Module 3-Medicare Part D Prescription Drug Coverage

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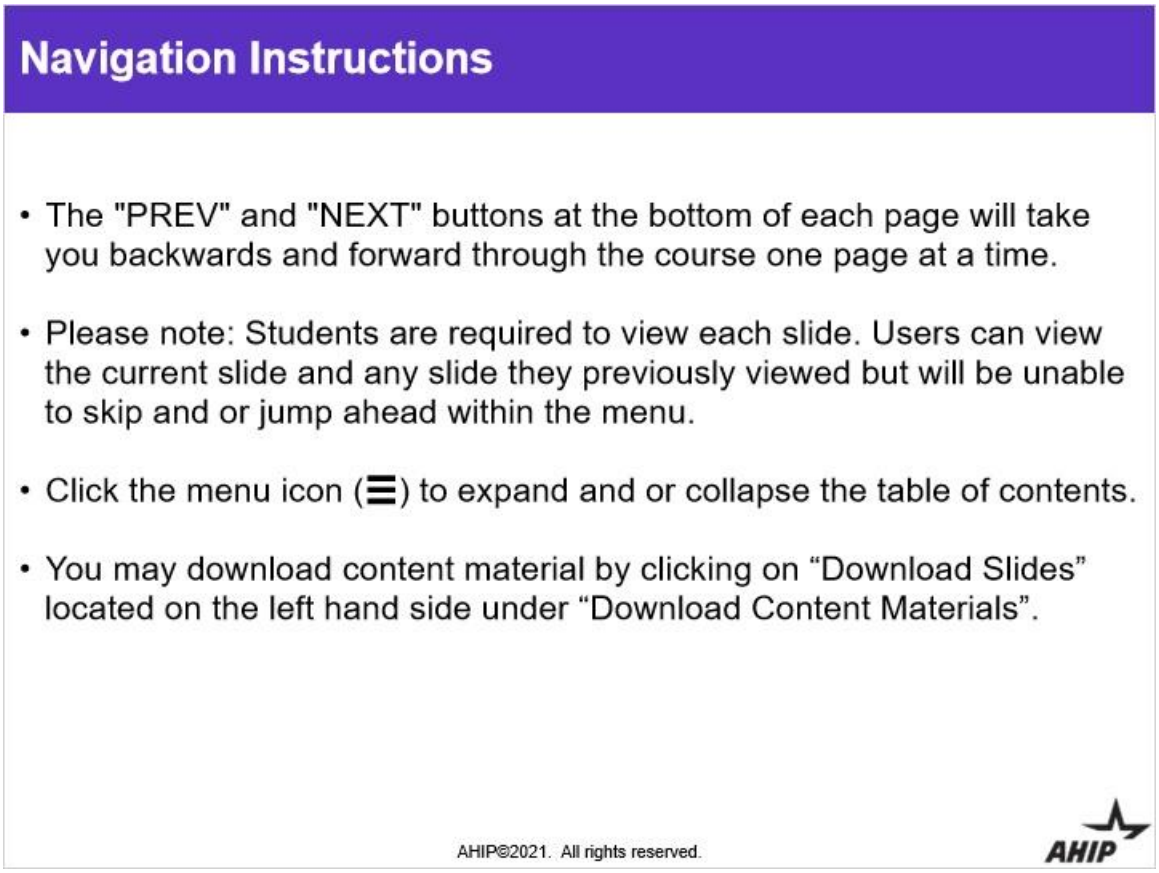
1.1 Medicare Part D Prescription Drug Coverage

1.2 Navigation Instructions



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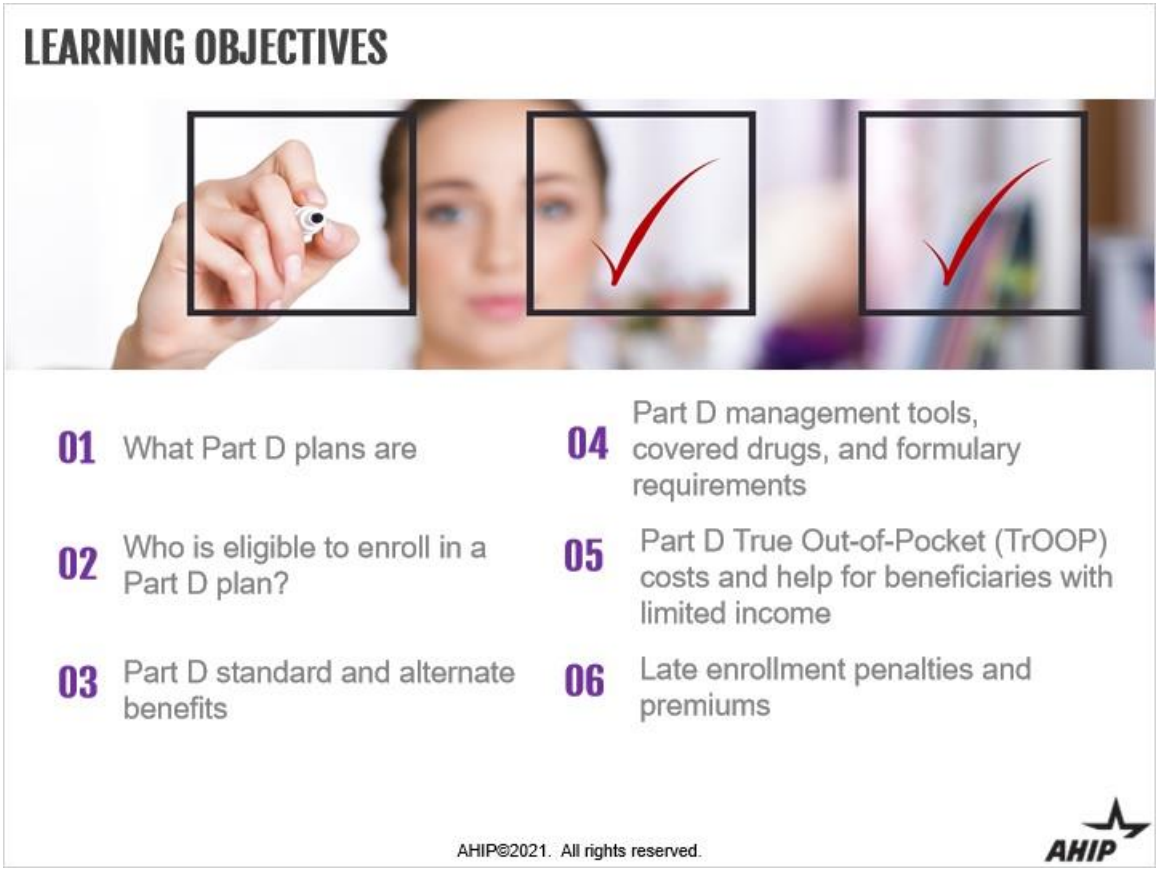
1.4 LEARNING OBJECTIVES



