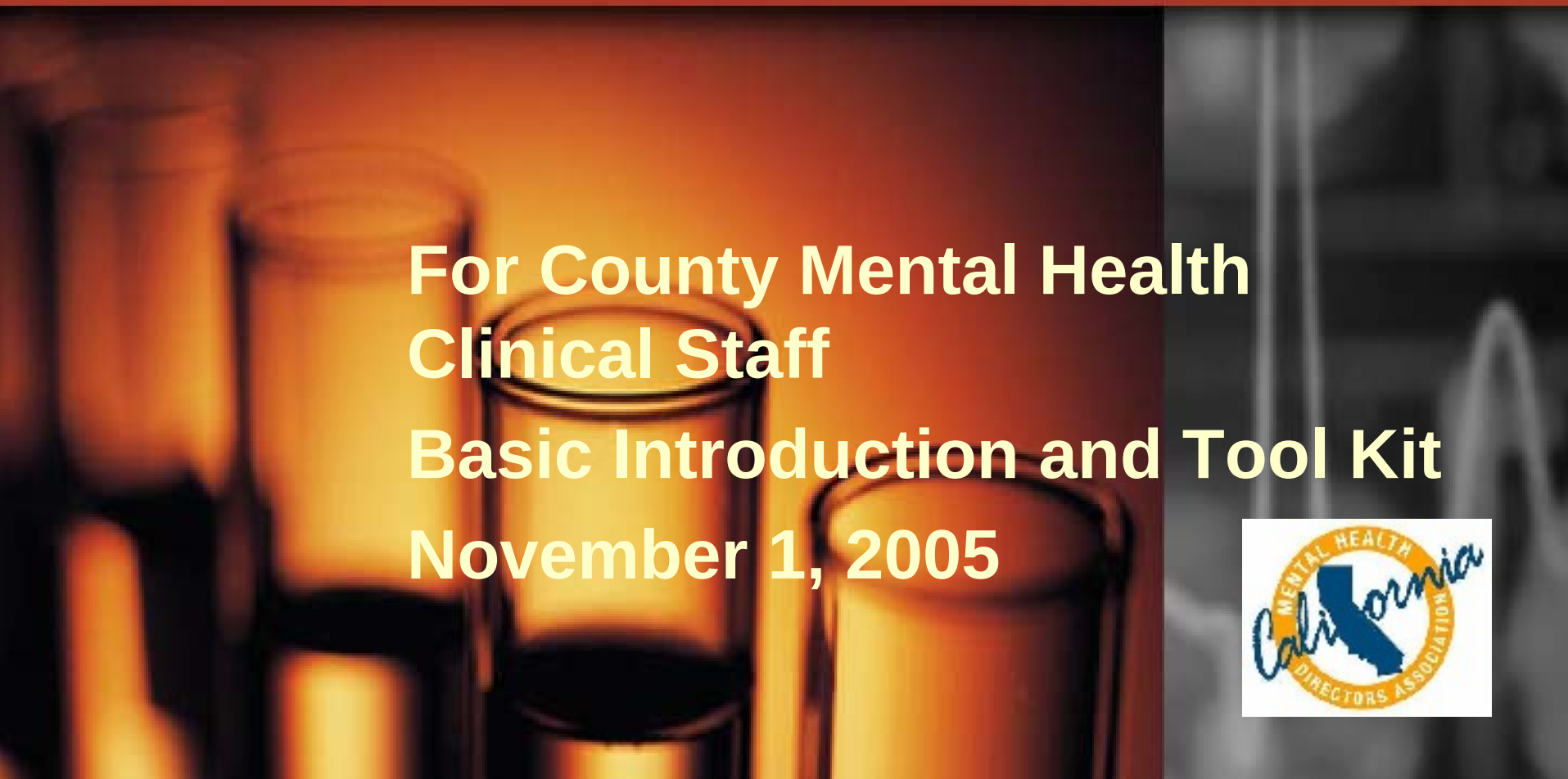
Medicare Modernization Act, Part D Prescription Drug Benefit



