Medicare
Part D Prescription Drug Coverage

Part 3

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Learning Objectives

☐ After reviewing “Part 3 - Medicare Part D Prescription Drug Coverage” you will be able to explain:

- What Part D plans are;
- Who is eligible to enroll in a Part D plan;
- Part D standard and alternate benefits;
- Part D management tools, covered drugs, and formulary requirements;
- Part D True Out-of-Pocket (TrOOP) costs and help for beneficiaries with limited income;
- Late enrollment penalties and premiums; and
- How Part D works with other coverage.
Training Roadmap: Part 3

- Medicare Part D Basics
- Part D Standard and Alternative Benefits
- Part D Management Tools
  - Covered Drugs
  - Formulary Requirements
- Part D Enrollee Costs and Assistance Programs
- Part D Late Enrollment Penalties and Premiums
- Part D and Other Coverage
Coverage of Medicare Part D benefits is provided by private companies.

- Medicare pays a share of the program costs.

The types of Part D plans are:

- Stand-alone Prescription Drug Plans (PDP)
- Medicare Advantage-Prescription Drug (MA-PD) Plans:
  - MA health plans that also cover Part D prescription drugs.
- Cost-PD Plans
  - Medicare health plans that cover Part D prescription drugs as an optional supplemental benefit.
Medicare Part D
Prescription Drug Program Basics

Beneficiaries enrolled in a --

☐ Medicare Advantage HMO or PPO may only obtain Part D benefits through their plan. They may not enroll in a standalone PDP. (Employer group plan enrollees may have additional choices.)

☐ MA MSA may only obtain Part D benefits through a standalone PDP.

☐ MA PFFS plan that offers Part D coverage may only obtain Part D benefits through that plan. If the PFFS plan does not offer Part D coverage, the beneficiary may enroll in a standalone PDP.

☐ Cost plan may obtain Part D benefit through their plan (if offered) or through a standalone PDP.

☐ Medicare-Medicaid plan may only receive Part D benefits through that plan.

☐ PACE plan may only receive Part D benefits through that plan.
Medicare Part D Eligibility

- Individuals entitled to Part A and/or enrolled under Part B are eligible to enroll in Part D plans.
- The beneficiary must live in the plan’s service area.
  - Part D plan coverage is provided through network pharmacies in the Part D plan’s service area, except that PFFS plans are not required to use a pharmacy network.
- Part D plans must enroll any eligible beneficiary who applies regardless of health status except in limited circumstances in the case of MA-PD plans under MA program rules (e.g., beneficiaries with ESRD or who do not meet the eligibility criteria of a chronic care SNP).
Part D Standard and Alternative Benefits
Part D Plan Benefits
Standard

- Part D plans must cover at least the Part D standard benefit or its actuarial equivalent.
- For 2017, the standard benefit requires the beneficiary to pay:
  - $400 deductible
  - 25% of prescription drug costs between $400 and $3,700 = $825
  - Part of the costs in the “Coverage Gap” - After total spending on drugs by the beneficiary, by certain subsidy programs and by the plan reaches $3,700 the beneficiary pays for 51% of generic drug costs and 40% of brand name drug undiscounted costs (drug manufacturers provide a 50% discount on brand name drugs).
    - The amount beneficiaries pay while in the coverage gap decreases by a small percentage each year until 2020 when they will be responsible for only 25% of brand and generic drug costs.
  - Nominal costs under catastrophic coverage: Once beneficiary expenditures (including drug manufacturer discounts) reach a total of $4,950, the beneficiary is through the coverage gap and reaches catastrophic coverage. On any future prescriptions the beneficiary pays either a co-pay of $3.30 for generic drugs or $8.25 for brand name drugs or a co-insurance of 5%, whichever is greater.
## Part D Plan Benefits
### The Standard Benefit Plan for 2017 (Updated Annually)

### Total Drug Expenditures

- **$8071.16** (varies depending on mix of brand-name and generic drugs)
- **$3,700**
- **$400**
- **$0**

### CATASTROPHIC COVERAGE
- **Plan Pays:** 95%
- **Enrollee Pays:** Greater of 5% or $8.25 brand/$3.30 generic

### COVERAGE GAP (DONUT HOLE)
- **Plan Pays:** 49% for generic drugs and 10% for brand-name drugs
- **Drug Manufacturer Discount:** 50% for brand name drugs
- **Enrollee Pays:** 51% of cost of generic drugs and 40% of cost of brand-name drugs

