

Medicare Part D: Prescription Drug Coverage

Health Assistance Partnership

Helping SHIPs help Medicare beneficiaries

Updated January 2010

**SHIP Resource Guide:
Medicare Part D:
Prescription Drug Coverage**

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Health Assistance Partnership

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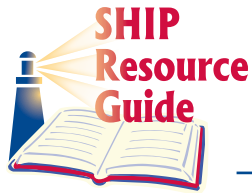


Table of Contents

MEDICARE PART D

Overview of Medicare Part D	1
Types of Drug Plans	
The Two Main Categories	5
Plan Variations	6
Eligibility and Enrollment	
Eligibility For Enrollment	11
Deciding to Enroll in a Part D Plan	11
How to Select a Plan	13
Enrollment Periods	16
How to Enroll	23
Disenrolling and Switching	24
Relationship to Medicare Advantage	
Introduction	25
Types of MA Plans	26
MA Plans and Part D	27
Costs and Prices	
Beneficiary Cost-Sharing	29
True Out-of-Pocket (TrOOP) Costs	31
Late Enrollment Penalty	34
Help for Low-Income Beneficiaries	
Eligibility	37
Levels of Low-Income Subsidy	40
Applying for Low-Income Subsidy	43
Eligible for Low-Income Subsidy: What Happens Next	46
Medicaid’s Role with Non-Part D Drugs	47
Redeterminations and Redeeming	48
Part D Plan Reassignment by CMS	50
Prescription Drug Assistance Programs and Medicare Part D	51

Access to Drugs and Formularies

Pharmacy Networks 55
Formularies 56
Cost-Containment Strategies 60
Medication Therapy Management Programs 62
Transition Policies 63

Grievance, Coverage Determinations, and Appeals

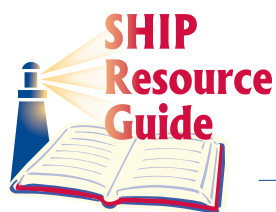
Grievances 67
Coverage Determinations 68
Appeals. 71

Marketing

Overview 73
Marketing Materials 76
Marketing Review 81
Special Guidelines 81
Promotional Activities 82
Employer/Union Sponsored 89
 Group Plans for Retirees

Resources 91

Appendices 93



OVERVIEW OF MEDICARE PART D

OVERVIEW

The Medicare Modernization Act (MMA) of 2003 created the Medicare Part D prescription drug program. The MMA's main purpose is to provide prescription drug coverage to Medicare beneficiaries through private insurance companies called plan sponsors. People with Medicare Part A, Part B, or both, are eligible to join a Part D drug plan of some kind.

Plan Sponsors

There are two ways to get Medicare drug coverage through these plan sponsors:

- Through stand-alone Prescription Drug Plans (PDPs). Generally, PDPs work with the Original Medicare program by adding drug coverage to the beneficiary's Part A and/or Part B health insurance.
- Through a Medicare Advantage (MA) plan, or health plan, that operates under Medicare Part C. For the most part, Medicare Advantage plans are open to those with both Part A and Part B. Examples of these plans include Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private-Fee-for-Service (PFFS) plans.

Medicare Advantage plans with Part D (MA-PDs) deliver health benefits equivalent to those in the Original Medicare program, including hospital, medical, and drug coverage, yet they are delivered outside of the Original Medicare program. When a beneficiary enrolls in an MA-PD, he joins a private health plan whose operation differs from that of Original Medicare and, in effect, opts out of Original Medicare. Thus, it is essential for beneficiaries to understand how joining an MA-PD plan could change their costs and access to health care providers, aside from the plan's Part D drug benefits. While many MA plans offer a Part D drug benefit, the MMA does not require all Medicare Advantage plans to do so.

The Standard Benefit Design

The federal government does not sponsor its own standard benefit drug plan. Rather, the MMA establishes a standard prescription drug coverage benefit design. The standard coverage design has an annual deductible, a 25 percent coinsurance amount, and a coverage gap which are established by law. A number of plan sponsors offer a Part D drug plan that conforms exactly to the standard coverage model. The MMA also allows Part D plan sponsors to use the standard coverage design as a baseline for other Part D drug plans with many different coverage features. These include plans that are actuarially equivalent to the

standard coverage benefit but have tiered copayments instead of the 25 percent coinsurance charge. Some plan sponsors also offer Part D plans, called alternative prescription drug coverage, that go beyond the coverage of standard plans. The plan sponsors, within broad guidelines, set the premiums, cost-sharing amounts, and coverage limits for their Part D plans. The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare, approves these private drug plans for inclusion in the Part D program using the standard coverage model as a baseline for coverage.