1.5 Training Roadmap: Part 1

1.6 Medicare Part D Prescription Drug Program Basics

Medicare Part D Prescription Drug Program Basics

- Medicare Part D covers certain prescription drugs, diabetic supplies, and vaccines.
- Coverage of Medicare Part D benefits is provided only through private companies. There is no fee-for-service Part D benefit.
- The types of Part D plans are:
  - Stand-alone Prescription Drug Plans (PDP)
  - Medicare Advantage-Prescription Drug (MA-PD) Plans:
    - MA health plans that also cover Part D prescription drugs.
  - Cost-PD Plans
    - Medicare cost plans that cover Part D prescription drugs as an optional supplemental benefit.

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1.7 Medicare Part D Eligibility

Medicare Part D Eligibility

- To be eligible for Part D, individuals must be:
  - entitled to Part A **and/or** enrolled under Part B; and
  - a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination)
- To be eligible for a particular Part D Plan, the individual must permanently reside in the Part D plan's service area. PDPs must enroll any eligible beneficiary who applies regardless of health status.
- MA-PD plans are subject to the MA eligibility rules, and may not enroll certain individuals such as:
  - those who are not both entitled to Part A and enrolled in Part B.
  - For Special Needs Plan or EGWPs, those who do not meet the additional eligibility criteria applicable to such plans.

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1.8 Medicare Part D Prescription Drug Eligibility

Medicare Part D Prescription Drug Eligibility

Individuals' eligibility to enroll in a stand-alone PDP depends on how they receive their medical benefits.

- Generally, only beneficiaries enrolled in Original Medicare, an MA MSA, a PFFS plan or a Cost plan may enroll in a standalone PDP to receive Part D benefits.
  - Beneficiaries enrolled in a MA MSA may only obtain Part D benefits through a standalone PDP.
  - Beneficiaries enrolled in a Cost plan or MA PFFS plan may obtain Part D benefits through their plan (if offered) or through a standalone PDP.
- Beneficiaries enrolled in a MA HMO or PPO may only obtain Part D benefits through their HMO or PPO plan.
  - In some cases, employer group plan enrollees may have additional choices.

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1.9 Medicare Part D Eligibility: Examples

Medicare Part D Eligibility: Examples

Ms. Singh just became eligible for Medicare. However, she is not eligible for premium-free Part A. She has chosen not to pay the premium to obtain Part A but will enroll in Part B. She asks her broker whether she can get coverage for her prescription drugs as well. Her broker correctly advises her that she is eligible to enroll in Part D and may choose among the free-standing PDPs available in the area in which she lives.

Mr. Bradley has Medicare FFS with a PDP. The PDP offers excellent low-cost coverage for the prescription drugs Mr. Bradley takes, and he would like to remain enrolled in it. However, Mr. Bradley is interested in enrolling in a Medicare Advantage plan to obtain additional coverage of the Medicare out-of-pocket amounts. To accommodate Mr. Bradley's wishes, his broker should help Mr. Bradley explore PFFS plans that do not include Part D and MSAs.

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1.10 Covered Part D Drugs

Covered Part D Drugs

Part D plans cover:

- Prescription drugs
- Biologics
  - Biologics are drugs made of natural sources (human, animal, or microorganism) that are not chemically synthesized, examples include allergy shots and gene therapies
- Insulin
- Medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze) or delivering insulin into the body (e.g., an inhalation chamber)
- Certain vaccines not covered by Part B, including:
  - Shingles vaccines
  - Tdap vaccines (tetanus, diphtheria, and pertussis/whooping cough)

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1.11 Formularies

Formularies

- Many Part D plans do not cover all the drugs because in some cases several similar drugs are available to treat the same medical condition.
- Part D plans include the Part D drugs they will cover on a list known as a "formulary."
  - Formularies are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
  - at least two drugs in each therapeutic category.
  - generic and brand-name drugs.