### INITIAL COVERAGE
- **Plan Pays:** 75% ($2475)
- **Enrollee Pays:** 25% ($825)

### DEDUCTIBLE
- **Enrollee Pays:** $400

### Enrollee Out-of-Pocket Cost
- **$4,950** - Annual out-of-pocket threshold
- **$1,225** - Initial Coverage Limit
- **$400** - Deductible
- **$0**
Part D Plan Benefits
Alternative

- Part D plan benefits may differ from the standard benefit under specific Medicare rules.
- In all cases the value of Part D benefits must be at least the same as the standard coverage.
- Some Part D plans may also include enhanced coverage for an additional monthly premium.
Part D Pharmacy Networks

☐ Enrollees may fill prescriptions for covered drugs at network pharmacies that contract with plans.
  ▪ Network pharmacies include retail pharmacies and may also include mail order pharmacies. Part D plans may designate preferred pharmacies that offer lower levels of cost-sharing than apply at non-preferred pharmacies.

☐ Under certain circumstances, enrollees may fill prescriptions for covered drugs at non-network pharmacies, but likely at higher cost to enrollees. For example:
  ▪ If the enrollee has an illness or loses a drug while traveling outside the service area
  ▪ If there are circumstances resulting in limited access to a drug through in-network pharmacies
Part D Drug Management Tools
Covered Drugs and Formulary Requirements
Part D Drug Management Tools

- Part D plans commonly use a variety of prescription drug benefit management tools, including:
  - A formulary: A list of drugs covered by the plan
  - Cost sharing tiers: Drugs may be grouped together by amount of cost sharing. Many plans group drugs into 3 or 4 tiers with lower tiers costing less than higher tiers, for example:
    - Tier 1: Generic drugs
    - Tier 2: Preferred brand-name drugs
    - Tier 3: Non-preferred brand-name drugs
    - Tier 4: High-cost drugs
Part D plans commonly use a variety of prescription drug benefit management tools, including:

- **Step therapy:** One or more similar lower cost drugs must be tried before other more costly drugs are tried, if necessary.
- **Prior authorization:** Requires the doctor to contact the plan before the plan will cover these prescriptions. The doctor must show the plan that the drug is medically necessary for it to be covered.
Covered Part D Drugs

- By law, Part D plans are permitted to cover any prescription drugs and biologicals that:
  - Must be covered by states that provide Medicaid prescription drug benefits
- Many Part D plans do not cover all of these drugs because in some cases several similar drugs are available to treat the same medical condition.
- Part D plans include the drugs they will cover on formularies that are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
  - At least two drugs in each therapeutic category
  - Generic and brand-name drugs.
Medicare Part D Medication Therapy Management: An Introduction

- Medicare Part D Medication Therapy Management (MTM) programs seek to provide individuals taking medication for chronic diseases with an optimal regimen of treatment for their conditions.

- All Medicare Part D sponsors are required to have a Medication Therapy Management (MTM) program with the exception of MA Private Fee for Service (MA-PFFS) and PACE organizations. Their MTM programs must be designed:
  - to ensure that covered Part D drugs prescribed to a targeted beneficiaries are appropriately used; and
  - to reduce the risk of adverse events, including drug interactions.
Medicare Part D
Medication MTM Requirements

☐ MTM is a patient-centered and comprehensive approach to improve medication use, reduce the risk of adverse events, and improve medication adherence. MTM program elements include:
  ▪ Comprehensive reviews of medications used on an annual basis;
  ▪ Quarterly medication reviews;
  ▪ Identification of medication related problems;
  ▪ Prescriber and beneficiary interventions to promote coordinated care; and
  ▪ Standardized action plans and summaries.

☐ The MTM program must be developed in cooperation with licensed and practicing pharmacists and physicians.
Medicare Part D
Eligible MTM Beneficiaries

- To be eligible for the program, a beneficiary must:
  - have multiple chronic diseases – for example diabetes, hypertension, and asthma;
  - be taking multiple Part D drugs, and
  - likely to incur drug costs of a specified amount (equal to or greater than $3,919 for 2017).

- Sponsors have some flexibility in designing their programs such as the minimum number of diseases that qualify a beneficiary for an MTM program. Information about specific criteria is available from each Part D plan and is available on the plan’s website.

- Enrollment in a Sponsor’s MTM program must be done using an opt-out method.

- Sponsors must target beneficiaries for enrollment in the MTM program at least quarterly.

