

Medicare Prescription Drug Improvement & Modernization Act

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Association

The Medicare Modernization Act

Objectives:

- Overview
 - Basics
 - Enrollment Information
- Enrollment Assistance
 - Steps to Enroll
 - Expectations for Dual Eligibles
- After Enrollment
 - Drug Coverage and Exceptions
 - Copayment Issues

Medicare/Medicaid Overview

- Medicare – Insurance coverage “earned through work.” Offered through the federal government.
 - Part A – “Hospital” coverage
 - Part B – “Physician” coverage
 - Part C – Medicare advantage
 - Part D – New prescription drug coverage
- Medicaid – Medical assistance based on financial need. State-specific.

Medicare Modernization Act

- Medicare Modernization Act (MMA):
 - Establishes the Medicare Part D prescription drug benefit
 - Begins January 1, 2006
 - Participation is voluntary*
- * *Medicaid clients who opt out of Part D will have no prescription drug coverage.*

Eligibility and Coverage

- Eligibility:
 - Entitled to Medicare Part A and/or
 - Enrolled in Part B

People with Medicare must enroll directly with an approved drug plan to get Medicare drug coverage.

Medicare Drug Coverage

- Offered by private insurers through:
 - Stand-alone Prescription Drug Plans (PDPs)
 - Medicare Advantage Plans (MADPs)
 - Special Needs Plans (SNPs)
 - Some employer and union plans

Available Plans in Washington

- PDPs:
 - 20 PDP organizations, offering 45 different plans
- MAPDs:
 - 10 MAPD organizations, offering 25 different plans

Washington PDP Organizations

- Humana Inc.
- Health Net
- Coventry Advantra Rx
- Sierra Rx
- Unicare
- PacifiCare Life & Health
- Asuris NW Health
- United Healthcare
- SilverScript
- Prescription Pathway
- WellCare
- YouRx Plan
- Cigna HealthCare
- United American Insurance
- Aetna
- ODS Advantage Rx
- Sterling Prescription Drug Plan
- FOX Insurance Company
- Community Care Rx
- Rx America

MADPs in Washington

- Kaiser
- Secure Horizons
- Spokane Community Care
- United Healthcare
- Health Net Options Plus
- Regence
- Group Health Cooperative
- Providence Health Plan
- Molina Advantage
- Asuris NW Health

Plan Details

- 25 PDPs have a \$0 deductible
- 21 PDP formularies cover more than 90% of the Top 100 prescription drugs
- 42 PDPs offer a mail-order benefit

Medicare Supplement Plans “Medigap”

- Medigap insurers cannot issue new drug policies that supplement Part D (after January 1, 2006)
- Supplemental Plans H, I and J:
Beneficiaries will have to choose between Medigap and the Medicare Prescription Drug Benefit
 - Medigap plan coverage is not as good as the Medicare Prescription Drug Benefit

Guidelines for Plans

- CMS must approve all plan formularies and provider networks
- CMS has issued plan guidance regarding:
 - Formularies
 - Pharmacy Access
 - Transitions

Standard Prescription Drug Plan

- Beneficiaries will have to pay:
 - Estimated \$35 monthly premium*
 - \$250 deductible
 - 25% of drug costs from \$25 to \$2,250
 - 100% of the drug costs from \$2,250 and \$5,100
 - The greater of \$2 and \$5 copays or 5% of drug costs of \$5,100

** Premiums can vary and may be more than listed*

Standard Benefit Costs

Plan Costs	Beneficiary Costs	
0	\$250	Annual Deductible
75% of Drug Costs	25% of Drug Costs	Co-insurance \$250 - \$2,250
0 of Drug Costs	100% of Drug Costs	Donut \$2,250 - \$5,100
95% of Drug Costs	5% of Drug Costs	Catastrophic >\$5,100

True Out-of-Pocket (TrOOP)

- TrOOP: The amount a beneficiary must spend on Medicare-covered drugs to reach catastrophic coverage.
 - Catastrophic coverage begins at out-of-pocket costs over \$3,600 and \$5,100 in total drug costs (total drug costs include what the beneficiary and other payers have paid).