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1.12 Drugs Excluded from Part D Coverage

Drugs Excluded from Part D Coverage

The following are excluded from the definition of a Part D covered drug:

- drugs covered under Part B
- drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
- vitamins
- medical foods formulated to be consumed or administered enterally under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act
- erectile dysfunction drugs (when used for sexual dysfunction)
- non-prescription drugs
- some off-label use drugs
- drugs covered under Part A and B (even if an individual does not have such coverage)

- Part D plans are permitted to offer supplemental benefits that cover drugs that otherwise meet the definition of a Part D prescription drug but are explicitly excluded from coverage, such as certain prescribed weight loss drugs.

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1.13 Part D Standard and Alternative Benefits

1.14 Part D Plan Benefits

Part D Plan Benefits

- All Part D plans must cover at least the Part D standard benefit or its actuarial equivalent.
  - Actuarial equivalent means that the value of Part D benefits must be at least the same as the standard coverage.
  - Benefit structures that are not standard, are known as “alternative” coverage.
- The standard benefit structure includes several coverage “phases” including:
  - a deductible
  - an initial coverage phase between the deductible and the initial coverage limit
  - a “coverage gap” phase between the initial coverage limit and the out-of-pocket threshold (this phase also used to be called the donut hole)
  - a catastrophic coverage phase that applies after the beneficiary reaches the annual out-of-pocket threshold
- Alternative benefits are also structured with some or all of these coverage phases.

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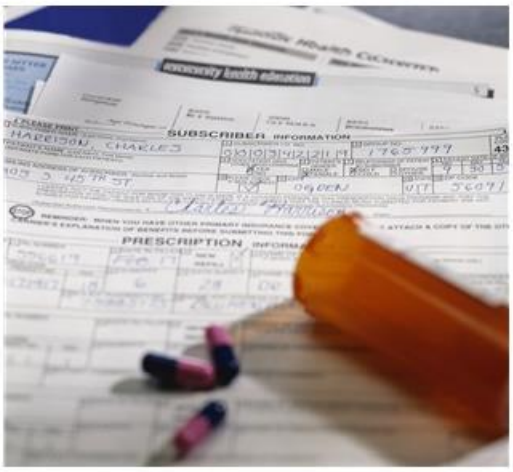
1.15 Part D Plan Benefits continued

Part D Plan Benefits continued

- Alternative coverage is prescription drug coverage that is at least actuarially equivalent to standard drug coverage, and that:
  - has an annual deductible that does not exceed the annual deductible under the standard benefit; and
  - imposes cost-sharing no greater than the standard benefit once the annual out-of-pocket threshold is met.
- Some Part D plans may offer enhanced coverage for an additional monthly premium (known as enhanced alternative benefits).
  - Coverage enhancements may include a reduction of the deductible; coverage of excluded drugs and/or an increase in the initial coverage limit.



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1.16 Standard Part D Plan Benefits for 2022

Standard Part D Plan Benefits for 2022

For 2022, the standard benefit requires the beneficiary to pay:

- A $480 deductible
- 25% of prescription drug costs during the initial coverage phase - that is, between the deductible and initial coverage limit of $4430 or the actuarial equivalent to an average expected coinsurance of no more than 25 percent of actual cost during the initial coverage phase.
- 25% of the cost of generic drugs and 25% of the undiscounted costs of brand name drugs during the "Coverage Gap" phase -
    - Note that, from a beneficiary perspective, there is no longer a "gap." However, spending after the initial coverage limit during the so-called coverage gap phase remains relevant, because, during this period of drug spending, drug manufacturers are responsible for 70 percent of the cost of the drug (known as the manufacturer discount). This 70 percent is attributed to beneficiary out-of-pocket costs and counts toward the spending necessary to reach the catastrophic coverage phase even though beneficiaries do not pay it.

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1.17 Part D Standard Benefits for 2022, Catastrophic Coverage

Part D Standard Benefits for 2022, Catastrophic Coverage

- Once beneficiary out-of-pocket costs (including the 70 percent drug manufacturer discounts) reach a total of $7,050, the beneficiary is through the "coverage gap" and reaches catastrophic coverage.
  - The out-of-pocket costs that count toward reaching the catastrophic limit are known as "true out-of-pocket" costs or TrOOP. In some instances, amounts not directly paid by the beneficiary, including the manufacturer discounts, count toward TrOOP.
- After reaching the annual out-of-pocket threshold, the beneficiary pays either a co-pay of $3.95 for generic drugs or $9.85 for brand name drugs or a co-insurance of 5%, whichever is greater.

