Medicare Part D

Basic Counselor Training

SHIP
State Health Insurance Assistance Program

disabilityrights WISCONSIN

Acknowledgement

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Medicare Part D: The Basics

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
  - The law is found at 42 CFR 423
  - Medicare Prescription Drug Benefit Manual
    - Coverage regulations and guidance
- 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: All 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 only 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 Keefe THE DENVER POST 2005

Part D Enrollment

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

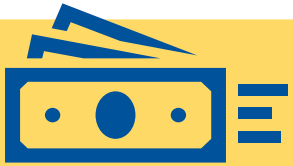
Initial Enrollment Period (IEP)

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

- Enrollment into Original Medicare Part A or B is retroactive due to disability

Part D IEP

  - Starting month of notice of eligibility for Medicare Part A, and
  - IEP lasts 3 full months after the month of receipt of the notice.

Retroactive Medicare Enrollment and Part D

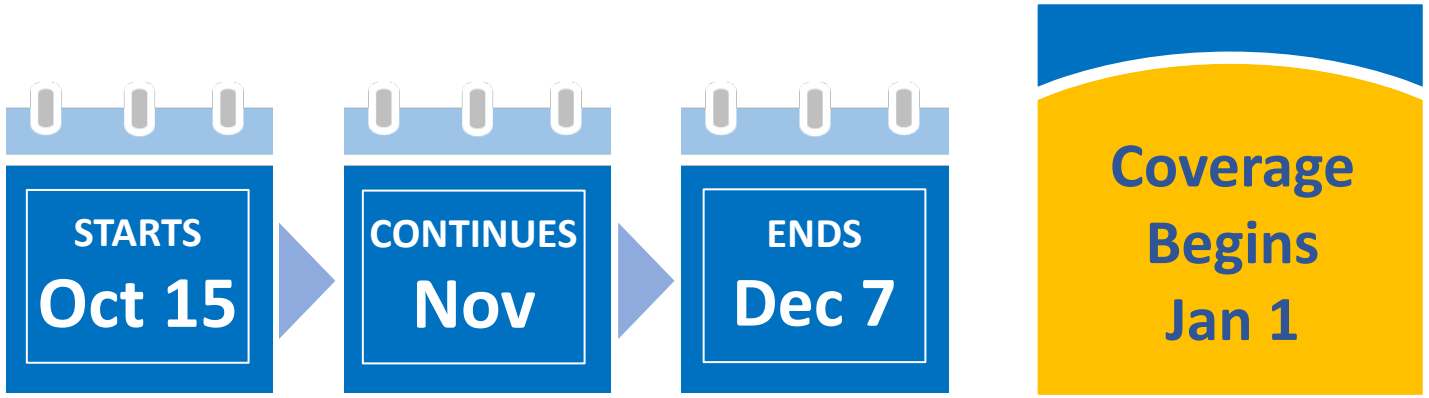
Example

In May 2023, John W. is found eligible for retroactive Social Security Disability effective June 2020. He receives a letter from SSA dated May 19, 2023 that Medicare Part A will be effective January 1, 2023.

When will the initial enrollment period for Part D begin?

- IEP for Part D will begin
  - May 2023
- IEP for Part D will end
  - August 31, 2023

Open Enrollment Period (OEP)



- 7-week period each year when beneficiaries can enroll, 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
    - May be subject to LEP
- Switch PDPs
- Switch to another Medicare Advantage with Part D (MAPD)
- Switch to Medicare Advantage (MA) 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 allow:
  - 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)

- Quarterly 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
- Gain/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
- Enrollment due to exception circumstances

SEP Usage and Ranking

- A SEP is considered “used” based on the month the application is made.
  - A PDP application is made in the month of February for enrollment effective March 1 for a person with LIS.
  - First quarter SEP is “used”.
- A person moves from Hawaii to Wisconsin. Then decides to change their MAPD back to Original Medicare.
  - In January plan is notified of the move to Wisconsin effective February 1
  - SEP is used in March to change to Original Medicare and a PDP to be effective April 1
- There is a ranking to the use of SEPs especially applicable during the OEP.
  1. IEP
  2. SEP
  3. OEP

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: Low Income Subsidy(LIS) eligibility 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 is additional to the plan premium
- LEP amount can 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!

