugs administered through a Part B-covered item, i.e., when used in conjunction with covered durable medical equipment (DME) (like a nebulizer or pump) in the patient's home.
- For drugs to be covered by Medicare Part B, the person will need to choose a pharmacy or supplier that is a participating durable medical equipment (DME) provider in the Medicare Part B program. With the DMEPOS Competitive Bidding program, you may have to use a contract provider in certain areas. You should ask the supplier if they are accredited.
- For Medicare Part B to cover a drug in a particular situation, all requirements have to be met, e.g., a drug must still be medically necessary.

Part B Drug Coverage – Certain Oral Drugs

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

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- Part B covers three categories of oral drugs with special coverage requirements: oral anti-cancer, oral anti-emetic, and under certain circumstances immunosuppressive drugs.
- A listing of the covered drugs are included on Appendices B & C at the end of the presentation.

NOTE: For long-term care facilities that do not qualify as a patient's home, we recommend that providers prescribing the above categories of drugs include in the written order both the diagnosis and indication for the drug as well as a statement of status such as "Nursing Home Part B."

Exercise

- A. Most outpatient drugs are covered under Medicare Part A.
1. True
 2. False

Exercise

B. Medicare Part A payments made to hospitals and skilled nursing facilities generally cover all drugs provided during a stay.

1. True
2. False

Lesson 2 - Medicare Part D

- Medicare Prescription Drug Coverage
- Part D Covered Drugs
- How Prescription Drugs are Dispensed

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This lesson provides information on:

- Medicare prescription drug coverage
- Coverage in various health care settings
- How Prescription Drugs are Dispensed

Medicare Prescription Drug Coverage

- Medicare Part D
- 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 (MA-PDs) Plans with Rx coverage
 - And other Medicare plans with Rx coverage

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- In Original Medicare, if you don't already have creditable prescription drug coverage (for example, coverage from a current or former employer or union which is at least as good as a Medicare plan) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- These plans are available through private companies under contract with Medicare. If you don't currently have creditable prescription drug coverage, you should think about joining a Medicare Prescription Drug Plan as soon as you're eligible.
- If you don't join a Medicare Prescription Drug Plan when you're first eligible and you decide to join later, you may have to pay a late enrollment penalty.
- As we discuss Medicare Part D, there are several important things to keep in mind.

Medicare Prescription Drug Plans are approved by Medicare and are run by private companies.

▪ 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 plan" 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 (Medigap policies) offered prescription drug coverage prior to 1/1/2006. This is not Medicare prescription drug coverage.

Medicare Drug Plans

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

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- Plans can be flexible in their benefit design, as long as what the plan offers is at least as good as the standard benefit established by CMS .
- 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.
- Benefits and costs may change from year to year.
- Plans must offer at least a standard level of coverage. The standard benefit in 2011 is shown on the chart on the following slide.
- In 2011 members pay 50% cost-sharing for brand-name drugs and 7% cost-sharing for generic drugs during the coverage gap. The cost-sharing amount during the coverage gap will continue to decrease until 2020, when the coverage gap will no longer exist.

Part D-Covered Drugs

- Prescription brand-name and generic drugs
- Approved by FDA
- Used and sold in U.S.
- Used for medically-accepted indications
- Includes drugs, biological products, and insulin
 - Supplies associated with injection or inhalation

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- 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.

NOTE: There are older drugs that never went through FDA approval processes. As plans review their formularies and find these drugs, they are removed from the formulary.

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 for period of time)

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- Plans must cover a range of drugs in the most commonly prescribed categories and classes. This helps make sure that people with different medical conditions can get the prescription drugs they need. The prescription drug list might not include your specific drug. However, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes none of the drugs on your plan's drug list will work for your condition, you can ask for an exception.
- Coverage and rules vary by plan, which can affect what a member pays.
- Some of the methods (rules) that plans use to manage their members' access to drug coverage include:
 - Formularies (list of covered drugs)
 - Prior authorization (Doctor requests before service)
 - Step therapy (type of prior authorization)
 - Quantity limits (limits quantity of prescription for period of time)

Exercise

- A. All Medicare Prescription Drug Plans must offer at least a standard level of coverage.
1. True
 2. False

Required Coverage

- “All” drugs in 6 categories
 - Cancer medications
 - HIV/AIDS treatments
 - Antidepressants
 - Antipsychotic medications
 - Anticonvulsive treatments for epilepsy and other conditions
 - Immunosuppressants
- See Appendices B-D for drug lists

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The Affordable Care Act has changed the requirement that Medicare cover “all or substantially all” drugs in 6 categories, to the requirement that Medicare cover “all” drugs in 6 categories to treat certain conditions:

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

See appendices B-D for a list of oral anti-cancer drugs, oral anti-emetics prescribed for use within 48 hours of chemotherapy, and immunosuppressive drugs.



For more information about drugs covered under Part B and Part D, visit www.cms.hhs.gov/PrescriptionDrugCovContra/.

Vaccines

- All Part D drug plans must cover
 - All commercially available vaccines (e.g., shingles vaccine)
 - Except those covered under Part B (e.g., flu shot)
- Contact drug plan for more information

- Medicare Part D drug plans must include all commercially available vaccines on their drug formularies, including the shingles vaccine (but not vaccines such as the flu and pneumococcal pneumonia shots that are covered under Part B).
- The plan member or the provider can contact the Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

Drugs Not Covered by Part D

- Medicare Part A or Part B covered drugs
 - Unless you don't meet Part A or B coverage requirements
- Plan may choose to cover excluded drugs
 - At their own cost
 - Share the cost with members

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- 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 self-administered.
- Plans may choose to cover excluded drugs at their own cost or share the cost with their members.
- A list of these drugs is included in Appendix E.

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
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- All Medicare drug plans have a list of prescription drugs that they cover called a formulary. Plans cover both generic and brand-name prescription drugs.
- Each 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 (the least expensive) - Are the same as a brand-name drugs in active ingredients, dosage, safety, strength, how taken, how it works in the body, quality, performance and intended use. Is safe and effective, and 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 FDA-approved. Today, almost half of all prescriptions in the U.S. are filled with generic drugs. In some cases, there may not be a generic prescription drug available for the brand-name prescription drug you take. Talk to your prescriber.

- **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.
- **Specialty Tier** – These drugs are unique and have a high cost.

Note: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment.

Prior Authorization

- Doctor must contact plan for prior authorization
 - Before prescription will be covered
 - Must show medical necessity for that particular drug
- Ask plan for prior authorization requirements
 - Process for requests may vary by plan

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- Plans may have rules that require prior authorization. Prior authorization means that 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.

Step Therapy

- Type of prior authorization
- Person must first try a similar, less-expensive drug
 - That has been 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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- 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 a specific medical 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.

Example of Step Therapy		
Step 1	Dr. Smith wants to prescribe a new sleeping pill to treat Mr. Mason’s occasional insomnia. There’s more than one type of sleeping pill available. Some of the drugs Dr. Smith considers prescribing are brand-name only prescription drugs. The plan rules require Mr. Mason to try the generic prescription drug zolpidem first. For most people, zolpidem works as well as brand-name prescription drugs.	
Step 2	If Mr. Mason takes zolpidem but has side effects, Dr. Smith can use that information to ask the plan to approve a brand-name drug. If approved, Mr. Mason’s Medicare drug plan will cover the brand-name drug for Mr. Mason.	
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▪ Example of step therapy:

- Step 1—Dr. Smith wants to prescribe a new sleeping pill to treat Mr. Mason’s occasional insomnia. There’s more than one type of sleeping pill available. Some of the drugs Dr. Smith considers prescribing are brand-name only prescription drugs. The plan rules require Mr. Mason to try the generic prescription drug zolpidem first. For most people, zolpidem works as well as brand-name prescription drugs.
- Step 2—If Mr. Mason takes zolpidem but has side effects, Dr. Smith can use that information to ask the plan to approve a brand-name drug. If approved, Mr. Mason’s Medicare drug plan will cover the brand-name drug for Mr. Mason.

Quantity Limits

- Plans may limit quantity of drugs they cover
 - Over a certain period of time
 - For reasons of safety and/or cost
- Doctor may need to request an exception
 - Additional amount is medically necessary

- For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time.
- If you require more, then your doctor may need to contact the plan to request an exception if he/she believes the additional amount is medically necessary. If the request is approved, the amount prescribed by the doctor will be covered.

Formulary Changes

- Plans may change categories and classes
 - Only at beginning of each plan year
 - Plan year is January through December
 - May make maintenance changes during year
- Plan usually must notify you 60 days before changes
 - May be able to use your drug until end of calendar year
 - May ask for exception if other drugs don't work
- Plans may remove drugs withdrawn from market
 - By the manufacturer or FDA without 60 day notification

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- 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, State Pharmacy Assistance Programs (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.

Prescription Drug Costs

- Costs vary by plan
- In 2011 most people will pay
 - A monthly premium
 - An annual deductible
 - Copayments or coinsurance
 - 50% on covered brand-name drugs in donut hole
 - 7% on generic drugs in donut hole
 - Pay very little after spending \$4,550 out-of-pocket

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- Costs vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, set by Medicare. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium. With every plan, once you have paid \$4,550 out of pocket (this includes payments from other sources, including the 50% discount paid for by the plan in the coverage gap) for drugs costs in 2011, you will pay 5% (or a small copayment) for each drug for the rest of the year.
- People with limited income and resources may be able to get extra help paying for their Medicare drug plan costs.
- The Affordable Care Act includes benefits to make your Medicare prescription drug coverage (Part D) more affordable. Starting January 1, 2011, if you reach the coverage gap, (also known as the “donut hole”) in your Medicare prescription drug coverage, you will get the following:
 - A 50% discount on covered brand-name drugs when you buy them at a pharmacy or order them through the mail.
 - Some coverage for generic drugs (7% discount). You can expect additional savings on your brand-name and generic drugs during the coverage gap over the next 10 years until it’s closed in 2020.