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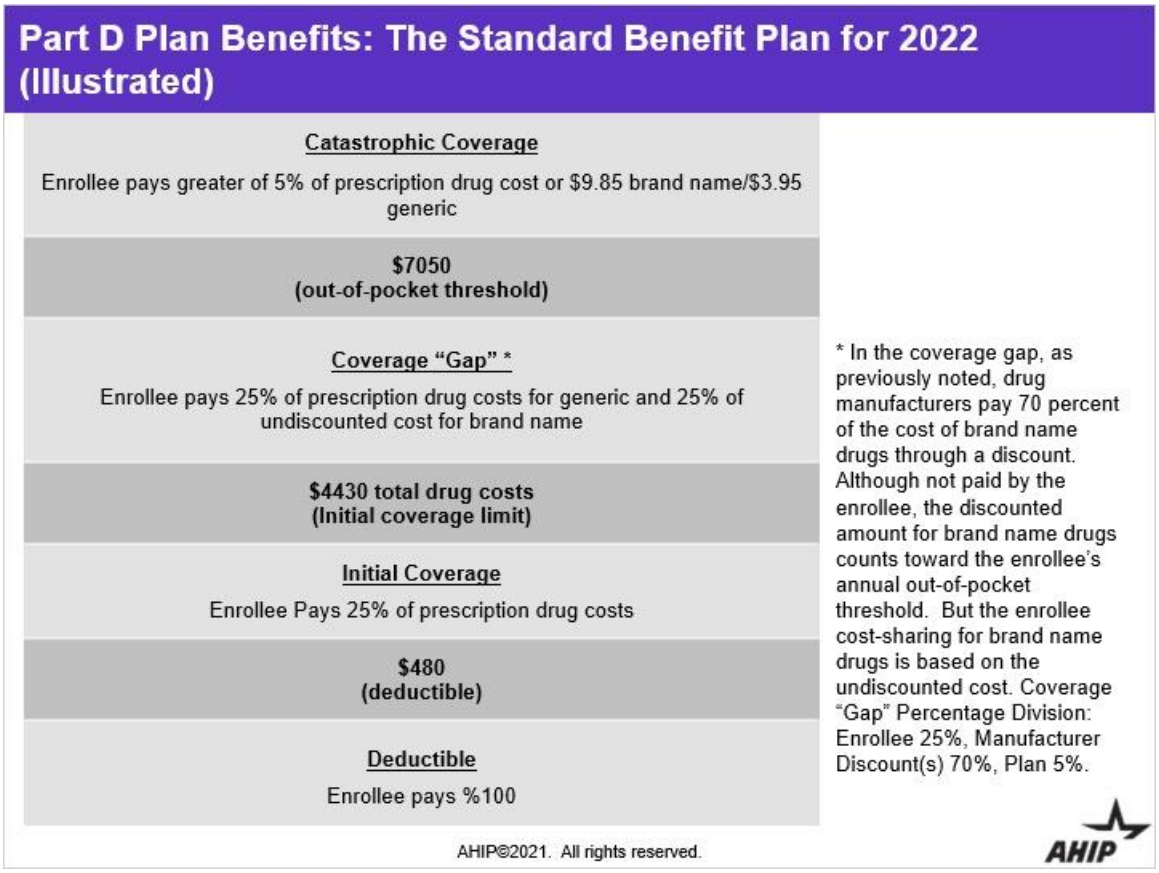
1.18 Part D Plan Benefits: The Standard Benefit Plan for 2022 (Illustrated)



1.19 Examples - Beneficiary Costs

Examples - Beneficiary Costs

Example 1: Standard Benefits

Ms. James is enrolled in a PDP with no monthly premium. She takes 3 prescription drugs with a total cost of $4000 annually. Ms. Baker pays $1360 for her drugs ($4000 (total drug cost) - $480 (deductible) = $3520 x .25 (initial coverage cost sharing percentage) = $880 + $480 (deductible) = $1360.

Example 2: Non-Standard Enhanced Coverage

Mr. Bingham is enrolled in a PDP with a $0 deductible and a $50 per month premium. His copayment for generic drugs is $5 and for a brand name is $25. Mr. Bingham takes several maintenance drugs. Two are generic and two are brand names. Mr. Bingham's annual drug cost is $1320. (2 generic drugs = $10/mo.) + (2 brand name drugs = $50/mo.) x 12 months = $720. In addition, Mr. Bingham will pay $600 in premiums per year ($50 x 12 months).

1.20 Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP): What Counts?

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP): What Counts?

Part D True Out-of-Pocket costs or "TrOOP" are out-of-pocket costs that count towards the annual out-of-pocket threshold to move into the catastrophic coverage phase

- TrOOP is calculated on an annual basis
- Generally, TrOOP includes beneficiary payments for Part D prescription drugs, including:
  - The annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold.
- After the initial coverage period, a drug manufacturer's discount for brand name drugs counts toward the true out-of-pocket costs.
- Generally, for drug costs to count toward TrOOP, drugs must be on the plan's formulary and be purchased at the Part D plan's participating network pharmacy.
- Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service also count toward TrOOP.
- Amounts paid by or through qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, health savings accounts, flexible spending accounts, and medical savings accounts also count toward TrOOP.

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1.21 "True Out-of-Pocket" Costs (TrOOP): What is Excluded?

"True Out-of-Pocket" Costs (TrOOP): What is Excluded?

Some costs do not count toward TrOOP cost including:

- Costs for drugs not on a Part D plan's formulary, unless the beneficiary requests and receives a formulary exception under which the plan covers the drug;
- Costs for over-the-counter (OTC) and other non-Part D drugs;
- Costs for covered Part D drugs obtained out-of-network (unless the plan's out-of-network coverage policy applies);
- Costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs, or another third party including:

Medicaid, State Children's Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements;

- Costs for drugs purchased outside the United States.

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1.22 Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Example 1: Mr. Reynolds takes several formulary drugs which have a total cost of $4000 per year. He uses a Health Reimbursement Arrangement (HRA) funded by his employer to pay his deductible and cost-sharing. Only the manufacturer discount for brand name drugs purchased in the coverage gap count towards TrOOP (i.e. 70% of the cost of those drugs). No costs that Mr. Reynolds pays for with HRA funds count.

Example 2: To address her acid reflux, Ms. Lopez has been taking a formulary drug and an over-the-counter medication. Only the amount Ms. Lopez pays for the formulary drug counts toward Ms. Lopez's out-of-pocket costs.

