Medicare Part D

Basic Counselor Training
Medicare Part D: The Basics
Acknowledgement

This project was supported by the Wisconsin Department of Health Services with financial assistance, in whole or in part, by grant number 90SAPG0091, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.
Objective

Build on your Knowledge of Medicare Part D
• Part D enrollment and eligibility
• Coverage of medications
• Exceptions and Appeals
• Plan structure and costs
• Extra Help and Low Income Subsidy
• SeniorCare

Practice Scenario
What is Medicare Part D?

• Voluntary Medicare Prescription Drug Benefit
  • Signed into law 2003
  • Coverage began January 1, 2006
  • Coverage regulations at 42 CFR 423
  • Prescription Drug Manual

• Provided by private insurance companies
  • Contracted with CMS to provide coverage
Who is eligible for Part D?

• Medicare beneficiaries must:
  • Be entitled to Part A and/or enrolled in Part B,
  • Live in the service area of the prescription drug plan,
  • Not be incarcerated
  • Enroll in a plan.
How to get Part D

• Two Ways to get Part D:
  • Stand-alone Prescription Drug Plan (PDP)
  • Prescription drug coverage included/bundled as part of a Medicare Advantage plan (MAPD)

Counselor Note: Basic concepts of Part D are the same whether the plan is a stand alone Part D plan or included in a Medicare Advantage plan bundle.
Wisconsin Part D

- Wisconsin is a Part D region
  - All stand alone Part D plans in Wisconsin are available in every county
  - Each plan may have a different pharmacy network in each county

- Medicare Advantage with Part D (MAPD)
  - Part D is separate from the Medical part of a MAPD
    - Premium, deductible, copay and coinsurance do not count toward MOOP
  - Each county MAPD drug plan is slightly different
    - Usually pharmacy network differences
Questions?
Enrollment

How and when to get a Part D prescription drug plan
I DID IT!

YOU FINISHED YOUR NOVEL!

I CHOSE A MEDICARE DRUG PLAN!

Mike Kelley, The Denver Post, 2005
Part D Enrollment

- Initial Enrollment Period (IEP)
- Open Enrollment Period (OEP)
- Special Enrollment Period (SEP) (in certain circumstances)
Initial Enrollment Period (IEP)

7-Month Period

If apply **before** 65th birthday month, coverage starts the month turning 65.

If apply **during** the 65th birthday month, coverage starts the next month.

If apply **after** 65th birthday month, coverage begins the next month.

Enrollment after the IEP, may pay a late enrollment penalty.
Initial Enrollment Period (IEP)

• 7-month window
  • 3 months before the first month eligible (turn 65 or 25th month receiving SSDI payments),
  • Month eligible, and
  • 3 months after the month eligible

• What if enrollment into Original Medicare Part A or B is retroactive?

Can enroll
  • Month of notice of eligibility for Medicare, and
  • Special enrollment period that lasts 3 months after the month of receipt of the notice.
Open Enrollment Period (OEP)

- 7-week period each year when beneficiaries can enroll in, disenroll, or switch Medicare Advantage Plans or Medicare drug plans
- This is the time to review health and drug plan choices
What changes can be made during the Open Enrollment Period (OEP)?

- Sign up for a new Part D plan (PDP)
  - If never enrolled
- Switch PDPs
- Switch to another Medicare Advantage with Part D (MAPD)
- Switch to Medicare Advantage and a stand-alone PDP
- Go back to Original Medicare and a standalone PDP
- Disenroll from a PDP or MA or MAPD
Special Enrollment Period (SEP)

• SEP gives a beneficiary the ability to make one election or choice within a certain period of time

• Different SEPs for different circumstances allows:
  • Disenrollment from a plan
  • Enrollment into a plan

**Counselor Note:** Enrolling in a plan automatically disenrolls from the previous plan
Examples of Special Enrollment Periods (SEPs)

