Medicare Part D

Basic SHIP Counselor Training

SHIP
State Health Insurance Assistance Program

MILWAUKEE COUNTY
Aging & Disabilities Services

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

- State of 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
Late Enrollment Penalty


I DID IT!
YOU FINISHED YOUR NOVEL!
I CHOSE A MEDICARE DRUG PLAN!
Mike Keefe THE DENVER POST 2005

Part D Enrollment Periods

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

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

- Retroactive enrollment into Original Medicare Part A due to SSA disability determination gives a different 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

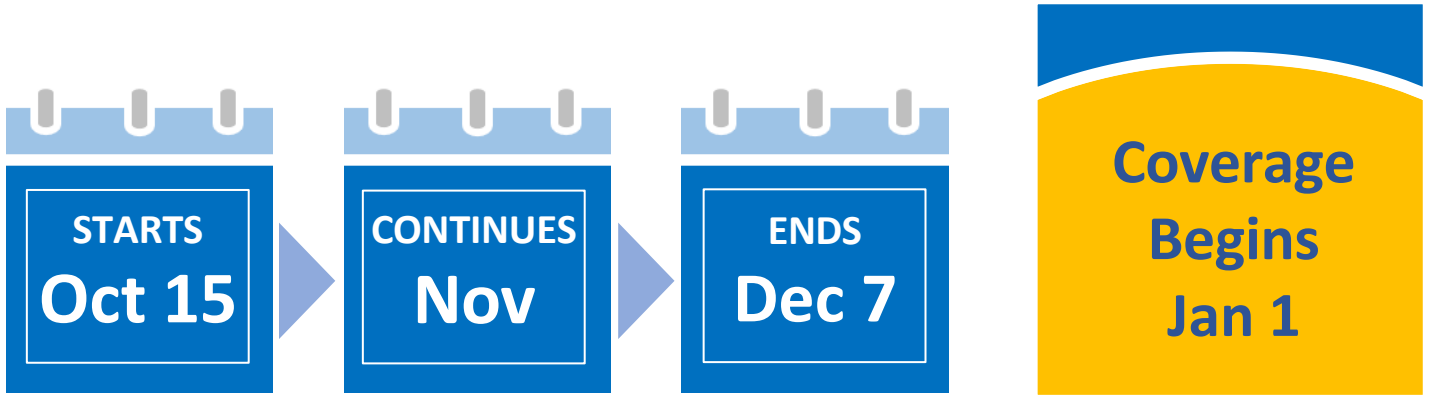
Example

In May 2025, John W. is found eligible for retroactive Social Security Disability effective June 2022. He receives a letter from SSA dated May 19, 2025 that Medicare Part A will be effective January 1, 2025.

When will the initial enrollment period for Part D begin?

- IEP for Part D will begin
  - May 2025
- IEP for Part D will end
  - August 31, 2025

Annual 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 or a break between enrollment or no creditable coverage
    - 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. Do not guess if a SEP applies, if in doubt, ask.

Examples of Special Enrollment Periods (SEPs)

- Monthly 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-Chart.pdf

SEP Usage and Ranking

- A SEP is considered “used” based on when the application is made.
  - A new PDP application is made in the month of February for enrollment effective March 1 for a person with LIS.
- 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 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)
- SEP does not align with the GEP

Part D Late Enrollment Penalty (LEP)

Individuals will be assessed a penalty if:

- IEP ends 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 during that time:
  - 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 tell the client 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

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

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, re: an external insulin 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

- 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.

Do not confuse Part D excluded drugs and not on formulary drugs

Questions?

Structure and Requirements for Part D Plans

Basic and Alternative Enhanced

Basic Part D plan structure effective 2025

Standard Structure -3 phases of coverage with monetary benchmarks

- Deductible
- Initial Coverage Limit
- Catastrophic Coverage – protection against high out of pocket expenses

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 true 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 benefit plans may not be cheaper for beneficiaries than purchasing certain items outside of the plan.

Additional Plan Requirements

Plans must:

- Make sure there is convenient access to retail pharmacies.
  - Specialty pharmacies, e.g., compounding pharmacies
  - Long Term Care pharmacies
- Have a process in place to get medically necessary drugs that are not on 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(s) 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 you are not sure if a drug needs a coverage determination, ask for help. 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

Questions?

