Medicare Part D – 2021 Annual Enrollment Period

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Thanks to Kelly Ann Murray, David Silva, Medicare Rights Center, Eric Hausman, Center for Medicare Advocacy

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Roadmap

- What is Part D?
- How Part D works – Coverage & Costs for those with no subsidy
- Extra Help or Low Income Subsidy & EPIC
- 2 Options for receiving Part D and choosing a plan
  1. Stand-alone Part D plan + Original Medicare or
  2. Medicare Advantage w/Prescription drug coverage
- Enrollment – New to Medicare, annual enrollment, automatic enrollment for Duals, Late Enrollment Penalty, Special Enrollment Periods
- Tips on Picking a Plan
- Coordination with Medicaid, EPIC, ADAP

Not covered – Appeals, requests for exceptions

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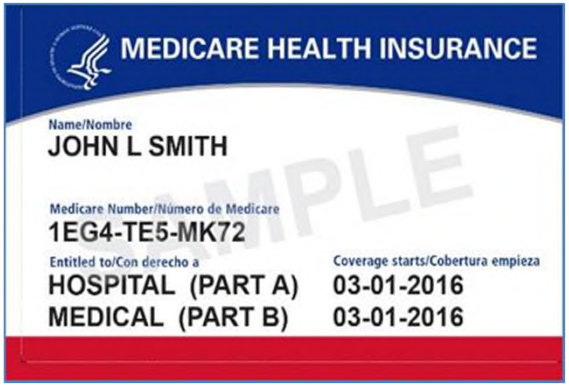
Medicare Refresher - Medicare Part A

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," premium up to $448/mo. (2020)
- If low-income, may qualify for Part A Buy-In to cover premium, even if not "insured"
- NEW Medicare Card➔



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Medicare Refresher - Medicare Part B

"Supplemental Medical Insurance"

- Covers **most outpatient care**: 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 (2020):
  1. premium of $144.60/mo **(expected $153.50 in 2021)**
  2. $198 annual deductible
  3. 20% coinsurance
- **Medicare Savings Program –** covers premium if low income; if in "QMB" also the 20% coinsurance.
- May purchase private MEDIGAP policy to cover costs of Parts A & B https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates

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Medicare Refresher – Part C
Medicare Advantage

- Surprise! There is no "Part C" benefit package.
- Instead, Part C is the name of the alternate Managed Care MODEL of delivering benefits under Parts A & B called "Medicare Advantage"
- Plan may offer Supplemental Benefits beside what's covered by Part A & B – more on this later
- Different models and cost structures – main ones are
  - HMO – must go in-network
  - PPO – may go out of network at greater cost
  - SNP – Special Needs Plans: D-SNP for Dual Eligibles (have Medicaid & Medicare), I-SNP for people in Nursing Homes
    C-SNP for chronic conditions
- No. of MA plans increased 76.6% nationally since 2017! (276 plans in NYS alone – 15 more than 2020). CMS encouraging growth. 42% all beneficiaries expected to enroll 2021

Medicare Part D – Summary

Prescription drug insurance coverage delivered exclusively through private health insurance plans, which contract with and are paid by federal govt. as Medicare benefit.

Who gets it?	• Must have Medicare Part A **or** Part B, and • Must enroll in a plan – either: 1. Stand-alone Prescription Drug Plan (PDP) 2. or Medicare Advantage Plan w/prescription drugs (MA-PD)

What do you get? Health insurance that covers outpatient prescription drugs & drugs in nursing home, with utilization management by insurance plan and limits on which drugs are covered.

Costs - subject to deductibles, premiums, co-payments, coverage gap,

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- What must be in Formulary?
- Utilization Management
- Formulary Changes
- Excluded Drugs

WHAT DRUGS ARE COVERED BY PART D

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What drugs are covered = FORMULARY

Formulary = Must have at least **two drugs** in each **Therapeutic Category** (e.g., Antidepressants, Cardiovascular Agents), and each **Pharmacologic Class** (e.g., MAO Inhibitors, Reuptake Inhibitors).

Six special classes - Formularies *must include "all or substantially all" generic and brand-name drugs in these classes:*

1. Antidepressants	2. Antipsychotics
3. Anticonvulsants	4. Antineoplastic (cancer)
5. Immunosuppressant (organ transplant)	6. Antiretroviral-HIV/AIDS

- Plans **may impose utilization management** for these six classes of drugs, but are discouraged from doing so for HIV/AIDS drugs.
- Plans **may not add new utilization review requirements on these special classes for members currently taking them.**

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What drugs are covered?

FORMULARY CHANGES

- Plans may change their formularies at **any time**, but **enrollees currently taking the affected drug are exempt from the change for the remainder of the plan year.**
- Types of formulary changes:
  - Plans may remove drugs from their formulary,
  - Move drugs to a less preferred tier status, or
  - Add utilization management requirements,
- Plans must provide **60 days' advance notice** to all members when they remove a drug from their formulary or change the cost-sharing.
- If they do not provide such notice, they must cover 60-day refill at the next refill.

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30-Day Transition Policy

- Within 90 days of enrollment (either from Jan. 1st or if switch plans mid-year with SEP)
- If member had been taking a drug that now is not on the plan formulary, or requires a Utilization Control -
- Plan must give 30-day supply of drug to allow member to either switch drugs or request an "exception" to approve drug
- Also applies if member stayed in the same plan, but plan's formulary changed the next year.
- See NCOA fact sheet*

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*https://www.ncoa.org/wp-content/uploads/part-d-transition-policy.pdf

What drugs are covered?

EXCLUDED DRUGS

- Certain drugs are **excluded** from and not covered by the Medicare drug benefit. If a drug is ***excluded***, it means that **no *basic* Part D plan can cover it**, although some *enhanced* plans may cover it. **Won't be on Planfinder!**
- Cost of excluded drug does not count towards TrOOP.
- Non-exhaustive list of excluded drugs:
  - Anorexia, weight loss, or weight gain
  - Cosmetic or hair growth
  - Prescription vitamins and minerals
  - Erectile dysfunction
  - Covered under Medicare Part A or Part B (next slide)
  - Prescribed "off-label" (treat condition not on drug's FDA-approved labeling or not approved in one of 3 pharmaceutical compendia)

  * Fertility drugs
  * Cold medicine
  * Over-the-counter
- Benzodiazapenes (Ativan, Valium) & barbiturates were excluded before, but since 2013 are covered by Part D

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What drugs are covered?

Who Pays for Excluded Drugs?

- **Medicaid** will still cover these drugs for dual eligibles, to the extent they were covered before (ie. over the counter – need Rx from MD)
- **EPIC** will cover Part D excluded drugs as long as they are on the EPIC formulary and the Part D deductible (if any) has been met (since 2013)
  - EPIC is NYS Rx subsidy for age 65+ https://www.health.ny.gov/health_care/epic/

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Is Drug not Covered because it is Part B not D?