For County Mental Health Clinical Staff

Basic Introduction and Tool Kit

November 1, 2005

Part D: What It Is, What It Does

- The Medicare Modernization Act (MMA) of 2003 created a new "Part D" program in Medicare, establishing a privatized Medicare prescription drug plan.
- Part D restructures traditional drug coverage under Medicare creating a new "voluntary" (premium and co-pay based) prescription drug benefit for Medicare enrollees.
- Eliminates state matching Medicaid funds (Medi-Cal) to cover prescription drugs for dual eligibles and low income individuals and shifts them into Medicare D plans for prescription drug coverage.
- Starting January 1, 2006, Medi-Medi clients will have to get their prescription drugs from Medicare, not Medi-Cal.
- Creates "stand alone" Prescription Drug Plans (PDPs).
- Creates integrated Medicare Advantage plans, which must include prescription drug coverage (MA-PD).
- The Centers for Medicare and Medicaid Services (CMS) is responsible for overseeing the implementation of the MMA and Part D.

Differences in Part D Plans

Prescription Drug Plans (PDPs)	Medicare Advantage + Prescription Drug Plans (MA-PDs)	Medicare Advantage Plans (MA)	Medicare Advantage Special Needs Plans (MA-SNPs)
Provide only prescription drug coverage	Provide health and prescription drug coverage.	Traditional health-only coverage (e.g. HMOs, PPOs, FFS) and not prescription drug coverage.	Limited to enrollees who have chronic conditions and/or who may be dual eligibles.
There are 8 PDPs that Medi-Medi clients will auto-enrolled into by CMS. Clients will start getting notices from CMS in early November letting them know that their prescription drug coverage is changing.	Some of these kinds of plans already exist such as Kaiser. If Medi-Medi clients are already in this kind of plan, their plan will facilitate enrollment on their behalf.		There are very few of these plans in existence at the moment. Additionally, there are numerous complexities associated with these plans that deserve further investigation.

Part D Provisions	General Policy Those At or Above 150% of FPL	Between 135% and 150% of FPL	Under 135% of FPL	Dual-Eligible
Annual Premium	$35 per month ($20 annually)	Sliding Scale	None	None
Deductible (person pays in full)	$250	$50	None	None
Co-payment	25% for drug costs between $250 and $2,250 100% for drug costs between $2,250 and $5,100	15% for drug costs between $50 and $5,100	$2 - $5 co-pays for drug costs up to $5,100	Under 100% FPL: $1 - $3 copays for drug costs up to $5,100 Above 100% FPL: $2 - $5 co-pays for drug costs up to $5,100 No copays for drug costs over $5,100
Doughnut Hole	$2,850 gap in coverage	n/a	n/a	n/a
Catastrophic Coverage for drug costs over $5,100	5% or copays $2-$5	Co-pays of $2-$5	100% covered	100% covered

Timeline: When It All Happens

Date	Action
May 31, 2005	CMS will begin sending mailings to Dual Eligibles and Low-Income subsidy eligible beneficiaries
June 20-30, 2005	CMS mails letters to Dual Eligibles explaining the transition to Part D
July 2005	CMS launches discussion phase of message campaign
July 1, 2005	SSA and State Medicaid offices can begin accepting applications for Low-Income subsidies
October 1, 2005	Approved Part D plans can begin marketing to beneficiaries

Timeline: When It All Happens

Oct 14 or 17, 2005	**CMS Web Portal of PDPs and MA-PDs itemizing drug benefits goes live.**
Oct 27 – Nov 10., 2005	**CMS mails auto-enrollment information to Dual Eligibles**
November 15, 2005	**Enrollment in Part D Drug Plans Begins**
January 1, 2006	**Medicaid Drug Benefit for Dual Eligible Ends**
May 15, 2006	**Initial Enrollment Period for Part D Ends**
Nov 15 through Dec 31	**Annual Coordinated Election Period (beginning in 2007)**