Medicare Part D Costs

What beneficiaries pay for Part D prescription coverage

MEDI
CARE
DRUG
BENEFIT
PART
D
Rx
PHARMACY

2025 Medicare Part D Costs

Deductible Phase $590	Initial Coverage Phase $2000	Catastrophic Phase
Beneficiary pays full cost of medications	Beneficiary pays either 25% or actuarially equivalent tier structure cost.	Beneficiary pays $0

Coverage Gap aka Donut Hole

Eliminated with the IRA effective January 1, 2025

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 for the current plan year
- Those with full Extra Help have no deductible
- Deductible counts toward TrOOP

Initial Coverage Level

- The amount the plan member pays and the plan pays toward TrOOP
  - 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

Catastrophic Coverage

- The Catastrophic Period begins when the beneficiary meets the True Out-of-Pocket (TrOOP) cost threshold.
- Effective 2024 the cost of drugs in catastrophic is reduced to $0

Part D plan premium

Plan premiums do not count toward TrOOP

- Premiums
  - For 2025, Wisconsin plan premium range
    - $0 - $130.60
  - Individuals with an income over $106,000 for an individual or $212,000 for a couple will have a higher Part D premium in 2025 (IRMAA)
  - LEP will increase the monthly premium as long as the beneficiary is enrolled in Part D

Counselor Note: Beneficiary's drug list is necessary to determine the most cost effective plan. Not plan premium.

TrOOP Calculation

- Beneficiary's TrOOP costs include:
  - Deductible
  - Cost-sharing costs
    - Copayments
    - Coinsurance
  - Payments made by organizations, programs, friends, family on beneficiary's behalf
- Premium does **NOT** count.
- Amount plan pays does count.
- Costs for enhanced benefits do **NOT** count.

Medicare Prescription Payment Plan (MP3)

- Signed into law as part of the Inflation Reduction Act of 2022
- Requires Part D plans give the option to members of spreading out of pocket drug costs over the plan year
- Must be offered by all plans
  - Stand alone Prescription Drug Plans
  - Medicare Advantage Plans
- Not everyone will benefit
  - Beneficiary on Extra Help/Low Income Subsidy (LIS) do not need to enroll
  - Plans that offer $0 copays on medications to members may not benefit
  - Enrollment in Part D late in the year, e.g., last quarter, should not enroll in M3P

M3P Eligibility

- Any plan member
  - Can opt into the payment plan at anytime during the year
    - The earlier in the year the better for spreading out the costs
- Must continue to pay monthly premium for the Part D plan
  - Can be disenrolled from plan if monthly premium is not paid
- Must pay Prescription Payment Plan amount
  - Can be disenrolled if monthly payment is not made
  - If disenrolled, will lose the payment plan and will continue with Prescription Drug Plan
    - Will still owe the past amount due
- Will receive **TWO** separate bills in the month for Part D plan premium and Prescription Payment Plan amount due.

How does the payment plan work?

- Plan members who opt into the plan:
  - Pay $0 for medications at the pharmacy counter
    - The plan pays the full amount of the negotiated price to the pharmacy
      - Includes the copays/coinsurance
  - Receive a bill from the plan for their cost sharing for the medication(s)
    - Bills will reflect charges from the previous month
      - E.g., February bill will reflect January amount due
    - Last bill of the year will be received and due in January 2026
      - For those who opted in and payments extend throughout the calendar year.

Counselor Note: The M3P can be very confusing. Refer all questions to a helpline or benefit specialist.

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
  Partial benefit programs-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 enroll in 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 category
  - Catastrophic Period – Zero copay
- Enrollment into Part D and waiver of Late Enrollment Penalty

Low Cost Plans (Benchmark Plans)

- To maximize savings with a subsidy, a LIS beneficiary should be enrolled 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