TrOOP

- Payment sources that can count towards TrOOP:
 - Beneficiaries
 - Families
 - State Pharmaceutical Assistance Program (SPAP)
 - Not-for-profit organizations
 - Individual health savings accounts

TrOOP

- Payment sources that do not meet TrOOP include:
 - Medigap policies
 - Employer or union plans
 - Tribal entities
 - State or local government entities
 - Medicaid prescription drug coverage
 - Any other third party arrangement

Costs

- The average PDP will charge:
 - A monthly premium
 - An annual deductible
 - Cost-sharing of \$3,600 a year to reach catastrophic coverage
- People with a limited income may receive a subsidy to cover some or all of these costs

Costs

- Dual Eligibles
 - People with Medicare and Medicaid will pay:
 - NO premium
 - Unless they choose an expensive plan
 - NO deductible, and
 - Copayments from \$1 - \$5 per drug (not applicable to nursing home residents)

Enrollment

- Open enrollment
 - November 15, 2005 – May 15, 2006
- Annual enrollment after 2005
 - People with Medicare can enroll every year from November 15th to December 31st
 - People can also change to a different plan at this time

Enrollment for Dual Eligibles

- Full dual eligibles NOT in a Medicare Advantage Plan (MADP) will be auto-enrolled in October 2005
- All clients who are auto-enrolled must be offered enrollment assistance
- These clients can choose a different plan beginning November 15, 2005
 - *After November 15th, dual eligible clients can choose a different plan each month*

Enrollment Assistance

- Questions to ask:
 - Does the person have any other drug coverage
 - Is the person eligible/willing to enroll in a Medicare Advantage Plan?
 - Has the person filled out a low-income subsidy (LIS) “extra help” application with Social Security?
 - Is the person eligible for any of DSHS’s programs, such as Medicaid?
 - *Some people may want to keep the coverage they have, depending upon how good the plan is (e.g., Veteran’s Administration, etc.)*

Enrolling in a Plan

- Get a list of all drugs a person takes (for the past 6 months)
- Find out all of the pharmacies the person uses
- Does the person need
 - Long term care pharmacies?
 - Mail order?
- How much does the person pay now for prescription drugs?

Enrolling in a Plan

- Enrollment Summary:
 - Go to the www.medicare.gov website (plan comparison tool), or
 - Call 1-800-MEDICARE
 - Find the plans that cover the person's drugs
 - Make sure the plan allows the person to use their pharmacy

Steps to Enroll

- Enrollment details:
 - Step 1: Compile an accurate drug list for each person.
 - Pharmacists or doctors can help with the list
 - Clients may provide this list
 - Clients should request a “patient profile” or “drug history report” from their pharmacy(ies) for the last six months
 - *This drug report should be request before starting the process of choosing a drug plan.*

Steps to Enroll

- Enrollment details:
 - Step 2: Meet with clients to compare MAs or PDPs
 - Using the website www.medicare.gov, type in the person's prescriptions
 - Compare MAs' or PDPs' drug coverage and pharmacy networks to the person's needs
 - If current PDP has best coverage, stay in PDP and go to Step 5.
 - If alternative plan(s) are better, go to Step 3.

Steps to Enroll

- Enrollment Details:
 - Step 3: Compare Plans
 - Use the www.medicare.gov website to screen PDPs for the following:
 - Formularies (list of covered drugs)
 - Pharmacy access (including access to LTC pharmacies), and
 - Copayments
 - Move to Step 4.

Steps to Enroll

- Enrollment Details:
 - Step 4: Help enroll in the best plan by:
 - Using www.medicare.gov, or
 - Calling 1-800-MEDICARE, or
 - Calling the PDP's toll-free telephone number, and
 - Go to Step 5.