Access to Drugs

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand name drugs. Under Medicare rules, Part D drug plan formularies must cover at least two drugs within each diagnostic or therapeutic class. Many plans actually cover more than two drugs in each class, though most plans do not have open formularies that cover all possible prescription medications.

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are located in the section on formularies on page 56.

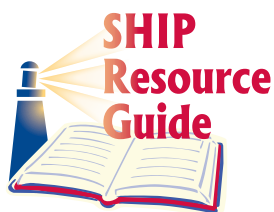
Creditable Coverage and Late Enrollment Penalties

Enrolling in the Part D program is voluntary. But the MMA established defined time frames when beneficiaries can enroll in and/or disenroll from a Part D drug plan. A decision not to join a Part D plan during an available enrollment period may result in late enrollment penalties added to the monthly premium for those who do not have existing creditable coverage. Creditable coverage is drug coverage that is financially equal to or better than Medicare's standard drug benefit. This means that people without creditable coverage who are eligible to join a Part D drug plan but choose not to do so may pay higher monthly premiums when they eventually sign up. In contrast, people with creditable coverage can keep their current coverage without penalty if they join a Part D drug plan later.

Note: You may already have some experience with Medicare and the Part D drug benefit, or you may be brand new to this work. Regardless, the Part D program will affect beneficiaries differently, and each encounter with a client may teach you something new. For this reason, the counseling experience is essential for learning about the Part D program in practical terms. This manual explains many of the concepts behind Medicare Part D, but it is in the actual counseling sessions where the real learning – and mastery of this material – begins.

Low-Income Subsidy or Extra Help

For people with limited financial means, the MMA established the low-income subsidy (LIS) or “Extra Help” program to help pay the premiums and other out-of-pocket costs connected with the Part D plans. The LIS is available for Medicare beneficiaries receiving Medicaid benefits, for those enrolled in one of the Medicare Savings Programs (MSPs), and for those whose monthly income is at or below 150 percent of the Federal Poverty Level (FPL). All who meet the income criteria must also have no more than \$12,510 for a single person (\$25,010 for a married couple) in countable assets from all sources (2010). The Social Security Administration (SSA) processes applications for the LIS program. When beneficiaries are found eligible for the LIS program, Medicare directly pays their drug plans for some or all of their Part D costs, including premiums, deductibles, and coinsurance charges or copayments.



TYPES OF DRUG PLANS

This section covers:

- The Two Main Categories
 - Plan Variations
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THE TWO MAIN CATEGORIES

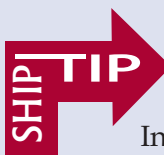
The Part D prescription drug benefit is available only through Medicare-approved plans from private insurance companies called “plan sponsors.” The MMA authorizes the plan sponsors to offer two major types of Medicare Part D drug plans. These are Prescription Drug Plans (PDPs) and Medicare Advantage plans with Part D (MA-PDs). The law gives plan sponsors significant room to design PDPs and MA-PDs with varied cost-sharing and formulary features. This section describes the two main types of plans and some of the variations federal law allows.

Prescription Drug Plans (PDPs)

- PDPs are stand-alone plans that offer only prescription drug benefits under Medicare.
- Generally, beneficiaries remain in Original (traditional, fee-for-service) Medicare for their Part A and Part B coverage.
- The MMA says that beneficiaries must have the ability to choose from at least two different types of Medicare Part D plans where they reside. One plan must be a PDP. (Beneficiaries residing in the U.S. Territories, including American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands, may not have access to two qualifying plans. This requirement may be waived for the territories.) Since most regions of the country (aside from the territories) have many more than two plans, this rule is interesting more than it is useful.

Medicare Advantage Plans with Part D (MA-PDs)

MA-PDs offer a Part D prescription drug benefit along with other Medicare-covered benefits including physician, hospital, diagnostic, home health care, and durable medical equipment services, through contracted provider networks. Beneficiaries still must pay their Part B premiums and they do have Medicare. Enrolling in Medicare Advantage essentially is an opt-out of Original Medicare. The MA-PD delivers Medicare benefits and serves as a primary insurer. MA-PDs include Medicare PPOs (Preferred Provider Organizations), HMOs (Health Maintenance Organizations), PFFS (Private Fee-for-Service) plans, SNPs (Special Needs Plans), among others. They operate under Medicare Part C and were formerly known as Medicare+Choice plans. All types of MA-PDs have variations among them.



Beneficiaries enrolled in MA-PD plans cannot use their Medicare Health Insurance cards (i.e., the red, white, and blue card) for any of their health care needs, including emergencies. They must use the MA-PD plans' cards every time they go to a doctor or hospital, so the plans will pay their claims. It's a good idea, though, to instruct clients to keep their Medicare Health Insurance cards in a safe place.