“Extra Help” Low Income Subsidy

- There will be extra help available to help offset the costs of the new prescription drug benefit.
- The Social Security Administration (SSA) is in charge of determining eligibility for the “extra help” low income subsidy (LIS).
- Applications can be found at any local social security office, county welfare office, or SSA can mail an application to you.
  - Applications cannot be xeroxed. Only an original, bar-coded application will be accepted by the SSA.
  - However, applications can also be completed online at www.ssa.gov
  - Verification can be done by phone with the SSA. Clients will need to be with the clinician to give verbal permission to SSA to verify status of LIS application.

“Extra Help” Low Income Subsidy

- Medi-Medi clients will be auto-enrolled into the extra help low income subsidy.
- All other Medicare clients have a two-step process they need to complete on their own.

  Step 1) They will need to apply for the LIS on their own.

  Step 2) They will then need to apply for their Part D prescription drug plan.
- SSA sent 19 million applications to individuals they believed would qualify for the LIS. To date, they have only received 3 million back.
- **WHEN IN DOUBT, FILL IT OUT.**
- **Questions on the “Extra Help” Low Income Subsidy: Call SSA at 800/772-1213. TTY 800/325-0778.**

“Extra Help” Low Income Subsidy

- **What information do I need to apply for the extra help?**

  -- Social Security number

  -- Financial information for you and your spouse (if married and living together), including:

  -- Deposits in bank accounts

  -- Income from pensions, investments or annuities -- face value of life insurance policies

  -- Individuals should apply even if they think they don’t have all of this information.

Educating Clients

Following are some basic steps to follow when educating clients about Medicare Part D.

1) Inform clients that the way they get their prescription drugs is changing.

2) Use the “inventory” brochure as a guide to mark down the type of health coverage the client currently has and the types of medication he/she is currently taking. The “inventory” brochure is the “Are You Ready” brochure completed by the World Institute on Disability.

3) Inform clients to keep all mail they receive from the Center for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA).

4) Let them know that there will be a co-pay. This is true for all clients, even Medi-Medi clients.

5) Inform them that the “Medicare & You 2006” handbook has a mistake, which indicates that there is no premium difference in cost for the prescription drug plans. Actually, there <u>are</u> premium differences in the prescription drug plans.

6) Inform clients that they should check with their local pharmacy to make sure that the Part D plan that they have been enrolled into or the plan that they are thinking about joining is accepted at their pharmacy.

7) Individuals can enroll into a Medicare Prescription Drug Plan or change their plan by calling 800-Medicare.

Educating Clients

For Medi-Medi Clients:

1) Make sure to tell clients that if they have both Medicaid (Medi-Cal) and Medicare that the SSA will automatically enroll them into the “extra help” low income subsidy.

2) Inform clients that if they have both Medicaid (Medi-Cal) and Medicare, CMS will auto-enroll them into a prescription drug plan. Let clients know that they will be getting a letter in the mail that will state which PDP or MA-PD they have been auto-enrolled into.

3) Let clients know that as soon as they know which plan they have been enrolled into, to contact you (their clinician), family member or gatekeeper to review the plan and its formulary to make sure that the drugs he/she needs is covered by the plan.

4) Let clients know that they can change the plan that they have been auto-enrolled into. If a client has both Medi-Cal and Medicare he/she can change their plan once every month.

Educating Clients

For Medicare Only Clients:

1) If a client has Medicare only, make sure to tell them that they will not be auto-enrolled into the “extra help” low income subsidy. These clients will need to complete the LIS application.

2) If a client has Medicare only, make sure to tell them that they need to enroll themselves into a prescription drug plan. And, let them know that their open enrollment period will end May 15, 2006.

3) Inform clients with Medicare only that if they delay waiting to enroll in a Part D prescription drug plan after May 16, 2006, they will be subject to a penalty for waiting. The penalty is 1% of the premium and this amount is incremental for every month they delay in waiting to enroll.