Steps to Enroll

- Enrollment Details:
 - Step 5: Be prepared to file a drug exception:
 - If the PDP does not cover all of the person's drugs, or
 - If medically necessary drugs have higher copayments (cost-sharing may be reduced).
 - *Exceptions can be filed beginning January 1, 2006.*

Expectations of Dual Eligibles

- Goal: All full dual eligible clients will be enrolled in a PDP that meets their needs by December 31, 2005.
- The following dual eligible clients must receive enrollment assistance through DSHS or AAA:
 - All Non-Service and In-Home clients
 - Residents in long-term care facilities if the facility is unable to provide assistance

Special Enrollment Periods

- Special enrollment periods can occur when:
 - Beneficiary moves out of the plan's service area
 - A plan terminates their contract with CMS
 - Beneficiary loses other “creditable” health insurance coverage
 - Moving out of or into a Nursing Facility

Postponing Enrollment

- Outcome: beneficiaries pay higher premiums if they do not enroll when they are first eligible
- Exception: There is no penalty for individuals who have good prescription drug coverage
- The penalty is 1% for every month the person waits to enroll

Enrollment Penalty

- Example:
 - Mr. Lee enrolls 12 months later than his initial enrollment period
 - With the base premium of \$37 a month, he is penalized 37 cents for each month he waited
 - The total penalty is \$4.44
 - Mr. Lee's monthly premium is \$41.50

Disenrollment

- Medicare beneficiaries may voluntarily disenroll from a plan during the annual or special enrollment periods
- Beneficiaries can be involuntarily disenrolled for:
 - Moving out of the service area
 - Losing eligibility
 - Termination of a plan's contract
 - A plan misrepresenting information

Low-Income Subsidy (LIS) - Overview

- LIS will assist people who meet eligibility requirements
- The extra assistance provides help with Medicare Part D:
 - Premiums
 - Deductibles
 - Copayments/Coinsurance

LIS Overview

- People with Medicare and Medicaid (dual eligibles) will automatically be eligible for LIS
- They do not need to apply for LIS
- CMS sent dual eligible clients a letter in May and June 2005, explaining that they will receive LIS assistance automatically
- Dual eligibles will have copays for each prescription. CMS's letter informs clients of this
 - *Exceptions: dual eligible clients living in nursing homes, ICF/MRs, or psychiatric hospitals will not have copays*

SSA's LIS Notices

- The Social Security Administration (SSA) determines eligibility for the LIS program
- SSA sent letters to Washingtonians who are not current DSHS clients, saying they may be eligible for LIS
- The letters and forms were mailed to them between May and August, 2005

SSA's Responsibilities

- SSA has primary responsibility for LIS determination
- Field offices should refer individuals to SSA for assistance:
 - Toll-free number (1-800-772-1213)
 - SSA's website (www.socialsecurity.gov)
 - Do you qualify? SSA has an online tool for self-screening
 - Local SSA office
 - Local events planned by SSA and community partners

LIS Eligibility Determination Process

- SSA's process is:
 - Automated and does not require individuals to provide income or assets verification, and
 - A one-step, convenient process for eligibility determination

LIS Application Form

- People must use SSA's "scannable" form or file online
- Do not photocopy the LIS application form from SSA
 - *Photocopied forms will be processed manually, and determinations will take longer*

SSA's Income Definition

- Income is earned and unearned income and includes:
 - Federal benefits (such as Social Security)
 - Wages
 - Rental income
 - Interest
 - Pensions
 - Annuities

LIS Eligibility: Resources

- Cash or “Liquid assets” that can be converted to cash within 20 days, including:
 - Bank accounts
 - Stocks and bonds
 - Real estate
- The primary home does not count as a resource
- Assets must be less than \$11,500 for an individual and \$23,000 for a couple
 - \$1,500 per person is allowed for burial costs