- SEP for those with Extra Help or Low Income Subsidy (LIS)
- Moving to or out of a service area
- Entering or leaving a long term care facility
- Loss of creditable prescription drug coverage
- Plan terminated by Medicare or does not renew
- Loss/Gain of Extra Help / LIS
- Enrollment in 5-Star Plan
Add Part D during GEP

• If enrolled in Medicare during the GEP

Can enroll in:
  ▪ Part D (if enrolled in Part A and/or Part B)
Part D Late Enrollment Penalty (LEP)

Individuals will be assessed a penalty if:

• IEP ended without enrollment in a Part D plan
• If it has been 63 days or longer since the individual was last enrolled in a Part D plan, and the individual:
  • Was eligible for Part D,
  • Not enrolled in Part D,
  • Not enrolled in creditable coverage, and
  • There is no applicable exception.

Counselor Note: LIS will waive the late enrollment penalty
Late Enrollment Penalty (LEP), continued

The LEP will be effective as long as the beneficiary is enrolled in Part D

- 1% of the national base premium for each full month eligible and without creditable drug coverage

- Multiply the number of uncovered months by 1% of the base beneficiary premium
  - Remember to let the client know that your calculation is only an estimate
    - CMS and the plan will inform the client of the exact amount
  - The LEP will be added to the plan premium

- Amount due will change every year
Check Your Knowledge

Why is Initial Enrollment Period (IEP) important?

a. Missed enrollment deadlines could result in penalties
b. It is the first opportunity to enroll in Medicare Part D
c. When you enroll impacts when your coverage begins
d. All of the above

Countdown timer: Answer the question before the bar disappears!
It’s July. Your client enrolled in Medicare last year but didn’t enroll in a Medicare drug plan and now needs Part D. Generally, when is the next chance to enroll in Part D?

a. Open Enrollment Period (OEP)
b. Initial Enrollment Period (IEP)
c. Their next birthday
d. 12 months after their IEP

Countdown timer: Answer the question before the bar disappears!
Questions?
Medicare Part D Coverage

What prescriptions Part D covers
Part D Drug Coverage

• Retail pharmacy prescription drugs
  • Requires a prescription
  • Used for an FDA medically accepted indication

• Plans do not have to cover all medications that are available except for certain categories
  • A minimum of two of the most commonly prescribed medications in each therapeutic category

Counselor Note: Part D plans must provide their members a list of covered drugs both online and in paper format.
Part D Excluded Drugs

- Excluded drugs include:
  - Medicare Part B drugs, e.g., outpatient drugs that require durable medical equipment like an external infusion pump
    - See CMS Medicare Parts B/C Coverage Issues chart
  - “Off label” prescriptions
  - Drugs not approved by FDA
  - Most prescription vitamins,
  - All weight loss/gain drugs, over-the-counter drugs, drugs for “cosmetic” purposes (e.g., hair loss), erectile dysfunction drugs
    - Prenatal vitamins are covered under Part D
    - Cialis may be covered for low blood pressure

Counselor Note: Medicaid may pay for excluded medication under Medicaid rules for those enrolled in both Medicare and Medicaid.
Off Label Drug Coverage

• Drugs must be prescribed for a “medically accepted indication”

• Supported by one of two drug compendia
  • American Hospital Formulary Service Drug Information
  • DRUGDEX Information System

• Best example of off label is Lidocaine patches

• CMS is clear that plans should limit off label drug coverage
  • Use utilization management tools
    • Point Of Sale Prior Authorization (POS PA)
  • PA edits can be and are used for transition fills
Questions?
Structure and Requirements for Part D Plans

Basic and Alternative Enhanced
Basic Part D Plans

Standard Structure - 4 phases of coverage

• Deductible
  • Can be zero or up to the limit set by law each year

• Initial Coverage Limit – 25% coverage limit
  • Can be zero copayments up to 25% coinsurance for Part D covered drugs

• Coverage Gap
  • Can vary amount paid if generic or name brand drug up to 25%

• Catastrophic Coverage – protection against high out of pocket expenses
  • 5% or LIS category one copay amount for the plan year
Enhanced Alternative Plan Structure

Same structure as a basic plan
Enhanced Coverage

• Plans may offer “enhanced benefits,”
  • Include medications that are not required by the laws governing Part D plans.
  • May include Part D excluded drugs such as vitamins/minerals
• Costs associated with enhanced benefits do not count towards out-of-pocket costs used to determine when a beneficiary has met the deductible or made it to the coverage gap or to the catastrophic coverage level.