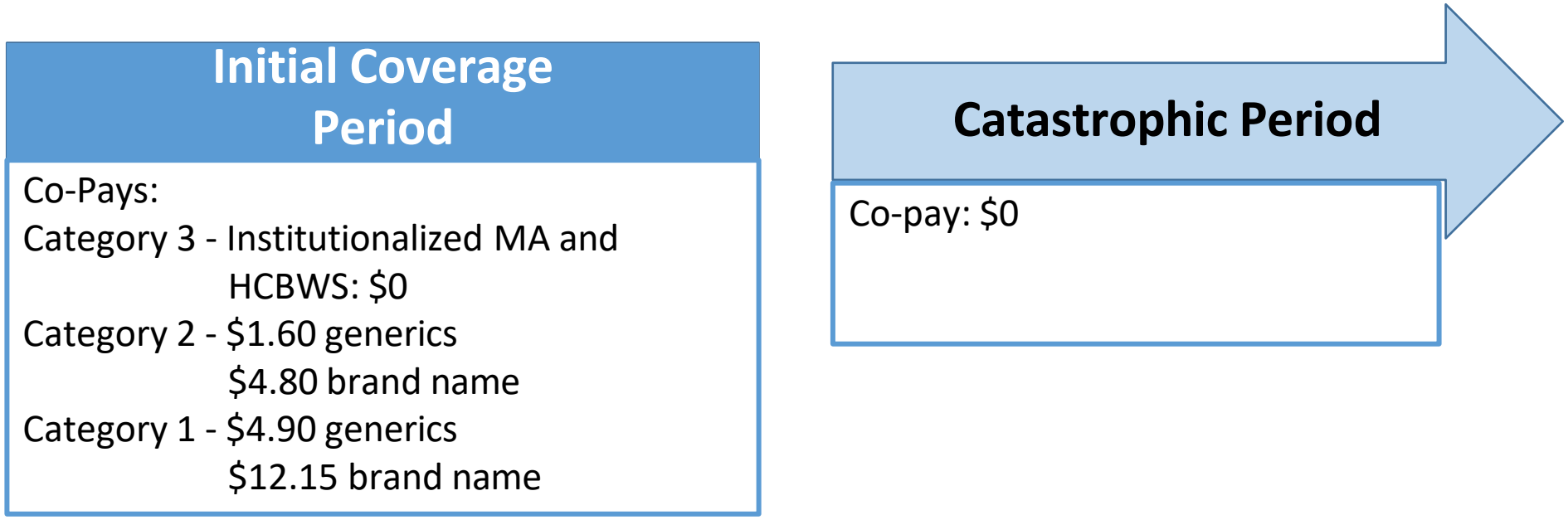
- LIS/Extra Help eligible can choose a Part D plan – “Choosers”
  - **If they do not choose a plan, CMS will choose a plan for them**
- AUTO-ENROLLMENT:
  - SSI recipients only who have not selected a Part D plan at the time of Medicare eligibility.
  - Effective first month of Medicare eligibility
- FACILITATED ENROLLMENT:
  - All other LIS eligible beneficiaries have facilitated enrollment.
  - Effective second month after either Medicare enrollment or after subsequent Medicaid eligibility
  - MSP only
  - FBDE Medicaid
  - Extra Help through SSA

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

Low Income Subsidy Copayment

- Category 1
  - Full benefit Medicaid eligible beneficiaries with income over 100% FPL
  - Eligible for MSP – SLMB and SLMB+ income 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 income below 100% FPL
- Category 3
  - Zero cost-sharing
  - Only full benefit dual eligible beneficiaries who are:
    - Institutionalized, e.g., Nursing home
    - Home and Community Based Services Waiver eligible
      - Family Care and/or IRIS at the nursing home level of care

2025 Medicare Part D LIS and Extra Help Structure



Check Your Knowledge

Your client who enrolled in Medicare last year but didn't enroll in a Medicare drug plan becomes eligible for full Medicaid. They receive a yellow letter in July 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.

Check Your Knowledge

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

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

LI NET Advocate and Beneficiary Resources | 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 Part D
- 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
  - Up to 36 months

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 from Humana

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 in most cases
- 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?

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

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.
- 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

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 is NOT creditable coverage for Part D

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

Counselor Note: Do not confuse COBRA with employer retirement benefit. If in doubt, ask or refer to a benefit specialist.

Questions?


SENIORCARE®
Prescription Drugs for Wisconsin Seniors
Rx

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
  - No monthly premium
  - 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

SeniorCare 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 Medicare 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 changed. They looked at their ANOC and saw that the premium is going up and 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?

QUESTIONS?