4) If individuals join by December 31, 2005, their coverage will begin January 1, 2006. If individuals join after January 1, 2006, their coverage in the new plan will begin the first day of the month after the month they join.

How to Join a Medicare Prescription Drug Plan

Individuals can join a Medicare Prescription Drug Plan or change their coverage in the following ways:

1) By paper application. Contact the company offering the drug plan you choose and ask for an application. Once you fill out the form, mail or fax it back to the company.

2) On the plan's website. Visit the drug plan company's website. You may be able to join online.

3) On Medicare's website. You will also be able to join a drug plan at www.medicare.gov on the web using Medicare's online enrollment center.

4) By calling 1-800-MEDICARE. You can join a drug plan by calling 1-800-MEDICARE (1-800-633-4227) and talking to a Medicare customer service representative. TTY users should call 1-877-486-2048.

Special Provisions

- **30-Day Fill.** CMS guidance stipulates that all plans should have an emergency 30-day fill policy during the transition period.
- **Exceptions Process.** All plans are required to have a Treatment Authorization Request (TAR) process. CMS refers to the TAR process as the Exceptions process. There are two types of exceptions: ***tier exceptions*** and ***formulary exceptions (coverage exception)***.
- **Tier exception:** An enrollee may request a tier exception to obtain a Medicare covered prescription drug at a lower cost (e.g. a client takes Depakote, but it's a tier 2 drug, which means the client will have to pay a higher co-pay for the drug).
- **Formulary exception:** There is also the formulary exception to obtain a Medicare-covered prescription drug that is not on a plan's formulary. If a plan rejects the Exceptions request, beneficiaries can appeal the decision.
- **Timeframes.** The plan must notify the enrollee and the prescribing physician involved of its determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours for expedited requests, or 72 hours for standard requests, after receipt of the request for a coverage determination or receipt of the physician's oral supporting statement for exceptions requests.

Special Provisions

- **Appeals Process.** There is a five step appeal process that beneficiaries can follow if the Exceptions request is denied.

  Step 1: The first step is an appeal to the plan itself.

  Step 2: If the plan's decision is unfavorable the appeal then elevates to an independent review entity.

  Step 3: If the independent review entity is unfavorable, the decision would be appealed to an Administrative Judge.

  Step 4: If still unsuccessful, the next appeal would be before the Medicare Appeals Council

  Step 5: If the exception is still denied, it goes to the Federal District Court.

- 60-Day Notice. Plans must give a 60-day notice to their enrollees if any of the medications in a plan's formulary are going to change. Plans must get approval from CMS prior to making any changes.

Marketing Guidelines for PDPs and MA-PDs

- **CMS** guidelines prohibit the following:

  --Door-to-door sales

  -- Unsolicited e-mails

  -- Plans must honor the National Do Not Call Registry and "do not call again requests"

  -- Plans must meet all state requirements for licensure, registration or certification.

  -- CMS will investigate complaints by consumers and other organizations. Call 1/800-Medicare to register complaints.

Consumer Awareness re: Marketing by PDPs and MA-PDs

- Consumers should not give out personal information (e.g., Social Security Numbers, bank account numbers, credit card numbers, etc.) to plan marketing representatives. Plans are not allowed to request such personal information in their marketing activities.

- Plans cannot call outside of the calling hours allowed by the federal government and states. Federal rules do not allow telemarketers to call before 8 a.m. or after 9 p.m.

- To stop repeated and unwanted sales calls, beneficiaries simply need to say "stop:" Plans are required to honor "do not call again" requests from beneficiaries. To register for the federal "do not call" list to prevent all unsolicited marketing calls, go to www.donotcall.gov.

- For additional information about drug plan options from an independent source, beneficiaries can go to www.medicare.gov, call 1-800-MEDICARE, or seek help from the local State Health Insurance Assistance Program or Area Agency on Aging to get personalized information about which drug plan may be best for them.