If can't find a drug on Part D plan formulary it may be Part B!

- **Part B** covers drugs that provider or facility must buy and supply:
  - injected or intravenous drugs generally administered in doctor's offices or in a dialysis facility –e.g. Sensipar (included in dialysis facility rate) p. 34 of https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf
  - drugs administered with DME (nebulizer, IV drugs, infusion pump)
  - Some outpatient **oral cancer drugs** (chemotherapy) that used to be only injectable, now Part B covers even if take at home.
- **Post-transplant** – if had Medicare Part A at time of transplant –(ie kidney) drugs are covered by Part B, otherwise Part D
- **Tetanus** shot – Part D if preventative; Part B if treatment for injury

VACCINES:

- PART B - Flu, Hepatitis B & Pneumonia vaccines
- Part D –Shingles, all other vaccines

Medicare Advantage Plan must cover Part B drugs! May now do step therapy for them (new 2020), in addition to prior authorization
https://www.medicareinteractive.org/pdf/B-vs-D-chart.pdf

What drugs are Covered?

Utilization Management – 3 types

- **Prior Authorization (PA)** –Prescribing physician must first request permission from the plan before it will cover the drug. To get a PA request approved, physicians must typically show that the patient has a certain diagnosis or test results.
- **Step Therapy (ST)** – plan will not cover the prescribed drug unless the beneficiary shows that they have first tried a specific list of alternative drugs which were either ineffective or produced negative side effects.
- **Quantity Limits (QL)** – plan will only cover a certain quantity of pills per month – or eyedrops, etc. If takes 2/day – Planfinder enter 60/month

Will Planfinder indicate QL? May need to look up PA and ST on plan website

Plans may impose UM for the **six protected classes** of drugs (slide 17), but:

- are discouraged from doing so for HIV/AIDS drugs and
- No new PA or ST requirements allowed for members who are currently taking drugs in 6 classes

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Part D - Costs in Each Phase

Basic Plan – No "Extra Help"

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Costs of Part D

1. Premium
2. Annual Deductible
3. Co-payments – during Initial Coverage Period
4. Coverage gap (aka “donut hole”)
5. Catastrophic coverage

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Premium and Deductible (2021)

- **Premium –** Average in NYS is $45.03
  - Highest is $94.80 AARP MedicareRx Preferred ($0 deductible)
  - Lowest is SilverScript SmartRx ($7.30)(but maximum deductible)
  - Enhanced plans may have higher premiums but not necessarily - No real logic.
- ***Basic*** *(not enhanced)* plans with premiums < **$42.27** (**benchmark premium NYS**) free if have Extra Help.
  - 7 basic plans have FREE PREMIUM with "Extra Help"
  - NYS has highest benchmark premium in USA
- **Deductible** – Maximum is **$445**. Four plans have a -0- deductible, others range from $100 to max.
  - FREE deductible with Full Extra Help.

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Coinsurance and Copayments

- Plans have a choice of charging coinsurance (% of drug cost) and/or fixed copayments.
- Most plans use TIERS for drugs on formulary
- Sample tiers – 2020 Silverscript Choice (NYS)

1.	Tier 1 – Preferred Generics	$ 0
2.	Tier 2 – Generics	$ 1
3.	Tier 3 – Preferred brand name	$47
4.	Tier 4 – Non-preferred drug	38%
5.	Tier 5 – Specialty tier	27%

- When choosing a plan, **note which tier drugs are on** and cost.
- **Preferred pharmacy** – costs lower
- Extra Help discount reduces cost!

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Standard Structure Part D in 2021

Ms. Smith prescription drug plan coverage begins on January 1. She doesn't get Extra Help. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Initial Coverage Period (ICP)	3. Former Coverage gap (Gap officially closed 2020)	4 Catastrophic coverage
Ms. Smith pays 100% of the first **$445** of her drug costs before plan starts to pay its share.	Ms. Smith pays a copayment on applicable Tier or up to 25% coinsurance until she has paid **$1032.50 (i**n addition to **deductible**). Her plan pays 75%. When total spent by her AND her plan reaches **$4,130** she enters next phase**.** **Her: $1032.50** **Plan: $3097.50** **Total $4130.00**	**Brand name:** **70%** - discount from **drug manufacturer** - counts as out-of-pocket spending **5%** - plan pays **25%** - consumer pays **Generic drugs:** 75% - paid by Plan **25%** - paid by Consumer When consumer's costs and Drug manufacturer (not plan) have spent total **$5,183.75** ("TROOP*) ➔ Catastrophic coverage *See next slide for more on TROOP – True Out of Pocket Costs	**Her total out of pocket spending has hit $6,550** (including 70% drug manufacturer discount). Total drug costs by her and plan = **$10,048.39** In Catastrophic Coverage **She pays until 12/31/21:** Greater of 5% OR $3.70 generic/ $9.20 Brand name 5% is greater for – generics @ $75 brand names @ $184

Part D Standard Benefit Design Parameters:	**2021**	**2020**	**2019**	**2018**
Deductible - After the Deductible is met, Beneficiary pays 25% of covered costs up to total prescription costs meeting the Initial Coverage Limit.	$445	$435	$415	$405
Initial Coverage Limit - Coverage Gap (Donut Hole) begins at this point. (The Beneficiary pays 25% of their prescription costs up to the Out-of-Pocket Threshold)	$4,130	$4,020	$3,820	$3,750
Out-of-Pocket Threshold - This is the Total Out-of-Pocket Costs including the Donut Hole.	$6,550	**$6,350**	**$5,100**	$5,000
Total Covered Part D Drug Out-of-Pocket Spending including the Coverage Gap - Catastrophic Coverage starts after this point.	$9,313.75	$9,038.75	$7,653.75	$7,508.75
Total Estimated Covered Part D Drug Out-of-Pocket Spending **including the Coverage Gap Discount (NON-LIS)**	$10,048.39 plus a 75% brand discount	$9,719.38 plus a 75% brand discount	$8,139.54 plus a 75% brand discount	$8,417.60 plus a 65% brand discount

https://q1medicare.com/PartD-The-MedicarePartDOutlookAllYears.php

TROOP – True Out of Pocket Costs

To proceed to each stage of the Part D year to get to "Catastrophic Coverage," only certain costs count = "True Out of Pocket Costs" – These include:

1. Only **formulary drugs count** (+ drugs plan approved as exception or on appeal) only - *Can't count* over-the-counter drugs, drugs excluded from Part D, drugs bought outside US (Canada, Mexico)
2. **Deductible & initial coverage period – count if paid by**
   - MEMBER, PLAN, Family/Friends, Charity,
   - **EPIC**, ADAP, Extra Help
   - **Cash** payments by manufacturer Pharmaceutical Assistance Program (PAP)
   - **DO NOT COUNT** cost of drugs directly provided by manufacturer PAP, Medicaid, VA, employer/group health plan, or purchased at non-network pharmacy
3. **In former donut hole** – count cost of formulary drugs paid by:
   - **manufacturer** (70% of brand name) and consumer (25% both brand name and generic) –
   - **NOT costs paid by plan** (5% cost of brand name, 75% cost of generic).

