

Medicare Part D

Prescription Drug Coverage

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Introduction



Medicare Part D – Summary

Who gives it?	Federal government – Centers for Medicare and Medicaid Services (CMS). Benefit delivered exclusively through private health insurance plans.
Who gets it?	People who already have Medicare Part A or Part B, and who have enrolled in a prescription drug plan.
Eligibility	<ul style="list-style-type: none"> ▶ Entitled to Medicare Part A OR enrolled in Medicare Part B; and ▶ Resides in the service area of a plan.
What do you get?	Health insurance that covers outpatient prescription drugs, subject to deductibles, premiums, co-payments, coverage gap, utilization management, and which drugs are covered.



Medicare Refresher

- Medicare Part A – Hospital Insurance
 - Covers inpatient hospital, skilled nursing facility, home health, and hospice care, subject to deductibles and copayments
 - No premium for most beneficiaries; if not “insured,” then up to \$441/mo.
 - If low-income, may qualify for Part A Buy-In to cover premium, even if not “insured”



Medicare Refresher

- **Medicare Part B – Supplemental Medical Insurance**
 - Covers most doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health, and some home health and ambulance services
 - Most beneficiaries pay premium of \$104.90/mo. plus \$147 annual deductible and 20% coinsurance
 - If low-income, may qualify for Medicare Savings Program to cover premium



Medicare Refresher

- **Medicare Part C – Medicare Advantage**
 - Optional mode for receiving Part A and B services through private managed care plans
 - Must have both Part A and B to be eligible for Medicare Advantage
 - Most Medicare Advantage plans now include Part D drug coverage (MA-PDs)
 - There are different variations on this theme:
 - HMO – must go in network
 - PPO – allow member to go out of network at greater cost
 - PFFS – allow member to see any Medicare provider, but only if provider is willing to accept plan's terms
 - MSA – high-deductible plan associated with special tax-free savings account to use for medical expenses
 - SNP – Special Needs Plans



Medicare Refresher

- **Medigap**

- Supplemental private insurance coverage that covers all or some of the deductibles and coinsurance for Medicare Parts A and B
- Plugs up some of the “gaps” in coverage of Part A and B (but not D)
- Most do not cover drugs
- Can't have Medicare Advantage and Medigap



Medicare Advantage

- **Advantages**

- Low costs
- Frills

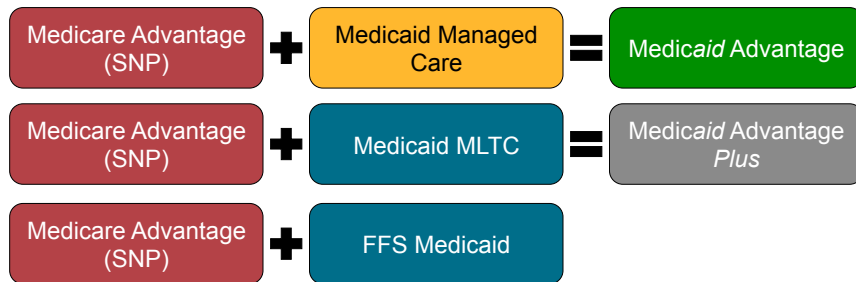
- **Disadvantages**

- Lock-In
- Limited provider choice
- Utilization management
- Special Needs Plans (SNPs) – Medicare Advantage for special populations
 - Dual eligibles
 - Institutional (nursing home residents)
 - Chronic condition (e.g., diabetes, heart disease)



Medicaid Advantage?

- Trend towards managed care for dual eligibles (Medicare and Medicaid via one HMO)
- When you enroll in a Medicaid Advantage or Medicaid Advantage Plus (MAP), you are in a Medicare Advantage SNP



Coverage and Cost

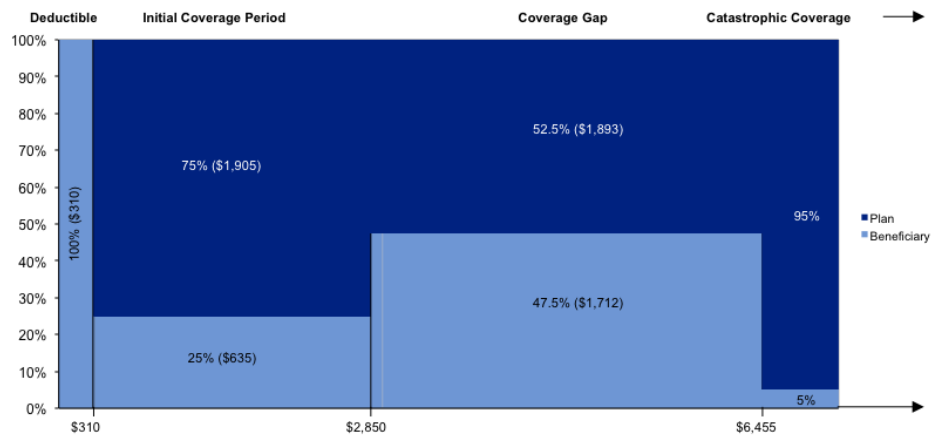


Costs of Part D

- Premium
- Deductible
- Co-payments
- Coverage gap (aka “donut hole”)
- Catastrophic coverage



Basic Benefit



What drugs are covered?

