Medicare Part D Legal Basics and 2022 Updates

NATIONAL CENTER ON LAW & ELDER RIGHTS

CHAPTER SUMMARY • October 2022

Georgia Burke, Justice in Aging

Murray Scheel, Justice in Aging

Key Lessons

1. In Medicare Part D, consumers face a choice of plans with many variables, including premiums, formularies, and benefit design. State Health Insurance Assistance Programs (SHIPs) and the Medicare Plan Finder can help Medicare beneficiaries review plan choices and determine which is most appropriate and cost-effective.
2. The Low-Income Subsidy ("LIS" or "Extra Help") significantly lowers costs for individuals with modest income and assets. It also offers more enrollment flexibility. People with Medicaid or Supplemental Security Income (SSI) are automatically enrolled. Others apply through the Social Security Administration.
3. If a Part D plan denies coverage for a needed prescription drug, a system of standard and expedited appeals is available to seek an "exception" to the denial.

Section 1: What is Part D?

Part D is the prescription drug benefit for Medicare. It started in January 2006. Part D is offered by private insurance companies that have a contract with the Medicare program to provide prescription insurance coverage to Medicare enrollees. Coverage is available either through a stand-alone prescription drug plan ("PDP"), or as part of the benefit package of a Medicare Advantage plan (MA-PD) that combines both health and prescription drug benefits.

Anyone enrolled in Medicare Part A or Medicare Part B is eligible to enroll in the Part D program. People who want to get their prescription drug coverage through a Medicare Advantage plan must be enrolled in both Part A and Part B. Of the 41 million people enrolled in Part D, about 60 percent receive the benefit through PDPs and 40 percent through MA-PDs.

An important part of the Part D program is the Low-Income Subsidy, also called "extra help," which significantly reduces the cost of the program for people with limited incomes. Extra help will be discussed in more detail in Section 4.

Section 2: Enrolling in Part D

When Can Someone Enroll or Change Plans?

An individual enrolls in a Part D plan either by:

- Creating a "My Medicare" account on line (if they have not already done so) and then following the links to select and enroll in one of the available plans (note that one's "My Medicare" account is separate and different from one's "My Social Security" account);
- Enrolling directly through a plan or plan broker; or
- By calling 1-800-Medicare.

Individuals should enroll in Part D at the same time that they first become eligible for Medicare. The Initial Enrollment period is the seven months surrounding an individual's sixty-fifth birthday, i.e., three months before the month in which an individual turns 65 up to three months after the month they turn 65. For example, Susan turns 65 on September 5th: she can therefore enroll in Medicare Part D any time from June 1st to December 31st of the year in which she turns 65.

Coverage under a Part D plan ordinarily starts on the first day of the month after an individual enrolls. If an individual enrolls in a Part D plan before the month of their 65th birthday, however, their coverage will not be effective until the first day of the month in which they turn 65. To continue the example: if Susan eagerly enrolls in a Part D plan on June 18 of the year she turns 65, her coverage will be effective September 1st—the month she turns 65—not July 1st. If Susan delays enrolling until her birthday, September 5, then her coverage will start October 1st. If she delays enrolling until October, then her coverage will start November 1st.

If an individual under age 65 qualifies for Medicare on the basis of a disability, the rules are similar. The Initial Enrollment Period is the seven months surrounding the first month that Medicare has enrolled them in Part A, i.e., three months before the first month of Medicare Part A and up to three months after that month.

Example

Social Security has found John to be disabled and eligible for Social Security Disability Income (SSDI). As a result, Medicare will automatically award him Medicare Part A effective as of the 25th month after the first month for which he was due a Social Security Disability payment. John became eligible for his first SSDI payment as of May 2020. Almost two years later, Medicare notifies him that he will be enrolled in Medicare Part A effective June 2022. John has from March 1 through September 30, 2022, to enroll in Medicare Part D. The same rules set forth above apply in his case regarding the effective date of coverage.

Each year, everyone with Medicare can change Part D or Medicare Advantage plans during the annual Open Enrollment Period, which extends from October 15 through December 7, with the new enrollment starting on January 1 of the following year. People who enroll in a Medicare Advantage plan have another period, extending from January 1 through March 31, called the Medicare Advantage Open Enrollment Period (MA-OEP). MA-PD members may move out of an MA-PD and join a PDP or another MA-PD during this period, but they may not use this MA-OEP to move between PDPs.