Important Things to Know

- **Transitional Care Questions**

  -- Part D will follow clients into IMDs and State Hospitals.
- **Consumer Issues**

  -- All dual eligibles will have a co-pay—even those at or below 100% of FPL. There is one exception--those who are "institutionalized" will not have a co-pay.

  -- Consumers already enrolled in an MA type plan will be enrolled in their current MA plan as long as it becomes an MA-PD. If, by chance, consumers are enrolled in an MA type plan (HMO) that forgoes becoming an MA-PD, they will be auto-enrolled into the lowest cost MA-PD plan.
- **100-day Script for Medi-Cal.** For those consumers who are dual eligibles, they can still have a script written and paid for by Medi-Cal before the end of 2005 for a 100-day supply of medication.

Important Things to Know

- **Providers**

  -- Benzos, barbituates and some over-the-counter medications will be covered by Medi-Cal for FY 05-06.

  -- Clinicians may want to begin a review of client charts to ensure that the appropriate releases of information (ROIs) are on file to converse with the client's current primary care physician (PCP).

- **Pharmacy**

  -- Pharmacies can waive co-pays, but it's up to the individual pharmacy to make this decision. Pharmacies that decide to waive co-pays will be the entity that "eats" the cost.

- **Plan & Formulary Questions**

  -- CMS guidance of "all or substantially all" in six therapeutic classes of drugs. Includes antidepressants and antipsychotics (including atypicals).

  -- How many plans will there be in California? There are 18 PDPs, 19 MA-PDs, and Medi-Medi clients will be auto-enrolled in 8 of the PDPs.

Table 3: Stand-Alone Prescription Drug Plans Eligible to Receive Auto-Enrolled Beneficiaries in California -- (PDP Region 32)

Data as of September 18, 2005

Organization Name
ANTHEM INSURANCE COMPANIES, INC.
HEALTH NET LIFE INS CO/HEALTH NET INS OF NY
HUMANA INSURANCE COMPANY
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
UNICARE
UNITED HEALTH CARE INSURANCE COMPANY
WELLCARE HEALTH PLANS
Total=8

Table 1: Stand-Alone Prescription Drug Plan Organizations in California (PDP Region)

Organization Name Offers at least 1 Prescription Drug Plan with a Premium <$20
AETNA LIFE INSURANCE COMPANY
ANTHEM INSURANCE COMPANIES, INC.
CA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CA
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY
HEALTH NET LIFE INS CO/HEALTH NET INS OF NY
HUMANA INSURANCE COMPANY
MARQUETTE NATIONAL LIFE INSURANCE COMPANY/PENNSYLVANIA LIFE INSURANCE COMPANY
MEDCO CONTAINMENT LIFE INSURANCE COMPANY
MEMBERHEALTH, INC.
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
RXAMERICA, LLC
SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
SILVERSCRIPT INSURANCE COMPANY
UNICARE
UNITED AMERICAN INSURANCE COMPANY
UNITED HEALTH CARE INSURANCE COMPANY
WELLCARE HEALTH PLANS

Total=18

Table 2: Medicare Advantage Prescription Drug Plan Organizations in California

Percent of Medicare Eligibles with Access to an MAPD plan

X = Offers at Least 1 Plan in State with no Additional Premium for Drugs

BLUE CROSS OF CALIFORNIA	100%	x
AETNA US HEALTHCARE	38%	
AIDS HEALTHCARE FOUNDATION	20%	
BLUE CROSS OF CALIFORNIA	6%	
CA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CA	34%	x
CALIFORNIA HEALTH PLAN	26%	x
CENTRAL HEALTH PLAN OF CALIFORNIA, INC.	20%	
CHINESE COMMUNITY HEALTH PLAN	2%	
HEALTH NET, INC.	63%	x
HONORED CITIZENS CHOICE HEALTH PLAN INC	20%	x
INTER VALLEY HEALTH PLAN, INC.	28%	x
KAISER FOUNDATION HP, INC.	72%	x
MOLINA HEALTHCARE OF CALIFORNIA	28%	
ORANGE COUNTY HEALTH AUTHORITY	6%	
PACIFICARE	69%	x
SAN MATEO HEALTH COMMISSION	2%	
UHP HEALTHCARE	30%	x
UNIVERSAL CARE	37%	x
WESTERN HEALTH ADVANTAGE	4%	

