Medicare Part D: The Prescription Drug Program Legal Basics & Update 2022

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Housekeeping

- All on mute. Use Questions function for substantive questions and for technical concerns.
- Problems getting on the webinar? Send an e-mail to NCLER@acl.hhs.gov.
- Written materials and a recording will be available at NCLER.acl.gov. See also the chat box for this web address.

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About NCLER

The National Center on Law and Elder Rights (NCLER) provides the legal services and aging and disability communities with the tools and resources they need to serve older adults with the greatest economic and social needs. A centralized, one-stop shop for legal assistance, NCLER provides Legal Training, Case Consultations, and Technical Assistance on Legal Systems Development. Justice in Aging administers the NCLER through a contract with the Administration for Community Living's Administration on Aging.

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About Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

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What is Part D?
An Overview

- Covers most prescription drug categories
- Offered by private insurance companies who have a contract with Medicare
- Eligibility: anyone enrolled in Medicare Part A or Part B
- Available either through:
  - Prescription Drug Plan—PDP
  - Medicare Advantage Plan—MA-PD

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Part D Overview

- Low income subsidy (AKA “extra help”) helps with Part D premiums, deductibles, and cost-sharing
- LIS is automatic for anyone with SSI or Medicaid, including Medicare Savings Programs (QMB, SLMB, QI)
- Others must apply through Social Security Administration on line

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Enrollment and Costs

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Enrollment Periods (1 of 3)

- Initial Enrollment Period—same as for Part A and B
  - If based on age: 3 months before the month you turn 65 until three months after: 7 months
    - *Susan turns 65 on Sept. 5; her Part D enrollment period is June 1 through Dec. 31*
  - If based on disability (SSDI): 3 months before the month you are first eligible for Medicare until 3 months after (7 months)
    - *John has SSDI effective Aug. 1, 2020; CMS automatically awards him Medicare Part A effective Sept. 1, 2022; his Part D enrollment period is June 1 through Dec.31*

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Enrollment Periods (2 of 3)

- Annual Open Enrollment (each year)
  - Oct. 15 – Dec. 7 for each year; benefits begin Jan. 1
- Medicare Advantage Open Enrollment Period (each year)
  - January 1 to March 31
  - Allows you to move out of a Medicare Advantage prescription drug plan (MA-PD) plan to a prescription drug plan (PDP) or between MA-PDs
  - Cannot move between PDPs or leave a PDP to join a MA-PD

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Enrollment Periods (3 of 3)

- Special Enrollment Periods
  - Dual eligible or LIS: Can switch Part D plans once every quarter for first three quarters of the year
  - Move out of service area
  - Move in or out of a Skilled Nursing Facility
  - Other special circumstances
- Enrollment starts the first day of the next month

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Late Enrollment Penalty

- You didn't have creditable coverage and didn't enroll when first eligible
- 1% of the national base premium x total uncovered months = LEP
- If had late enrollment penalty and have Medicare based on disability, you get new enrollment period when turning 65
- If get LIS, no late enrollment penalty

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Income-Related Monthly Adjustment Amount (IRMAA)

- If income in 2023 is $97,000/year or more (≥$194,000 for a couple) then enrollee is charged an Income-Related Monthly Adjustment Amount (IRMAA)
- This is in addition to the premium amount
- Assessed on a sliding scale based on income and ranges from $ 12.20/mo. to $76.40/mo. on top of the plan premium

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Plan Design

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Plan Choices

- On average 22 prescription drug plans (PDPs) to choose from in a given zip code
- Premiums average $33.50/month and range from $7.00/month to $100/month
- Between 3-10 benchmark plans/region have zero premium if LIS
- Some Medicare Advantage prescription drug plan (MA-PDs) have zero premium

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Drug Coverage

- Plan formularies vary
- Must cover all drugs in 6 protected classes
- Usually must offer two drugs in each therapeutic category
- No coverage of over-the-counter (OTC) drugs, ED drugs, fertility drugs, or weight loss drugs. Off-label uses OK only if the use is supported by a listing in a designated compendium

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Formulary Design (1 of 2)

- Deductible up to $505—some plans have $0
- Tiers—most common design is 5 tiers
- Charges—a copay or a percentage of the negotiated price
- Specialty tiers—no tiering exception
- Overall, charges must be actuarially equivalent to 25% of negotiated price
- May also have preferred and non-preferred pharmacy prices