SSA's Family Size Definition

- Family size includes:
 - Individuals
 - Spouses
 - Relatives living with – and receiving at least 50% in financial support from – the individual
 - *Relative means someone related by blood, marriage, or adoption*

3 Levels of Assistance

- Group 1
 - Full benefit dual-eligibles with incomes below 100% of Federal Poverty Level (FPL)
- Group 2
 - Dual eligibles over 100% of the FPL
 - Anyone on Medicare Savings Plan (QMB, SLMB, QI)
 - Other Medicare beneficiaries with incomes below 135% of FPL with assets under \$7,500/\$10,500
- Group 3
 - For persons from 135% up to 150% of FPL with assets below \$11,500/\$23,000

LIS – Group 1

- Who?
 - Full dual eligibles with incomes at or below 100% of FPL
 - Full dual eligibles who live in a nursing facility
- Eligible individual pays:
 - Premium \$0
 - Deductible \$0, and
 - Copayments are \$1 or \$3 per drug (not applicable if living in a nursing facility)

LIS – Group 2

- Who?
 - Dual eligibles with an income above 100% FPL (\$798 per month)
 - MSP clients
 - Individuals with income up to 135% of FPL with “assets” that are less than \$7,500 for an individual/\$10,500 for a couple
- Eligible individual pays:
 - Premium \$0
 - Deductible \$0, and
 - Copayments are \$2 or \$5 per drug

LIS – Group 3

- Who?
 - Individuals with income from 135% up to 150% of the FPL (\$1076 - \$1196 per month)
 - Individuals with “assets” that are less than \$11,500 for an individual/\$23,000 for a couple
- Eligible individual pays:
 - Premium (sliding scale) based on income
 - Deductible - \$50
 - Coinsurance 15% per prescription, and
 - Catastrophic coverage is \$2 or \$5 per prescription once annual out-of-pocket costs reach \$3,600

Cost Comparison

Standard	LIS Group 1	LIS Group 2	LIS Group 3
\$250 Deductible	\$0 Deductible	\$0 Deductible	\$50 Deductible
25% Coinsurance	\$1 – \$3 per drug	\$2 – \$5 per drug	15% Coinsurance
100% Donut	\$1 – \$3 per drug	\$2 - \$5 per drug	15% Donut
5% Catastrophic	\$0	\$0	\$2 - \$5 per drug

Part D Covered Drugs

- Medicare will pay for the following drugs:
 - Prescription drugs
 - Biologicals (i.e., Procrit, Raptiva)
 - Insulin (and insulin injection supplies)
 - Vaccines
 - Smoking cessation drugs
 - Compounded drugs (2 or more drugs added together by a pharmacy)

Part D Drug Coverage

- Each plan develops its own drug formulary
- Plans must cover at least 2 drugs in each category and class of drugs
- CMS encourages plans to provide a “broad range” of coverage for prescription drugs

Part D Drug Coverage

- Plans must ensure that the formulary does not discriminate
 - For example, a plan must not discourage enrollment of people with Alzheimer's disease, diabetes, or high blood pressure
- Plans must give 60 days' notice prior to changing the formulary

Formulary Specifics

- Definition: A formulary is a list of drugs that a health plan will cover
- Formulary tools that a plan may use include:
 - Prior authorizations
 - Quantity limits
 - Step therapy
 - Cost-sharing tiers

Guidelines for formulary tools are set by each health plan, and may vary

Formulary Controls

- Prior Authorization (PA):
 - A process to determine medical necessity for a specific drug
 - PA drugs are usually high cost or have health risks
 - Plans maintain a list of drugs requiring a PA
 - If a PA is not approved, then the drug will not be covered

Formulary Controls

- Quantity Limits:
 - A limit on the quantity of drug that is covered
 - Drugs with quantity limits are usually high cost or have special health risks
 - Plans maintain a list of drugs with quantity limits
 - Higher quantities can be covered, if a PA is approved