- Formulary
- Utilization Management
 - Prior Authorization
 - Step Therapy
 - Quantity Limits
- Formulary Changes
- Excluded Drugs



Extra Help

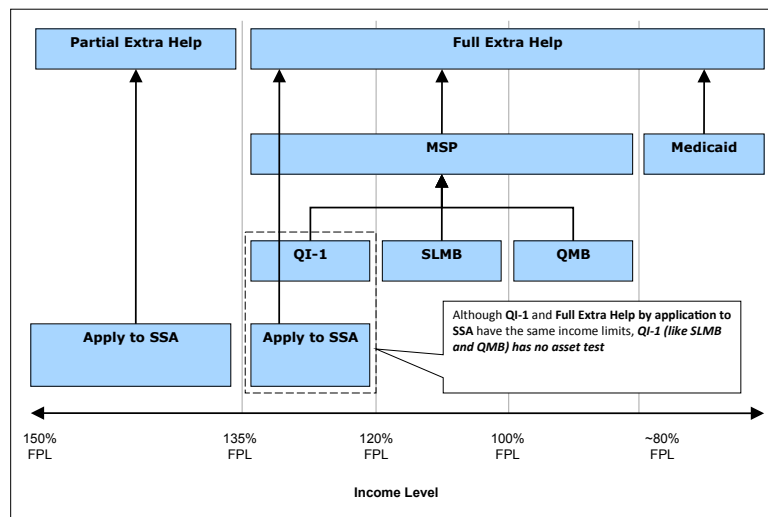


Extra Help – Summary

Who gives it?	Federal government – Centers for Medicare and Medicaid Services (CMS) Those who are not deemed eligible must apply through the Social Security Administration (SSA) pursuant to separate eligibility rules administered by SSA
Who gets it?	Medicare beneficiaries who are eligible for Part D and who have limited income and/or resources
Eligibility	<ul style="list-style-type: none"> ▶ Deemed Eligible by receiving Medicaid, MSP, or SSI; OR ▶ Application approved by SSA under one of the following: <ul style="list-style-type: none"> ◦ Full Extra Help Income below \$1,293/mo. (single), \$1,745/mo. (couple) Resources below \$8,580 (single), \$13,620 (couple) ◦ Partial Extra Help Income below \$1,436/mo. (single), \$1,939/mo. (couple) Resources below \$13,300 (single), \$26,580 (couple)
What do you get?	Subsidy that reduces or eliminates many of the costs associated with Medicare Part D drug coverage



Many paths to Extra Help



Medicare Savings Program

- If you only remember one piece of advice, it's this:

MSP ROCKS!

- \$1,200/yr. raise to Social Security check
- Extra Help with Part D saves about \$4,000/yr.
- No more Late Enrollment Penalty for Part B
- No more Late Enrollment Penalty for Part D
- Special Enrollment Period for Part B
- Special Enrollment Period for Part D
- No resource test
- One-page application
- QMB covers Medicare cost-sharing
- Cute acronyms



Summary of Extra Help Coverage

	Full Extra Help						Partial Extra Help		
	Standard Benefit	Dual in Nursing Home or Waiver	Dual < 100% FPL	Dual 100% - 135% FPL	MSP	Applicant < 135% FPL	135% - 140% FPL	140% - 145% FPL	145% - 150% FPL
Method of Enrollment	N/A	Deemed	Deemed	Deemed	Deemed	Application	Application	Application	Application
Premium	\$39.41/mo. ⁽¹⁾			None ⁽²⁾			25% ⁽³⁾	50% ⁽³⁾	75% ⁽³⁾
Deductible	\$310			None ⁽⁴⁾			\$63 ⁽⁵⁾		
Co-Pays From meeting deductible to \$2,850	25%	\$0	\$1.20 generic, \$3.60 brand	\$2.55 generic, \$6.35 brand	\$2.55 generic, \$6.35 brand ⁽⁶⁾	\$2.55 generic, \$6.35 brand	15% ⁽⁷⁾		
Coverage Gap \$2,850 - \$6,455	~47.5% ⁽⁸⁾	There is no coverage gap for Full or Partial Extra Help recipients. They pay the same co-pays they were paying before reaching \$2,850 until they reach the \$6,455 catastrophic threshold.							
Catastrophic Co-Pays > \$6,455	Greater of: \$2.55 generic \$6.35 brand - or - 5%	\$0 - The catastrophic threshold is reached when the total amount paid for covered Part D drugs - the amount paid by the plan plus the copayments paid by the client - reaches \$6,455. No copays are charged after that point.					\$2.55 generic, \$6.35 brand ⁽¹⁰⁾		