Counselor Note: Enhanced plans may not be cheaper for beneficiaries than purchasing these items outside of the plan.
Additional Plan Requirements

• Make sure there is convenient access to retail pharmacies.
  • Specialty pharmacies

• Have a process in place to get medically necessary drugs that are not on the formulary
  • Exception process

• Provide useful enrollee information, such as
  • How formularies work,
  • How to save money with generic drugs, and
  • How to navigate the grievance and appeals processes.
Utilization Management Tools

- Prior Authorization (PA)
  - Plan requires a PA before coverage of certain drugs. Plan makes coverage determination.

- Quantity Limits (QL)
  - Excess amounts over most common dosage level. Plan makes coverage determination.

- Step Therapy
  - Requires trying another drug before covering the prescribed drug. Coverage determination needed to override.

- Medication Therapy Management (MTM)
  - Manages beneficiaries with complex needs with drugs, usage, adverse effects, and drug interactions.
Tiering

• Plans group drugs for payment purposes.
  • Can have up to 6 tiers
• Each tier has separate co-pay/coinsurance amount.
• For any covered prescription, a plan may charge
  • Tier 1 drugs = $4
  • Tier 2 drugs = $47
  • Tier 3 drugs = 50%
  • Tier 4 specialty drugs = 33%

Counselor Note: See tiering for client’s drug list on the Plan finder or plan website
Check Your Knowledge

Plans can use what tools to manage drug coverage?

a. Prior Authorization
b. Quantity Limits
c. Step therapy
d. All of the above

Countdown timer: Answer the question before the bar disappears!
Questions?
Exceptions and Appeals

When prescriptions are not covered at all or at an affordable cost
Coverage Determinations/Exceptions

• Any decision made by the Part D plan regarding
  • Receipt of or payment for a prescription medication not on formulary
  • Tiering
  • Amount of copay
  • Quantity limit
  • Step therapy
  • Prior authorization
Formulary Exceptions

• Part D plan members have the right to appeal denials of drug coverage
• Plan members can also request exceptions:
  • Coverage of a drug that’s not on a formulary;
  • Challenge a plan’s PA requirement, step therapy, or quantity limit requirements; or
  • Change a drug’s tiered cost-sharing
• Standard Exception request – 72 hours
• Expedited Exception request – 24 hours

Counselor Note: Plans must get the information needed from the prescriber in order to make a determination of coverage. This can extend the timeline.
Denied at the Pharmacy Counter

• Request a “transition fill”
  • If available

• Contact the prescriber

• Contact the plan to obtain a coverage determination in case the person chooses to pursue a formulary exception

• Explore other plans to see if another plan might provide better coverage
  • If SEP available
Transition Fill Policy

• All plans **must** have a transition policy
• It’s an important beneficiary protection for those unfamiliar with the plan’s formulary requirements
• One 30-day temporary fill within the first 90 days of coverage
• Plans **must** send a letter explaining what steps are needed to continue to receive the medication within 3 days.