Standard Structure in 2011

Ms. Smith joins the ABC Prescription Drug Plan. Her coverage began on January 1, 2011. 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 First \$310	 25%	 100%	 5%
<small>Ms. Smith pays the first \$310 of her drug costs before her plan starts to pay its share.</small>	<small>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus deductible) reaches \$2,840</small>	<small>Once Ms. Smith and her plan have spent \$2,840 for covered drugs, she is in the coverage gap. In 2011 she gets a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap.</small>	<small>Once Ms. Smith has spent \$4,550 out-of-pocket for the year, her coverage gap ends. Now she only pays a small copayment for each drug until the end of the year.</small>
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This is an example showing what a person with Medicare drug coverage would pay each year in a defined standard plan. Very few plans actually follow this design. Drug plan costs will vary.

- **Monthly premium**—Varies by plan. You still pay the Part B premium if you have Part B. In a Medicare Health Plan (like an HMO, or a Medicare Cost Plan) with drug coverage, the plan premium may include Rx drug coverage.
- **Yearly deductible (you pay \$310 in 2011)**—What you pay for prescriptions before your plan begins to pay. Some drug plans don't have a deductible.
- **Copayments or coinsurance (you pay 25%)**—Your share at the pharmacy for your covered prescriptions after the deductible. The drug plan pays its share.
- **Coverage gap (you pay 100%)**—Most plans have a coverage gap, which begins after you and your drug plan have spent a certain amount of money for covered drugs (\$2840 in 2011). In 2011 you will get a 50% discount on brand-name drugs that counts toward your out-of-pocket spending, and helps you get out of the coverage gap.
- **Catastrophic coverage (you pay 5%)**—Once you reach your plan's out-of-pocket limit, you get "catastrophic coverage" and you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

Note: There is no coverage gap if you get Extra Help. You will pay a small or no copayment once you reach catastrophic coverage.



Reference: Page 77 of *Medicare & You 2011* (CMS Product No 10050).

Medicare Prescription Drug Coverage Premium

- Higher income beneficiaries pay higher Part D premium
 - Uses same thresholds used to compute income-related adjustments to the Part B premium
 - As reported on your IRS tax return from 2 years ago
- Effective January 2011
- Required to pay if have Part D coverage

New in
2011

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- Reducing Part D Premium Subsidy for High-Income Beneficiaries - Starting in January 2011, this provision adjusts Part D premiums (i.e., reduces government premium contribution) for high-income beneficiaries on a sliding scale. The income thresholds and corresponding percentage reductions in government premium contributions are the same as those in the Part B income-related premium adjustment amount (IRMAA). CMS is directed to provide information annually to the Social Security Administration (SSA) on the national Part D base beneficiary premium to calculate premium adjustment amount as well as data on the threshold amounts.
- SSA will identify beneficiaries that are subject to the premium adjustment based on income data received from the Internal Revenue Service and will deduct this adjustment from beneficiary Social Security payments (i.e., premiums otherwise charged by Part D plans will not change as a result of this provision).
 - Those who do not have enough money in their Social Security benefit will be billed by either CMS or RRB to pay the amount each month. This means that for some beneficiaries, they will pay their plan each month for their monthly premium and will pay CMS or RRB each month for their IRMAA amount. (The Part D-IRMAA amount is paid directly to the government and not the plan.)

Beneficiaries subject to the Part D-IRMAA must pay the extra amount in addition to their plan's monthly premium. This includes individuals who have Part D coverage through an employer (but not through retiree drug subsidy or other creditable coverage.)



Reference: Social Security Administration, SSA Publication No. 05-10161 January 2010



See Section 3308 of the Affordable Care Act.

Income-Related Adjustment to Part D Premium		
If your Yearly Income in 2009 was		In 2011 You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or below	\$170,000 or below	Base Premium (BP)
\$85,000.01 – \$107,000	\$170,000.01 – \$214,000	BP + \$12.00*
\$107,000.01 – \$160,000	\$214,000.01 – \$320,000	BP + \$31.10*
\$160,000.01 – \$214,000	\$320,000.01 – \$428,000	BP + \$50.10*
\$214,000.01 or higher	\$428,000.01 or higher	BP + \$69.10*
*per month		
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- If your yearly income in 2009 was 85K or less for an individual or \$170K or less for a couple, you pay the base premium.
- You pay a higher amount, based on your yearly income, if your yearly income in 2009 was higher than 85K for an individual or \$170K for a couple. The amount of the IRMAA is adjusted each year, as it is calculated from the annual beneficiary base premium.

Which Payment Sources Count Toward TrOOP?

Sources That Count	Sources That Don't Count
<ul style="list-style-type: none"> • Plan member payments • Payments by family member or other individuals • Most state pharmacy assistance programs • Extra Help subsidy • Charities (not if established/controlled by current or former employer or union) • Indian Health Services • AIDS drug assistance programs 	<ul style="list-style-type: none"> • Group Health Plans (including employer and union retiree coverage) • Government-funded programs (including TRICARE and VA) • Manufacturer Patient Assistance Programs • Other third-party payment arrangements

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- Sometimes you may hear Part D out-of-pocket costs referred to as “true out-of-pocket” costs, or TrOOP.
- Payments that count toward TrOOP 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
 - effective January 1, 2011, Indian Health Services and AIDS Drug Assistance Programs will count due to section 3314 of the Affordable Care Act
 - Pharmaceutical manufacturers under the coverage gap manufacturer discount program
- The following payments don’t count as true 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-priced 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. Click on “More Resources” and then “Patient Assistance Program Directory.”)
 - Other third-party payment arrangements
- For coverage gap and TrOOP questions, you can:
 - Call the plan
 - Call 1-800-MEDICARE (1-800-633-4227)
 - Visit http://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp (Chapter 14 in the Medicare Prescription Drug Benefit Manual)
 - Call the pharmacist
 - Call the state Medical Assistance office

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

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- 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.

Your Rights

- Plan doesn't cover a drug or
- Drug cost higher than you think you should pay
 - Follow plan's process to request coverage determination
 - Ask for an exception (a type of coverage determination)
 - You can appeal if request is denied
- If your network pharmacy can't fill a prescription as written, the pharmacist will explain how to contact your drug plan

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- If you belong to a Medicare drug plan, and the plan will not cover a drug you need, you have the right to do the following:
 - Get a written explanation (called a "coverage determination") from your Medicare drug plan if your plan won't cover or pay for a certain prescription drug you need, or if you are asked to pay a higher share of the cost.
 - Ask your Medicare drug plan for an exception (which is a type of coverage determination.) If you ask for an exception, your doctor or other prescriber must give your drug plan a supporting statement that explains the medical reason for the request (such as why similar drugs covered by your plan won't work or may be harmful to you). You can ask for an exception for these reasons:
 - You or your prescriber believe that you need a drug that isn't on your drug plan's list of covered drugs.
 - You or your prescriber believe that a coverage rule (such as step therapy) should be waived.
 - You believe you should get a non-preferred drug at a lower copayment because you can't take any of the alternative drugs on your drug plan's list of preferred drugs.
- You or your prescriber must contact your plan to ask for a coverage determination. If your network pharmacy can't fill a prescription as written, the pharmacist will give or show you a notice that explains how to contact your Medicare drug plan so you can make your request.

Part D Coverage Determinations

- Part D plan coverage determination
 - May rely on information from physicians
 - Should not replace plan's process
 - Pharmacists help in determining Part D status
 - Explain prior authorization requirements
 - Provide more information to plan

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- Part D plans may rely on the information physicians include with the prescription for making coverage determinations to the same extent they rely on acquiring similar information directly from physicians on prior authorization forms (e.g., diagnosis information to determine if the prescription is related to a Medicare-covered transplant, long-term care location, etc.)
- This information is intended to facilitate, but not replace, a plan's existing processes for making a coverage determination. Pharmacists may need to explain to enrollees how the prior authorization requirements are met. They may also need to provide the Part D sponsor additional information to establish that the drug is covered by Part D.
- To get a coverage determination, you can do either of the following:
 - Pay for the prescription, save your receipt, and ask the plan to pay you back by requesting a coverage determination.
 - Request a coverage determination if your plan requires you to try another drug before it pays for the drug prescribed for you, or there is a limit on the quantity or dose of the drug prescribed for you, and you disagree with the requirement or limit.
- A standard request for a coverage determination (including an exception) should be made in writing (unless your plan accepts requests by phone). You or your prescriber can also call or write your plan for an expedited (fast) request. If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how to file an appeal. You should read this decision carefully, and call your plan if you have questions.

Exercise

B. If a family member pays for your covered prescription costs, they do not count as a True Out-of-Pocket (TrOOP) cost.

- A. True
- B. False

Lesson 3 - Eligibility and Enrollment

- Eligibility Requirements
- When to Join
- Late Enrollment Penalty
- Creditable Coverage

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- Eligibility and Enrollment will explain:
 - Eligibility requirements
 - When to join
 - Late enrollment penalty
 - Creditable coverage

Part D Eligibility Requirements

- To be eligible to join a Prescription Drug Plan
 - You must have Medicare Part A **and/or** Part B
- To be eligible to join Medicare Advantage plan w/drug coverage
 - You must have Part A **and** Part B
- You must live in plan's service area
 - You cannot be incarcerated
- You **must** be enrolled in a plan

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- Anyone who has Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance), or both Part A and Part B, and 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.
- 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.