Enrollment



Enrollment Periods

- Initial Enrollment Period (IEP)
 - Seven-month window around initial entitlement to Medicare
- Annual Coordinated Election Period (ACEP)
 - **October 15 – December 7, 2013**, with changes effective January 1, 2014
 - Can make any change regarding Part D or Medicare Advantage



Enrollment Periods

- Special Enrollment Periods (SEP)
 - Dozens of different exceptions; most important are:
 - Perpetual SEP for people with Extra Help
 - SPAP SEP – one additional plan change any time for EPIC members
 - SEP to enroll in a Five-Star PDP or MA plan anytime
 - Involuntary loss of creditable coverage: two months after loss of coverage
 - Plan moves or terminates, or member moves
 - Member moves into or out of a nursing home
 - Member enrolled based upon misleading or incorrect information provided by plan employees, agents, or brokers



Enrollment Periods

- Annual Disenrollment Period
 - This period runs from January 1 – February 14 each year, during which members of Medicare Advantage plans can disenroll and return to Original Medicare + a PDP
 - Cannot enroll in Medicare Advantage, switch MA plans, or switch PDPs during this time



Late Enrollment Penalty (LEP)

- You pay a higher premium for Part D for the rest of your life if you delay enrolling after first becoming eligible
- Exceptions:
 - Creditable Coverage
 - Extra Help



Automatic Enrollment

- **Medicaid** (dual eligibles) – random auto-assignment to a “benchmark” drug plan, which means premium free for Medicaid
- **Medicare Savings Program** – same
- **EPIC** – “intelligent” auto-assignment to a drug plan based on past prescriptions.

WARNING: Assigned plan may not be best. Check *Planfinder* on www.medicare.gov for utilization controls, drug not on formulary



Reassignment

- CMS reassignment
 - Plan goes above benchmark
 - Plan terminates
- Choosers whose plans will no longer be benchmark will have to switch plans or pay a higher premium



Coordinating With Other Coverage



Medicaid

- Dual eligibles no longer get drugs through Medicaid; only through Part D
- Limited Wrap-Around – Medicaid will still pay for:
 - Excluded Drugs
 - Effective October 1, 2011, Medicaid will no longer wrap around to cover the four special classes of drugs (usually already covered by Part D)(anti-depressants, atypical anti-psychotics, anti-convulsants, anti-retrovirals (HIV/AIDS), anti-rejection (post-transplant) if not on a person's Part D plan's formulary



New York Prescription Saver Card

- Eligibility
 - 50 to 64 years old, or
 - Persons who are under age 50 and have a disability
- Income Limits
 - \$35,000 annual income for a single person
 - \$50,000 annual income for a couple
- Can use during donut hole



EPIC

- After disastrous cuts to EPIC in 2012, most of the program has been restored to its 2011 state
- Fee
 - Income eligibility threshold: \$20,000 yearly/singles, \$26,000/couples.
 - Members are charged an annual fee on a sliding scale basis. Fee ranges from \$8 to 300 and is waived for full "Extra Help" recipients.
- Deductible
 - Income eligibility threshold: \$20,001-\$35,000 yearly (single); \$26,001-\$50,000 yearly (couples).
 - No fee charged, but no EPIC coverage until member's out of pocket Part D drug costs meet deductible, which ranges from \$530 to \$1,715, based on the household income.



EPIC

- If your Part D plan has a deductible, EPIC does not cover drugs during the deductible, nor will your costs in the Part D deductible count towards the EPIC deductible
- Premium Subsidy
 - EPIC will continue to pay the Part D premium for members with annual income < \$23,000 (single) and \$29,000 (married)
 - For members with higher income, EPIC will give a credit against the deductible for the cost of Part D premium
- Once you meet the Part D deductible, EPIC will once again wrap around Part D coverage at the pharmacy!
 - Non-formulary
 - Excluded
 - Co-payments



EPIC

If Member co-pay without EPIC is...	EPIC member pays this amount
Up to \$15	\$3
\$15 – \$35	\$7
\$35 – \$55	\$15
Over \$55	\$20



Other sources of drug coverage

- Medigap
- Patient Assistance Programs (PAPs)
- Veterans Health Care



Some Notes on Obamacare

- People with Medicare do not have to do anything about the new Health Benefit Exchange!
 - The standardized health insurance products available on the NY Exchange (“New York State of Health” or NYSOH) do not work well as secondary coverage to Medicare
 - They are also not cost-effective options for Medicare recipients
 - Medicare recipients are not eligible for premium or cost-sharing subsidies through the Exchange
 - The open enrollment period for the Exchange is completely separate from (although around the same time as) open enrollment for Medicare
 - Obamacare also created a new category of Medicaid in New York, called MAGI (aka Alternative Benefit Plan or Medicaid Benchmark). People with Medicare CANNOT obtain Medicaid through this category, but are considered Non-MAGI.



PlanFinder Demonstration

<http://medicare.gov/find-a-plan>



THE END!