There also are Special Enrollment Periods (SEPs) that may apply to individuals depending on their circumstances. Individuals with Low Income Subsidy can change plans once a quarter for the first three quarters of the year. Examples of other special enrollment periods include when people move out of a plan's service area, or enter or leave a skilled nursing facility ("nursing home"), or when people receive erroneous information from a federal official. There are other circumstances that can trigger a Special Enrollment Period (see the link above for the complete list).

What is the Late Enrollment Penalty?

People who do not enroll when first eligible and who do not have "creditable coverage" will be subject to a late enrollment penalty. Creditable coverage is coverage that is actuarially as good as the basic Part D benefit. If an individual has creditable coverage through an employer or other source, the insurer will provide an annual written notice affirming creditable status.

Example

To return to our example above, at age 65 Susan is still working and has creditable prescription insurance through her employer's group health insurance. She plans to continue working until she is 68. She can delay enrolling in a Part D plan until she stops working and loses her employer-based prescription insurance without incurring any late enrollment penalty.

The late enrollment penalty is 1% of the national base premium amount ($33.37 in 2022, $32.74 in 2023) multiplied by the total number of uncovered months. The result is then added permanently to the individual's monthly Part D premium. People with the Low-Income Subsidy are not charged a late enrollment penalty.

Are Higher Income Individuals Charged Higher Premiums?

Individuals with income at or above $97,000/year in 2023 are charged an Income-Related Monthly Adjustment Amount (IRMAA). This addition to the premium amount is assessed on a sliding scale based on income and ranges from $ 12.20/mo. to $76.40/mo. on top of the plan premium.

Section 3: How Do Part D Plans Work?

Consumers in all states have a wide range of choices, on average 22 PDPs plus some MA-PDs. PDP premiums vary greatly, with an average estimated cost in 2023 of about $31.50/month, and premiums ranging from under $10 to $100 or more per month. MA-PD choices also vary widely, with some plans having a zero premium. Besides differing in price, plans differ in how they design their payment structure, the drugs they cover, the terms under which they cover them (e.g., whether they require prior authorizations, etc.), and the pharmacies in their networks.

Plan Payment Structure Can be Complex

Plans may impose an annual deductible charge (up to $505 in 2023), but many do not. All plans divide drugs into payment tiers. Typically plans have five tiers, each with its own co-insurance amount. Preferred tiers offer lower co-insurance than non-preferred tiers. For each tier, plans can impose either a co-payment (which is a set amount) or co-insurance (which is a percentage of the full drug price).

Once total drug costs (i.e., what the insurance company paid plus what the patient paid out of pocket) reach a certain amount ($4,660 for 2023), an individual enters the coverage gap, usually referred to as the donut hole. In the donut hole, copays are set at 25% of the cost of the drugs. If an individual's calculated out-of-pocket (copay/co-insurance) costs exceed $7,400, they then move into the catastrophic coverage category with payments capped at five percent of a drug's cost.

Changes as a result of the Inflation Reduction Act that will 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.

Changes resulting from the Inflation Reduction Act that will take effect in later years:

- Catastrophic Period: Starting in 2024, when out-of-pocket drug costs reach the "catastrophic" threshold, the enrollee will have no further copays for the rest of the year (good news for people on expensive HIV drugs).
- Annual Premium Increases: Premium hikes on drug plans will be limited starting 2024 to no more than 6% for all beneficiaries through 2029.
- Limit on out-of-pocket expenses in Medicare Part D: Starting in 2025, Part D out-of-pocket expenses will be capped at $2000/year, and can be spread out on a monthly basis, i.e., the maximum out-of-pocket expense for any month will be $167.
- Drug Price Negotiation: CMS will be able for the first time to negotiate Part D payment rates for drugs. This will be rolled out slowly, however, and will not go into effect until January 2026, and at that time only for the top ten most expensive drugs. The number of negotiated drugs will gradually increase over the succeeding years.

Plan Formularies Vary

Part D plans have latitude, within certain constraints, to determine which drugs they cover and on what tier. CMS must approve all formularies and they must be designed so they do not discriminate against members with particular conditions. Plans must cover all or virtually all HIV/AIDS drugs, immunosuppressant medications, antidepressants, antipsychotics, anticonvulsants for seizure disorders, and anticancer drugs that are not covered by Part B. For other categories of drugs, plans are usually required to include at least two drugs in each class. Plans may impose utilization management controls such as quantity limits, step therapy requirements, or prior authorization requirements.