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Sample Tiering Structure (AARP MedicareRX Saver Plus)

Annual Prescription Deductible: $400

Initial Coverage Stage	Preferred Retail Cost Sharing (30 days)	Standard Network Pharmacy Cost Sharing (30 days)	Mail Order Pharmacy (90 days)
Tier 1: Preferred Generic Drugs	$1 co-pay	$3 co-pay	Preferred: $0 co-pay Standard: $9 co-pay
Tier 2: Generic Drugs	$2 co-pay	$6 co-pay	Preferred: $0 co-pay Standard: $18 co-pay
Tier 3: Preferred Brand Drugs	$21 co-pay	$31 co-pay	Preferred: $58 co-pay Standard: $93 co-pay
Tier 4: Non-Preferred Drugs	30% of the cost	36% of the cost	Preferred: 30% of the cost Standard: 36% of the cost
Tier 5: Specialty Tier Drugs	25% of the cost	25% of the cost	Preferred: 25% of the cost Standard: 25% of the cost

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Donut Hole

- After you and the plan together spend a certain amount on your drugs ($4,660 in 2023) you enter the donut hole
- In the donut hole, you pay 25% of the cost of the drugs
- You get out of the donut hole after your out-of-pocket drug costs have exceeded $7,400
- After donut hole, you get catastrophic coverage and only pay 5% until the start of the new plan year

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Formulary Design (2 of 2)

- Plans may impose utilization management restrictions
  - prior authorization
  - step therapy
  - quantity limits
- Plan must show specific requirements for each drug on its website
- Beneficiary may seek an exception to a utilization management requirement

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Encouraging Consumer Choice

- Point consumer to resources
  - Plan Finder
  - SHIP counseling
- Report marketing abuses to CMS Regional Office
- Remember: LIS beneficiaries can switch plans up to three times a year, once per quarter each of the first three quarters of the year

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Part D for People With Low Incomes

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What is the LIS Benefit?

Full Benefit <135% FPL and <$8,400 assets ($12,600 couple)	Partial Benefit <150% FPL and <$14,010 assets ($27,950 couple)
Pays premiums on any benchmark plan	Partially pays premiums on any benchmark plan
No Part D deductible	Enrollee may be charged up to $99 annual deductible
No donut hole	No donut hole
Co-pays run from $0 to about $10	15% co-insurance
Zero co-pay above out-of-pocket threshold	Limited co-pay above out-of-pocket threshold

Looking ahead: In 2024 Full LIS income limit will rise to 150% FPL. No more partial LIS.

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LIS Enrollment

- Automatic if enrolled in:
  - SSI
  - Medicaid
  - Medicare Savings Programs (QMB, SLMB, QI)
- If you have "Spenddown" Medicaid, meet it once
- Others must apply through Social Security Administration

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Simplified Counting Rules

- What counts as assets?
  - Cash and bank accounts, including checking, savings, and CDs
  - Real estate outside of your primary residence
  - Stocks and bonds, including U.S. savings bonds
  - Mutual funds and retirement accounts (e.g., 401k, 403b, IRAs)
- What doesn't count as assets or income?
  - In-kind services as income (e.g., family member allows enrollee to live with them rent-free)
  - Savings set aside for burial expenses up to $1,500 ind./$3,000 for couple
  - Life insurance policies
  - Primary residence and tangible property, e.g., a car

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Auto-Enrollment of LIS Beneficiaries

- Assigned to a zero premium “benchmark” plan
- Benchmark plans can change annually depending on plan bids
- Assignment is random—may not match well with drug needs
- If assigned and plan loses benchmark status in a later year, will be reassigned
- If voluntarily changes plans, becomes a “chooser” and is not subsequently reassigned
- Choosers receive tan letter in November if their plan premium rises

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For LIS Beneficiaries: Bad Choices + Inertia = Wasted $$

- Too many choices, confusing
- Auto-assignment is random
- Plan costs and benefits change from year to year—few beneficiaries review their choices annually
- Marketing can mislead—especially LEP consumers

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Low-Income Net (LI-NET)

- Humana administers the Point of Sale enrollment process for LIS eligibles that are not enrolled in a Part D plan
- Acts as a temporary plan for newly enrolled full dual eligible
- Provides reimbursement to individuals who have retroactive Medicare prescription drug coverage
- Open formulary, with no utilization management restrictions on any drugs, and no pharmacy network restrictions