**Counselor Note:** CMS’ Part D Transition Fill Policy may be found [here](#). If there is a problem with a transition fill, contact a benefit specialist or Helpline for assistance.
Reconsideration and Appeals

For unfavorable coverage determinations

• Five levels of appeals
  • Redetermination (Part D Plan Sponsor)
  • Reconsideration (Independent Review Entity)
  • ALJ hearing
  • Medicare Appeals Council
  • Federal District Court

Medicare Part D Appeal Process is [here](#)

**Counselor Note:** Refer all requests to for appeals to a Helpline or Benefit Specialist
Questions?
Medicare Part D Costs

What beneficiaries pay for Part D prescription coverage
Part D plan costs

Each part of the Plan structure has a monetary value attached

• Premiums
  • All stand alone PDPs have a monthly premium
  • Individuals with an income over $97,000 for an individual or $194,000 for a couple will have a higher Part D premium in 2023 (IRMAA)
  • LEP will increase the monthly premium

Counselor Note: Beneficiary’s drug list is necessary to determine the most cost effective plan.
2023 Medicare Part D Standard Structure

**Initial Coverage Period**
Beneficiary pays either 25% or actuarially equivalent tier structure.

**Coverage Gap**
Beneficiary pays 25% of brand name drugs and 25% of generic drugs.

**Catastrophic Period**
Beneficiary pays 5% or $4.15/generics $10.35/brand names.

Effective January 1, 2023 – December 31, 2023
<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
</table>
| **DEDUCTIBLE**                 | Beneficiary pays up to $505  
(In some plans, preferred generics are not subject to the deductible.) |
| **INITIAL COVERAGE**           | Up to 25% of drug costs  
75% or more of drug costs  
Until total drug costs reach $4,660 |
| **(FORMER) COVERAGE GAP**      | 25%  
75%  
"Donut Hole"  
Until the beneficiary's total out-of-pocket costs reach $7,400 |
| **GENERICS**                   | 25%  
75% |
| **BRAND-NAME DRUGS**           | 25%  
5%  
70% |
| **CATASTROPHIC BENEFIT PERIOD**| 5% co-insurance or $4.15 generic / $10.35 brand-name, whichever is higher  
15%  
80% |
Deductible

- The Centers for Medicare and Medicaid Services (CMS) determines the plan year deductible
  - Part of the standard structure
- Plans can vary the amount but cannot be more than the CMS set amount for the plan year
  - Zero up to full deductible
- Those with full Extra Help have no deductible
Initial Coverage Level

• The amount the plan member pays and the plan pays
  • 25% beneficiary
  • 75% plan
  • Or beneficiary pays the plans negotiated price reduced amount
    • Could be any amount from $0 up to the medication tier cost

• Many do not get out of the initial coverage level
  • If all medications are generic

• Amount needed to meet the benchmark varies year to year
Coverage Gap aka Donut Hole

• **STILL EXISTS**

• CMS gradually from 2011 – 2020 aligned the coverage with the initial coverage level

• Plan members pay 25% of the cost of medication

• Must meet the coverage gap cost benchmark to proceed to the next coverage level.

• Only certain amounts paid count toward True Out Of Pocket
Coverage gap TrOOP Calculation

• Beneficiary’s TrOOP costs include:
  • Deductible
  • Cost-sharing costs
    • Copayments
    • Coinsurance
  • Coverage gap payments
    • Drug company discount amount of brand name cost
    • Payments made by organizations, programs, friends, family on beneficiary’s behalf
• Premium does NOT count.
• Amount plan pays does NOT count.
• Costs for enhanced benefits do NOT count.
TrOOP in Coverage Gap

• Generic and Brand Name drug costs count differently for TROOP

• Generic drug
  • 25% paid for the drug counts

• Brand name drug
  • Of the total cost of the drug, the manufacturer pays 70% to discount the price. Then the plan pays 5% of the cost. Together, the manufacturer and plan cover 75% of the cost. Plan member pays 25% of the cost of the drug.
  • There’s also a dispensing fee. The plan pays 75% of the fee, and member pays 25% of the fee.
Generic Drug Subsidy Example:

Mr. Evans reaches the coverage gap in his Medicare drug plan. He goes to his pharmacy to fill a prescription for a covered generic drug. The price for the drug is $20, and there's a $2 dispensing fee that gets added to the cost. Mr. Evans will pay 25% of the plan’s cost for the drug and dispensing fee ($22 x .25 = $5.50). The $5.50 he pays will be counted as out-of-pocket spending to help him get out of the coverage gap.
Mrs. Anderson reaches the coverage gap in her Medicare drug plan. She goes to her pharmacy to fill a prescription for a covered brand-name drug. The price for the drug is $60, and there's a $2 dispensing fee that gets added to the cost, making the total price $62. Mrs. Anderson pays 25% of the total cost ($62 x .25 = $15.50).