Check Your Knowledge

It is April. Your client enrolled in Medicare last September 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,
  - Approved by the FDA, and
  - Used for an FDA medically accepted indication.
- Plans do ***not*** have to cover all medications that are available
  - Must cover a minimum of two of the most commonly prescribed medications in each therapeutic category
    - Includes compounded medications
  - Includes biologics, e.g. Humira
  - Insulin and supplies associated with the delivery of insulin

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,
    - Prenatal vitamins are covered under Part D
  - All weight loss/gain drugs, over-the-counter drugs, drugs for “cosmetic” purposes (e.g., hair loss), erectile dysfunction drugs
    - Cialis may be covered for low blood pressure

Counselor Note: Do not confuse excluded drugs with non formulary drugs. Medicaid may pay for excluded medication under Medicaid rules for those dually enrolled in both Medicare and Medicaid. Ask if you are not sure.

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 prescription usage is Lidocaine patches
  - post-herpetic neuralgia, i.e., Shingles pain only
- 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

Medicaid Coverage of Drugs

<u>Do not confuse Part D excluded drugs and not on formulary drugs</u>

- Medicaid stops paying for Medicare Part D drugs when eligible for Medicare.
- Claims must be submitted to the Part D plan for denial before Medicaid will pay.
- Medicaid will pay at their rate and client may have a copay.

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 plan year
- Initial Coverage Limit – 25%
  - Can be zero copayments up to 25% coinsurance for Part D covered drugs
- Coverage Gap – 25%
  - Coinsurance for generic or name brand drug
  - Must meet the True Out Of Pocket (TrOOP) amount
- Catastrophic Coverage – protection against high out of pocket expenses
  - Zero copay after meeting TrOOP

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 through 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 aka Coverage Determination
- 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.

Counselor Note: If not sure if a drug needs a coverage determination, contact a helpline. Do not guess.

Tiering

- Plans group drugs for payment purposes.
  - Can have up to 6 tiers
- Each tier has separate co-pay/coinsurance amount.
- Some plans can exempt certain tiers from meeting the deductible, etc.
- 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. Please check with a helpline for assistance with questions on tiering.

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!

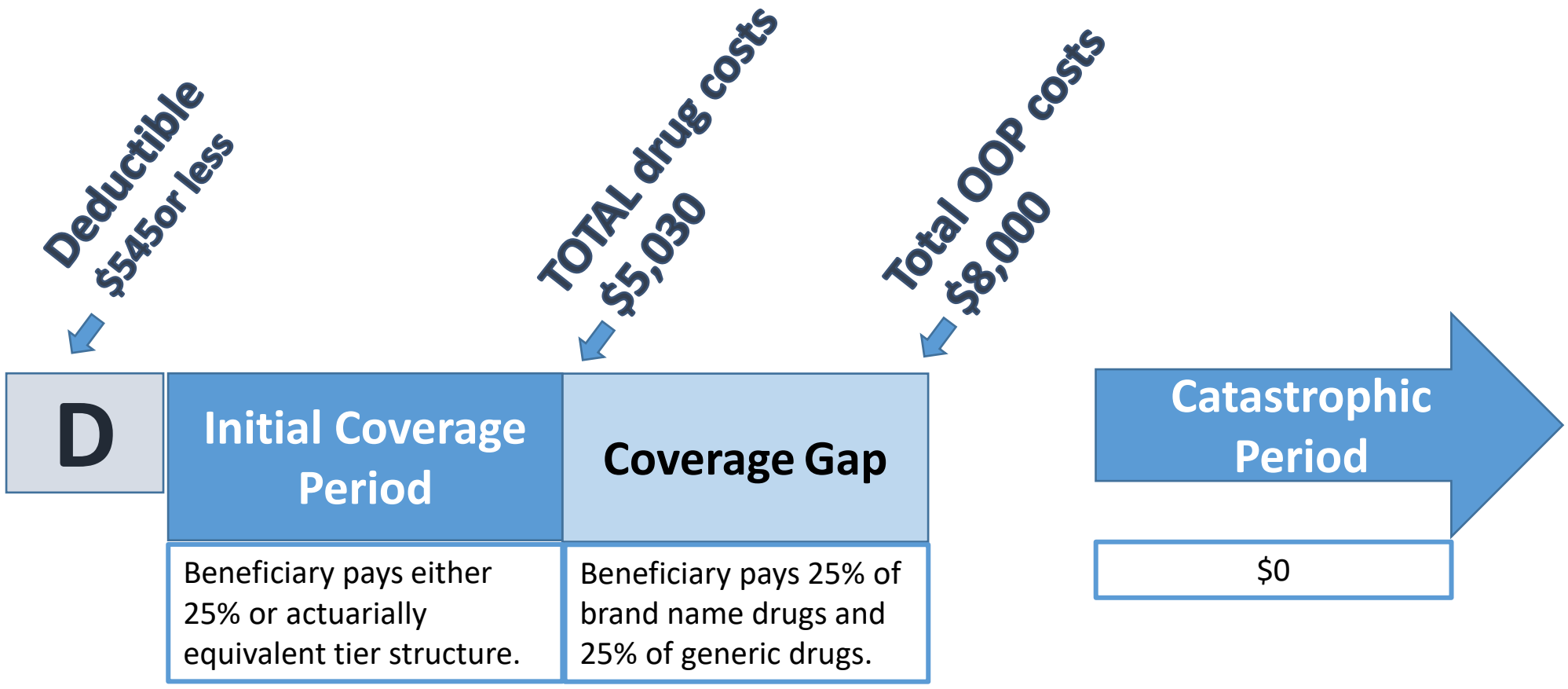
Questions?