Joining or Switching Part D Plans	
Special Enrollment Periods (SEP)	<ul style="list-style-type: none"> ▪ You permanently move out of your plan's service area ▪ You lose other creditable Rx 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 ▪ Or in exceptional circumstances
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- In certain situations, you may get a Special Enrollment Period including :
 - If you permanently move out of your plan's service area.
 - If you lose your other creditable prescription drug coverage.
 - If you were not adequately informed that your other coverage was not creditable, or that the coverage was reduced so that it is no longer creditable.
 - When you enter, reside in, or leave a long-term care facility like a nursing home.
 - If you qualify for Extra Help, you have a continuous Special Enrollment Period and can change your Medicare prescription drug plan at any time.
 - Or in exceptional circumstances, such as if you no longer qualify for Extra Help.

New Special Enrollment Period

- Can enroll in 5-Star Medicare Advantage plan
 - Only if enrolled in MA plan with rating of 4.5 or less or
 - Enrolled in Original Medicare but eligible for MA
- Enroll at any point during the year
 - once per year
- New plan starts first of month after enrolled
- Effective December 8, 2011

New in
2011

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Medicare Drug Coverage

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- CMS announced the establishment of a special enrollment period (SEP) that will allow Medicare beneficiaries eligible for MA plans to enroll in a 5-star MA plan at any point during the year. The general parameters of the SEP are as follows:
 - For purposes of the SEP, an MA plan must have 5 stars as of the 2011 Annual Enrollment Period (AEP), regardless of the rating used for purposes of 2012 quality bonus payments.
 - As currently constituted, the new SEP will apply only for purposes of enrolling in a 5-star MA plan or in 5-star stand-alone Part D plan. Beneficiaries are not permitted to enroll in any other Medicare health plan under this special enrollment period.
 - Individuals will be eligible for this SEP if they are either enrolled in MA plan, or enrolled in Original Medicare, and meet the MA eligibility requirements. Note: Eligible beneficiaries already enrolled in a 5-star MA plan **are** eligible to change to another 5-star plan during the SEP.
- Enrollment requests made using this SEP will be effective the first of the month following the month the enrollment request is received. Once an individual enrolls in a 5-star MA plan, the individual's SEP ends for that plan year, and the individual will be limited to making changes only during other applicable election periods (e.g., annual enrollment period or another valid SEP). Individuals will be able to enroll in 5-star MA plans directly through the plan, through 1-800-MEDICARE or www.medicare.gov.
- MA plans that have received an overall 5-star rating will be required to accept these SEP requests, similar to any other SEP or initial enrollment for a newly eligible individual, unless the plan is closed per a CMS-approved capacity limit.
- To find rating information, visit www.medicare.gov to compare plans.
- Starts December 8, 2011.

Late Enrollment Penalty

- Higher premium for those who wait to enroll
 - Additional 1% of base beneficiary premium
 - Every month eligible and not enrolled
 - For as long as they have Medicare drug coverage
 - Except those with creditable drug coverage
 - At least as good as Medicare drug coverage

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- If you choose not to join a Medicare prescription drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you decide to enroll later.
- 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 months the person was eligible but not enrolled in a plan and did not have creditable drug coverage. The penalty calculation is not based on the premium of the plan the individual is enrolled in. The base beneficiary premium (\$32.34 in 2011) 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 member 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.)
- People who have another source of drug coverage—through a former employer, for example—may choose to stay in that plan and not enroll in a Medicare prescription drug plan. If your other coverage is at least as good as Medicare prescription drug coverage, called “creditable” coverage, you will not have to pay a higher premium if you later join a Medicare prescription drug plan. Your other plan will notify you about whether or not your coverage is creditable. This notice will explain your options. You can contact your plan’s benefits administrator for more information.
- Some examples of coverage that may be considered creditable include:
 - Group Health Plans (GHPs)
 - State Pharmaceutical Assistance Programs (SPAPs)
 - VA coverage and Military coverage including TRICARE.
- If you don’t agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You will need to fill out a reconsideration request form (that your drug plan will send you), and you will have the chance to provide proof that supports your case, such as information about previous creditable prescription drug coverage.

When Coverage Begins for Newly Entitled

- All people newly entitled to Medicare
 - 7-month Initial Enrollment Period 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 of application
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- 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 can 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 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.

Creditable Drug Coverage

- Prior Rx 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
 - e.g.; employer group plans, retiree plans, VA, TRICARE and FEHB

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- 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.
- 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.

Penalty Calculation – Late Enrollment

- National base beneficiary premium
 - \$32.34 in 2011
 - 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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- 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 (\$32.34 in 2011) 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, 2010, the end of his IEP. He did not have creditable prescription drug coverage and first enrolled in a Part D plan in December 2010, 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 2010 (7 months). Since the national base beneficiary premium in 2011 is \$32.34, the penalty would be \$2.30 per month. ($\$30.36 \times .07 = \2.26 , rounded to the nearest 10 cents = \$2.30). 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.

Part D Coordination of Benefits Employer Group Health Plan (EGHP) Situations	
Under this Circumstance	Part D Plans
If Medicare is primary and your EGHP prescription drug coverage is secondary	Generally pay first
If your EGHP prescription drug coverage is primary This applies if you : –Are age 65 or over with EGHP based on current employment of self or spouse (firm with 20 or more employees) –Have Medicare based on a disability with EGHP (firm with 100 or more employees) –Have Medicare based on ESRD during the 30-month coordination period with EGHP and firm is any size	Deny primary claims
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- It is not unusual for people with Medicare to receive prescription drugs through more than one insurer. Coordination of Benefits (COB) allows plans that provide prescription coverage for people with Medicare to determine their respective payment responsibilities. This process avoids mistaken payments and prevents confusion about which insurance should pay. Generally, Medicare provides primary coverage for prescription drugs when a person has other coverage. Whenever Medicare is primary, the Part D plan is billed and will pay first
- Part D plans will always deny primary claims for members with employer group health plan (EGHP) if Medicare is the secondary payer. That would apply for:
 - Persons age 65 or over with EGHP based on current employment of self or spouse by a firm with 20 or more employees
 - Persons with Medicare based on a disability with large EGHP (100 or more employees)
 - Persons with Medicare based on ESRD during the 30-month coordination period with EGHP and firm is any size

Part D Coordination of Benefits

Non-Employer Group Health Plan Situations

Under this Circumstance	Part D Plans
If the plan is aware that an enrollee has workers' compensation, Black Lung Program, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related injury	Will not pay primary
In all other instances (i.e., plan does not know whether covered drug is related to an injury)	Will always make conditional primary payment to ease burden on the policyholder

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- In non-EGHP Medicare Secondary Payer (MSP) situations, the Part D plan will not pay primary if it is already aware that the enrollee has workers' compensation, Black Lung Program, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related injury. For example, when an enrollee refills a prescription previously paid for by Worker's Compensation, the Part D plan may deny primary payment and default to the secondary payer.
- In all other non-EGHP MSP situations, such as when a plan does not know whether a covered drug is related to an injury, Part D plans will always make a conditional primary payment to ease the burden on the policyholder.
- The payment is "conditional" because it must be repaid to Medicare once a settlement, judgment, or award is reached. The proposed settlement or update should be reported to Medicare by calling 1-800-MEDICARE and asking for the Medicare Coordination of Benefits Contractor, or by mailing relevant documents to the COB contractor.

Exercise

- A. VA and TRICARE are exempt from sending information annually about whether it is creditable coverage.
1. True
 2. False

Exercise

- B. People receiving Extra Help (LIS) have a continuous Special Enrollment Period.
1. True
 2. False

Lesson 4 – Extra Help with Drug Plan Costs

- 
- What it is
 - How to qualify
 - Enrollment
 - Continuing eligibility
 - Your costs with Extra Help

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Extra Help with Drug Plan Costs explains:

- What it is
- How to qualify
- Enrollment
- Continuing eligibility
- Your costs with Extra Help

What is “Extra Help”

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

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- 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.

Qualifying for Extra Help

- You automatically qualify for Extra Help if
 - You get full Medicaid benefits
 - You get Supplemental Security Income (SSI)
 - Medicaid helps pay your Medicare premiums
- All others must apply with Social Security
 - 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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- 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.

NOTE: A list of the letters sent to people with Medicare regarding Extra Help (Low Income Subsidy) is provided in the back of the corresponding workbook (see Appendix F).

Income and Resource Limits

■ Income

- Below 150% Federal poverty level

2011
amounts

- \$1,361.25 per month for an individual* or
- \$1,838.75 per month for a married couple*
- Based on family size

■ Resources

2011
amounts

- Up to \$12,640 (individual)
- Up to \$25,260 (married couple)
 - Includes \$1,500/person funeral or burial expenses
 - Counts savings and investments
 - Does not count home you live in

*Higher amounts for Alaska and Hawaii

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Extra Help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources. People meeting the following income and resources levels are eligible for Extra Help:

Income

- Below 150% Federal poverty level
- \$1,361.25 per month for an individual* or
- \$1,838.75 per month for a married couple*
- Based on family size

Resources

- Up to \$12,640 (individual)
- Up to \$25,260 (married couple)
 - Includes \$1,500/person funeral or burial expenses
 - Counts savings and investments, but not the home you live in
- 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 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 can be cashed 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: There are higher income amounts for Alaska and Hawaii. Extra Help isn't available to people in the US territories. Territories have their own rules for providing residents help with Medicare drug plan costs.