Pharmacies and Part D

- Must use **in-network pharmacy**, or Part D plan won't pay, and cost won't count toward TROOP
- In-network pharmacies are further divided between **preferred** and **non-preferred**. Although the plan will cover a beneficiary's drugs in a non-preferred pharmacy, out-of-pocket cost will be higher.
- 2021 planfinder improved re pharmacy – can search for pharmacies by name, add up to 4 pharmacies + mail order
- Plans may not require members to use **mail-order pharmacies**, but may provide incentives, like cheaper co-pays. 42 C.F.R. § 423.120(a)(10)
- **Residents of nursing homes -** Drug plans are required to contract with any qualified pharmacy willing to participate in the plan's Long Term Care network. Plans must have a network of pharmacies that provide convenient access for nursing home residents enrolled in the plan

Subsidy for everyone on Medicaid and Medicare Savings Program – plus some others with low income and assets

Extra Help

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Extra Help – Summary

Who gives it?

Federal Part D subsidy administered by CMS.

Eligibility administered by Social Security Administration (SSA) for those without Medicaid or MSP.

Who gets it & How?

- **Medicaid, SSI and MSP** recipients – **DEEMED ELIGIBLE** for **FULL EXTRA HELP**
- **OR APPLY to SSA** for:
  - **Full Extra Help -135% FPL (same as QI-1)**
    Income below $1,436/mo. (single), $1,940/mo. (couple)
    Resources below $ 9,360 (single), $14,800 (couple)(2020)
  - **Partial Extra Help – 150% FPL**
    Income below $1,596/mo. (single), $2,155.50/mo. (couple)
    Resources below $14,610 (single), $29,160 (couple) (2020)
  - RESOURCE amounts above include $1500 burial fund. Most SSI exclusions apply except cash value life insurance excluded and IRA principal COUNTED. Must count spouse's resources if live together.

If income < 135% better to apply for MSP!

What do you get?

Subsidy that reduces or eliminates many of the costs associated with Medicare Part D drug coverage

See complex rules for household size, income assets – http://policy.ssa.gov/poms.nsf/lnx/0603030001

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Extra Help 2021	No Subsidy	Full Extra Help < 135% FPL	Partial Extra Help 135- 150% FPL
Premium	range	"Benchmark" premium 100% subsidized (**$42.27** - 2021)	Pay 25% - 75% benchmark
Deductible	$455 maximum	None	Lower of $92 or plan deductible
Initial Coverage Period	25% or tiered copays	> 100% FPL $3.70 generic $9.20 brand < 100% FPL $1.30 generic $4.00 brand **$0 – Nursing Home, MLTC, waivers –TBI, NHTD, OPWDD** GIS 12-MA-005	15 % cost-sharing (or plan copays if less)
Former Donut Hole	You pay 25% brand & generic		
Catastrophic Coverage	Greater of 5% OR $3.70 generic $9.20 Brand name (5% is greater for generics @ $75 and brand names @ $184)	No copays once reach catastrophic coverage	$3.70 generic/ $9.20 brand

Medicare Savings Program

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

MSP ROCKS!

  - $1,754.40/yr. raise to Social Security check ($146.40/mo 2020)
  - Extra Help with Part D saves about $4,000/yr.
  - Eliminates Late Enrollment Penalty for Part B or Part D (but more restricted in 2019)
  - Special Enrollment Period for Part B and Part D
  - **No resource test**
  - One-page application
  - QMB covers Medicare cost-sharing
  - Cute acronyms

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Extra Help – NYS MSP Tip

- In NYS always better to apply for MSP than stand-alone Extra Help, because:
  - **No Asset Test** for MSP, but Extra Help has strict one (previous slides)
  - **Income diverted to a Pooled Income Trust doesn't count** toward eligibility for Medicaid or MSP ➔ Extra Help. So even higher income people get Extra Help if using a pooled trust for Medicaid/MSP
  - **Same income limit** for both – **135% FPL**
  - **Auto-enrolled in Extra Help** with any MSP
- **Partial Extra Help** – if **income between 135% FPL and 150% FPL** may benefit by applying for this at SSA – can apply online. But note strict Resource Test.
- If approved by SSA, must return annual renewal form.

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Extra Help – Redemption!!

- If authorized for Medicaid for just **1 MONTH** in 2020 → get Extra Help for ALL 2020
- If that **one month** is in the ***last 6 months of 2020*** then you get **Extra Help for the rest of 2020 and all of 2021!**
- Receive notice that "**redeemed**" for Extra Help for 2021.
  - If NOT redeemed for 2021, get GREY notice in 9/2020
- If client's income > MSP and Medicaid limit – but resources are within Medicaid limits - ask if she has PAST medical bills that meet her spend-down! Some past bills can be combined to be used to meet the spend-down in the month of application! Then deemed eligible for Extra Help all year and maybe the next year.
- See **EPIC slides** below – costs paid by EPIC or ADAP count toward spend-down.

Extra Help – Medicaid Spend-down Tip!!

- EXAMPLE. Tina receives SSD of $1500/mo so her spenddown is about $600/mo. She is too young for EPIC (< 65). You confirm her resources are under Medicaid limits. She comes to you in July 2020.
- ASK if she has
  - PAST **UNPAID medical bills incurred in last 6 years that are "viable" – still subject to collection --**or
  - PAST **PAID medical bills incurred in last 3 months**
  - These can offset the SPEND-DOWN in the month of initial eligibility (application month) and depending on amount – for additional months.
- Tina has an unpaid medical bill from 3 years ago of $500 now in collection and she paid $100 in copayments in the last 3 months. She can combine the $600 in bills to meet her spend-down in month of application. She will get Extra Help for the rest of 2020 and for the entire 2021 because her Medicaid is active in the second half of 2020.