Medicare Part D Costs

What beneficiaries pay for Part D prescription coverage

MEDI
CARE
DRUG
BENEFIT
PART
D
Rx
PHARMACY

2024 Medicare Part D Standard Structure



Effective January 1, 2024 – December 31, 2024

Part D plan costs

Each part of the Plan structure has a monetary value attached

- Premiums
  - For 2024, plan premium range
    - $0 - $106.60
  - Individuals with an income over $103,000 for an individual or $206,000 for a couple will have a higher Part D premium in 2024 (IRMAA)
  - LEP will increase the monthly premium

Counselor Note: Beneficiary's drug list is necessary to determine the most cost effective plan.

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.

TrOOP – Generic Drugs

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.

TrOOP – Brand Name Drugs

Brand Name Drug Subsidy

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.
- For 2024 the cost of drugs is reduced to $0

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 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 a benchmark plan
- “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

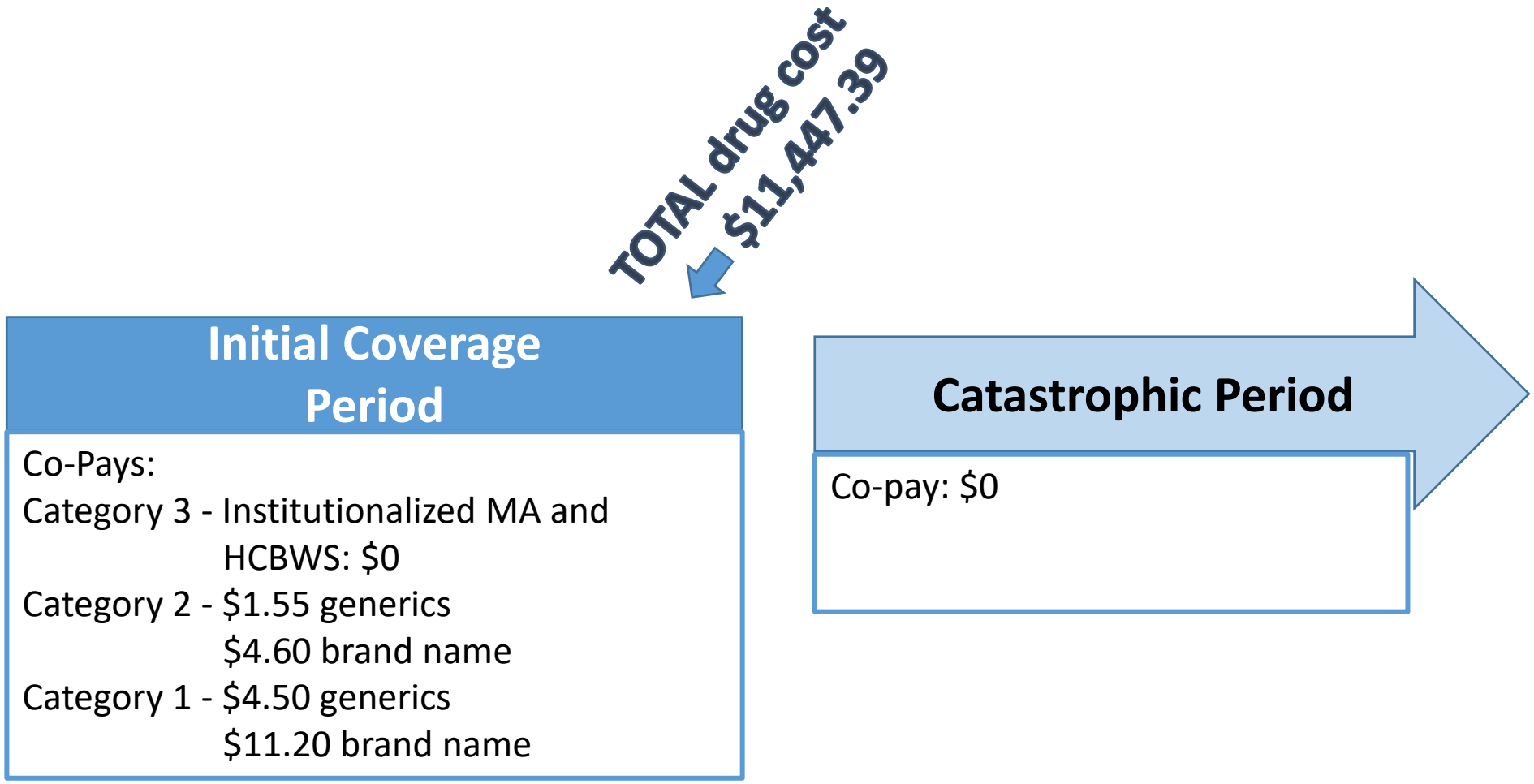
- LIS/Extra Help eligibles can choose Part D plan – “Choosers”
  - **If haven’t chosen, CMS will choose for them**
- AUTO-ENROLLMENT:
  - SSI recipients only who have not selected a Part D plan at the time of Medicare eligibility.
  - Effective first month of Medicare eligibility
- FACILITATED ENROLLMENT:
  - All other LIS eligible beneficiaries have facilitated enrollment.
  - Effective second month after either Mediare 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

2024 Medicare Part D LIS and Extra Help Structure



Effective January 1, 2024 – December 31, 2024

Check Your Knowledge

It's July. Your client who enrolled in Medicare last year but didn't enroll in a Medicare drug plan becomes eligible for Medicaid. They receive a letter that a plan has been chosen for them. 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!

15

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
  - Open retail pharmacy network
- 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
- Outside of POS, 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

Counselor 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

- State must inform Medicare of Medicaid status
- Wisconsin uploads once per month

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

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

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:

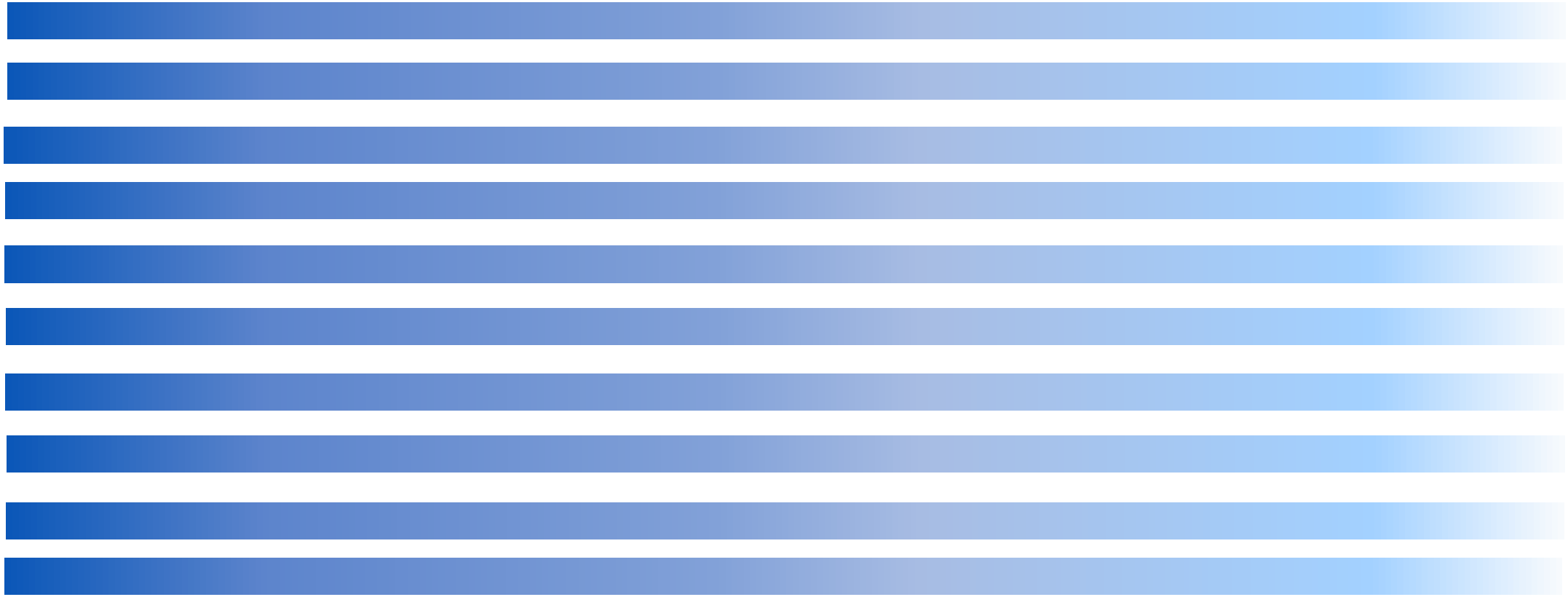
Include a cover sheet/memo about your client, outlining FBDE status effective date, a short statement and any other information you feel that will get the subsidy in place faster

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

Questions?

Break

To help you track when we'll resume, each bar takes 1 minute to disappear from the slide…



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

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?

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

c. Grey

d. Green

Countdown timer: Answer the question before the bar disappears!

Questions?

Miscellaneous

Things you need to be aware of

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

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?

SENIORCARE®

Prescription Drugs for Wisconsin Seniors