Applying for Extra Help

- Multiple ways to apply
 - Paper application
 - www.socialsecurity.gov
 - State Medical Assistance office
 - Local organization
- You or someone on your behalf can apply

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- Eligibility for Extra Help may be determined by either Social Security or your state Medicaid office.
- You can apply for Extra Help by:
 - Completing a paper application that you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
 - Applying with Social Security at www.socialsecurity.gov on the Web
 - Applying through your state Medical Assistance office
 - Working with a local organization, such as your State Health Insurance Assistance Program (SHIP)
- You can apply on your own behalf, or your application can be filed by a personal representative with the authority to act on your behalf, such as Power of Attorney, or you can ask someone else to help you apply.



Under Section 113 of MIPPA, Social Security is directed to transmit data from the LIS application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for Medicare Savings Programs (MSP). The states are directed to treat the data as an application for MSP benefits, as if it had been submitted directly by the applicant.

Medicare and Full Medicaid

- You are auto-enrolled in a plan unless
 - You are already in a Part D plan
 - You choose and join a plan on your own
 - You 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 on yellow paper
- You have a continuous Special Enrollment Period

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- 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 covers. 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 will not pay for their drugs that Medicare would have covered.
- 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.

Others Qualified for Extra Help

- Facilitated into a plan unless
 - You already are in a Part D plan
 - You choose and join own plan
 - You're enrolled in employer/union plan receiving subsidy
 - You call the plan or 1-800-MEDICARE to opt out
- Coverage is effective 2 months after CMS notifies
- Will get facilitated enrollment letter on green paper
- Have continuous Special Enrollment Period

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- 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.

Note: A list of the letters sent to people with Medicare regarding Extra Help (Low Income Subsidy) is provided in the back of the corresponding workbook.

People New to Extra Help

- You can apply for Extra Help any time
 - If denied, can reapply if circumstances change
- If in a Medicare drug plan and later qualify
 - Plan is notified you qualify for Extra Help
 - Plan refunds costs back to effective date of Extra Help
 - Deductibles/Premiums
 - Cost-sharing assistance

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Medicare Drug Coverage

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- 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.

Limited Income Newly Eligible Transition Program (LI NET)

CMS program operated by Humana, Inc.

- Provides point of sale coverage for Low Income Subsidy beneficiaries without Part D plan
- Provides retroactive coverage for full benefit dual eligible beneficiaries and SSI-only beneficiaries
- Has an open formulary
- Requires no prior authorization
- Has no network pharmacy restrictions
- Includes standard safety and abuse edits

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- LI NET stands for the Limited Income Newly Eligible Transition Program and it is a CMS program.
- The LI NET program provides point of sale coverage for Low Income Subsidy (LIS) beneficiaries without a Part D prescription drug plan and LI NET provides, in addition to point of sale, retroactive coverage for full benefit dual eligible beneficiaries and SSI-only beneficiaries.
- LI NET has an open formulary (Part D covered drugs), requires no prior authorization and has no network pharmacy restrictions. (CMS cannot require a pharmacy to use LI NET.)
- LI NET includes standard safety and abuse edits (e.g., 'refill too soon' or 'therapy duplication).
- LI NET is operated by a single contractor, Humana, Inc. on behalf of CMS. It became effective on January 1, 2010.

Who is Eligible for LI NET?

All Low Income Subsidy (LIS) Beneficiaries, including:

- Full-benefit dual eligible beneficiaries
 - Have Medicare and full Medicaid benefits
- SSI-only beneficiaries
 - People with Medicare who receive Supplemental Security Income but do not have Medicaid
- Partial-benefit dual eligible beneficiaries
 - People with Medicare who qualify for Medicare Savings Programs (MSP) but not full Medicaid
- LIS Applicants
 - People who have been awarded the LIS

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- Low Income Subsidy (LIS) provides “Extra Help” with Part D premiums and copayments.
- All Low Income Subsidy (LIS) beneficiaries are eligible for LI NET and these include:
 - Full-benefit dual eligible beneficiaries have Medicare and full Medicaid benefits, i.e., QMB Plus, SLMB Plus;
 - SSI-only beneficiaries are beneficiaries with Medicare who receive Supplemental Security Income (SSI) but do not have Medicaid;
 - Partial-benefit dual eligible beneficiaries are beneficiaries with Medicare who qualify for Medicare Savings Programs (MSP) but not full Medicaid, i.e., QMB Only, SLMB Only and QI; and
 - LIS Applicants who have applied for, and have been awarded, the LIS through SSA or their state and their eligibility is determined.
- The next slide includes other important information related to eligibility.

Who Is Eligible for LI NET?

People who:

- Have a valid Medicare Card
- Are Part D eligible
- Are not enrolled in a Part D plan
- Are not enrolled in a retiree drug subsidy plan
- Are not enrolled in a Part C plan which does not allow concomitant enrollment in a Part D plan
- Have not opted out of auto-enrollment
- Have a permanent address in the 50 states or DC

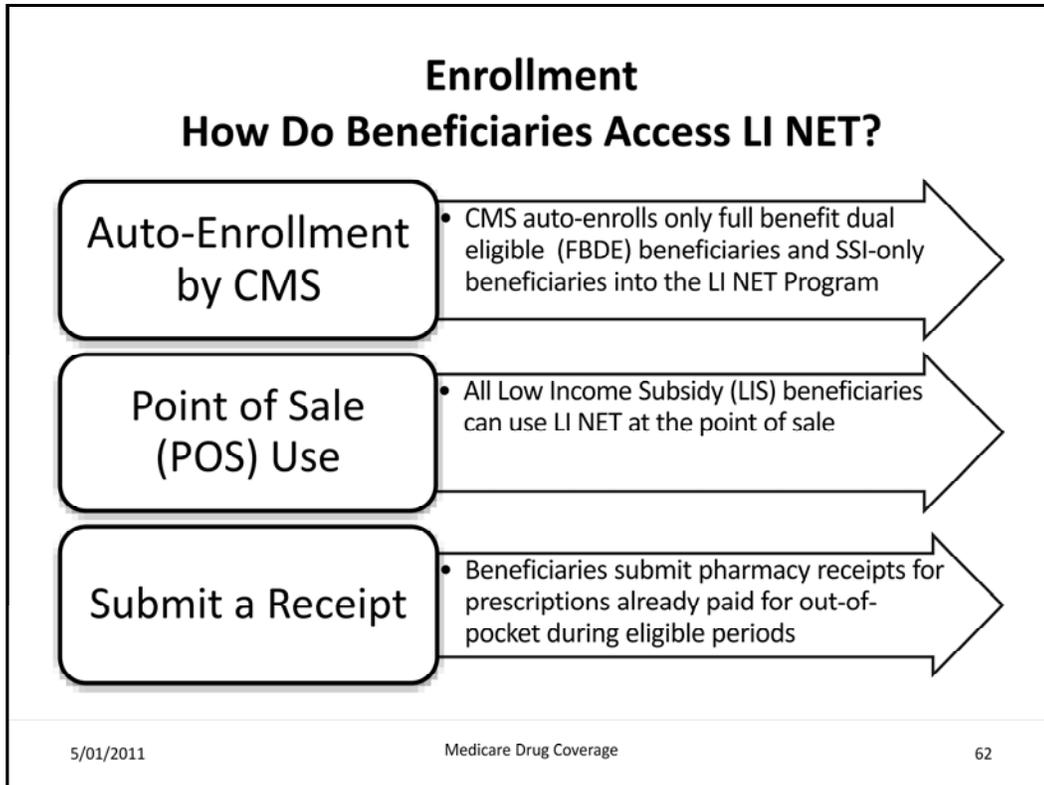
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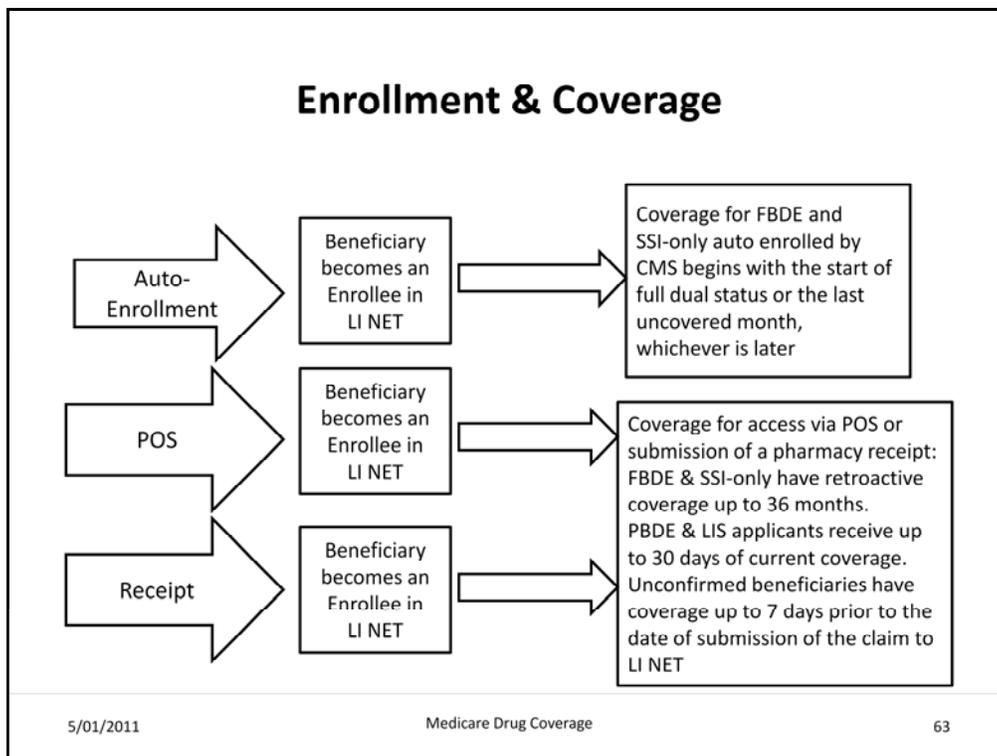
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- In addition to the information discussed on the previous slide, to be eligible for LI NET, beneficiaries must:
 - Have a valid Health Insurance Claim Number (HICN) which is on their red, white, and blue Medicare Card;
 - Be Part D eligible;
 - Not be enrolled in a Part D plan;
 - Not be enrolled in a retiree drug subsidy plan;
 - Not be enrolled in a Part C plan which does not allow concomitant enrollment in a Part D plan;
 - Have not opted out of auto-enrollment; and
 - Have a permanent address in any of the fifty states or Washington, DC.