The amount Mrs. Anderson pays ($15.50) plus the manufacturer discount payment of $42 ($60 x .70 = $42) count as out-of-pocket spending. So, $57.50 counts as out-of-pocket spending and helps Mrs. Anderson get out of the coverage gap. The remaining $4.50, which is 5% of the drug cost ($3) and 75% of the dispensing fee ($1.50) paid by the drug plan, doesn't count toward Mrs. Anderson's out-of-pocket spending.
Catastrophic Coverage

• The Catastrophic Period begins when the beneficiary meets the True Out-of-Pocket (TrOOP) cost threshold.
• Cost of drugs are reduced to 5% or category one Low Income Subsidy (LIS) amount
Questions?
Extra Help, Low Income Subsidy (LIS)

Additional information about how Part D works with Extra Help
Who receives Low Income Subsidy (LIS)?

Three groups of people receive LIS:

- **Full Benefit Dual Eligibles (FBDE)** = Full subsidy
  Full benefit Medicaid and Medicare

- **Medicare Savings Program (MSP)** = Full subsidy
  QMB, SLMB, SLMB+

- **Extra Help Individuals (Social Security)** = Full or Partial subsidy
  Depends on income and assets
  Apply at Social Security

**Counselor Note:** Medicaid requires Medicare eligible members to get Medicare Part D
Full Subsidy Benefits

• Premium - 100% subsidy for standard low cost plan up to the regional “benchmark”
• Deductible – None
• Cost-sharing
  • Initial Coverage Period - Reduced to applicable LIS levels
  • Catastrophic Period – Zero copay
• Coverage Gap – None
• Enrollment into Part D and Waiver of Late Enrollment Penalty
Low Cost Plans (Benchmark Plans)

- To maximize savings with a subsidy, a LIS beneficiary must be in one of these plans.
- “Benchmark” is the maximum regional premium subsidy for a full LIS/Extra Help individual.
- Low cost (benchmark) plans are standard/basic Part D plans.

**Counselor Note:** If a full subsidy person enrolls in an enhanced plan, they will have to pay the portion of the premium attributed to the enhanced benefit, even if the total plan premium is below the benchmark amount.
LIS Auto and Facilitated Enrollment

• LIS/Extra Help eligibles can choose Part D plan – “Choosers”
  • If haven’t chosen, CMS will – wants them in Part D plans!

• AUTO-ENROLLMENT:
  • SSI recipients only who have not selected a Part D plan at the time of Medicare eligibility.
  • Effective first month of Medicare eligibility

• FACILITATED ENROLLMENT:
  • All other LIS eligible beneficiaries have facilitated enrollment.
  • Effective second month after either Medicare enrollment or after Medicaid eligibility
  • MSP only
  • FBDE Medicaid
  • Extra Help through SSA

Counselor Note: If the beneficiary is already in a Part D plan when becomes LIS eligible, they will remain in that plan unless they choose to change.
Full Subsidy Copayment Levels

- **Category 1**
  - Full benefit Medicaid eligible beneficiaries over 100% FPL
  - Eligible for MSP – SLMB and SLMB+ at or below 135% FPL
  - Eligible for SSA Extra Help - income at or below 149% FPL & lower resources

- **Category 2**
  - Full benefit Medicaid eligible beneficiaries up to 100% FPL

- **Category 3**
  - Zero cost-sharing
  - Full benefit dual eligible beneficiaries
    - Institutionalized
    - HCBS (Family Care, IRIS) at the nursing home level of care
Partial Subsidy for 2023

• Premium - 25% to 100% subsidy of premium up to the “benchmark”

• Deductible – No more than the amount set for the plan year

• Co-insurance – No more than 15%

• Copayments - No more than Level One LIS copays

• Coverage Gap – None

• Waiver of Late Enrollment Penalty
It’s July. Your client who enrolled in Medicare last year but didn’t enroll in a Medicare drug plan becomes eligible for Medicaid. When will Part D begin?

a. Open Enrollment Period (OEP)
b. Effective the month of Medicaid eligibility

c. September 1
d. January of the following year.