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 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. Also, one of Harry's expensive drugs will not be covered. 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?

Request CEU/CEH

- Complete the Zoom survey following this training to request a CEU/CEH certificate
- You must attend live trainings to be eligible to receive a certificate.
  - Attendance will be verified using Zoom attendance reports
- The CEU/CEH is being provided through University of Wisconsin-Stevens Point, an accredited university. The continuing education certificate may cover several professions from social workers, counselors, educators, etc. The training attendee can submit the CEH certificate to their area of practice for approval.

Please send CEU/CEH questions to Pamela Watson, MIPPA grant program coordinator,
pamela.watson@dhs.wisconsin.gov

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Disability Rights Wisconsin
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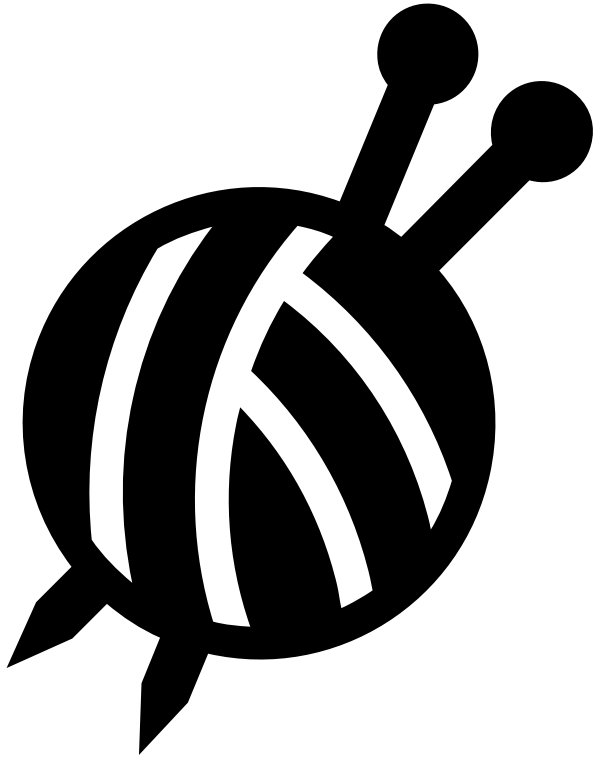

QUESTIONS?