- For your information, sometimes prescription drug claims are rejected by LI NET because beneficiaries go to the pharmacy without the necessary information to process a claim. To process a claim, the pharmacist must be able to verify Medicare eligibility, and the HICN (Medicare ID number) must be entered in the mandatory Cardholder ID Field. The claim will reject if this field is left blank or a valid HICN is not entered. (The Medicare number includes a letter and it is not always an "A.") In addition, beneficiaries must show proof of Medicaid or LIS status, such as a Medicaid card or award letter or an LIS award letter. If known, the pharmacist enters the Medicaid number or the SSN in the Patient ID Field.



- There are three ways for an eligible beneficiary to access the LI NET program:
- Auto-Enrollment – CMS auto-enrolls only FBDE beneficiaries and SSI-only beneficiaries into the LI NET program.
- (Partial benefit dual eligible (PBDE) beneficiaries and LIS applicants are not automatically enrolled into the LI NET program.)
- Point of Sale (POS) Use – All LIS beneficiaries can use LI NET at the point of sale.
- Submitting a receipt – Beneficiaries submit pharmacy receipts (not just a cashier’s receipt) for prescriptions already paid for out-of-pocket during eligible periods.



- Coverage for full benefit dual eligible (FBDE) and SSI-only beneficiaries who are auto enrolled by CMS begins with the start of full dual status or the last uncovered month whichever is later.
- Coverage for beneficiaries who access LI NET through point of sale or by submitting a pharmacy receipt is as follows:
 - Full benefit dual eligible beneficiaries and SSI-only beneficiaries are eligible for retroactive coverage up to 36 months (or as far back as 1/1/2006 if Medicaid determination goes back to that point in time).
 - Partial benefit dual eligible beneficiaries and LIS applicant beneficiaries receive up to 30 days of current coverage.
 - Unconfirmed beneficiaries are those persons who show evidence of Medicaid or LIS eligibility to the pharmacy at point of sale (POS), but for whom there is no evidence of Medicaid or LIS eligibility in CMS' systems. For these persons, coverage is up to 7 days prior to the date of submission of the claim to LI NET.
- All Low Income Subsidy (LIS) eligible beneficiaries are prospectively enrolled on a random basis into a Prescription Drug Plan (PDP) with a premium amount at or below the LIS premium subsidy amount. Therefore, any LI NET enrollment is temporary and ends prior to the prospective enrollment into a PDP.

Auto- and Facilitated Enrollment

- CMS identifies and enrolls people each month
 - Randomly assigned to plans
 - Premiums at or below regional low-income premium subsidy amount
 - May join MA plan meeting special needs
- If you are already enrolled in an MA plan
 - You'll be enrolled in the same plan with Rx coverage (MA-PD)
 - If offered by your current plan

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- CMS assigns 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.

Enrollment Notices

- CMS notifies people of enrollment in a PDP
 - Auto-enrollment letter on yellow paper
 - Facilitated enrollment letter on green paper
 - Denotes either full or partial subsidy
 - Includes list of area plans at/below regional low-income premium subsidy amount
- MA plan sends notice if enrollment in MA-PD

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- 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.

Note: A list of the letters sent to people with Medicare regarding Extra Help (Low Income Subsidy) is provided in the back of the corresponding workbook (see Appendix F).

Re-establishing Eligibility for People Who Automatically Qualify

- CMS re-establishes eligibility in the Fall
 - For next calendar year
 - If you no longer automatically qualify
 - CMS sends letter in September on gray paper
 - Includes SSA application
 - If you automatically qualify & your copayment changed
 - CMS sends letter In early October on orange paper

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- In August 2010, CMS re-established eligibility for calendar year 2011 for people who automatically qualified for Extra Help in 2010. 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, 2011.
 - People who were automatically eligible for 2010 continued to qualify for Extra Help through December 2011. If they were no longer eligible, their automatic status ended on December 31, 2010.
 - People who no longer automatically qualified for Extra Help in 2011 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 2011, 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: they are institutionalized with Medicare and Medicaid, they have Medicare and Medicaid, they get help from Medicaid paying Medicare premiums (belong to a Medicare Savings Program), or they get Supplemental Security Income benefits but not Medicaid
 - If people who no longer automatically qualified in 2011 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.
- Note:** A list of the letters sent to people with Medicare regarding Extra Help (Low Income Subsidy) is provided in the back of the corresponding workbook (see Appendix F).

Continuing Eligibility

- People who are already qualified
 - Four types of redetermination processes
 - Initial
 - Cyclical or recurring
 - Subsidy-changing event (SCE)
 - Other event (change other than SCE)

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- 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

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

- B. People who were automatically eligible for Extra Help for 2011 continue to qualify for Extra Help through December 2011.
1. True
 2. False

Lesson 5 - Comparing and Choosing Plans

- Things to Consider
- Plan Finder Tool
- Special Populations

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Comparing and Choosing Plans explains:

- Things to consider
- Plan Finder Tool
- Special populations

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?
 - Could joining a plan affect a family member's coverage?

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- 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.
- 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).

Drug Plan Options

- You can get your Medicare Part D coverage through
 - Medicare Prescription Drug Plans
 - Medicare Advantage and other Medicare plans
 - Some employers and unions

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- People with Medicare can choose one of the following ways to get their prescription drug coverage:
 - Medicare Prescription Drug Plans
 - Some Medicare Advantage and other Medicare plans
 - Some employers and unions

Steps to Choosing a Prescription Drug Plan

- There are 3 steps to choosing a prescription drug plan
 1. Collect information
 2. Use Plan Finder to compare plans
 3. Decide on a plan and enroll

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- There are 3 steps to choosing a prescription drug plan
 1. Collect information
 2. Use Plan Finder to compare plans
 3. Decide on a plan and enroll

Step 1: Collect Information

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

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. They'll also need their zip code and Medicare card.

Step 2: Use Medicare Plan Finder

- Detailed information about Medicare health and prescription drug plans
- Find doctors or other health care providers and suppliers who participate in Medicare.
- Information about quality of care provided by plans, nursing homes, hospitals, home health agencies, and dialysis facilities.

The image is a screenshot of the Medicare.gov website. At the top, there is a search bar and navigation links. Below that, the main heading is "Medicare Plan Finder". The page contains a form titled "Find Your Medicare Plan" with fields for "Enter Your ZIP Code", "For a Personalized Search, Enter Your Medicare Information: (Optional)", "Last Name", "Effective Date for Part A", "Date of Birth", and "Date of Birth". There is a "Find Plans" button at the bottom of the form. To the right of the form, there is a section titled "Additional Tools" with links to "What Is the Medicare Plan Finder", "Find and Compare Medicare Plans", "Search by Plan Name or ID", "Enroll Now", "Find Formulas to your area", "Find Ways to Lower Your Costs During the Coverage Gap", "Find out about your Medicare Choices", "End Stage Renal Disease", "Medicare and VA Benefits (TRICARE)", and "Veteran benefits (VA)".

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Step 2 – Use the Medicare Plan Finder

- Get detailed information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide. Visit www.medicare.gov.
- Find doctors or other health care providers and suppliers who participate in Medicare.
- See what Medicare covers, including preventive services.
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, home health agencies, and dialysis facilities.
- Look up helpful Web sites and telephone numbers.
- View Medicare publications

Step 3: Decide and Enroll

- Decide which plan is best for you and join
- Enroll directly with the plan
 - Mail or fax paper application to plan
 - Online (plan’s website or www.medicare.gov)
 - Telephone
 - 1-800-MEDICARE (TTY 1-877-486-2048)
 - The plan

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- Step 3: After you pick a plan that meets your needs, call the company offering it, and ask how to join. You may be able to join by telephone, by paper application, or online. You will have to provide the number on your Medicare card when you join.
 - 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.
- These steps, and worksheets to help with this process, are available in *Your Guide to Medicare Prescription Drug Coverage* (CMS Pub. #11109).

What New Members Can Expect

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

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- 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.

Annual Notice of Change

- All Part D plans send to all members in the Fall
 - May arrive with Evidence of Coverage
- Review the ANOC carefully
- Will include information for upcoming year
 - Summary of Benefits
 - Formulary
 - Changes
 - New premium
 - Cost sharing – copayments and coinsurance
 - Other

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- 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 the Fall.
- You should read the Annual Notice of Change carefully. 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.

NOTE: A list of the letters sent to people with Medicare regarding Extra Help (Low Income Subsidy) is provided in the back of the corresponding workbook.