For more information about Medicare Advantage Plans, see Relationship to Medicare Advantage on page 25.

EXAMPLE *Pamela is newly retired and has no supplemental insurance to pay for the coinsurance and deductible costs in Original Medicare. Since her doctor and local hospital are in the Premiere Gold HMO's provider network, she decided to enroll in that MA-PD plan. She gets Part D prescription drug coverage with a zero monthly premium and no annual deductible.*

PLAN VARIATIONS

Standard and Alternative Coverage Designs

Guidelines for the four varieties of Medicare Part D plans are set forth in CMS's *Medicare Prescription Drug Benefit Manual (PDBM)*, available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp.

1. The first is the defined standard prescription drug coverage benefit design. CMS approves all other drug plan benefit designs based on the value of this standard, defined coverage.
2. The second type of Part D plan is an actuarially equivalent standard plan. Both this plan and the defined standard plan have the same annual deductible (\$310 in 2010). The main difference between these two types is the actuarially equivalent plans have tiered copayments rather than a 25 percent coinsurance charge. In its *PBDM*, CMS refers to both of these standard designs as "basic" drug benefit types.

3. The third type of Part D plan is a basic alternative plan. The basic alternative plans must be equal in value to standard plans but may have lower deductibles and different cost-sharing structures.
4. The fourth type of Part D plan, the enhanced alternative plan, has supplemental benefits that may include reduced cost-sharing amounts and broader formularies. Monthly premiums for alternative and enhanced plans are sometimes higher than those for standard plans.

The drug plans themselves vary considerably in terms of monthly premiums and cost-sharing structures – some use set copayments and others have percentage-based coinsurance charges. It is important to note that many specific features of these plans change from year to year, including the premiums, annual deductible, and coverage limits. Plan sponsors also can alter the cost-sharing structures, the scope of their formularies, and their cost-control systems. CMS and the plan sponsors agree to their Part D contracts on an annual basis.

Below are more details on the four varieties of Part D plans:

1. Defined Standard Plan (Basic Benefit)

The MMA defines the costs of the standard benefit as a plan with:

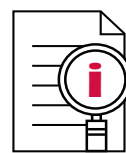
- A monthly premium
- A \$310 annual deductible (for 2010)
- A 25 percent coinsurance for the cost of covered drugs up to an initial coverage limit of \$2,830 (2010)
- A coverage gap (“doughnut hole”) between \$2,830 and \$6,440 (in 2010) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010

2. Actuarially Equivalent Standard Plan (Basic Benefit)

The MMA defines the costs of the actuarially equivalent standard benefit as a plan with:

- A monthly premium
- A \$310 annual deductible (for 2010)

SHIP TIP Because Part D plan costs change annually, SHIP counselors can provide beneficiaries a valuable service by offering to run plan comparisons for their clients. Your client’s needs and the plans themselves change, so the “best” plan for this year might not be the best for next year.



For more information, see Access to Drugs and Formularies on page 55.

- A cost-sharing structure that may have flat copayments instead of a 25 percent coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to the initial coverage limit of \$2,830 (for 2010)
- A coverage gap (“doughnut hole”) between \$2,830 and \$6,440 (in 2010) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010

3. Basic Alternative Plan (Basic Benefit)

The MMA defines the costs of the basic alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible (ranging from \$0 to \$310 in 2010)
- A cost-sharing structure that may have flat copayments instead of a 25 percent coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit that is no less than \$2,830 (for 2010).
- A coverage gap (“doughnut hole”) between \$2,830 and \$6,440 (in 2010) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010

4. Enhanced Alternative Plan (Enhanced Benefit)

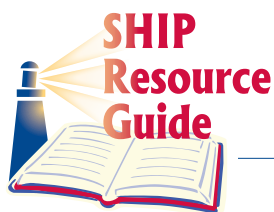
The MMA defines the costs and coverage of the enhanced alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible (ranging from \$0 to \$310 in 2010)
- A cost-sharing structure that may have flat copayments instead of a 25 percent coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit that is no less than \$2,830 (for 2010).
- If included, a coverage gap (“doughnut hole”) between \$2,830 and \$6,440 (in 2010) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans. Some enhanced alternative plans will offer some coverage throughout the coverage gap

- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010
- Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage

When counseling clients about which type of plan to choose, it is important to understand the major differences between these four Part D plan designs. This information about each plan is available each year on the Landscape of Plans, at <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/>. Note that the *Medicare Prescription Drug Plan Finder* (Plan Finder), available at <http://www.medicare.gov/MPDPE>, does not distinguish plans in this way.