Total: 19

Glossary of Terms

- **Auto-Assignment:** For individuals who receive both Medicare and Medicaid benefits, the Centers for Medicare and Medicaid will randomly assign the person to a prescription drug plan effective January 1, 2006.
- **Co-Pay:** A fee that the individual pays each time they purchase a drug. Individuals who are dually eligible for Medicaid and Medicare must also pay co-pays, which are established in the law.
- **Cost Tiers:** A system that drug plans use to price medications. Generic drugs are generally on the first and least expensive tier, followed by brand-name drugs, and then specialty drugs, with each subsequent tier requiring higher out-of-pocket costs.
- **Centers for Medicare and Medicaid Services (CMS):** The federal agency with responsibility for implementing the Medicare Modernization Act, issuing regulations, approving the drug plans, providing technical assistance to the public, etc.

Glossary of Terms

- **Deductible:** An amount the individual must pay before Medicare will begin paying for drugs. Dual eligibles are not required to pay deductibles.
- **Drug Formulary:** A list of prescription medications that a drug plan *will* pay for. When medications are not listed on a drug plan's formulary, then the drug plan will not pay for them.
- **Dual eligible:** An individual who receives both Medicare and Medicaid benefits.
- **Excluded Drug:** There are certain drugs, or uses of drugs, that the law excluded from the definition of a Medicare Part D drug. This means that they cannot be provided as part of basic coverage.
- **Exception:** The Prescription Drug Plans must have an exceptions process for enrollees to request that their plan cover a medically necessary drug not on its formulary.
- **Extra Help Low Income Subsidy (LIS):** Subsidies that are available to low income individuals to help offset the costs of the prescription drug coverage. Individuals who are dually eligible for Medicare and Medicaid will automatically receive the extra help; others must apply for the assistance.

Glossary of Terms

- **Legally Authorized Representative:** An individual who can select and enroll in a Medicare prescription drug plan on behalf of a person with a cognitive disability. CMS has stated that each state will decide who is considered a legally authorized representative for this purpose.
- **MA Plans**. Medicare Advantage Plans are health plans without prescription drug coverage and encompass Managed Care Plans (HMOs), Preferred Provider Organization Plans (PPOs), Private Fee-for-Service Plans (FFS) and Medicare Specialty Plans.
- **MA-PD (Medicare Advantage + Prescription Drugs) plan.** Managed care program that will replace Medicare+Choice plans. These plans will include both health and prescription drug coverage.
- **Medicare Modernization Act (MMA) of 2003:** The federal law that created the Medicare drug benefit and also resulted in all of the changes for dual eligibles.
- **Off-label use:** When a drug is prescribed for a reason other than the FDA approved use.
- **Part D:** The section of law within the MMA that establishes the new Medicare prescription drug coverage**.**

Glossary of Terms

- **PDP (Prescription drug plan):** A “stand-alone” prescription drug insurance company. Each PDP will have its own formulary, pharmacy network and its own procedures.
- **Pharmacy Network:** The list of pharmacies that are contracting with a prescription drug plan (PDP)**.**
- **Premium:** Monthly fees that a plan charges for the prescription drug coverage.
- **Prior Authorization:** A requirement by the PDP that a doctor must get approval from the plan before prescribing selected medications.
- **Step-Therapy:** A requirement by the PDP that a person must try one medication before the doctor may prescribe another, more expensive one.
- **Transition Plan:** The transition plan describes how each PDP will handle the situation where an individual who is stabilized on a drug regime enrolls in a plan that does not include the person’s medication.