Special Populations

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

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- There are certain populations or groups that may have some different rules for Medicare prescription drug coverage. They include:
 - State Pharmacy Assistance Program (SPAP) participants
 - People in long-term care facilities
 - Residents of U.S. territories

State Pharmacy Assistance Programs (SPAP)

- SPAPs can provide wraparound coverage help
 - Reduce states costs
 - Expand population served
- In most cases SPAP incurred costs
 - Count toward true out-of-pocket limit (TrOOP)
 - Won't count in certain cases
 - Drug not on plan formulary
 - Denied coverage due to utilization management
 - Other reasons

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- 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. However, it doesn't count in some cases, such as if the drug is not in the plan formulary, or the plan denied coverage due to utilization management.

Residents of Long-Term Care Facilities

- Get 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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- 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.

U.S. Territories

- Part D program is the same except no Extra Help
- Territory helps residents with Medicare & Medicaid
 - Different from Extra Help
 - Enhanced Allotment Plan (EAP) (Medicaid grant funded)
 - May cover plan premiums, coinsurance, copays and/or deductibles
 - May provide supplemental coverage

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- 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.

Exercise

- A. Plan Finder gives you details on all of the following topics except:
1. Health plans
 2. Prescription plans
 3. Medicare appeals information
 4. Regulations
 5. Quality of Care

Exercise

B. In most cases, costs incurred by a state pharmacy assistance program will not count toward out-of-pocket limit.

1. True
2. False

Lesson 6 – Coverage Determinations and Appeals

- Coverage Determinations
- Exceptions
- Appeals

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Medicare Drug Coverage

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Coverage Determinations and Appeals explains:

- Coverage Determinations
- Exceptions
- Appeals

Coverage Determination

- Initial decision by plan
 - Which benefits a member is entitled to receive
 - Amount member is required to pay for a benefit
- May be standard
- May be expedited
 - If life or health is seriously jeopardized

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- 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.
- 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.
 - 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.

Part D Exception Requests

- Two types of exceptions
 - Tiers
 - e.g., getting Tier 2 drug at Tier 1 cost
 - Formulary
 - Drug not on plan’s formulary or
 - Access requirements
- Requests can be made only by you, your appointed representative, or the prescriber
- Requires supporting statement from physician

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There are two types of exceptions—tier exceptions (e.g., getting a Tier 2 drug at the Tier 1 cost), and formulary exceptions that either allow coverage for a drug not on the plan’s formulary, or relaxed access requirements.

- To have lower costs, many plans place drugs into different “tiers” on their lists. Each tier costs a different amount. Each plan can divide its tiers in different ways. A drug in a lower tier will cost you less than a drug in a higher tier.

Example:

- Tier 1—Generic drugs. Tier 1 drugs will cost the least.
- 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 1 and Tier 2 drugs. You, your prescriber (such as a doctor), or your appointed representative can ask the plan to cover the prescription you need by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the “Model Coverage Determination Request” form. You can get a copy of this form by visiting <http://www.medicare.gov/publications/pubs/pdf/11112.pdf>
- Exception requests require a supporting statement from the prescriber. In general, the statement must indicate the medical reason for the exception. The prescriber may submit the statement orally or in writing.

Note: If you want to appoint a representative to help you with a coverage determination or appeal, you and the person you want to help you must complete the “Appointment of Representative” form (Form CMS-1696), and send it with your coverage determination or appeal request. A copy of this form is provided as a handout in the back of the corresponding workbook. You can also get a copy of this form by visiting <http://www.cms.gov/cmsforms/downloads/cms1696.pdf>. You can also appoint a representative with a letter signed and dated by you and the person helping you. Your letter must include the same information that is requested on the Appointment of Representative form. The form or letter must be sent with your coverage determination or appeal request.

Approved Exceptions

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

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- 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 Enrollment Period.

Coverage Determination Timeframe

- Plan must notify of coverage determination
 - Standard request within 72 hours
 - Expedited request within 24 hours
 - Exception involved
 - Time clock starts when plan receives physician statement
 - Missed timeframe
 - Goes to independent review entity
 - MAXIMUS – www.medicarepartdappeals.com
 - Skip 1st level of appeal

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Medicare Drug Coverage

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- 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 time 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 for review, and the request will skip over the first level of appeal (redetermination by the plan). The Independent Review Entity is MAXIMUS. Their contact information is available at www.medicarepartdappeals.com.
- A job aid is provided to outline the appeal process including timelines.

Requesting Appeals

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

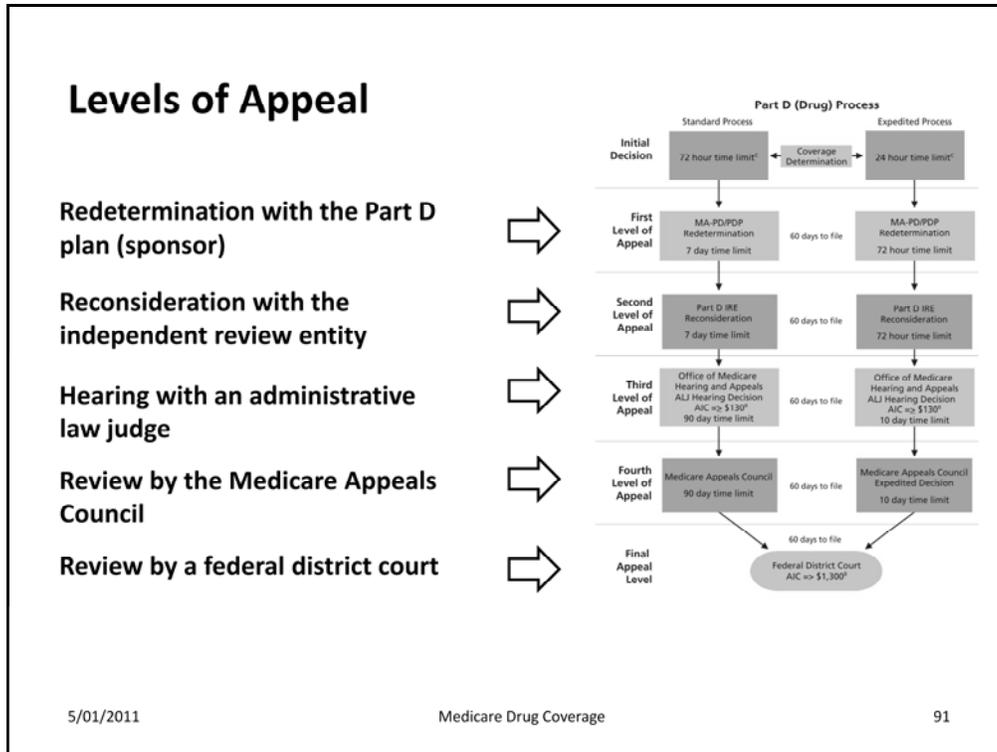
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Medicare Drug Coverage

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- In general, appeal requests must be made in writing. However, plans must accept expedited redetermination requests that are submitted orally as well. 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 NMTP USB wafer card/CD Suite under "Job Aids."



Levels of Appeal

- If you ask for a coverage determination and you disagree with the plan’s decision, you can appeal the decision. There are five levels of appeal available to you. You must follow the order listed below:
 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

- Additional information about the appeals process is available in *Your Guide to Medicare Prescription Drug Coverage* CMS Publication No. 11109.
- **Note:** A copy of this chart is provided as a handout in the corresponding workbook (see Appendix G).

Exercise

- A. If an exception request is approved, it is usually valid for refills for the remainder of the plan year.
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

Exercise

A. Quantity limits are lifetime limits.

1. False
2. True



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Medicare Drug Coverage

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2011 Standard Drug Benefit

Benefit Parameters	2010	2011
Deductible	\$310.00	\$310.00
Initial Coverage Limit	\$2,830.00	\$2,840.00
Out-of-Pocket Threshold	\$4,550.00	\$4,550.00
Total Covered Drug Spend at OOP Threshold	\$6,440.00	\$6,447.50
Minimum Cost-Sharing in Catastrophic Coverage	\$2.50/\$6.30	\$2.50/\$6.30
LIS Copayments	2010	2011
Institutionalized	\$0	\$0
Up to or at 100% FPL	\$1.10/\$3.30	\$1.10/\$3.30
Other LIS	\$2.50/\$6.30	\$2.50/\$6.30
Partial LIS Deductible/Cost-Sharing	\$62/15%	\$63/15%

Oral Anticancer Drugs

The oral anti-cancer drugs covered by Part B include, but are not limited to:

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

NOTE: This list is subject to change.

Oral Anti-Emetics Prescribed for Use Within 48 Hours of Chemotherapy

The following lists the oral anti-emetic (anti-nausea) drugs covered under Part B. This is not an exhaustive list and it is possible for the list of drugs to change over time.

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

NOTE: This list is subject to change.

Immunosuppressive Drugs

This lists the immunosuppressive drugs covered by Medicare Part B. Again, this list is subject to change:

- 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

NOTE: This list is subject to change.

Drugs Not Covered by Part D

Drugs excluded by law from Medicare coverage:

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.
- 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

NOTE: Benzodiazepines and barbiturates will be covered starting in 2013.



Guide to Consumer Mailings from CMS, Social Security and Plans in 2011/2012

(All notices available online are hyperlinked, but note that current year versions for many notices aren't posted until fall.)