**Countdown timer:** Answer the question before the bar disappears!
Check Your Knowledge Bonus question

Your client who enrolled in Medicare last year in December but didn’t enroll in a Medicare drug plan, becomes eligible for Medicaid in August. Will your client have a Late Enrollment Penalty?

a. Yes

b. No

Countdown timer: Answer the question before the bar disappears!
Questions?
Limited Income Newly Eligible Transition Program (LINET)

Additional information about how Part D works with Extra Help
What is LINET?

• LINET is a temporary Medicare Part D program that provides immediate prescription drug coverage for Medicare beneficiaries who qualify for Medicaid or Extra Help and have no prescription drug coverage.

• LINET is administered by Humana
LINET Eligibility

• Must be Part D eligible and enrolled in Medicaid or Extra Help
• Not enrolled in a Part D plan
• Not enrolled in an RDS (retiree drug subsidy) plan
• Not enrolled in a Medicare Advantage plan which does not allow enrollment in LINET
• Has not opted out of Part D enrollment
• Have a permanent address in the fifty States or DC
LINET Eligibility Benefits

- Provides immediate prescription coverage at the pharmacy counter; enrollment is processed by claim submission
- Limited pharmacy network restrictions
  - Open formulary
- No premiums
- Coverage usually lasts about two months
- Retroactive reimbursement may be available for out-of-pocket expenses
LINET Excluded Drugs

• There are drug categories not payable
  • Non FDA approved drugs

• There are indication-based Authorization for certain drugs
  • Opioid drug edits
  • Validation of a Medicare Part D covered diagnosis prior to payment, e.g.
    • Lidocaine Patches
    • Fentanyl
    • Nuvigil
    • Cialis
LINET Requirement for Enrollment

• Evidence of LIS will be required before Point Of Sale (POS) enrollment
  • Necessary because of the number of beneficiaries who never became LIS eligible
• Best Available Evidence (BAE) must be submitted and approved before receipt of prescription
  • Medicaid eligibility is automatically checked at the pharmacy counter
• Can take up to 7 days for processing
• One time authorization for immediate need
• If eligible, will receive a welcome letter and card
Retroactive reimbursement

How can a beneficiary request retroactive reimbursement?

• Complete the Direct Member Reimbursement Form located in the LINET welcome letter or on our website at Humana.com/LINET
• Attach copy of receipt or printout from the pharmacy and proof of payment
• Mail or fax completed form with receipt

Send information to:
LINET
P.O. Box 14310
Lexington, KY 40512-4310
Fax: 877-210-5592
LI NET Resources

LI NET Program Help Desk 1-800-783-1307

SHIP dedicated line (for Advanced SHIP Counselors with Unique IDs)
- 1-866-934-2019

Faxing BAE
- 1-877-210-5592

Faxing Immediate Need information
- 502-580-6644

Note: 4 Steps for Pharmacy Providers is found at www.humana.com/LINET. Problems with LINET should be referred to a helpline or benefit specialist.
Best Available Evidence (BAE)

Enrolled in Part D Plan, but plan does not have beneficiary LIS/Extra Help information
CMS Policy on Best Available Evidence (BAE)

- Part D sponsors are **required** to accept BAE
  - Can be submitted by anyone
- Must accept different forms of evidence
- Must establish the subsidy status
- Must update their system within 48-72 hours
- Provide access to covered Part D drugs at reduced cost-sharing
- Policy is found on [cms.gov](http://cms.gov)
Acceptable Best Available Evidence (BAE)