Certain drugs are never covered by Medicare. They include over the counter drugs, drugs prescribed for colds, erectile dysfunction drugs (unless prescribed for other purposes), and drugs for weight loss or anorexia. Drugs prescribed "off label" can only be covered if the off-label use is supported by a listing in one of three commercial compendia listed in the Part D statute.

Some prescription drugs are covered by Medicare Part B, rather than Part D. These are primarily drugs that are not self-administered, and also include oral anti-cancer and related anti-nausea drugs and drugs used with nebulizers and other drug delivery devices. For drugs covered by Part B, co-insurance is generally 20% of the Medicare approved amount and LIS does not apply.

SHIP Counseling Helps Beneficiaries Navigate Part D Complexities

Choosing the plan that includes all of one's drugs and that also is cost-effective is daunting for most people with Medicare. They can get one-on-one assistance from State Health Insurance Programs (SHIPs) where trained volunteer counselors offer free and unbiased guidance. At the Medicare.gov website, consumers also can find and sort plan options based on the drugs they use, the pharmacies they prefer, and their zip code.

Section 4. The Part D Low Income Subsidy ("Extra Help")

The Medicare Low-Income Subsidy (LIS), also called Extra Help, offers significant savings in the costs of Part D. LIS beneficiaries also experience a simplified program design and have a SEP that allows them to change plans once a quarter for the first three quarters of the year.

LIS Enrollment

Enrollment in the LIS is automatic for Medicare beneficiaries who receive SSI payments or Medicaid benefits, including those who are only in Medicare Saving Programs (QMB, SLMB and QI). Others may apply through the Social Security Administration. The LIS is available for individuals with incomes up to 150% of the Federal Poverty Level and up to $15,510 ($30,950 for a couple) in assets. Asset and income counting rules are simpler than those usually applied by state Medicaid agencies. Currently, there are two types of LIS: full and partial.

Individuals enrolled in SSI, Medicaid, or a Medicare Savings Program get "full" LIS, which means they have the lowest copays and pay no Part D premium and no deductible. Individuals who do not qualify for any of those programs but who have incomes between 135% and 150% of the federal poverty level get "partial" LIS, which means they pay reduced premiums, deductibles, and copays. Under the 2022 Inflation Reduction Act, however, the income limit for full LIS will rise in 2024 to 150% of the Federal Poverty Level, essentially erasing the current two tiers of LIS.

LIS Benefits

The financial benefits of the LIS are substantial. With the full LIS benefit, "benchmark" plans (those with a premium below a threshold set by CMS each year) are available to LIS enrollees without premiums. LIS co-pays range from $0 to approximately $10 for high-cost drugs, there is no donut hole, and there are no co-pays in the catastrophic coverage category. Instead of five tiers, LIS beneficiaries only face two co-payment tiers and charges do not vary depending on whether they use preferred or non-preferred in-network pharmacies. Those with partial LIS (between 135% and 150% FPL) pay partial premiums, can be charged a limited deductible, and have higher, though still modest, co-pays. Individuals with the LIS also are allowed to change plans once a quarter for the first three quarters of the year.

Auto-Enrollment into Plans

To ensure that people with LIS get the Part D benefit, CMS auto-enrolls them into a PDP if they do not choose a plan themselves. Auto-enrollment is limited to "benchmark" plans and is random, so the plan may or may not be a good fit for someone's prescription drug needs. An individual auto-enrolled in a plan should double-check whether the plan provides them with the best coverage given their prescription needs, and if not, switch to a better plan as soon as possible.

Low-Income NET (LI-NET)

CMS attempts timely auto-enrollment of LIS beneficiaries so that, if they are new to Medicare, they are enrolled on their first day of eligibility. If for any reason this does not happen, a beneficiary may appear at the pharmacy needing a prescription but not have any insurance. To address this situation, CMS created a point of sale enrollment process that enrolls an individual for two months in LI-NET ("Low Income NET"), a plan with an open formulary and no utilization management or pharmacy restrictions. In many cases, LI-NET enrollment can be completed right at the pharmacy and the individual can leave with the needed prescription.

What to Do When a Medicare Enrollee is Eligible for Part D and LIS but Has Not Yet Enrolled in Either

Susan contacts her SHIP office or other advocate with a problem: She just turned 65, now has Medicare A and B, but is unsure how to enroll in a Part D plan. Moreover, she is low-income (less than 150% of federal poverty level with only $5000 in savings) and doesn't know how she can afford prescription coverage on top of her monthly Medicare Part B premium. She has only three days of Drug Z left and urgently needs to get her prescription refilled. What can an advocate do in this urgent situation?