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LI-NET

- LIS-eligible individual presents at pharmacy without a Part D plan, pharmacy contacts LI-NET to secure Point of Sale (POS) enrollment
- Pharmacy can immediately fill prescription and bill LI-NET
- LI-Net enrollment lasts 2 months, then auto-enrollment into a PDP
- Advocate can contact LI-NET with eligible individual and enroll them in LI-NET pending award of LIS and Part D plan
- See Chapter Summary for details of process

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Best Available Evidence (BAE)

- Plans must provide access to Part D drugs at LIS levels when presented with evidence of LIS eligibility, even if their own systems do not show LIS
- Examples of BAE:
  - Medi-Cal card
  - State document confirming Medicaid eligibility
  - Letter of award of QMB or other MSP
  - Letter of award of LIS
- Each plan must have BAE contact to promptly receive and review documents
- If need for Rx is urgent, plan required to provide emergency supply at LIS co-pay while determining status

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Inflation Reduction Act 2022

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Inflation Reduction Act: Changes That Take Effect in 2023

- Insulin
  - Co-pays for insulin will be capped at $35 per month
- Vaccines
  - Many vaccines, e.g., Shingrex (for Shingles) will be free, i.e., no cost-sharing
- Drug Pricing
  - Increases in drug prices will be limited to no more than the rate of inflation

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Inflation Reduction Act:
Changes That Take Effect in Later Years

- Catastrophic Period
  - Starting 2024, when out-of-pocket costs reach “catastrophic” threshold, no further copays for the rest of the year
- Annual Premium Increases
  - Premium hikes on drug plans limited starting 2024 to no more than 6% for through 2029
- Limit on out-of-pocket expenses
  - Starting 2025, capped at $2000/year, and can be spread out on a monthly basis, maximum for any month will be $167
- Drug Price Negotiation
  - CMS for the first time can negotiate Part D drug payment rates, Won’t take effect until 2026

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Appeals

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Denial

- At the pharmacy:
  - Computer tells pharmacist that drug is not approved
  - Pharmacist may or may not have enough info to explain the reason
  - Pharmacist hands you a generic notice of appeal rights with plan contact info
  - *Denial at the pharmacy does not trigger an appeal—Beneficiary or prescriber must ask for a COVERAGE DETERMINATION by calling or writing the plan.*

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Resolving a Denial Without the Need for an Appeal

- Ask plan precisely why coverage was denied,e.g.,
  - inadequate diagnosis code
  - lack of medical necessity
  - lack of prior authorization or step therapy
  - requested quantity or duration exceeds plan limits
- Sometimes denials can be quickly resolved by having prescriber:
  - provide full, correct the diagnosis
  - formally request prior authorization
  - provide explanation why step therapy will not work
  - explain why dosage or duration is medically necessary

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Starting an Appeal

- Plan handbook will provide details on where and how to file
  - Can call plan if questions
- File an Exception—the name for a Coverage Determination request if the medical necessity of the requested drug is the issue
- Support by the prescriber is critical to the success of an appeal

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Appeal Process

- Coverage determination by plan
  - Standard—72 hours
  - Expedited—24 hours
- Reconsideration by plan
- Redetermination by Independent Review Entity (IRE)
  - Maximus is the IRE
- Review by Administrative Law Judge at HHS
  - Video conference or telephone hearing
- Review by Medicare Appeals Council
- Federal district court

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Appeal

- If granted, exception lasts until the end of the plan year
  - Plan has the option to renew
- If LIS—consider whether switching plans is a better option

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Tiering Exceptions

- Plans sometimes deny coverage when your drug is on a high tier and there is a preferred drug on a lower tier
  - Prescriber can request a prior authorization or otherwise file a statement showing that lower tier drug is not as effective or would have adverse effects
  - You get the co-pay for the lower tier
  - Not available for specialty tier drugs
  - An underutilized exception

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Appeals—Advocacy Concerns

- Success rate at IRE and ALJ are high—value of perseverance
- Delays, lost documents, missed deadlines, ALJ backlog
- Keeping the provider engaged and on board
- Delays in effectuation

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Additional Resources

- Medicare.gov
  - 1-800-Medicare
  - TTY Users: 977-486-2048
- Medicare and You Handbook
- SHIPs: 1-800-434-0222
- MedicareRights.org
- MedicareAdvocacy.org

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Questions?

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Visit Our Website: ncler.acl.gov

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Case Consultations

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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