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1.23 Part D Pharmacy Networks

Part D Pharmacy Networks

- Part D coverage is generally provided through contracted pharmacies (network pharmacies) in the Part D plan's service area, except that PFFS plans are not required to use a pharmacy network but may choose to have one.
  - Network pharmacies include retail pharmacies and may also include mail-order pharmacies.
  - Within their networks, Part D plans may designate some pharmacies as preferred pharmacies that offer lower levels of cost-sharing ("preferred cost-sharing") than apply at other network pharmacies ("standard cost-sharing").
- Enrollees are generally required to fill prescriptions for covered drugs at network pharmacies.
- Under certain circumstances, enrollees may fill prescriptions for covered drugs at out-of-network (non-network) pharmacies, but possibly at a higher cost to enrollees. For example:
  - If the enrollee has an illness or loses a drug while traveling outside the service area.
  - If there are circumstances resulting in limited drug access through an in-network pharmacy.

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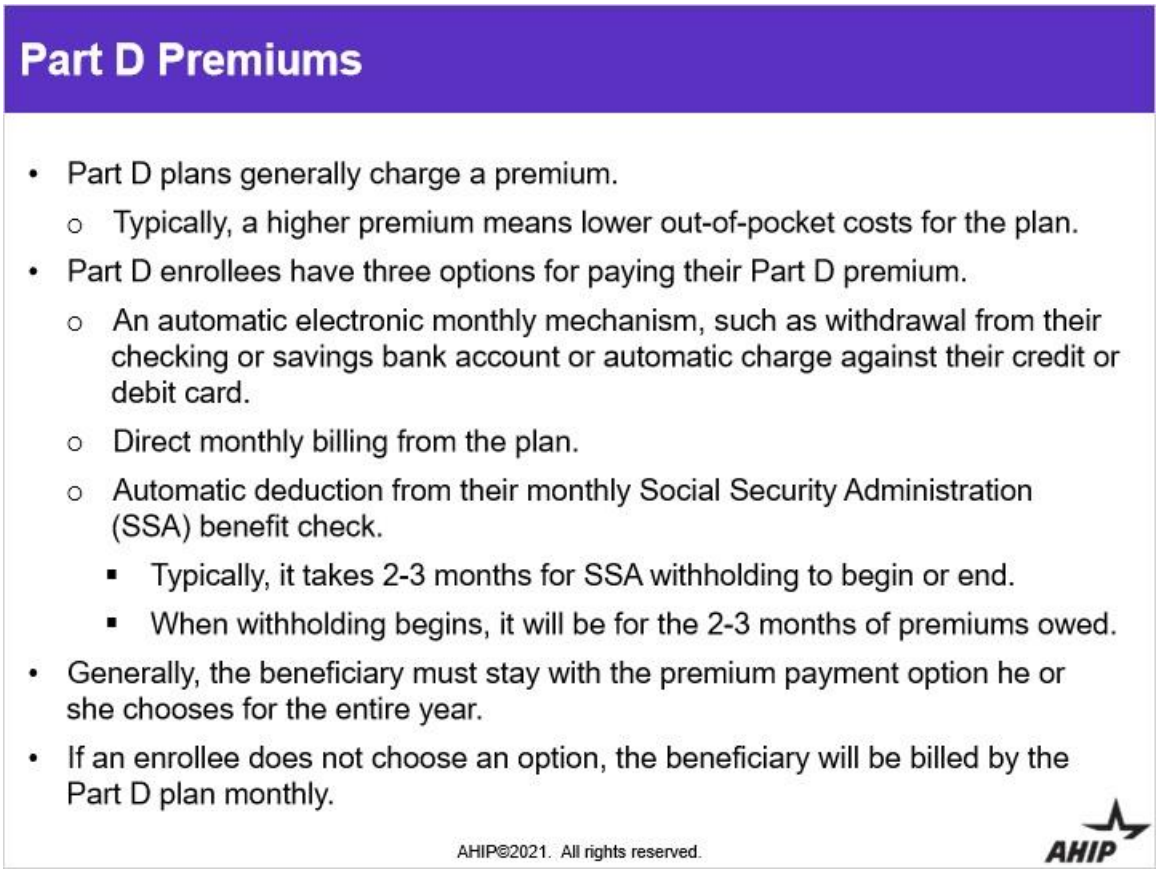
1.24 Part D Premiums and Late Enrollment Penalties

1.25 Part D Premiums



1.26 Part D Late Enrollment Penalty

Part D Late Enrollment Penalty

- Beneficiaries may have to pay a premium penalty to join a Part D plan if:
  - They do not have creditable drug coverage and do not enroll when first eligible for Part D.
  - There have been at least 63 continuous days following a beneficiary's initial enrollment period for Part D during which the beneficiary did not have either Part D or creditable drug coverage.
- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.
- In general, the penalty is in effect for as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty.