EXAMPLE *Maria takes a costly maintenance medication for a rare condition. When a SHIP counselor helped Maria compare formulary lists on the Medicare Prescription Drug Plan Finder, they found only two plans that cover her medication at the dosage prescribed. Both are enhanced plans; no basic plans covered her medication. One of the enhanced plans even covers Maria's medication through the coverage gap; therefore she decides to enroll in that plan. This choice allows Maria to keep her annual costs more predictable.*



ELIGIBILITY AND ENROLLMENT

This section covers:

- Eligibility for Enrollment
- Deciding to Enroll in a Part D Plan
- How to Select a Plan
- Enrollment Periods
- How to Enroll
- Disenrolling and Switching

ELIGIBILITY FOR ENROLLMENT

Given all the choices available for Medicare prescription drug coverage, it is essential for SHIP counselors to help clients determine whether they can enroll, whether they want to enroll, how to enroll, and when to enroll in a Medicare drug plan. The first step in the process is to ask if your client is enrolled in Medicare. Anyone who has Medicare Part A and/or Part B is eligible for a Part D plan.

DECIDING TO ENROLL IN A PART D PLAN

Everyone who is eligible for Part D has a choice to make about whether to enroll in a Part D drug plan. That choice depends largely on whether they have other health insurance that covers prescription drugs. For clients who currently have no coverage for prescription drugs, enrolling in Part D can save them money over time. On the other hand, clients who already have prescription drug coverage face a different set of options based on if and how their current coverage works with Part D.

It is important for all Medicare beneficiaries to make informed decisions about their drug coverage. Medicare beneficiaries with the following types of coverage have special considerations:

- Retiree or union coverage
- Medigap or Medicare Supplement plans
- Veterans Administration (VA) and/or TRICARE for Life
- Federal Employee Health Benefit Program (FEHBP)
- Medicaid
- Medicare Savings Programs (QMB, SLMB, QI)

Creditable Coverage

For beneficiaries with existing insurance coverage for prescription drugs, it is important to learn if that coverage is “creditable.” Creditable coverage means that the insurance benefit is as good as – or better than – the coverage in Medicare’s basic benefit.

The drug coverage in many retiree or union health plans, TRICARE for Life, the VA, and the Federal Employee Health Benefit Program (FEHBP) is creditable coverage. The drug coverage in three standardized Medigap insurance policies (Plans H, I, and J) sold between 1992 and 2004 is not creditable, but the drug coverage in some Medigap policies that pre-date 1992 is creditable. Similarly, the drug coverage in some Medigap policies sold through 2005 in Massachusetts, Minnesota, and Wisconsin is creditable. If the policy was issued before 1992 (or before 2006 in the three states), contact the benefits administrator at the insurance company to ask whether the benefit is considered creditable.

SHIP counselors often help clients learn if they have creditable coverage. The MMA requires insurers to notify people annually about the creditable status of their health plans. This notice may be an official letter, or it may appear in a health plan update, such as a newsletter. It is important for your clients who have creditable coverage to keep these notices in a safe place for possible future reference. Another way to get information on creditable coverage is to call the benefits office for the retiree health plan.

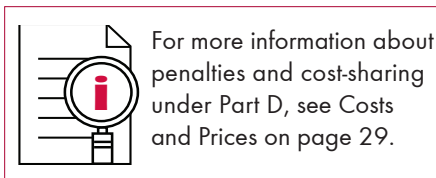
People who have creditable coverage for prescription drugs do not need to enroll in a Part D drug plan now, or perhaps ever. It is also important to know that some people who have creditable coverage through an employer or union health plan could permanently lose their retiree health benefits if they enroll in a Part D drug plan. Under the terms of some group insurance contracts, retirees may lose all of their health benefits and forfeit their creditable coverage (along with spousal coverage) by enrolling in other coverage, like a Medicare drug plan.

EXAMPLE *Michelle has a PPO through her union as part of her retirement package. Her current plan adequately covers her medications. The PPO’s annual newsletter announced that the coverage is considered creditable. Even though Michelle has heard of Part D and considered enrolling, a SHIP counselor reminded her that she does not need to enroll in a Part D plan.*

Late Enrollment Penalty (LEP)

CMS charges a late enrollment penalty to Part D-eligible beneficiaries when they do not have a Part D plan or creditable coverage. The penalty is assessed if and when these beneficiaries enroll in Part D. CMS calculates the penalty based on the number of months an eligible beneficiary was not enrolled in Part D or other creditable coverage.