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
Mid-May	Social Security	Social Security LIS and MSP Outreach Notice (SSA Pub. Forms L447 & L448)	Informs people who may be eligible for Medicare Savings Programs (MSPs) about MSPs and the Extra Help available for Medicare prescription drug coverage.	<ul style="list-style-type: none"> If you think you qualify for Extra Help, you should apply. Apply for Extra Help through Social Security.
Mid-May	CMS	<u>LIS Choosers Reminder Notice</u> (Product No. 11465) (TAN Notice)	Reminds people who get Extra Help and chose a drug plan on their own with a premium liability that other drug plans are available for \$0 premium as long as they qualify for Extra Help.	If you're thinking about switching plans, make sure the plan covers the prescriptions you take and includes the pharmacies you use.
Early September	Social Security	<u>Social Security Notice to Review Eligibility for Extra Help</u> (SSA Form No. 1026)	Informs people selected for review that they should see if they continue to qualify for Extra Help. Includes an "Income and Resources Summary" sheet.	If you get this notice, you must return the enclosed form in the enclosed postage-paid envelope within 30 days or your Extra Help may end.
September	Plans	<u>Plan Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)</u> <u>Model ANOC</u>	By September 30 , people will get a notice from their current plan outlining 2012 formulary, benefit design, and/or premium changes.	Review changes to decide whether the plan will continue to meet your needs in 2012.
September	Plans	<u>Plan LIS Rider</u> <u>Model LIS Rider</u>	By September 30 , all people who qualify for Extra Help will get an LIS rider from their plan telling them how much help they'll get in 2012 towards their Part D premium, deductible, and copayments.	Keep this with your plan's Evidence of Coverage (EOC), so you can refer to it if you have questions about your costs.
September	Employer/Union Plans	<u>Notice of Creditable Coverage</u>	By September 30 , employer/union and other group health plans must tell all Medicare-eligible enrollees whether or not their drug coverage is creditable.	Keep the notice.
September	CMS	<u>Loss of Deemed Status Notice</u> (Product No. 11198) (GREY Notice)	Informs people that they no longer automatically qualify for Extra Help as of January 1, 2012.	Apply for Extra Help through Social Security (application and postage-paid envelope enclosed) or a State Medical Assistance (Medicaid) office.

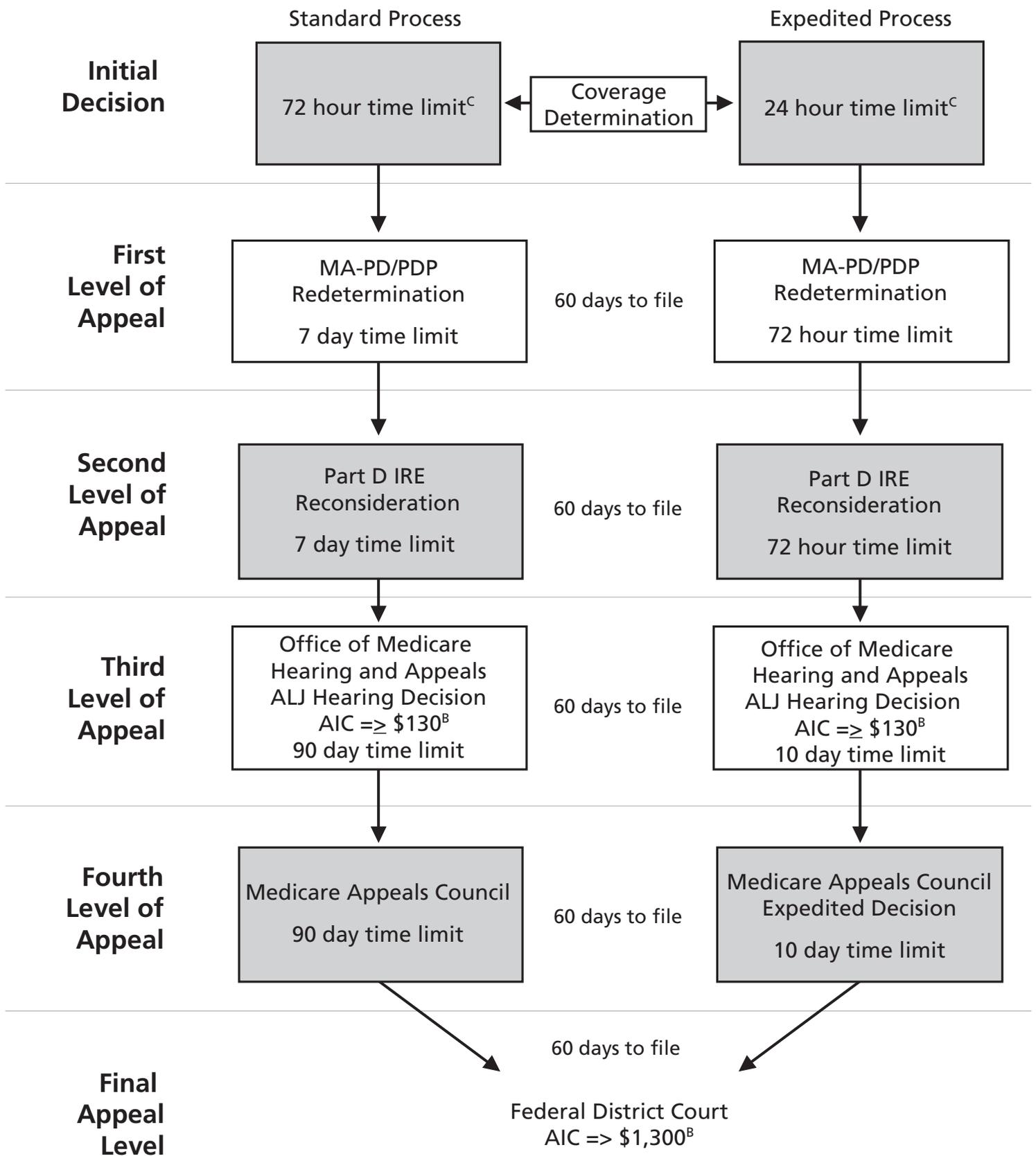
Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
Late September	CMS	<u>“Medicare & You” 2012 Handbook</u>	Mailed to all Medicare households each fall. Includes a summary of Medicare benefits, rights, and protections; lists of available health and drug plans; and answers to frequently asked questions about Medicare.	Keep the handbook as a reference guide. You can also download a copy online at www.medicare.gov .
October	Plans	<u>Plan Marketing Materials</u>	On October 1, plans begin sending marketing materials for 2012.	Use this information to compare options for 2012.
October	Plans	<u>Plan Non-Renewal Notice</u>	By October 2, people whose 2011 plan is leaving the Medicare program in 2012 will get notices from plans.	You must look for a new plan for coverage in 2012.
October	CMS	<u>Change in Extra Help Co-payment Notice</u> (Product No. 11199) (ORANGE Notice)	Informs people that they still automatically qualify for Extra Help, but their co-payment levels will change starting January 1, 2012.	<ul style="list-style-type: none"> Keep the notice. No action, unless you believe an error has occurred.
		<u>Reassignment Notice – Plan Termination</u> (Product No. 11208) (BLUE Notice)	Informs people that their current Medicare drug plan is leaving the Medicare Program and they will be reassigned to a new Medicare drug plan effective January 1, 2012, unless they join a new plan on their own by December 31, 2011.	<ul style="list-style-type: none"> Keep the notice. Compare plans to see which plan meets your needs. Change plans, if you choose, in early December.
Late October	CMS	<u>Reassignment Notice – Premium Increase</u> (Product No. 11209) (BLUE Notice)	Informs auto-enrollees that because their current Medicare drug plan premium is increasing above the regional LIS premium subsidy amount, they will be reassigned to a new Medicare drug plan effective January 1, 2012, unless they join a new plan on their own by December 31, 2011.	<ul style="list-style-type: none"> For more information call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048; check “Medicare & You”; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Late October/ Early November	CMS	<u>MA Reassignment Notice</u> (Product No. 11443) (BLUE Notice)	Informs people who get Extra Help and whose current Medicare Advantage (MA) plan is leaving the Medicare Program that they will be re-assigned to a Medicare drug plan effective January 1, 2012 if they don't join a new MA or PDP plan on their own by December 31, 2011.	<ul style="list-style-type: none"> Keep the notice. Compare plans to see which plan meets your needs. Change plans, if you choose, in early December. For more information call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048; check “Medicare & You”; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
Early November	CMS	LIS Choosers Notice (Product No. 11267) (TAN Notice)	Informs people who get Extra Help and chose a Medicare drug plan on their own that their plan's premium is changing, and they'll have to pay a portion of their plan's premium in 2012 unless they join a new \$0 premium plan.	<ul style="list-style-type: none"> Keep the notice. You may want to look for a new plan for coverage for 2012 with a premium below the regional low income subsidy benchmark. (Notice includes list of local plans with no premium liability.) Change plans in early Dec. if you choose.
November	CMS	CMS Non-Renewal Reminder Notice (Product No. 11433 & Product No. 11438)	Reminds people who don't get Extra Help and whose plan is leaving the Medicare Program that they need to choose a new plan for 2012.	You must look for a new plan for coverage in 2012.
November	Social Security	Social Security Part B & Part D Income-Related Premium Adjustment Notice	Tells higher-income consumers about income-related Part B and Part D premium adjustments. Includes the information in the December BRI notices (see below).	Keep the notice.
November	Social Security	Social Security LIS Redetermination Decision Notice Begins	Social Security begins mailing notices letting people know whether they still qualify for Extra Help in the coming year.	<ul style="list-style-type: none"> Keep the notice If you believe the decision is incorrect, you have the right to appeal it. The notice explains how to appeal. If you have questions, call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).
Late November	Social Security	Social Security LIS and MSP Outreach Notice (Form SSA-L441)	Informs people who may be eligible for Qualified Disabled Working Individual (QDWI) about the Medicare Savings Programs and the Extra Help available for Medicare prescription drug coverage.	<ul style="list-style-type: none"> If you think you qualify for Extra Help, you should apply. For more information about the Extra Help or if you want to apply, call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).
December	Social Security	Social Security Benefit Rate Change (BRI) Notice	Tells people about benefit payment changes for the coming year due to cost of living increases, variations in the premiums that are withheld, etc.	Keep the notice.
December	CMS	Reassign Formulary Notice (Product No. 11475 & Product No. 11496) (BLUE Notice)	Informs people who get Extra Help and were affected by reassignment which of the Part D drugs they took in 2011 will be covered in their new 2012 Medicare drug plan.	<ul style="list-style-type: none"> Consider whether this plan is right for you, or whether another plan might cover more of your drugs. Compare this Medicare drug plan with others in your area. For more information call 1-800-MEDICARE; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
January	CMS	<u>CMS Non-Renewal Action Notice</u> (Product No. 11452)	Reminds people who don't get Extra Help and whose Medicare plan left the Medicare Program that they need to join a new Medicare drug plan if they want Medicare drug coverage for 2012.	You must join a Medicare drug plan by February 29 if you want Medicare drug coverage for 2012.
Daily - ongoing	CMS	<u>Deemed Status Notice</u> (Product No. 11166) (PURPLE Notice beginning in Sept/Oct)	Informs people that they will automatically get Extra Help, including people 1) with Medicare and Medicaid, 2) in Medicare Savings Program, and 3) who receive Supplemental Security Income (SSI) benefits.	<ul style="list-style-type: none"> • Keep the notice. • No need to apply to get the Extra Help. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	<u>Auto-Enrollment Notice</u> (Product No. 11154) (YELLOW Notice)	Sent to people who automatically qualify for Extra Help because they qualify for Medicare & Medicaid and currently get their benefits through Original Medicare. These people will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	<ul style="list-style-type: none"> • Keep the notice. • No need to apply to get the Extra Help. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	<u>Auto-Enrollment - Retroactive Notice</u> (Product No. 11429) (YELLOW Notice)	Sent to people who automatically qualify for Extra Help with a retroactive effective date because they either 1) qualify for Medicare & Medicaid or 2) get Supplemental Security Income (SSI). These people will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	<ul style="list-style-type: none"> • Keep the notice. • No need to apply to get the Extra Help. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.