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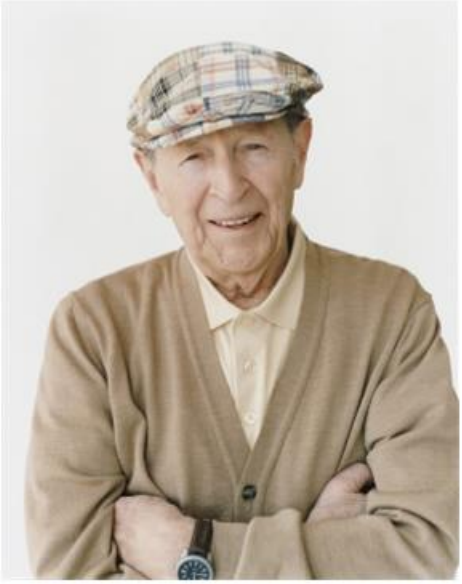
1.27 Late Enrollment Penalty Examples

Late Enrollment Penalty Examples

Mr. Russell did not sign up for Part D when he first became eligible because he had creditable coverage through his employer. Mr. Russell retired two years ago and lost his prescription drug coverage on the date he officially retired. He can no longer afford his prescription drugs and has approached a broker about enrolling in a Part D plan. His broker advised him that the advertised premiums for the plans he is considering could be substantially increased because he has not had credible coverage for two years and might be subject to a late enrollment penalty of 24%. His broker wisely directed him to the Social Security Administration (SSA) to see if he is eligible for the low-income subsidy. The SSA confirmed his eligibility allowing him to avoid the financial penalty.



Mr. Smith did not enroll in Part B or D when he became eligible because he had comprehensive health and drug coverage through his wife's employer. As a result of divorce, he lost eligibility for employer payment for the coverage and chose not to pay the COBRA premiums because they were too high. He enrolled in Part B immediately upon losing the employer coverage, but 6 months later has realized that it does not cover his substantial drug costs. He is interested in enrolling in Part D. He is not eligible for a low-income penalty. Mr. Smith will pay a premium penalty of 1% for each month he was without creditable coverage.

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1.28 Part D Drug Management Tools and Formulary Requirements

1.29 Part D Drug Management Tools

Part D Drug Management Tools

Part D plans commonly use a variety of prescription drug benefit management tools, including:

- A formulary: A list of drugs covered by the plan
- Cost-sharing tiers: Drugs may be grouped by the amount of cost-sharing. Many plans group drugs into 3 or 4 tiers with lower tiers costing less than higher tiers, for example:
  - Tier 1: Generic drugs
  - Tier 2: Preferred brand-name drugs
  - Tier 3: Non-preferred brand-name drugs
  - Tier 4: High-cost drugs or "specialty drugs"

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1.30 Part D Drug Management Tools, continued

Part D Drug Management Tools, continued

Prescription drug benefit management tools used by Part D plans may also include:

Step therapy: One or more similar lower-cost drugs must be tried before other costlier drugs are covered, if necessary.

Prior authorization: Requires the doctor to contact the plan and request authorization before the plan will cover the prescription drugs. The doctor must show the plan that the drug is medically necessary for it to be covered.

Substitution: Part D sponsors may substitute generic drugs for brand name drugs if the generic drugs have the same or lower cost-sharing and certain conditions are met.

Comprehensive Addiction and Recovery Act (CARA) programs: Plans may impose certain limitations on the prescribers or pharmacies a beneficiary can use to manage utilization for beneficiaries who are at risk of misusing or abusing frequently abused drugs, such as opioids.

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1.31 Transition Requirements

Transition Requirements

- Enrollees initially enrolling in Part D, those switching plans, and current enrollees affected by formulary changes must receive coverage of at least a one-month fill (unless a lower amount was prescribed) of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.
- To the extent that a current enrollee in a long-term care setting is outside his or her 90-day transition period, the sponsor must still provide a one-month supply of nonformulary Part D drugs while an exception or prior authorization request is being processed.
- During the transition period:
  - The Part D plan does not apply prior authorization or step therapy rules.
  - The enrollee and his/her physician can request an exception to the Part D plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

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1.32 Transition Example

Transition Example

Example 1: Mr. Patterson recently moved out of the service area of his MA-PD and had to enroll in a new MA-PD Plan. One of the drugs that Mr. Patterson was prescribed is not on the new plan's formulary. When Mr. Patterson's current supply of the drug runs out, he can get at least another month of his drug covered as long as he requests a refill within 90 days of his new coverage. If Mr. Patterson wishes to see if the plan will continue coverage of this drug, he should work with his prescribing physician to request a formulary exception.

Example 2: Mr. Cooley changed PDPs during open enrollment. When he went to have his prescription refilled, he was informed that the drug he takes is subject to step therapy requirements under his new PDP plan (that is, a requirement to try a lower-cost drug first, before his drug would be covered). Mr. Cooley can get at least a one-month refill of his drug covered without trying the lower-cost drug as long as it is within 90 days of his change in coverage.

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1.33 Enrollee Rights: Requesting Coverage Determinations and Appealing Decisions

Enrollee Rights: Requesting Coverage Determinations and Appealing Decisions

- Part D Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a determination of whether the plan will cover a drug (a coverage determination) or appeal a coverage decision.
    - Enrollees may appeal coverage determinations, decisions on exceptions, or requests concerning tiering or formularies.
- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

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1.34 Enrollee Rights: Requesting Exceptions for Drugs

Enrollee Rights: Requesting Exceptions for Drugs

- Enrollees have the right to request coverage of a drug that is not on the Part D plan's formulary or to request coverage of formulary drugs at a less costly formulary tier. Such requests are known as formulary exception requests.
- If a doctor thinks an enrollee needs a drug that is not on the formulary, the enrollee or the doctor can apply for a formulary exception.
- A standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary exception.

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1.35 Enrollee Rights: Filing Grievances

Enrollee Rights: Filing Grievances

- Beneficiaries may also file complaints about their Part D plan or their pharmacies. These complaints are known as grievances.
- Grievances include complaints about issues such as pharmacy wait times, a plan's failure to mail a beneficiary requested material, or the length of hold time on the plan customer service line.
- Grievances do not include complaints about a Part D sponsor's refusal to cover a drug or approve an exception request. Beneficiaries must resolve such issues through the appeals process.