- See more about spenddown at http://www.wnylc.com/health/entry/46/

EPIC - age 65+

If over income for Medicaid, or MSP or Partial Extra Help

- NO ASSET TEST! Anyone 65+ should join!!!!
- High Income Limits – with deductibles at higher incomes
- Fee Plan
  - Income cap: **$20,000** yearly/singles, **$26,000**/couples.
  - Annual fee on a sliding scale basis. Fee ranges from $8 to $230 (single) and to $300 (couple).
  - Fee waived for Full "Extra Help" recipients. Note Medicaid recipients NOT eligible for EPIC unless they have a spend-down.
- Deductible Plan
  - Income: $20,001-**$ 75,000** yearly (single);
    $26,001-**$100,000** yearly (couples).
  - No fee, but no EPIC coverage until member's out of pocket Part D drug costs meet EPIC deductible, which ranges from $530 to $2,430 (singles), or $650 - $3,215 (couples), based on the household income.
- More later on how EPIC works with Part D (#63-65)

2020-21 Changes in Medicare Advantage

CHOICE OF 2 MODELS: STAND ALONE PLAN VS. MEDICARE ADVANTAGE

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Option 1 for Receiving Part D

1. **ORIGINAL MEDICARE (Parts A and B)**

+

2. **Stand-Alone Part D Prescription Drug Plan ("PDP") +**
   - 28 Plans in NYS in 2021 – SEE LIST http://www.wnylc.com/health/entry/161/
   - 9 companies sponsor these 28 plans (down from 10 in 2019 - "Journey" plans from MII Life Insurance Magellan plan CLOSED)

+

3. OPTIONAL: **Medigap** (for Parts A and B)

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OPTION 2: Medicare Part C – Medicare Advantage w/Prescription Drug (MA-PD)

- Enroll in **private managed care insurance plan for Part A and B** services **plus** most plans **include Part D (MA-PDs)**
- Must have both Part A and B to be eligible
- Different models – costs vary
  - HMO – must go in-network
  - PPO – may go out of network at greater cost
  - PFFS – may 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: D-SNP for dual eligibles, I-SNP for people in NHs. C-SNP for chronic conditions

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Medicare Advantage

- **Same benefits as Original Medicare Parts A & B** (and usually D) – may add supplemental benefits
- **COST** - Premiums vary, coinsurance & deductibles don't have to be exactly same as Original Medicare but actuarially equivalent
- CMS "Medicare & You" etc. emphasize how premiums are lower in 2021, but that is NOT the most important factor in cost!
- ***Networks*** – June 2020 federal regs diluted network capacity (Time & Distance) requirements in rural areas, allow telehealth to meet requirement

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42 CFR § 422.100(d), 422.101 (2018 change)

Medicare Advantage

Maximum Out of Pocket Charge (MOOP)

- When member reaches MOOP limit with deductibles and copays ***for Part A & B services (not Part D)***➔ no more copayments for the year.
- Allows different MOOP for in-network vs. out of network (if plan has out of network)
- 2019 – ACA cap on MOOP increases expired. In-Network MOOP ↑ $1250 in one year!
- 2021—
  - In-Network MOOP Max **$7,550** (↑ from $6,700)
  - In-Network MOOP Min $3,450 (↑ from $3,400)
  - Combined In- & Out of Network MOOP Max **$11,300** (↑ from $10,000)

42 CFR § 422.100(d), 422.101 (2018 change)

Medicare Advantage pro's and con's

- Advantages
  - **More predictable costs** (fixed copay instead of 20% approved rate but not for all services.. More expensive services charge 20%)
  - ***May* be cheaper** – many plans have no premiums (vs. Medigap)
  - **Frills** – dental, gym, cash card for over the counter – and **NEW "supplemental benefits"** personal care, ramps (next slide)

- Disadvantages
  - **Lock-In for the year**, unless have a Special Enrollment Period (SEP)
  - **Network**: Limited to provider network and drug formulary of 1 plan – including new Medicare services (acupuncture, dialysis in MA plans)
  - **More Utilization management** – prior approval, step therapy (new step therapy allowed for Part B drugs in MA 7/20) – but new prior auth rules for some outpatient procedures in *Original Medic*are*
  - **Cost** - 20% coinsurance for chemotherapy etc, high copay for SNF rehab care & high deductibles. Maximum Out of Pocket (MOOP) cost $7550 = $629/mo. Could buy a Medigap instead. But if don't need hi-cost services, then MA is cheaper than Medigap.

*https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf eff 7/2020

SHOULD YOU ENROLL IN A PART D PLAN OR SWITCH PLANS?

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Who should not or does not have to enroll?

Retirees/ Union plan members & Veterans

- People in retiree/union plans must contact plan administrator before switching to a different plan.
  - They or their dependents may lose their other health coverage under the retiree/union plan if they enroll in a Part D plan or MA-PD. This could be ALL health coverage not just prescription drugs.
    - This is because federal govt. subsidizes those plans to encourage them to cover prescription drugs instead of dumping their members onto Part D. Can't "double dip" with 2 subsidized plans.
  - Even if they don't lose other coverage, they may not need to enroll in Part D/MA-PD because their coverage is good and subsidized.
  - Can be confusing because their retiree/union plan may be administered by & under name of a big health insurance company – may not be obvious it's retiree/union coverage.
- Veterans, Tricare for Life military – do not need to enroll in Part D.

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Who should / should not enroll?

COBRA & MEDICARE

- May 2020 – in response to mass layoffs from COVID, & eligibility of many workers for COBRA, US DOL issued FAQ* & revised employee form notices explaining how COBRA & Medicare interact
- CMS also announced a new reminder letter that will be sent to people one month before Medicare coverage starts (as part of IEP package) reminding them to review options, make choices (starting late 2020)
- If eligible for but not enrolled in Medicare when lose group health coverage, must enroll in Medicare A/B within 8 months or will have Late Enrollment Penalty when do enroll. COBRA does NOT prevent that penalty.
- Different if already have Medicare when opt for COBRA. Medicare is primary

https://www.dol.gov/newsroom/releases/ebsa/ebsa20200501 (links to FAQ & new form notices) also see COVID Medicare enrollment issues https://www.cms.gov/files/document/enrollment-issues-covid-ab-faqs.pdf

What if last year's plan is fine?

- If last year's PDP or MA-PD plan still covers all of consumer's drugs at the correct dosages, with no new utilization controls, at acceptable cost, and pharmacies still in network (and for MA-PD also covers preferred providers at acceptable costs)
- No need to change plans unless plan is closing.
- Do not have to enroll in same plan – will automatically stay in the plan.
- But need to check if current plan still meets needs!
- *See below* re plans that are closing.