- A copy of a state document that confirms active Medicaid status
- A printout from Forward Health Interchange enrollment file
- A screen shot from CARES or Forward Health showing Medicaid status
- Other state documentation, e.g. notice of decision
- Social Security (SSA) award letter for Extra Help
The State of Wisconsin

• Sends a file to CMS every month
  • Usually @ the 20th of every month
• Every person who is Medicare/Medicaid eligible
  • Entire state is submitted
• Information is not always timely
  • If Medicaid process after state submission timefram
BAE and Home and Community Based Services (HCBS)

• HCBS = zero copays
• The BAE is both the enrollment in Medicaid waiver and the functional screen page indicating Nursing Home Level of Care
• Other evidence, e.g. remittance advice showing Medicaid payment, etc.
• Qualifies if receiving HCBS services
• CARES/Forward Health must reflect waiver
How to Submit BAE

• Call the plan
• Fax the plan
• Email the plan

Practice tip:
Include a cover sheet/memo about your client, outlining FBDE status effective date, a short statement that the state of Wisconsin has not uploaded the information, and any other information you feel that will get the subsidy in place faster

Counselor Note: This can be tricky. If unable to access the needed information refer to a helpline or benefit specialist
Part D Miscellaneous

Additional information about how Part D works with Extra Help
Reassignment

• CMS reassignment for following year
  • Part D plans (PDPs) that will be above the Low Income Subsidy (LIS) benchmark for the following year.
  • PDPs and Medicare Advantage plans that are terminating.

• CMS does not reassign “choosers”
  • LIS eligible with 100% premium subsidy, and
  • Has voluntarily chosen a plan.
  • Unless plan is terminating or reducing service area, and chooser would be left with no Part D coverage.
Deeming

• CMS looks at Medicaid data from states in July of every year and uses that data to determine LIS eligibility for the upcoming year.

• Those who receive Medicaid, even for one month, during or after the July window, will be deemed eligible for the subsidy for the remainder of the current year and through the end of the following year.

• Those who received Medicaid in the current year, even for one month, but lost it before the July window, are eligible for the subsidy for the remainder of the current year.
Questions?
To help you track when we’ll resume, each bar takes 1 minute to disappear from the slide…
Important Notices

Annual notices sent by CMS and Part D plans
CMS Notices

• CMS publishes a list of its mailings each year
  • consumer-mailings.pdf (cms.gov)

• Different colors for different notices
  • Yellow – received any time of year
  • Blue – received any time of year
  • Purple – received any time of year
  • Gray – received only in September
Important CMS Notices

• Gray – Loss of Deemed Status (loss of extra Help)
• Yellow – Auto enrollment notice
• Blue – Reassignment notice
• Purple – Notice of LIS/Extra Help

Counselor Note: It is important to recognize the color of the notices. That way you are able to verify if the client was notified of changes or auto enrollment.
Annual Notice of Change (ANOC)

• Every Part D and Medicare Advantage plan member gets an Annual Notice of Change letter from their plan by September 30th
  • Explains changes for the coming year
• Plan could have same name but different costs, formulary, and rules
  • Different set of plans available every year
  • Plans change their list of covered drugs and cost structure.
  • Plans can add prior authorization requirements or quantity limits
  • Plans can change drug tiers for particular drugs

Counselor Note: Even if individual is happy with the current plan, they should always revisit during the Open Enrollment Period (OEP).
Why revisit plan every year?

• Low premium may not be the lowest cost plan.
• Low deductible may not be the lowest cost plan.
• Cost during coverage gap may not be the lowest cost plan.
• Enhanced coverage may not save money.
• Basing plan choice on coverage of one drug may not lead to best plan choice.
Check Your Knowledge

It is open enrollment. Your client’s Medicaid ended on June 30. What color letter should the client have received?

a. Yellow
b. Blue
   - Grey
   - Green

Countdown timer: Answer the question before the bar disappears!
Questions?
Miscellaneous

Things you need to be aware of
Other Prescription Coverage

• Those with “creditable coverage” can decline Part D with no risk of penalty later.
• The beneficiary should get notice of creditable coverage from the employer each year
• SeniorCare is creditable coverage.