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1.36 Part D Assistance Programs

1.37 Help for Individuals with Limited Income and Limited Resources

Help for Individuals with Limited Income and Limited Resources

If a beneficiary has limited income and resources, he/she may qualify for the low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. In 2021, to qualify for the LIS:

- Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically as follows:
  - 48 states $19,320 (individual)/$26,130 (couple)
  - Alaska $24,135 (individual)/$32,655 (couple)
  - Hawaii $22,230 (individual)/$30,060 (couple)
- Beneficiaries' resources may not exceed $14,790 (individual)/$29,520 (couple).

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1.38 Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply for the low-income subsidy (LIS) - also called extra help - through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
  - If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
  - Or call SSA at 1-800-772-1213 (TTY users can call 1-800-325-0778) or apply online at https://secure.ssa.gov/i1020/start to apply for help with Part D costs.
- After SSA or the State approves an application for extra help, it is effective the first day of the month in which the individual applied.

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1.39 Certain Individuals Automatically Quality for Extra Help

Certain Individuals Automatically Quality for Extra Help

Individuals automatically qualify for Extra Help if they have Medicare and meet any of these conditions:

- They have full Medicaid coverage;
- They get help from their state Medicaid program paying their Part B premiums (in a Medicare Savings Program);
- They get Supplemental Security Income (SSI) benefits.

Medicare mails these individuals a purple letter to let them know they automatically qualify. They should keep this letter for their records. They do not need to apply for Extra Help if they get this letter.

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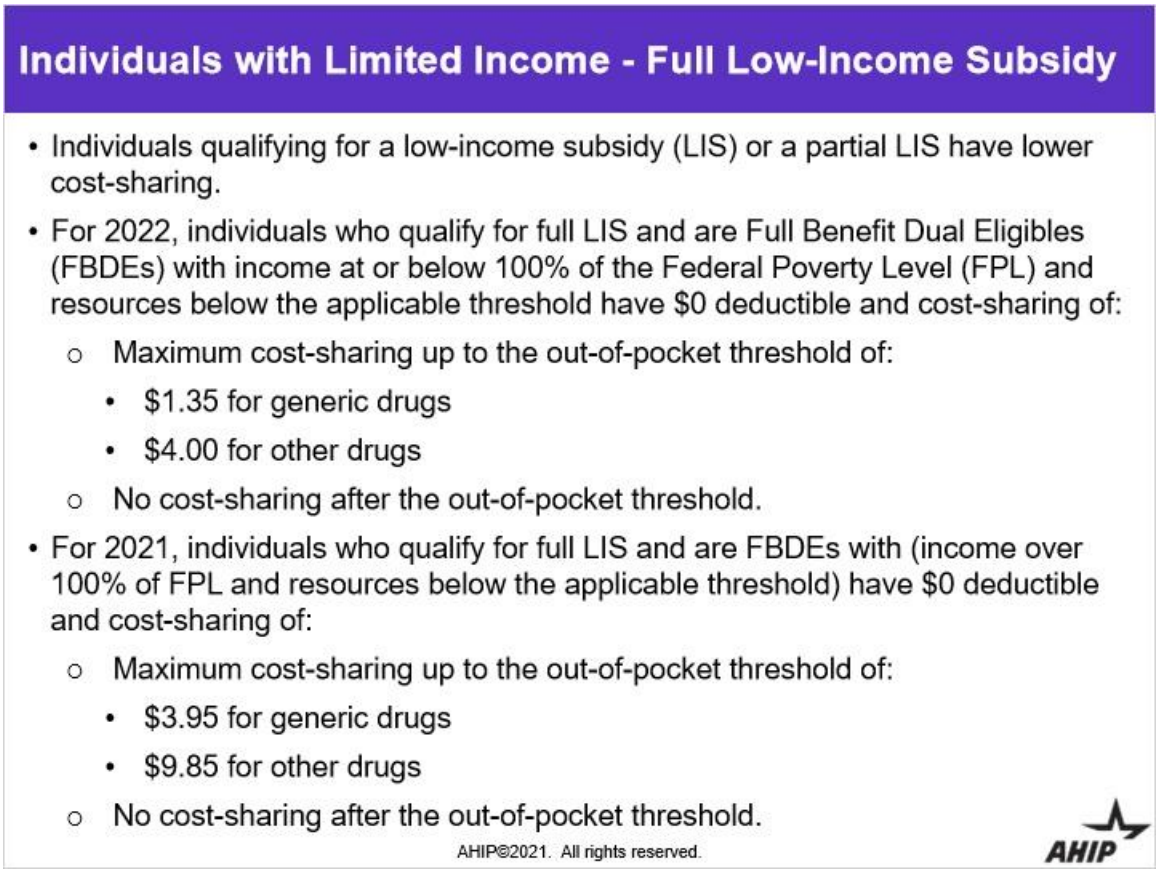
1.40 Individuals with Limited Income - Full Low-Income Subsidy