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Enrollment

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Enrollment Periods

- **Initial Enrollment Period (IEP)(For Part B and Part D)**
  - Seven-month window around initial entitlement to Medicare
  - **ICEP – Initial Coverage Election Period –**when new Medicare beneficiary may first enroll in Medicare Advantage – with or without drug benefit. Usually same as IEP, but different when defer Part B enrollment at 65 because you or spouse are working
- **Open Enrollment Period (OEP)**
  - **October 15 – December 7** with changes effective January 1st of next year
  - **Can make any change regarding Part D or Medicare Advantage**

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Medicare Advantage Open Enrollment Period (OEP) (CHANGED in 2019)

1. **January 1 – March 31st - may make one Medicare Advantage (MA) plan change :**
   - From MA plan to MA plan or
   - From MA plan to Original Medicare, with or without Part D
   - CANNOT change from Original Medicare to MA plan
   - CANNOT change stand-alone Part D plan (PDP)
   - **ONE change only --** effective 1st of following month
2. New Medicare beneficiaries **who enrolled in MA** plan during ICEP may change plan or switch to Original Medicare once in the 3-month period that starts month becomes entitled to both Part A and Part B and ends the last day of the 3rd month of entitlement

42 CFR§ 422.62(a)(3)(i)(amended July 2018)
42 CFR § 422.62(a)(3)(ii)

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Special Enrollment Periods (SEP's)

- Dozens of exceptions allow enrollment into a PDP or MA-PD outside of the Open Enrollment Period. See next slides and end of this PowerPt.
- 2020 regs added 2 new & codified old SEPs*
  - Plan placed into receivership
  - Plan consistent poor performer
  - Revised catch-all SEP for "exceptional circumstances" where no other SEP applies (misleading info, circumstances beyond ben'y control prevented timely enroll or disenroll, adverse health consequences if SEP

https://www.cms.gov/files/document/cy2021-pdp-enrollment-and-disenrollment-guidance.pdf - SEPS are pp. 21-45), catch-all SEP at Ch. 2, §30.4.4.21

*42 C.F.R. §§ 422.62(b) for MA, 423.38(c) for Part D

See Medicare Rights Center SEP Chart https://www.medicareinteractive.org/pdf/SEP-Chart.pdf

Disaster/FEMA SEP extended to COVID

- SEP for beneficiaries who were eligible for -- but unable to make -- an election because they were affected by the COVID-19 pandemic
- SEP also expanded to State- and Local-declared emergencies (not just federal)
- SEP to enroll, disenroll, switch PDP or MA plan. COVID declared national disaster 3/13/20
- SEP from start of "incident period" to later of end date in declaration or 2 calendar mo's after it ends.
- Must have had another valid election period at the time of the incident period which did not exercise.

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https://www.cms.gov/files/document/cy2021-pdp-enrollment-and-disenrollment-guidance.pdf at p. 40

PDP Plans closing in 2021- SEP & Reassignment of Extra Help enrollees

- 3 PDPs are closing in 2021:
  1. Magellan Rx Medicare Basic - Benchmark (basic) plan
  2. Journey RX Standard - Benchmark (basic) plan
  3. Journey Rx Value - -Enhanced plan
- All members must pick a new plan for 2021. Those with Extra Help (full or partial) will be **randomly reassigned to a benchmark plan** if they don't pick one for 2021. Receive blue notices in Oct. and Dec.*
- **All members of the 3 plans will have a SEP from 12/8/20 – 2/28/21.**
  - This gives them extra time beyond the AEP to pick a new plan.
  - Effective date is JAN. 2021 if they enroll in 12/20. If they enroll in Jan. or Feb. enrollment is effective the following month.
- Additionally, members of these plans with **Extra Help have more SEP's**:
  - In 1st Quarter of 2021 – may change one time effective next month based on having **Extra Help**, and
  - Those who were "**reassigned**" by CMS in 2021 to a plan they don't like may change plans in 1st quarter. So arguably can change 2x in Q1.

https://www.cms.gov/files/document/cy2021-pdp-enrollment-and-disenrollment-guidance.pdf § 30.3.2, 30.3.4, 30.3.8(14) - all SEPS are pp. 21-45); * https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf

MA-PD Plans closing - Reassignment of Those with Extra Help

- If MA-PD Plans are closing in a county ("Service Area Reduction") or altogether – members with Extra Help are reassigned by CMS to a stand-alone PDP, not to an MA-PD.
- Will be assigned to **benchmark PDP** sponsored by same company if there is one, otherwise random.
- Many MA-PDs and D-SNPs closing in NYS in 2021. Download Excel lists in this article http://www.wnylc.com/health/entry/161/
- **SNP's CLOSED IN 2021: (varies by county) - see Chart of SNPs - filter by COUNTY column.**
  - ArchCare Community Choice (HMO D-SNP)(NYC, 5 other counties)
  - CenterLight Healthcare Direct Complete Plan (HMO I-SNP)(NYC, Westchester, Nassau)
  - Centers Plan for Nursing Home Care (HMO I-SNP) (Monroe County)
  - Health Pointe Direct Complete Plan (HMO I-SNP) (NYC, Westchester, Nassau)
  - Sunrise Advantage Plan - Reflections C-SNP and HMO I-SNP (Nassau and Suffolk)

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Medicare Advantage-PD plans closing in certain counties or statewide in 2021

- **Members with Extra Help in these plans reassigned –**
  - **Humana has a benchmark PDP – members of those MA-PD plans assigned to that PDP. Others will be random reassignment.**
- **Members without Extra Help not reassigned – must enroll in new plan.**

Closing plans: (see http://www.wnylc.com/health/entry/161)

- **Bright Advantage** Choice (HMO)(in NYC) – closing
- **Empire MediBlue Plus** H8432-013 (HMO) closing in Manhattan only, in other counties being crosswalked
- **Humana Choice** H5970-023 (PPO) & H5970-022 (PPO) closing (NYC, Long Island - same plan different ID available)(Humana Choice plan ID 021 not closing - members being crosswalked)
- **Humana Gold Plus** H3533-023 (HMO)(closing in NYC, Nassau & Suffolk counties but same plan with different IDs available)
- **Humana Gold Plus** H3533-030 (HMO) closing in BRONX, but same plan name with different ID available
- **Sunrise Advantage** Community Plan (HMO) is closing

https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataplan-crosswalks/2021-part-cd-plan-crosswalk; https://q1medicare.com/

MA-PD plans being "crosswalked" to another MA-PD plan

- Some plans are consolidating with another plan from same company, usually with the same plan name but different ID number.
- Or a plan is closing but members "crosswalked" to another plan, usually to plan of the same name.*
  - Wellcare Rx is closing but being crosswalked to Wellcare Compass.
- Members (with and without Extra Help) do not have to do anything to move to the new plan, but should still check coverage for 2021.
- List of plans online here http://www.wnylc.com/health/entry/161/#crosswalk

*https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataplan-crosswalks/2021-part-cd-plan-crosswalk

New 2019

SEP for Those Auto-Enrolled by CMS or NYS

- Individuals who are auto-enrolled into a Part D plan by CMS or State have a SEP to enroll into a different plan
  - May make **one-time election before the enrollment is effective or within 3 months of effective date or notification of the assignment, whichever is later**
- Who is auto-enrolled by CMS or State?
  - **Auto-enrollment**- When Medicaid approved, you are enrolled in Extra Help. Then CMS **randomly** assigns you to a "benchmark" basic plan if not already in a Part D plan;
  - **Facilitated enrollment** ("intelligent" auto-assignment for new EPIC members not in a plan), or
  - **Reassignment** –
    - If old plan terminated (see previous slide re 3 closing plans in 2021)
    - If old plan's premium increased so **plan no longer benchmark** – those with FULL EXTRA HELP who were auto-enrolled in that plan are reassigned to a benchmark plan (none in 2021)

2 SEP's for people with Extra Help –New 2019

Until 2019, beneficiaries with LIS could change Part D/MA plans every month. Changes starting 2019:

1. **People with LIS** limited to **1 change per calendar quarter** and --
   a. Only during **first 3 quarters** of year. **In 4th quarter**, can only change during AEP for January 1st of next year (unless have another SEP, like those in plans that are closing).
   b. This SEP NOT available for those identified as "At risk" or "potentially at risk" for misuse of frequently abused drugs. "At risk" designation determined by plan, with written notice that beneficiary can appeal
2. **When LIS first approved, discontinued, or changed** from Partial to Full LIS or vice versa -- **may change plans within 3 months of the change/approval** effective 1st of the next month (Or from notification of such a change, whichever is later).
   - EX: lost Medicaid in Feb. 2020 so have Extra Help rest of 2020, but not re-deemed for 2021. Have SEP Jan – Mar of 2021.