Mail Date	Sender	Mailing/Color	Main Message	Consumer Action
Daily - ongoing	CMS	<u>Facilitated Enrollment Notice</u> (Product No. 11186 & Product No. 11191) (GREEN Notice)	Informs people who either 1) belong to a Medicare Savings Program or 2) get Supplemental Security Income (SSI), or 3) applied and qualified for Extra Help that they will be automatically enrolled in a drug plan unless they decline coverage or enroll in a plan themselves.	<ul style="list-style-type: none"> • Keep the notice. • If you don't join a plan, Medicare will enroll you in one. • Compare Medicare prescription drug plans with others to meet your needs. • For more information call 1-800-MEDICARE; check "Medicare & You"; visit www.medicare.gov, or contact the State Health Insurance Assistance Program (SHIP) for free personalized help.
Daily - ongoing	CMS	<u>FBDE RDS Notice</u> (Product No. 11334)	Informs people with Medicare & Medicaid who already have qualifying creditable drug coverage through an employer or union that they automatically qualify for Extra Help, and can join a Medicare drug plan if they want to at no cost to them.	Contact your employer or union plan to learn how joining a Medicare drug plan may affect your current coverage.
Daily – ongoing	Social Security	<u>Initial IRMAA Determination Notice</u>	Sent to people with Medicare Part B and/or Part D when Social Security determines whether any IRMAA amounts apply. Notice includes information about Social Security's determination and appeal rights.	Keep the notice.

Part D (Drug) Process



Full Low-Income Subsidy (LIS)/Extra Help (2011) - 48 STATES + DC						
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary
Duals (people with Medicare & full Medicaid) who reside in long-term care facilities	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	None
Other people with Medicare and Medicaid, including those enrolled in a Medicare Savings Program (MSP)	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	Co-pay: \$1.10 generic/\$3.30 brand name if income ≤ 100% FPL (\$902.50/month single or \$1,214.17 married) Co-pay: \$2.50 generic/\$6.30 brand name if income > 100% FPL or if MSP-only No co-pay after \$6,447.50 limit
Non-duals with income < 135% FPL	\$1,218.38/month or less if single; \$1,639.13/month or less if married	\$8,180 or less if single; \$13,020 or less if married*	No if on SSI; otherwise yes	No	No	Co-pay: \$2.50 generic/\$6.30 brand name No co-pay after \$6,447.50 limit
Partial Low-Income Subsidy (LIS)/Extra Help (2011) - 48 STATES + DC						
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary
Non duals with income < 135% FPL AND assets between \$8,180 and \$12,640 if single, or between \$13,020 and \$25,260 if married*	\$1,218.38/month or less if single; \$1,639.13/month or less if married	Between \$8,180 and \$12,640 if single; between \$13,020 and \$25,260 if married*	Yes	No	\$63	Co-insurance: 15% (up to \$6,447.50) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit
Non duals with income between 135 and 150% FPL	\$1,353.75/month or less if single; \$1,821.25/month or less if married	\$12,640 or less if single; \$25,260 or less if married*	Yes	Sliding scale	\$63	Co-insurance: 15% (up to \$6,447.50 limit) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit

* All asset eligibility limits include \$1,500/person burial allowance

Updated: November 17, 2010

Full Low-Income Subsidy (LIS)/Extra Help (2011) - ALASKA							
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary	
Duals (people with Medicare & full Medicaid) who reside in long-term care facilities	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	None	
Other people with Medicare and Medicaid, including those enrolled in a Medicare Savings Program (MSP)	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	Co-pay: \$1.10 generic/\$3.30 brand name if income ≤ 100% FPL (\$1127.50/month single or \$1,517.50 married) Co-pay: \$2.50 generic/\$6.30 brand name if income > 100% FPL or if MSP-only No co-pay after \$6,447.50 limit	
Non-duals with income < 135% FPL	\$1,522.13/month or less if single; \$2,048.63/month or less if married	\$8,180 or less if single; \$13,020 or less if married*	No if on SSI; otherwise yes	No	No	Co-pay: \$2.50 generic/\$6.30 brand name No co-pay after \$6,447.50 limit	
Partial Low-Income Subsidy (LIS)/Extra Help (2011) - ALASKA							
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary	
Non duals with income < 135% FPL AND assets between \$8,180 and \$12,640 if single, or between \$13,020 and \$25,260 if married*	\$1,522.13/month or less if single; \$2,048.63/month or less if married	Between \$8,180 and \$12,640 if single; between \$13,020 and \$25,260 if married*	Yes	No	\$63	Co-insurance: 15% (up to \$6,447.50) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit	
Non duals with income between 135 and 150% FPL	\$1,691.25/month or less if single; \$2,276.25/month or less if married	\$12,640 or less if single; \$25,260 or less if married*	Yes	Sliding scale	\$63	Co-insurance: 15% (up to \$6,447.50) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit	

* All asset eligibility limits include \$1,500/person burial allowance

Updated: November 17, 2010

Full Low-Income Subsidy (LIS)/Extra Help (2011) - HAWAII						
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary
Duals (people with Medicare & full Medicaid) who reside in long-term care facilities	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	None
Other people with Medicare and Medicaid, including those enrolled in a Medicare Savings Program (MSP)	Meet State Medicaid financial eligibility rules	Meet State Medicaid financial eligibility rules	No, receive it automatically	No	No	Co-pay: \$1.10 generic/\$3.30 brand name if income ≤ 100% FPL (\$1,038.33/month single or \$1,396.67 married) Co-pay: \$2.50 generic/\$6.30 brand name if income > 100% FPL or if MSP-only No co-pay after \$6,447.50 limit
Non-duals with income < 135% FPL	\$1,401.75/month or less if single; \$1,885.50/month or less if married	\$8,180 or less if single; \$13,020 or less if married*	No if on SSI; otherwise yes	No	No	Co-pay: \$2.50 generic/\$6.30 brand name No co-pay after \$6,447.50 limit
Partial Low-Income Subsidy (LIS)/Extra Help (2011) - HAWAII						
Beneficiary Group	Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance for Drugs on Plan Formulary
Non duals with income < 135% FPL AND assets between \$8,180 and \$12,640 if single, or between \$13,020 and \$25,260 if married*	\$1,401.75/month or less if single; \$1,885.50/month or less if married	Between \$8,180 and \$12,640 if single; between \$13,020 and \$25,260 if married*	Yes	No	\$63	Co-insurance: 15% (up to \$6,447.50) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit
Non duals with income between 135 and 150% FPL	\$1,557.50/month or less if single; \$2,095/month or less if married	\$12,640 or less if single; \$25,260 or less if married*	Yes	Sliding scale	\$63	Co-insurance: 15% (up to \$6,447.50) Co-pay: \$2.50 generic/\$6.30 brand name after \$6,447.50 limit

* All asset eligibility limits include \$1,500/person burial allowance

Updated: November 17, 2010



**E-mail: NMTP@cms.hhs.gov
Website: cms.gov/NationalMedicareTrainingProgram**

**Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244**