1.41 Individuals with Limited Income - Full LIS but not FBDE and Partial LIS

Individuals with Limited Income - Full LIS but not FBDE and Partial LIS

- For 2022, individuals who qualify for full LIS but are not FBDEs with income up to 135% of the Federal Poverty Level and resources below the applicable threshold have a $0 deductible and cost-sharing of:
  - Maximum cost-sharing up to the out-of-pocket threshold of:
    - $3.95 for generic drugs
    - $9.85 for other drugs
  - No cost-sharing after the out-of-pocket threshold.
- For 2022, individuals who qualify for Partial LIS (income less than 150% of the Federal Poverty Level and resources below the applicable threshold) have a $99 deductible and maximum cost-sharing of:
  - 15% up to the maximum out-of-pocket threshold
  - Maximum cost-sharing after the out-of-pocket threshold of:
    - $3.95 for generic drugs
    - $9.85 for other drugs

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1.42 Other Help for Low-Income - Pharmaceutical Assistance Programs

Other Help for Low-Income - Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low-income individuals in obtaining drugs at reduced or no costs.
- Some states have assistance programs designed specifically for their residents.
  - Some programs are "qualified" State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
  - Becoming familiar with your state's programs may help a beneficiary address cost-sharing for prescriptions.

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1.43 Part D and Other Coverage

1.44 Employer/Union Coverage of Drugs

Employer/Union Coverage of Drugs

- Employer or Union Coverage: Employers/unions will notify their employees of whether their non-Medicare prescription drug coverage is "creditable" (coverage that, on average, equals at least as much as Medicare's standard Part D coverage expects to pay) via an annual statement.
  - If coverage is creditable and the beneficiary keeps it, he/she will not incur a premium penalty if he/she later loses or drops the employer coverage and joins a Part D plan.
  - If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during his/her initial eligibility period to avoid the late enrollment penalty.
- If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, he/she can compare that coverage with available Part D plans to decide whether to enroll in Part D.

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1.45 Employer Coverage of Drugs, continued

Employer Coverage of Drugs, continued

- The beneficiary should check with the employer or union benefits administrator before making any change from their employer/union coverage.
    - If a beneficiary drops employer/ union prescription drug coverage, he/she may not be able to get it back and may also lose health coverage.
- If the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days, there will not be a late enrollment penalty.

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1.46 Medicaid Drug Coverage

Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don't choose a plan, Medicare will select one for them.

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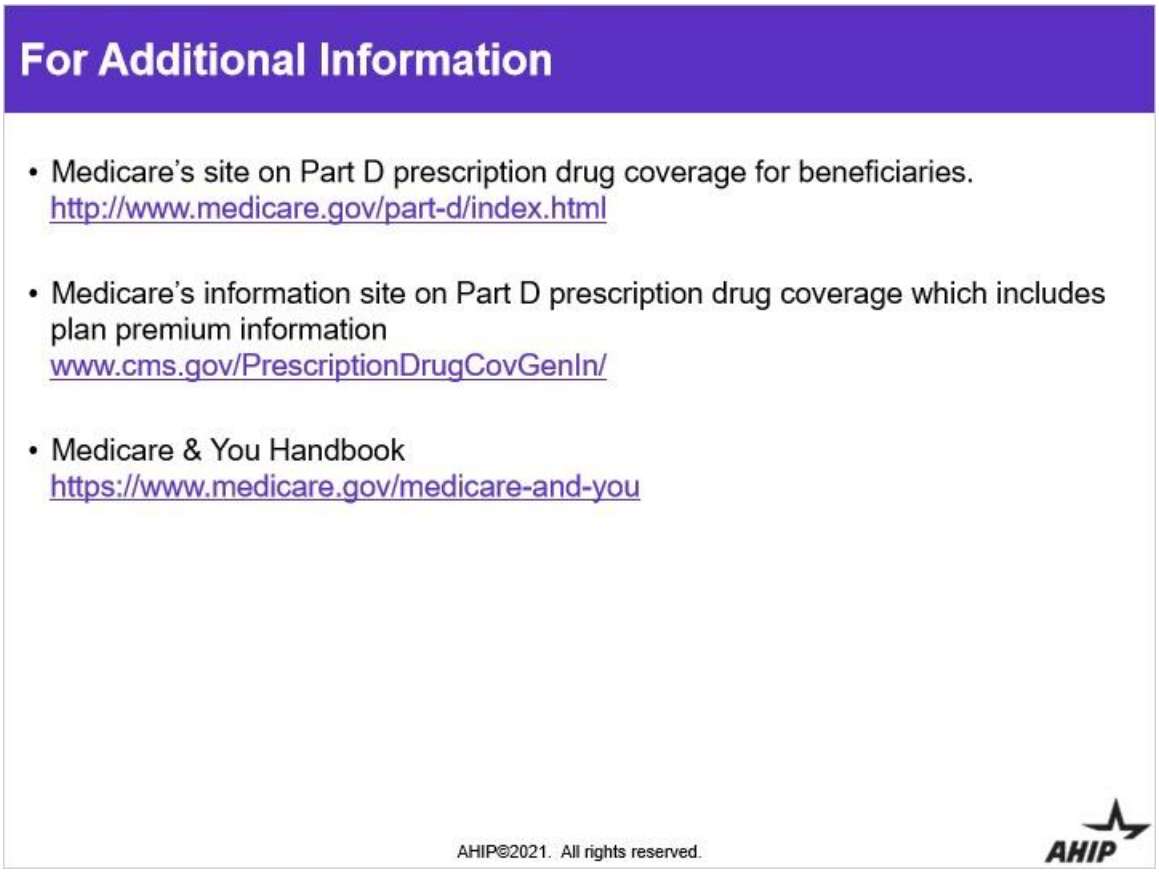
1.47 For Additional Information



1.48 THANK YOU