Formulary Controls

- Step Therapy:
 - Trial of one or more less costly alternative drugs prior to allowing coverage of the more expensive drug
 - Example: A patient must try Prilosec before coverage of Nexium is allowed
 - Drugs requiring step therapy are usually high cost
 - If step therapy is not completed, the more costly drug may not be covered

Formulary Controls

- Sometimes a PA can bypass step therapy if medical necessity is proven
- Step therapy is unsuccessful if:
 - Adverse side effects occur, or
 - Treatment is not effective
- After step therapy is proven unsuccessful, then a higher cost drug can be approved

Formulary Controls

- Cost-sharing tiers – different levels of copay amounts depending on the type of drug
 - Generic drugs have the lowest copay amount
 - Formulary drugs have the next lowest copay
 - Non-formulary drugs have the highest copay

Comprehensive Drug Coverage

- CMS requires plans to cover the majority of drugs in the following classes/categories:
 - Anticonvulsants (for seizures)
 - Antidepressants
 - Antineoplastics (for cancer treatment)
 - Antipsychotics
 - Antiretrovirals (for HIV/AIDS treatment), and
 - Immunosuppressants (for transplants)

Part D Exclusions

- Medicare will not pay for drugs to treat:
 - Anorexia, weight loss, or weight gain
 - Fertility
 - Cosmetic conditions or hair growth
 - Symptoms of cough or colds
 - Prescription vitamins
 - Except prenatal vitamins and fluoride preparations

More Part D Exclusions

- Medicare will not pay for the following drugs:
 - Barbiturates (e.g., Phenobarbital)
 - Over-the-counter (OTC) drugs
 - Benzodiazepines (e.g., Valium, Xanax)
- Medicaid may cover these drugs depending on legislative funding
- Plans may provide coverage for Part D exclusions as part of a step therapy program at no cost to the beneficiary

Exceptions Process

- Plans must have an exceptions process
- The process must ensure access to medically necessary prescription drugs covered by Medicare

Exceptions Process

- Plans must make a decision in:
 - 24 hours for emergencies
 - 72 hours for “regular” exceptions
- If a plan denies an exception request, the person can appeal
- If approved, exceptions are allowed for the entire calendar year

Changes for Medicaid Clients

- Clients who have both Medicare and Medicaid:
 - Will not receive prescriptions through Medicaid
 - Will need to choose a plan
 - CMS will auto-enroll clients in October, and
 - Clients must ensure their drugs are on the plan's formulary, or risk loss of drug coverage
 - Will have copayments for drugs if they live in boarding homes (not applicable to nursing home residents)

Critical Issues for Long Term Care Facilities

- Dual eligible clients will be auto-enrolled in October
- Auto enrollment may mean that:
 - Your residents are not enrolled in the best plan for them
 - The plan may not cover his or her current prescription medications
 - The plan may not contract with the pharmacy you are currently using

What This Means to You

- If your residents are auto enrolled into a plan that does not work, they will need to switch plans before December 31, 2005
- Private pay residents will need help deciding if they should even enroll in a plan
- It will take between 60 and 90 minutes to help a resident choose a plan
- Medicare's website and toll-free number will have the best tool to compare drug plans

What We Hope LTC Facilities Will Do

- Learn about the new Medicare Prescription Drug Program
- Help residents in the enrollment process
- Ensure residents are enrolled in the plan that will best work for them

Issues to Look at After January 1st

- Washington will not cover most prescription drugs for your dual eligible clients
- Dual eligible residents will have copays starting January 1, 2006
- There will be ongoing plan changes
- There will be changes to Service Contributions
- For boarding home clients, Part D will not cover the cost for repackaging

For more information, contact Medicare at:

1-800-MEDICARE (1-800-633-4227)

www.medicare.gov

*For information on Low-Income Subsidy Program,
contact Social Security at:*

1-800-772-1213

www.ssa.gov

For information on SHIBA, contact the HelpLine at:

1-800-562-6900