- Information on MTM programs is available on the Centers for Medicare and Medicaid Services website (http://www.cms.gov/Medicare/Prescription-Drug-Coverage/). Information is also available on the Medicare website (http://www.medicare.gov) and through the Medicare Plan Finder (http://www.medicare.gov/find-a-plan/questions/home.aspx).
Drugs Excluded from Part D Coverage

☐ By law, Part D plans are not permitted to include the following under their Part D covered benefits:
  • Drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
  • Vitamins
  • Medical foods formulated to be consumed or administered entirely under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act.
  • Erectile dysfunction drugs (when used for sexual dysfunction)
  • Non-prescription drugs
  • Some off label use drugs
  • Part B covered drugs

☐ Part D plans are permitted to offer supplemental benefits that cover certain drugs not covered under Part D.
Mid-year Formulary Changes

☐ Formulary changes must be approved by CMS
☐ Part D plans cannot make any formulary changes during the first 60 days of the contract year, unless it is in response to a drug’s removal from the market.
☐ After March 1st, Part D plans may make some mid-year formulary changes including:
  - Removal of a drug that is being withdrawn from the market by the FDA or manufacturer;
  - Replacing brand name with new generic drugs, but only following 60 days notice to affected enrollees; and
  - Other changes only if the enrollees currently taking the affected drug are exempted for the remainder of the year.
Transition Requirements

- Enrollees initially enrolling in Part D, those switching plans, and current enrollees affected by formulary changes must receive coverage of a single 30-day fill of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.

- Enrollees who reside in a long-term care facility must receive coverage for fills of at least 91 days of their non-formulary drugs, as necessary, following enrollment under the Part D plan.

- During the transition period:
  - The Part D plan does not apply prior authorization or step therapy rules.
  - The enrollee and his/her physician can request an exception to the Part D plan’s formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.
Requesting Exceptions for Drugs

- Enrollees have the right to request a formulary exception either for coverage of non-formulary drugs or for coverage of formulary drugs at a less costly formulary tier.
- If a doctor thinks an enrollee needs a drug that is not on the formulary, the enrollee or the doctor can apply for a formulary exception.
- To facilitate their request, a standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary exception.
- Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision.
- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan’s toll-free number and website for requesting a coverage determination.
Part D Enrollee Costs and Assistance Programs
Part D Enrollee Costs:
“True Out-of-Pocket” Costs (TrOOP)

- Part D True Out-of-Pocket costs or “TrOOP” are out-of-pocket costs enrollees incur that count towards the annual out-of-pocket threshold to move into catastrophic coverage.
  - Calculated on an annual basis.
  - Generally, includes payments for Part D prescription drugs:
    - For the annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold
    - After the initial coverage period, a drug manufacturer’s discount for brand name drugs counts toward the true out-of-pocket costs.
  - Generally drugs must be on the plan’s formulary and purchased at a plan’s participating network pharmacy
  - Amounts paid or borne by AIDS drug assistance programs and the Indian Health Service count toward TrOOP.
Part D Enrollee Costs: “True Out-of-Pocket” Costs (TrOOP), cont’d.

☐ Some costs do not count toward the Part D true out-of-pocket (TrOOP) cost total including:

- Costs for drugs not on a Part D plan’s formulary, unless the beneficiary receives an exception under which the plan covers the drug;
- Costs for over-the-counter (OTC) and other non-Part D drugs;
- Costs for covered Part D drugs obtained out-of-network (unless the plan’s out-of-network policy applies);
- Costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs (such as Medicaid), or another third party;
- Costs for drugs purchased outside the United States.
Help for Individuals with Limited Income and Limited Resources

☐ If a beneficiary has limited income and resources, he/she may qualify for the low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. In 2016, to qualify for the LIS:

- Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically as follows:
  - 48 states - $17,820 (individual)/$24,030 (couple) in 2016.
  - Alaska - $22,260 (individual)/$30,030 (couple) in 2016.
  - Hawaii - $20,505 (individual)/$27,645 (couple) in 2016.
- Beneficiaries resources may not exceed $13,640 (individual)/$27,250 (couple).
**Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office**

- Beneficiaries with limited income and resources should be encouraged to apply for the low income subsidy (LIS) – also called extra help – through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
  - Tell beneficiaries to call 1-800-MEDICARE (1-800-633-4227) and say “Medicaid” for the State Medicaid office phone number. If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
  - Or call SSA at 1-800-772-1213 or apply online at: [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp) to apply for help with Part D costs.

- After SSA or the State approves an application for extra help, it is effective the first day of the month in which the individual applied.
Other Help For Low-Income – Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low income individuals in obtaining drugs at reduced or no costs.
- Some states have assistance programs designed specifically for their residents.
  - Some programs are “qualified” State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
  - Becoming familiar with your state’s programs may help a beneficiary address cost-sharing for prescriptions, particularly in the coverage gap.
Assistance Programs –
What Counts toward TrOOP?