There are many more SEPS ! Some in last slides… also see MRC Chart.

How to Switch Plans

- Whether during the Annual Enrollment Period or during a SEP
- **You switch plans simply by enrolling in the new plan.**
  - To switch from an MA-PD, either enroll in another MA-PD or enroll in a PDP. That automatically disenrolls you from the old plan.
  - If you were in a MA-PD and you enroll in a PDP, you'll automatically be switched to Original Medicare.
  - To switch from PDP to a new PDP – just enroll. That disenrolls you from the old PDP.

Switch is effective the 1st of the next month

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Late Enrollment Penalty (LEP)

You pay a higher premium for Part D **for the rest of your life** if you delay enrolling after you first becoming eligible, or **within 63 days of end of "Creditable Coverage."**

- 1% per full month without Part D or creditable coverage (Starting with June 2006 or first full month after end of your IEP, whichever later)
  - Based on "base beneficiary premium*" (not "benchmark")
    - $33.06 (2021) -- 1% = $.33/mo.
    - EX: 10 year delay = 120 months -- $39.60/mo. increase
- **Extra Help EXCEPTION**: No LEP for beneficiaries with Extra Help (Full or Partial)
  - LEP ends when beneficiary eligible for Extra Help or MSP
- **SSD Exception** -- LEP ends for disabled beneficiary (SSD) who becomes 65
- Plan determines LEP, you may request Recon

*https://www.cms.gov/files/document/july-29-2020-parts-c-d-announcement.pdf

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Late Enrollment Penalty– what is Creditable Coverage?

- What is "Creditable Coverage" that allows delay in enrolling in Part D with no penalty? Must be coverage that is as comprehensive as basic Part D coverage.
- **Employer, union** – Some is, some isn't. They must give annual notice of whether coverage is "creditable."
- **EPIC -** EPIC was creditable drug coverage prior to 2012, so no LEP for any months with EPIC between 2006 and 2011. No longer is creditable coverage.
  - EPIC may pay all or portion of LEP
    - If income below $23,000/$29,000 -- EPIC pays up to LIS subsidy amount (benchmark premium – 2021 $42.27)
    - If premium below subsidy amount, EPIC pays difference toward LEP
- **VA/Tricare** – Creditable

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TIPS ON CHOOSING A PLAN

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Choosing a Plan – Tips for PDP's

- https://www.medicare.gov/plan-compare/#/?lang=en
- Use Planfinder to identify plans that cover **all Part D drugs** at preferred pharmacies with the **fewest utilization controls**.
  - If drug not appear, is it **excluded**? Is it **Part B**? If so, ignore it.
- Planfinder – since 2020 -
  - Drugs NO LONGER saved for future searches unless you log into **MyMedicare.gov** – login and password; otherwise use general search and must enter drugs every time. Can't identify which plan client is in. *SHIP counselor can call to identify plan, subsidy.*
  - MyMedicare.gov - if log in, costs calculated based on your subsidy. Otherwise you must know whether you have a subsidy and which one. If you don't know which type of Extra Help, it assumes you have FULL Extra Help.
  - Select preferred PHARMACY (up to 4 pharmacies)
  - EPIC -- will not show on Planfinder.
- Q1Medicare.com – can compare costs 2020 to 2021

Planfinder improvements 2021

- **Default sort from lowest out of pocket cost + Premium**
- Improved **pharmacy** selection – can change from plan details page; can locate by name and address, can select up to 4
- Drug lists, adds 1 – 2x/year fill options; can add drugs any time
- Drug data footnotes – frequency not covered, etc.
- **Flags plans offering $35 insulin** – 2021 "Senior Savings Model" **TIP: don't filter plans by those offering this benefit.** Not always cheapest plans and don't want to filter out other plans.
- Drug prices updated biweekly
- Easier to print to a PDF
- Medicare Advantage plan searches:
  - Plan type filter – HMO, PPO, SNP, etc.
  - Display renal dialysis benefit info
  - Can filter by extra's – dental, vision, gym – but this should not be main criteria

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Choosing a Plan – Medicare Advantage

- Planfinder shows *estimated* annual costs for medical costs other than Part D – it's not individualized.
- Planfinder now has more info – once click on a plan, can find copays/coinsurance for all key services:
  - Hospital, outpatient deductibles, NEW dialysis
  - Skilled Nursing Facility coinsurance, # days fully covered
  - Outpatient copays – primary care, specialist, ER
  - Lab tests, radiology, ambulance, etc.
- Look up providers on plan website– are they in network?
  - Doctors, hospital, lab, etc.
  - NEW: Dialysis, acupuncture, transplant center, opioid treatment,
  - If not , client must be willing to switch providers.
- Take any Part B drugs? Look at prior auth, step therapy requirements
- Consider Original Medicare:
  - Can client afford Medigap instead?
  - Is client QMB-eligible?

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2019 change – no longer requires that MA plans of same company have "substantial differences"

- **Meaningful difference no longer required** between plans offered by same company, meaning**an** economic/actuarial difference in the coverage.
- **No longer requires uniformity** in premium, benefits and level of cost-sharing for beneficiaries in plan service area
- This increased "flexibility" means:
  - Variance of MA plans may increase greatly
  - **More difficult to compare plans** and make decisions – much info won't be on Planfinder.
- EX. Wellcare has 18 MA-PD plans in NYS in 2021 – 7 in Bronx - 3 PPOs – Absolute, Summit, Today's Options Advantage Plus 550B Choice and 3 HMO's - Compass, Element, Preferred. 1 HMO closed - WellCare Rx
- Sometimes same name - Just ID number distinguishes them. But benefits, costs vary!