Some people choose not to enroll in Part D because they have no prescription drug costs now, or they are overwhelmed by the process. Because of the potential for penalties, it is very important for you and your clients to know whether their current coverage is creditable. One group exempt from the penalty is those eligible for the low-income subsidy – they will not have a late enrollment penalty.



EXAMPLE *Charlie has been in enrolled in Original Medicare, Part A and Part B, since 1988. He pays for an individual Medicare Supplement (Medigap) policy that costs \$120 per month and has no prescription drug coverage. Until recently he took very few medications. But when he began taking Lipitor and Hydrochlorothiazide and using Xalatan eye drops, his retail drug costs became very expensive. He wanted to keep his Medigap policy and all of his Medicare hospital and doctor coverage the same, but wanted to pay less for his medications. Charlie joined a PDP and pays a \$25.00 monthly premium for prescription drug coverage.*

Charlie will face a penalty because he did not have creditable coverage or a Part D plan, despite being eligible for Part D.

HOW TO SELECT A PLAN

There are many factors to consider for beneficiaries who decide to enroll in a Part D plan. Dozens of plans are available in most areas of the country. It is incredibly difficult to compare all of the plans to each other, so many SHIPs use a number of factors to help narrow down the list of possible plans for each person they assist. This keeps the process more manageable and also helps beneficiaries choose a plan because the list of appropriate plans is often a good deal shorter than the list of all plans. To help them choose the most appropriate plan, bear in mind the following categories:

- **Original Medicare or Medicare Advantage**

The first factor beneficiaries should consider is whether they want to be in Original Medicare or in a Medicare Advantage plan. Beneficiaries who are in Original Medicare must join a stand-alone Prescription Drug Plan (PDP) to receive Medicare drug coverage. Generally, beneficiaries who are in Medicare Advantage plans must enroll in a Medicare Advantage plan with Part D coverage (MA-PD) to receive the Medicare drug benefit. Exceptions to this rule exist for some types of MA plans, the most common of which are Private Fee-for-Service (PFFS) plans and Medicare Medical Savings Accounts (MSAs).

- **Access to Needed Drugs**

Another major factor to consider when selecting a Part D drug plan is the extent to which the plan provides coverage for needed drugs. It is critically important to compare the beneficiary's prescribed medications to Part D plans' formularies (i.e., lists of covered drugs). Because so many Part D plans are available to most beneficiaries, using the formulary to narrow down that list of plans is a helpful practice.

After filtering out Part D plans that do not include all of a beneficiary's medications on their formularies, there are other factors to consider related to the formulary. Specifically, Part D plans may apply utilization management tools to certain drugs on their formularies. Some examples of these tools include prior authorization, step therapy, and quantity limits. Since utilization management may make it more difficult for enrollees to access their needed prescriptions, it is important to consider this factor when comparing the plans' formularies.

- **Access to Pharmacies**

Another factor to consider is the plans' pharmacy networks. It is important to check if a beneficiary's preferred pharmacy is in the plan's network, and if not, to make sure that convenient alternatives exist. Plan networks are important because Part D plans will not pay for prescriptions at non-network pharmacies, except in emergencies. A drug plan's network pharmacies may change from year to year. Some drug plans also have "preferred pharmacies" within the network that offer lower prices than other network pharmacies.

Other pharmacy access concerns include alternative methods of getting prescriptions. Many plans offer a mail-order program, though the law does not require it. All plans must allow access to home infusion pharmacies and to long-term care (LTC) pharmacies for those who reside in LTC facilities.

Mind the Gap

Most beneficiaries who enter the coverage gap, or "doughnut hole," must pay the full, negotiated price for their prescription drugs until they reach catastrophic coverage. There are a few choices that may make the coverage gap easier to afford. First, beneficiaries with high prescription drug costs could consider enhanced Part D drug plans with coverage in the gap, if available. Second, some states have State Pharmaceutical Assistance Programs (SPAPs) that help beneficiaries with their drug costs. Finally, some pharmaceutical companies have programs, called Patient Assistance Programs (PAPs), to assist beneficiaries with the costs of their drugs. Both SPAPs and PAPs have requirements that differ from program to program. These assistance programs may change the time an enrollee spends in the coverage gap, so those with very high drug costs should consider this option carefully.

It is important to remember that those with the low-income subsidy (LIS) have continuous coverage through the gap.

• Plan Costs

Many beneficiaries will consider costs and prices when selecting a Part D plan. The total yearly costs of being enrolled in a Part D plan depend on the monthly premium, annual deductible, copayments or coinsurance for each drug, and any drug costs that the beneficiary will owe in the coverage gap. Monthly premiums range significantly; in one state, monthly premiums may be as low as \$12 and as high as \$150. In another state, the range of costs for the same plans may be higher. Annual deductibles in 2010 will range from \$0 to \$310, annually. A deductible is the amount that an enrollee must spend out-of-pocket on formulary drugs before the plan begins to pay its share of the costs for each prescription filled. Finally, the Plan Finder lists the cost of each drug covered by Part D plans. Copayments may be as low as \$0 for certain drugs and as high as several hundred dollars for others. Coinsurance percentages vary considerably from plan to plan.

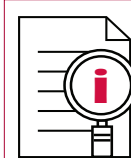
Beneficiaries who qualify for LIS have different cost considerations. Most of these beneficiaries have access to premium-free plans with no annual deductible, reduced or eliminated cost-sharing for each drug, and no coverage gap. Remember, though, that plan formularies will vary, so not all LIS plans are appropriate for all LIS beneficiaries.

Other Considerations

Beneficiaries in the process of selecting appropriate Part D plans may consider other factors before enrolling in a plan. One consideration for these beneficiaries is service area. A plan's service area includes the counties, states, regions, or territories in which an enrollee may use the plan. Some plans are national, meaning their service area is nationwide. Others are regional and have geographic limitations on their pharmacy networks.

Another factor beneficiaries consider is the quality information that CMS makes available about each plan. The Plan Finder shows quality information for the following categories: drug plan customer service, member complaints and staying with drug plan, member experience with drug plan, and drug pricing and patient safety. These quality measures offer beneficiaries a source of objective information which they can use to compare plans.

An additional factor for beneficiaries to understand is the concept of lock-in. Beneficiaries who opt to join Part D plans should understand that after enrollment, they may have only limited opportunities to make changes to their coverage. Once an enrollment choice is effective, most beneficiaries are "locked-in" to their selected plan for the remainder of the plan year. This lock-in feature does not apply to beneficiaries who have a SEP.



For more information, see Special Enrollment Periods on page 18.

ENROLLMENT PERIODS

The MMA does not allow most beneficiaries to enroll in or disenroll from Part D plans at any time. Most beneficiaries have limited time frames to enroll in, disenroll from, or switch Part D plans. Two notable exceptions are beneficiaries who qualify for LIS and beneficiaries living in long-term care facilities; these individuals may make monthly plan enrollment changes.

There are three enrollment period categories: initial, yearly, and special. A beneficiary's first chance to enroll in Medicare, and thus to join a Medicare drug plan, is called the Initial Enrollment Period (IEP). Yearly scheduled enrollment periods (including the Annual Enrollment Period and Open Enrollment Period) are set times of year when the law permits beneficiaries to change their Part D plans. Special Enrollment Periods (SEPs) enable beneficiaries under specific circumstances to make plan changes outside of initial or yearly opportunities. SEPs are designed, for example, to permit beneficiaries who move out of a plan's service area or into a long-term care facility to make changes.

Note: The IEP is also referred to as the ICEP or the Initial Coordinated Election Period.

Initial Enrollment Period (IEP)

Generally, an individual becomes eligible for Medicare on the first day of the month of the individual's 65th birthday or the 25th month of disability. The three months before, the month during, and the three months after this eligibility date are known as the Part B Initial Enrollment Period (IEP). This time frame is also the IEP for Part D benefits. Beneficiaries who do not enroll in a Medicare drug plan during their IEP generally will not be able to enroll in a plan until the following Annual Enrollment Period (AEP), unless they qualify for a special enrollment period, or SEP. Note that if a beneficiary does not have creditable drug coverage and does not enroll in a Medicare drug plan during the IEP, he will likely have a late enrollment penalty added to his Medicare drug plan's premium if and when he enrolls.

Note: Those who enroll in Part D in the first three months of their IEP must wait until the 1st day of the month of Medicare eligibility for coverage to begin.

Initial enrollment for Medicare works differently for some people with disabilities. For those with end-stage renal disease (ESRD), beneficiaries must file a written application for those benefits when they become eligible. Those who have had a kidney transplant and those who have had kidney dialysis for three months are entitled to Medicare Part A. Part D eligibility begins upon entitlement to or enrollment in Medicare Part A and/or Part B. Thus, upon filing an application for Medicare Part A coverage, beneficiaries are entitled to enroll in a Part D plan.

Part D eligibility and enrollment for those with Lou Gehrig’s disease (amyotrophic lateral sclerosis, ALS) is more similar to the process for those with disabilities. The 24-month waiting period that applies to most beneficiaries with disabilities does not apply to those with ALS. These individuals have a 5-month waiting period; their Part A coverage begins on the sixth month of the ALS disability. Thus, these beneficiaries have seven months of a Part D IEP. Their IEP begins in the second month of ALS disability and continues to three months past the month their Part A benefits begin.