☐ Enrollees may receive assistance for Part D costs, but costs paid by many assistance programs do not count toward TrOOP cost.

- Included entities – costs do count towards TrOOP for:
  - Qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, non-government and Indian Health Service funded tribal coverage, AIDS Drug Assistance Programs, health savings accounts, flexible spending accounts, and medical savings accounts.

- Excluded entities – costs do not count towards TrOOP for:
  - Medicaid, State Children’s Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements.
Part D Late Enrollment Penalties and Premiums
Part D Late Enrollment Penalty

- Beneficiaries generally have to pay a penalty to join a Part D plan if:
  - They do not have creditable coverage and do not enroll when first eligible for Part D.
  - There has been a period of at least 63 continuous days following a beneficiary’s initial enrollment period for Part D during which the beneficiary did not have either Part D or creditable coverage.

- Creditable coverage is prescription drug coverage that expects to pay, on average, at least as much as Medicare’s standard Part D coverage expects to pay.

- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.
Late Enrollment Penalty, cont’d.

- In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty as long as they are not disenrolled from their Part D or other creditable drug coverage for 63 days or longer.
Part D Premium Payment

☐ Part D enrollees have three options for paying their Part D premium.
  ▪ (1) Automatic electronic monthly mechanism, such as withdrawal from their checking or savings bank account or automatic deduction from their credit or debit card;
  ▪ (2) Direct monthly billing from the plan; or
  ▪ (3) Automatic deduction from their monthly Social Security Administration (SSA) benefit check.
    • Typically it takes 2-3 months for SSA withholding to begin or end.
    • When withholding begins, it will be for the 2-3 months of premiums owed.
    • If a beneficiary is considering this option, he/she should call the plan first.

☐ Generally the beneficiary must stay with the premium payment option for the entire year.
Part D and Other Coverage
Employer/Union Coverage of Drugs

Employer or Union Coverage: Employers/unions will notify their employees of whether their prescription drug coverage is “creditable” (coverage that, on average, equals at least as much as Medicare’s standard Part D coverage expects to pay) via an annual statement.

- If coverage is creditable and the beneficiary keeps it, he/she will not incur a premium penalty if he/she later loses or drops the employer coverage and joins a Part D plan.
- If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during his/her initial eligibility period to avoid the late enrollment penalty.

If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, he/she can compare that coverage with available Part D plans to decide whether to enroll in Part D.
Employer Coverage of Drugs, cont’d.

- The beneficiary should check with the employer or union benefits administrator before making any change.
  - If a beneficiary drops employer/union prescription drug coverage, he/she may not be able to get it back and also may lose health coverage.

- If the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days, there will not be a late enrollment penalty.
Beneficiaries in Original Medicare with Medigap Drug Coverage

- Medigap plans H, I, and J with drug coverage could no longer be sold as of January 1, 2006.
- Some beneficiaries may have decided to keep their Medigap policy with the drug coverage they had before January 1, 2006.
  - Insurers are required to notify beneficiaries annually whether or not the prescription drug coverage they have is creditable (coverage that expects to pay, on average, at least as much as Medicare’s standard Part D coverage expects to pay).
Beneficiaries in Original Medicare with Medigap Drug Coverage, cont’d.

☐ For beneficiaries who decided to keep their Medigap policy with the drug coverage they had before January 1, 2006:
  - They may continue to keep the Medigap policy with drug coverage; OR
  - They may keep their Medigap coverage with the drug portion of the coverage removed and enroll in a Part D PDP plan; OR
  - They may drop their Medigap coverage and enroll in a MA-PD plan or other health plan with a PDP.

☐ If these beneficiaries choose a Part D plan now, they must pay a Part D late enrollment penalty unless their Medigap coverage was creditable.
  - Note: See Part 1, “Medicare Program Basics,” for more information on Original Medicare and Medigap (Medicare supplement insurance).
Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don’t choose a plan, Medicare will select one for them.
- Medicaid beneficiaries can change Part D plans throughout the year.
For Additional Information

☐ Medicare’s site on Part D prescription drug coverage for beneficiaries.

☐ Medicare’s information site on Part D prescription drug coverage for Part D sponsoring organizations.
  ▪ [www.cms.gov/PrescriptionDrugCovGenIn/](http://www.cms.gov/PrescriptionDrugCovGenIn/)

☐ Medicare & You Handbook.
  ▪ [http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf)