

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

## Legal Basics: Medicare Part D The Prescription Drug Program



Georgia Burke, Directing Attorney



Amber Christ, Senior Staff Attorney

Tuesday, May 16, 2017

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

- All on mute. Use Questions function for substantive questions and for technical concerns.
- Problems with getting on to the webinar? Send an e-mail to [trainings@justiceinaging.org](mailto:trainings@justiceinaging.org).
- Slides and a recording are available at Justice in Aging – Resources for Advocates – Webinars: <http://www.justiceinaging.org/resources-for-advocates/webinars>. See also the chat box for this web address.

# JUSTICE IN AGING

---

FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

# Road Map

- What is Part D?
- Enrollment and Costs
- Plan Design
- Low Income Subsidy
- Appeals
- Resources

# What is Part D?

# Part D Overview

- Added to Medicare in 2006
- Covers most prescription drug categories. Does not pay for over the counter drugs
- Offered by private insurance companies contracted with Medicare
- Eligibility: anyone enrolled in Medicare Part A or Part B
- Available either through:
  - Prescription Drug Plan—PDP
  - Medicare Advantage Plan—MA-PD

# Part D Overview

- Low income subsidy (AKA “extra help”) helps with premiums, deductibles and cost-sharing.
- LIS is automatic for anyone with SSI or Medicaid, including Medicare Savings Programs (QMB, SLMB, QI)
- Others apply through Social Security Administration.

NOTE: Medicaid beneficiaries who become eligible for Medicare must use Part D for their drug coverage.

# Enrollment and Costs



# Enrollment Periods

- **Initial Enrollment—Same as for Medicare A and B**
  - 3 months before month you turn 65 until three months after: 7 months. If you qualify for disability, it is a 7 month period around the 25th month of your qualification for SSDI
- **Open Enrollment (each year)**
  - Oct. 15 – Dec. 7 for each year; benefits begin Jan. 1
- **Medicare Advantage Disenrollment Period (each year)**
  - Jan. 1-Feb 14. New enrollment starts March 1.
  - Allows you to move out of an MA-PD plan to a PDP.
  - Cannot move between PDPs or between MA-PDs.

# Enrollment Periods

- Special Enrollment Periods
  - Dual eligible or LIS
  - Move out of service area
  - Move in or out of a Skilled Nursing Facility
  - Other special circumstances
- Enrollment starts the first day of the next month

# Late Enrollment Penalty

- You didn't have creditable coverage and didn't enroll when first eligible
- 1% of the national base premium x total uncovered months = LEP
- If had late enrollment penalty and have Medicare based on disability, you get new enrollment period when turning 65
- If get LIS, no late enrollment penalty

# IRMAA

- Income at or above \$85,000 single/\$170,000 couple
- Sliding scale from \$13.30 to \$76.20 extra per month

# Plan Design

# Plan Choices

- Between 18 (Alaska) and 25 (New Jersey) PDPs to choose from.
- Premiums range from \$14.50 to \$179/mo.
- Between 3-10 benchmark plans/region have zero premium if LIS
- Some MA-PDs have zero premium

# Drug Coverage

- Plan formularies vary
- Must cover all drugs in 6 protected classes
- Usually must offer two drugs in each therapeutic category
- No coverage of OTC drugs, ED or fertility drugs, weight loss drugs. Off label uses OK only if the use is supported by a listing in a designated compendium

# Formulary Design

- Deductible up to \$400—some plans have \$0
- Tiers—most common design is 5 tiers.
- Charges—set copay or a percentage of the negotiated price.
- Specialty tiers—25%. No tiering exception.
- Overall, charges must be actuarially equivalent to 25% of negotiated price
- May also have preferred and non-preferred pharmacy prices.



# Sample Tiering Structure

## (AARP MedicareRx Saver Plus)

Annual Prescription Deductible	\$400		
Initial Coverage Stage	Preferred Retail Cost Sharing (30 days)	Standard Network Pharmacy Cost Sharing (30 days)	Mail Order Pharmacy (90 days)
Tier 1: Preferred Generic Drugs	\$1 co-pay	\$3 co-pay	Preferred: \$0 co-pay Standard: \$9 co-pay
Tier 2: Generic Drugs	\$2 co-pay	\$6 co-pay	Preferred: \$0 co-pay Standard: \$18 co-pay
Tier 3: Preferred Brand Drugs	\$21 co-pay	\$31 co-pay	Preferred: \$58 co-pay Standard: \$93 co-pay
Tier 4: Non-Preferred Drugs	30% of the cost	36% of the cost	Preferred: 30% of the cost Standard: 36% of the cost
Tier 5: Specialty Tier Drugs	25% of the cost	25% of the cost	Preferred: 25% of the cost Standard: 25% of the cost

# Formulary design

- Plans may impose utilization management restrictions
  - prior authorization
  - step therapy
  - quantity limits
- CMS must approve utilization management
- Plan must show specific UM requirements for each drug on its website
- Beneficiary may seek an exception to a utilization management requirement

# Donut Hole

- After you and the plan together spend \$3,700, you fall into the donut hole
- In the donut hole, you pay 40% of the negotiated price for brand drugs and 51% for generics
- You get out of the donut hole after spending \$4950
- After donut hole, you get catastrophic coverage and only pay 5% until the start of the new plan year.
- Donut hole shrinking. Will disappear in 2020.

# Encouraging Consumer Choice

- Point consumer to resources
  - Plan Finder
  - SHIP counseling
- Report marketing abuses to CMS Regional Office
- Remember: continuous SEP for LIS beneficiaries

# Part D for People with Low Incomes

# What is the LIS benefit?

Full Benefit <135% FPL and <\$7,390 assets	Partial Benefit <150% FPL and <\$12,320 assets
Pays premiums on any benchmark plan	Partially pays premiums on any benchmark plan
No Part D deductible	Beneficiary may be charged up to \$82 annual deductible
No donut hole	No donut hole
Co-pays range from \$0 to \$8.25	15% co-insurance
Zero co-pay above out-of-pocket threshold	Limited co-pay above out-of-pocket threshold

# LIS Enrollment

- Automatic if enrolled in:
  - SSI
  - Medicaid
  - Medicare Savings Programs (QMB, SLMB, QI)
- If you have a Share of Cost, meet it once
- Others apply through Social Security Administration.

# Simplified Counting Rules

- What counts as assets?
  - Cash and bank accounts, including checking, savings, and CDs
  - Real estate outside of your primary residence
  - Stocks and bonds, including U.S. savings bonds
  - Mutual funds and IRAs
- What doesn't count as assets or income?
  - In-kind services as income
  - Assumes you are setting aside \$1,500/\$3,000 for burial expenses (assets).
  - Insurance policies
  - Primary residence and car



# Auto-enrollment of LIS Beneficiaries

- Assigned to a zero premium “benchmark” plan
- Benchmark plans can change annually depending on plan bids
- Assignment is random-may not match well with drug needs
- If assigned and plan loses benchmark status in a later year, will be reassigned
- Beneficiary can always change plans. Continuous SEP
- If voluntarily changes plans, becomes a “chooser” and is not subsequently reassigned.
- Choosers receive tan letter in November if their plan premium rises.

# LI-NET

- Humana administers the Point of Sale enrollment process for LIS eligibles that are not enrolled in a Part D plan.
- Acts as a temporary plan for newly enrolled full dual eligible
- Provides reimbursement to individuals who have retroactive Medicare prescription drug coverage
- Open formulary, with no utilization management restrictions on any drugs, and no pharmacy network restrictions.

# LI-NET

- If an LIS-eligible individual presents him/herself at the pharmacy without a Part D plan, there is the Point of Sale (POS) enrollment by LI-NET.
- If the pharmacy has reasonable assurance that the individual qualifies for the LIS, and has no other prescription drug coverage, the pharmacy can immediately fill the prescription(s) and bill the claim to LI-NET.
- LI-Net enrollment lasts 2 months, then auto-enrollment into a PDP
- Issue: Some pharmacists are unfamiliar with LI-NET

# Best Available Evidence (BAE)

- Plans must provide access to Part D drugs at LIS levels when presented with evidence of LIS eligibility, even if their own systems do not show LIS.
- Examples of BAE:
  - Medi-Cal card
  - State document confirming Medi-Cal eligibility
- Each plan must have BAE contact to promptly receive and review documents
- If need for Rx is urgent, plan require to provide emergency supply at LIS co-pay while determining status

# For LIS beneficiaries

## Bad choices + inertia = wasted \$\$

- Too many choices, confusing
- Auto-assignment is random
- Plan costs and benefits change from year to year. Few beneficiaries review their choices annually
- Marketing can mislead—especially LEP consumers

# Appeals

# Starting an appeal

- At the pharmacy:
  - Computer tells pharmacist that drug is not approved
  - Pharmacist may or may not have enough info to explain the reason
  - Pharmacist hands you a generic notice of appeal rights with plan contact info.

Denial at the pharmacy does not trigger appeal rights. Beneficiary or prescriber must ask for a COVERAGE DETERMINATION by calling or writing the plan.

# Starting an appeal

- Request for a coverage determination about drug coverage is an EXCEPTION request
  - Need physician supporting statement re medical necessity
  - Exception lasts until the end of the plan year. Plan has the option to renew.
  - If LIS—consider whether switching plans is a better option



# Tiering Exceptions

- When your drug is on a high tier and there is a preferred drug on a lower tier
  - Physician showing that lower tier drug is not as effective or would have adverse effects
  - You get the co-pay for the lower tier
  - Not available for specialty tier drugs
  - An underutilized exception

# Appeal process

- Coverage determination by plan
  - Standard—72 hours
  - Expedited—24 hours
- Reconsideration by plan
- Redetermination by Independent Review Entity (IRE)
  - Maximus is the IRE
- Review by Administrative Law Judge at HHS
  - Video conference or telephone hearing
- Review by Medicare Appeals Council
- Federal district court

# Appeals—Advocacy Concerns

- Success rate at IRE and ALJ are high.  
Value of perseverance
- Delays, lost documents, missed deadlines, ALJ backlog
- Keeping the provider engaged and on board
- Delays in effectuation

# Additional Resources

# Additional Resources

- Georgia Burke, Managing Attorney
  - [gburke@justiceinaging.org](mailto:gburke@justiceinaging.org)
- Amber Christ, Senior Staff Attorney
  - [achrist@justiceinaging.org](mailto:achrist@justiceinaging.org)
- [www.Medicare.gov](http://www.Medicare.gov)
- 1-800-Medicare
  - TTY Users: 977-486-2048
- Medicare and You Handbook
- SHIPs 1-800-434-0222
- [www.justiceinaging.org](http://www.justiceinaging.org)
- [www.medicarerights.gov](http://www.medicarerights.gov)
- [www.medicareadvocacy.org](http://www.medicareadvocacy.org)

# Case Consultation

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at [NCLER@justiceinaging.org](mailto:NCLER@justiceinaging.org).