42 CFR §§ 422.254 ,422.256, § 422.100(d)

D-SNPs Dual-Special Needs Plans

- Covers Medicare Parts A, B, and D
- Must have Medicaid to enroll
- Plan is NOT a Medicaid plan – does not PROVIDE Medicaid services but caters to Medicaid recipients
- HMOs not PPO's – may not go out of network
- Benefits Medicaid recipients because:
  - Network providers MUST accept Medicaid
  - Full Dual eligible cannot be billed for Medicare deductibles and coinsurance. With a regular MA plan, network providers that don't take Medicaid may bill for plan coinsurance.
  - SHOULD coordinate with Medicaid services
- Downside –
  - Marketing features "extras" that should be covered by Medicaid anyway. Including new "supplemental benefits."

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D-SNPs Dual-Special Needs Plans - 2021 Default Enrollment

- In 2021, new Default Enrollment will start.
- Mainstream managed care members who become enrolled in Medicare will be default enrolled into a Dual-SNP, with right to opt out. Usually to one affiliated with same plan.
  - "Well duals" without home care will be enrolled in **Medicaid Advantage** (mega-HMO combining Medicare and Medicaid).
  - Duals who received home care thru mainstream plan default enrollment to **Medicaid Advantage Plus** plan – a combo of Dual-SNP + MLTC plan + Medicaid managed care all in one.
- Many new Dual-SNPs are expanding in 2021 to be ready.
  - *Plans newly launching a Dual-SNP*: Aetna
  - *Plans expanding Dual-SNPs to new counties or adding more Dual-SNPs*: Centers Plan, Elderplan, Emblemhealth, Empire MediBlue, Hamaspik, Human, Integra, Metroplus, UnitedHealth, Wellcare
  - *Dual-SNP already offered for*: Agewell, Nascentia, Healthfirst, Riverspring, Senior Whole Health, VillageCare, VNSNY

New 2021 – On Dialysis? May enroll in MA-PD

- **Currently, ESRD beneficiaries are EXCLUDED from Medicare Advantage**, so receive coverage largely through Original Medicare, unless they developed ESRD while enrolled in a Medicare Advantage plan.
- **Starting 2021**, beneficiaries with ESRD (end-stage renal disease/kidney failure) may enroll in a Medicare Advantage plan.
- **COST** – Maximum plan may charge is 20% (same as Original Medicare – but can't buy a Medigap!)
  - Plan may have lower coinsurance – should be on PlanFinder.
  - Medicare Advantage plans not responsible for organ acquisition costs of kidney transplants.
- **In-Network WARNING**: Dialysis center, nephrologist, and facility/ surgeon where plans to have transplant, must be part of the **plan's network**. Network adequacy requirements do not apply to dialysis centers!!

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2019-20 Expanded "Supplemental benefits" in Medicare Advantage

- **2019** - "compensate for physical impairments, … ameliorate functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization" ➔ Home care, adult day care, ramps, power wheelchairs, nutrition services, caregiver support
  - 46% more plans offering these in 2021 than in 2020
- **2020 –Special Supplemental Benefits for the Chronically Ill (SSBCI)**
  - **2021**: plans have more flexibility to target any medically complex chronic condition, not just ones specified in 2020. *Member won't know if eligible until after enrolled – beware of marketing promises!!*
    - Must be life threatening or significantly limit the overall health or function of the enrollee, and "have a reasonable expectation of improving or maintaining the health or overall function" (not necessarily permanently)
    - Have a high risk of hospitalization or other adverse health outcomes; and
    - Require intensive care coordination.
  - **Non-health related** benefits OK -- **meals, transportation for non-medical reasons**, **ramps**, **air conditioners**, or **air filter,** as well as home care, reduced cost-sharing or deductibles for different conditions, therapeutic massage
  - 4-fold increase in no. of plans offering these since 2020. Mostly SNP's.
- Will benefits be meaningful or just marketing ploy? Home care max 10 hours/mo.

New Medicare Benefits – Acupuncture 2021, Opiod Treatment -2020

- **Both Original Medicare & Medicare Advantage**
  - Must be Medicare provider.
  - MA plan – must be in network.
  - Referral – not required in Original Medicare/ MA plan – may require referral/ prior approval
- **Acupuncture** - Only covered for lower back pain lasting > 12 weeks but MA plans may cover other conditions
  - Pain must have no known cause (surgery, disease)
  - Original Medicare - Max 12 sessions within 90 days, plus 8 more if improvement shown (max 20/year).
    - MA plans may give more sessions
- **Cost** – Acupuncture -20% coinsurance/MA plan copays. Opiod treatment was free in 2020 – unclear in 2021

New Medicare Advantage demo program - Hospice

- **Visiting Nurse Service of NY** is one of 9 insurance companies nationwide testing a new Hospice benefit in 1 MA plan in 2021.
  - **VNSNY CHOICE Total (HMO D-SNP)** –NYC, Long Island & Westchester
- Part of new **Value-Based Insurance Design** (VBID) Model - plans may provide supplemental benefits targeting certain chronic conditions or socio-economic status (ie reduced cost sharing to encourage use of high-quality clinical services). Includes non-health services.
- **Normally, hospice benefit is carved out of Medicare Advantage**–
  - Normally - provided thru Original Medicare even though in MA, plan using Original Medicare costs & coverage rules.
  - Member has choice of using providers/costs in Original Medicare or MA plan for non-terminal conditions.
- **In new Demo**, hospice benefit provided within plan.
  - Must provide palliative care to eligible enrollees, irrespective of the election of hospice
  - Concern: **NETWORK** – hospice provider must be in network.
  - **Who makes decisions** - eligibility for hospice? Plan? Provider?

https://innovation.cms.gov/innovation-models/vbid

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Coordinating With Other Coverage

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Medicaid + Part D – Dual Eligibles

- Dual eligibles get all drugs thru Part D except for drugs excluded from Part D – still provided by Medicaid
- **If not in Part D plan when Medicaid approved**
  - In about 2 months CMS will **assign you RANDOMLY to a Part D plan**. *Best to choose a plan based on your drugs! May only change plans 1x/quarter!*
  - Until then, Medicare will enroll you in **Limited Income Newly Eligible Transition (LI NET)** for temporary coverage.
  - LI NET must cover all Rx at any pharmacy as long as drug not excluded from Part D. Show pharmacy your YELLOW automatic enrollment notice from Medicare to prove that LI NET should cover you. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/11154.pdf

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Medicaid and Part D - Dual Eligibles

Reimbursement for Rx Paid at Full Price in Part D Plan

- **LI NET will be retroactive** back to Medicaid or SSI start date (if you had Medicare then) or to your last enrollment in a Part D plan, whichever is later.
- Send copies of the following to LI NET for reimbursement:
  - Proof of Medicaid or SSI eligibility, or proof of last Part D enrollment
  - Reimbursement form - http://apps.humana.com/marketing/documents.asp?file=2830217
  - Drug receipts
  - LI NET's Help Desk 1-800-783-1307
- Example: Susan has Medicare and applied for Medicaid on June 5, 2019 and was approved effective June 1, 2019 by Notice dated July 28, 2019. She is not yet in a Part D plan. She can request reimbursement from LiNet for cost of prescriptions she paid since June 1st.