The advocate can assist Susan with filing an on-line application for LIS. The advocate can then contact LI-NET by phone with Susan at 1-800-783-1307 and assist her in getting enrolled in LI-NET. Susan's member number for LI-NET will be her Medicare number. The advocate should be sure to get the BIN number, PCN number, and Group number for LI-NET from the representative. The advocate can now contact the pharmacy to inform it that Susan is enrolled in LI-NET and provide the pharmacy with the processing numbers (Susan's Medicare number, LI-NET BIN (015599) and PCN (05440000) (no group number)). The pharmacy should then be able to fill the prescription with LI-NET coverage.

The advocate should encourage Susan to make an appointment with a SHIP counselor to pick a plan that meets her needs. Since Susan also appears to qualify for a Medicare Savings Program, the advocate can also direct her to the local Medicaid office to apply.

What to Do When a Medicare Enrollee Already Has a Part D Plan and Then Receives LIS

In some cases, individuals who are already in a Part D plan subsequently qualify for LIS. If the plan records do not correctly show LIS status, but the individual has evidence of LIS enrollment, such as a letter from Social Security, MSP enrollment letter, or a Medicaid card, the pharmacy should be able to contact the Best Available Evidence (BAE) department of the plan and get an on-the-spot reduction in co-payment amount. Alternatively, an advocate can fax or email the proof on the individual's behalf to the BAE department. If the individual has difficulty producing BAE, plans have an affirmative obligation to take steps to help the member confirm LIS status (e.g., the plan can contact Social Security directly to verify LIS enrollment).

Section 5. Filing an Appeal

Plan members have the right to appeal any denial of access to a prescription drug or payment for a drug. There are several levels of appeal but the most important part is getting started.

The most frequent scenario is that the beneficiary presents a prescription to the pharmacy and the plan rejects the claim. The pharmacist is required to provide the individual with a generic notice entitled "Medicare Prescription Drug Coverage and Your Rights," which states that a beneficiary can file an appeal and tells the individual how to contact the plan to do so.

Getting Started

A denial at the pharmacy does not automatically trigger an appeal. When there is a denial, either the beneficiary or the prescriber should contact the plan to learn exactly why the prescription was denied. There may be an easy solution, like switching to a different brand that is on the plan's formulary or fulfilling a utilization management requirement (i.e., getting the prescriber to file the necessary request for prior authorization, or step therapy override, or quantity limit override).

If doing so does not work, and the beneficiary wants to appeal, they must start by asking the Part D plan for a "coverage determination." If the plan has denied coverage for medical reasons, e.g., they do not believe the medication or the quantity prescribed is justified for the condition, then the beneficiary can ask for what is called an "exception." The request for an exception should be supported by a written statement from the prescribing healthcare provider explaining why the medication at issue is medically necessary. The health care provider's statement should be filed with the Part D plan.

The standard timeframe allowed for a plan to decide whether to grant an exception is 72 hours from receipt of health care provider's statement. If the physician certifies in their statement that a delay of 72 hours would jeopardize the life or health of the member or the ability to regain maximum function, the plan must make an expedited decision on the requested exception within 24 hours.

Pursuing Additional Levels of Appeal

If an exception request is denied, there are additional levels of appeal:

- Reconsideration—a paper review within the plan of its original decision;
- Redetermination by the Independent Review Entity (IRE), also a paper review;
- Review by a Medicare Administrative Law Judge by video conference or telephone;
- Review by the Medicare Administrative Council; and
- Federal District Court.

In thinking about appeal strategies, advocates should keep in mind that support from the health care provider is the critical factor for success. Advocates should also be aware that often it is necessary to get to an independent review—either at the IRE or ALJ level—to get success. Perseverance frequently is rewarded.

Conclusion

Advocates can play a critical role in helping Medicare beneficiaries navigate the Medicare Part D program. The Part D Low-Income Subsidy is particularly vital in making Part D benefits available and accessible to those with low incomes.

- NCLER: Medicare Parts A, B & C: Webinar
- NCLER: An Advocate's Guide to Appealing Prescription Drug Denials: Webinar
- NCLER: Accessing Benefits & Supports for Older Adults with Long COVID: Webinar

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

This Chapter Summary was supported by contract with the National Center on Law and Elder Rights, contract number HHS75P00121C00033, from the U.S. Administration on Community Living, Department of Health and Human Services, Washington, D.C. 20201.