EXAMPLE *Richard turns 65 on April 17. His IEP for Medicare Part B and Part D begins on January 1 and ends on July 31. If he enrolls in a Part D plan in January, February, or March, Richard’s coverage takes effect on April 1. If he enrolls in a Part D plan in April his coverage starts on May 1. Likewise, if he enrolls in July, his Part D coverage starts on August 1. If Richard does not enroll in a Part D plan during his IEP, the next opportunity to enroll in a Medicare drug plan is November 15 at the start of the AEP.*

Yearly Opportunities for Enrollment: AEP and OEP

Beneficiaries who already are enrolled in Medicare drug plans may change plans or disenroll from their plans during the Annual Enrollment (or Election) Period (AEP). The AEP is six weeks long, and runs from November 15 through December 31 each year. A decision to enroll or disenroll during the AEP is effective usually for the entire calendar year starting on January 1. Beneficiaries who make more than one enrollment choice during the AEP will be enrolled only into the plan with the latest date of application. This means that beneficiaries can change their minds throughout the AEP. While this may be helpful for some individuals, keep in mind that unscrupulous sales agents can undo a plan selection made during an earlier SHIP counseling session with a client. The only exception is for beneficiaries who have a Special Enrollment Period (SEP) opportunity.

Note: *The AEP is also referred to as the ACEP or the Annual Coordinated Election Period.*

A separate yearly enrollment period for changes related to Medicare Advantage plans is called the Open Enrollment Period (OEP). It lasts for three months, from January 1 to March 31 each year. During the OEP, Medicare beneficiaries have an opportunity to make one limited change to the way they receive their Medicare benefits. Any change made during the OEP takes effect on the first of the following month.

The types of changes beneficiaries can make during the OEP are limited (see table below). Specifically, individuals cannot sign up for Medicare drug coverage if they don’t already have it. They also cannot drop Medicare drug coverage if they are enrolled in Part D plan (including an MA-PD plan). An enrollment choice made during the OEP is in effect for the entire remaining calendar year starting on the effective date of coverage, unless a beneficiary has a SEP opportunity.

Type of Coverage on January 1	Allowed During OEP	NOT Allowed During OEP
MA-PD	<ul style="list-style-type: none"> • Different MA-PD • Original Medicare + PDP • MA-PFFS + PDP 	<ul style="list-style-type: none"> • MA-only • Original Medicare only
MA-only	<ul style="list-style-type: none"> • Different MA-only • Original Medicare only 	<ul style="list-style-type: none"> • MA-PD • Original Medicare + PDP
MA-only PFFS + PDP	<ul style="list-style-type: none"> • MA-PD • Original Medicare + Same PDP • Different MA-only PFFS +same PDP 	<ul style="list-style-type: none"> • MA-only • Original Medicare only
Original Medicare + PDP	<ul style="list-style-type: none"> • MA-PD • MA-only PFFS + Same PDP 	<ul style="list-style-type: none"> • MA-only • Different PDP
Original Medicare only	<ul style="list-style-type: none"> • MA-only 	<ul style="list-style-type: none"> • MA-PD • Original Medicare + PDP
Medicare Medical Savings Account (MSA)	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A

EXAMPLE Erika was enrolled in Original Medicare and a stand-alone PDP last year. She did not change plans during the six-week AEP that year. On February 3 of the next year, Erika talked with a SHIP counselor about enrolling in a different Part D plan. The counselor explained that she cannot switch to another PDP, but she can change to an MA-PD plan. Erika enrolled in an MA-PD plan on February 10. Her new coverage took effect on March 1. In joining the MA-PD plan, she also must comply with the MA-PD plan's rules and is no longer in Original Medicare for the rest of that year.

Special Enrollment Periods (SEPs)

Special Enrollment Periods (SEPs) enable Medicare beneficiaries to make Part D plan enrollment changes in special situations. CMS's *PDP Guidance: Eligibility, Enrollment, and Disenrollment* (available online at <http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdateFINAL2010.pdf>) describes a SEP this way:

Special enrollment periods constitute periods outside of the usual IEP, AEP or OEP when an individual may elect a plan or change his or her current plan election. As detailed below, there are various types of SEPs, including SEPs for dual eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet "exceptional conditions" as CMS may provide, consistent with §1860D-1(b) of the Act and §423.38(c) of the Part D regulations.

(...)

Certain SEPs may be limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the PDP, the individual may subsequently enroll in

a new Part D plan within the SEP time period. Once the individual has enrolled in a new Part D plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, the SEP ends when the individual enrolls in a new Part D plan or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.