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Medicaid + Part D = Dual Eligibles

If Already in Part D When Medicaid Approved

- **Best Available Evidence --** Extra Help will take a few months to activate. Meantime, **give pharmacist Medicaid acceptance notice**, **proof receives SSI, or screenshot showing active Medicaid** as "**Best Available Evidence**" of LIS eligibility. Plan and pharmacy must only charge Extra Help copays.
- **Ask plan to reimburse client** for copays/deductible paid in excess of Extra Help limits, back to effective date of Medicaid, including retro period.
- https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Best_Available_Evidence_Policy.html

EPIC – age 65+ Benefits

- **Part D & EPIC deductible** -- Must first meet Part D deductible before EPIC pays. Your costs in the Part D deductible DO NOT count toward the EPIC deductible
- **Premium Subsidy**
  - Low income - EPIC pays the Part D premium (benchmark - **$42.27 - 2021**) < $23,000 (single) -< $29,000 (married).
    - If you have EPIC AND Extra Help -- each can pay $42.27 - 2x benchmark premium! So you can join a more expensive enhanced plan!
  - Higher income, EPIC gives a **credit against the deductible** for the cost of benchmark Part D premium - **$42.27 x 12 mo.= $507.24**
- **Copays** --Once meet Part D & EPIC deductibles, EPIC "wraps around" Part D coverage by **subsidizing copays and coinsurance! See next slide.**
  - Only pays for Part D drugs on plan formulary (or if plan approved exception) and Part D-excluded drugs
  - No doughnut hole! Continues to wrap around Co-payments

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EPIC – Help with Co-Pays or Coinsurance

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

Example: Tier 6 Drug Copay is $300/mo.
EPIC member pays $20 EPIC pays $280.

Full Extra Help example: Brand Extra Help copay $9.20.
EPIC member pays $3 EPIC pays $6.20.

EPIC is an SPAP – State Pharmaceutical Assistance Program

- As an SPAP, **costs paid by EPIC,** not just by member Count toward **"TROOP"** – count toward meeting the threshold for member to move into doughnut hole and then into Catastrophic Coverage!
- Costs paid by **EPIC and ADAP** count toward the **Medicaid Spend-Down**! (May qualify for Extra Help for a full year by meeting spend-down for one month.
  - Costs paid by EPIC and ADAP – not just member copay - paid in 3 months before month of Medicaid application count)
  - Call EPIC for printout of costs
- In 1st example on previous slide, $300 is counted toward TROOP and can be counted toward Medicaid spend-down – which may qualify client for Medicaid and EXTRA HELP!!

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Other sources of drug coverage or discounts

- **Patient Assistance Programs (PAPs)** –
  - cash assistance from PAP, not free or discounted drugs, counts toward TROOP
  - Find them at https://medicineassistancetool.org/
  - https://www.needymeds.org/
- **Veterans Health Care**
- **ADAP –** for HIV/AIDS. Payments count toward troop AND can be used to meet Medicaid spend-down. http://www.wnylc.com/health/entry/197/ Must enroll in Part D as condition of ADAP eligibility.

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Switching Plans outside of the Annual Enrollment Period – SEPS Other than for Dual Eligibles/ Extra Help

MORE ON SPECIAL ENROLLMENT PERIODS

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SEP - Medicare Part B & Marketplace

- Coalition seeking extension of SEP that expired Sept. 30, 2019
- For individuals who qualify for premium-free Part A based on age or disability who delayed or declined Part B since they thought they could continue their Marketplace Qualified Health Plan coverage with tax credits/subsidies.
- **If extended**, they will be able to apply for Equitable Relief through **new deadline** by requesting, in writing, a special enrollment period to enroll in Medicare Part B without a Late Enrollment Penalty

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More SEPS: at age 65, new to MA-PD

1. **SEP65- switch from Medicare Advantage to PDP**
   - Aged beneficiary enrolls in **Medicare Advantage** plan (with Part D) during Initial Coverage Election Period
   - Must have enrolled "surrounding their 65th birthday" – within 3 months before or after 65th bd
   - 12 months from effective date to enroll in stand-alone Part D plan (PDP) and Original Medicare
2. **Medicare Advantage "TRIAL" SEP**
   - If enroll in Medicare Advantage plan when first eligible at age 65, within 12 months may disenroll from their first Medicare Advantage plan to go to Original Medicare + PDP + Medigap
   - IF dropped Medigap to enroll in MA-PD plan for first time, 12 months to return to Original Medicare & enroll in PDP & reinstate Medigap.
     - PDP SEP begins month of MA disenrollment plus two months

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More Special Enrollment Periods

1. **SPAP (EPIC) SEP** – one plan change/year any time for EPIC members (SPAP = State Pharmaceutical Assistance Program)
2. **SEP to enroll in a 5-Star** PDP or MA-PD plan once/plan year -SEP runs from when ACEP ends December 8 to November 30th of the next year
3. **SEP EGHP** - Loss of creditable coverage thru Employer Group Health Plan, including retiree and COBRA. SEP ends two months after end of coverage (can't just not pay EGHP premium)
4. Member **moves into or out of a nursing home** (2 months)

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More SEPS –Member moves

- Member moves to a different state, and sometimes within state, so different Medicare Advantage or Part D plans available as result of permanent move
- Lasts for two months following month of move (or from when notified old plan – timing is complicated!)
- If was in prison, or lived out of US – so not eligible for Part D, and now move to USA or get out of prison – this SEP applies.

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More SEPS

1. **LOSS OF PART B ➔ Involuntarily Disenrolled from an MA-PD** plan because must have Parts A and B for Medicare Advantage
   - But continue to have Part A
   - SEP to enroll in stand-alone Part D plan
2. **Disenrollment from Part D to Maintain Retiree or Other Creditable Coverage, Including VA and Tricare**
   - Part D SEP to disenroll from Part D or MA-PD plan (NOT to enroll in or switch plans)
   - Some retiree health insurance is federally subsidized. Can't be in two subsidized plans – double dipping. By staying in Part D plan, risk losing retiree coverage, which may be better than PDP or MA-PD, or may cover spouse.

SEPS to correct mistakes

- **Part D Plan Enrollment Not Legally Valid SEP --** used when a Part D plan enrollment was not complete, such as if it was not signed by the beneficiary. Or mistake - client thought she was buying a Medigap policy or enrolling in a Medicaid managed care plan with a similar name, not a PDP. CMS must approve, and can make it retroactive.
- **Part D Federal Error SEP - f**ederal employee errors can cause a Part D plan enrollment that should not have happened. Federal errors might also prevent an intended enrollment into a Part D plan. CMS decides on a case-by-case basis whether to approve
- Member enrolled based upon misleading or incorrect information provided by plan employees, agents, or brokers

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THANK YOU

More information at nylag.org

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