Counselor Note:
Always make sure that the beneficiary understands the implications of declining any private insurance before a final decision is made to alter existing coverage.
COBRA

• COBRA enrollees must notify their COBRA plan when Medicare eligible
• If the COBRA plan allows both that plan and Medicare Part D, they should coordinate,
  • But sometimes the meshing of insurances doesn’t go well.

Counselor Note:
COBRA is creditable coverage for Part D **not** Part B
Coupons and Part D

• An easy way to get lower prices for prescriptions
  • GoodRx
  • SingleCare

• Drugs purchased with a coupons do not count towards deductible

• Plans can allow purchase price to count towards TROOP while in the coverage gap.
  • Must submit receipts

**Counselor Note:**
These types of programs do not take the place of Part D and are not considered creditable coverage.
Questions?
What is SeniorCare

• State Pharmaceutical Assistance Program (SPAP)
  • Considered creditable coverage
• WI resident and 65 years of age or older
• No income or asset limit
  • Both spouses’ income count, even if one is under age 65
• $30 annual enrollment fee
  • Renewal every year
• Will coordinate with Part D
  • Can have both SeniorCare and a Part D plan.
SeniorCare Costs

• Income determines the level of SeniorCare coverage
  • Level 1 = <160% FPL
  • Level 2a = 161-200% FPL
  • Level 2b = 201-240% FPL
  • Level 3 = >240% FPL

• Deductible
  • Level 2a - $500/person
  • Level 2b - $850/person
  • Level 3 – Spend down to 240% FPL and $850/person

• Copays
  • $5 generic
  • $15 brand
SeniorCare, continued

• SeniorCare formulary
  • Not as inclusive as Medicaid

• Cannot be on Medicaid and SeniorCare at the same time.

• Only 2 levels are considered State Pharmaceutical Assistance Program (SPAP)
  • Level 2b
  • Level 3

• Can enroll in a Part D plan
  • Many use SeniorCare to help pay for medications in the deductible

• Can have a Special Enrollment Period (SEP) to enroll in a Part D plan
Resources

• Department of Health Services webpage: FAQs, publications, and application information
  https://dhs.wisconsin.gov/seniorcare/index.htm
  • Information about SeniorCare (P-10078)
  • Medicare Part D and Extra Help for SeniorCare Members (P-10074)
  • Spenddown and Deductible (P-10086)

• Apply via a paper application:
  • SeniorCare Application (F-10076)
  • SeniorCare Authorization of Representative (F-10080)

• SeniorCare Customer Service hotline: 1-800-657-2038
Questions?
Counseling Skills

Referrals and expectations
How to determine with what your client needs help

Sample questions:

1. When did your Medicare start?
2. When did your plan start?
3. Did you lose employer health coverage?
4. Do you have VA, Tricare or any other prescription coverage?
5. Did you just become eligible for Medicaid?
6. Why was your medication not covered?
7. Do you have paperwork?
When to Refer

• “Basic-level” SHIP counselors should be able to:
  • Describe Medicare Part D and use the Part D plan finder
  • Explain and assist with enrollment
  • Recognize when assistance is needed with coverage of prescriptions, and
  • Recognize when an individual may qualify for financial help.

Counselor Note: Refer a client to a benefit specialist or a helpline for further assistance with Part D unique coverage questions or appeals.
Part D Scenario

It is open enrollment. Harry and Sally are in your office for their appointment to check on a plan for the coming year. The couple have been on the same plan for a number of years and have never thought about changing. They looked at their ANOC and saw that the premium is going up. It will be very expensive next year. They want to know if there is another plan in which they can both enroll.

What information do you need and how do you explain Part D coverage to them?
QUESTIONS?