In addition to the above-mentioned SEPs, there are certain other SEPs that correspond to Part D plans, including PDPs and MA-PDs. See the descriptions below.

- **Change in Residence**

Beneficiaries have the right to a SEP under the four following circumstances related to a change in residence:

- Those with a change in permanent residence that places them outside of their Part D plan's service area
- Those with new Part D and/or MA plans available due to a change in permanent residence
- Those not eligible for Part D because they have been living outside of the U.S. and have returned to the U.S.
- Those not eligible for Part D because they were incarcerated and are now released

This SEP has certain notice procedures. For people who notify their plan in advance of their move, their SEP begins the month before the move and continues for two months. For those who give notice of the move upon moving or afterwards, the SEP begins upon notification and continues for two months. People may request for the effective date of this SEP enrollment to be up to three months after they notify their plan but not earlier than the date of the move.

There are other procedures for those who do not notify their plans of their moves. If the plan learns from CMS (or otherwise) that an enrollee has lived outside of the plan's service areas for more than six months, the enrollee's SEP begins upon discovery of that move and continues for two months after the move.

- **Dual-Eligible Beneficiaries and Upon Losing Dual-Eligibility**

All dual-eligible beneficiaries (including those with both Medicare and Medicaid and those who are in Medicare Savings Programs) have a SEP that begins upon becoming dual-eligible and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from Part D plans, including PDPs and MA-PD plans, at any time. The effective date of the change is the first of the month following the request for the change.

- **Contract Violation**

Part D plan enrollees who demonstrate to CMS that the PDP sponsor violated a material provision of its contract or materially misrepresented the plan during marketing have a SEP opportunity to change to another Part D plan. The SEP begins upon CMS's determination of the violation and continues subject to the discretion of CMS. CMS also may approve retroactive disenrollments in these cases, depending on the severity of the situation. In considering cases for retroactive disenrollment, CMS will consider certain factors. A tip sheet on retroactive disenrollment is available on HAP's Web site at <http://www.hapnetwork.org/assets/pdfs/retroactive-disenrollment-tips.pdf>.

- **Non-Renewals or Terminations**

Beneficiaries whose plans end due to non-renewal on January 1 of a plan year have a SEP from October 1 to December 31 of the prior year. In these circumstances, CMS requires these plans to give a 90-day notice to enrollees. The effective date of the enrollment may be on November 1, December 1, January 1, or February 1, but not before the plan receives the enrollment request.

For enrollees of plans that terminate their contracts, their SEP begins two months before the termination effective date and ends one month past the termination effective date. These plans are required to give a 60-day notice to enrollees. The effective date of the enrollment may be the month after notice is given until two months after the termination effective date.

For enrollees of plans whose contracts CMS terminates, their SEP begins one month before the termination effective date and ends two months past that date. CMS requires these plans to give a 30-day notice to enrollees. The effective date of the enrollment may be up to three months after the month of termination but not before the plan receives the enrollment request.

Note: In some instances plans may terminate their contracts mid-year. CMS also can terminate a plan's contract if there are multiple contract violations or if the plan is insolvent.

- **Involuntary Loss of Creditable Coverage**

Beneficiaries who involuntarily lose creditable prescription drug coverage are eligible for a SEP. An involuntary loss includes a reduction in the amount or type of coverage that makes it no longer creditable. But a loss of coverage because an individual failed to pay premiums does not constitute an involuntary loss.

This SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The

effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be prospective; however, it may be no more than two months from the end of the SEP.

- **Not Adequately Informed about Creditable Coverage**

Those not adequately informed of a loss of (or that they never had) creditable coverage have a SEP to enroll in a Part D plan (including an MA-PD plan). Established on a case-by-case basis, this SEP begins upon approval from CMS and continues for two additional months.

- **Error by a Federal Employee**

On a case-by-case basis, CMS may grant a SEP to those whose enrollment or non-enrollment in a Part D plan (including an MA-PD plan) is not valid due to the action, inaction, or error of a federal employee, including customer service representatives (CSRs) at 1-800-MEDICARE. This SEP begins upon approval from CMS and continues for two additional months.

- **Exceptional Conditions**

- **SEP EGHP:** Medicare beneficiaries who have access to an Employer/Union Group Health Plan (EGHP) have a SEP to elect a Part D plan or vice versa during the period of time when the EGHP allows plan changes. The effective date of the enrollment may be up to three months after the request for enrollment or disenrollment but not before the plan receives the request.
- **Disenrollment Connected to a CMS Sanction:** If CMS sanctions a Part D plan sponsor and enrollees disenroll due to the issue that led to the sanction, CMS may authorize a SEP on a case-by-case basis for those enrollees.
- **PACE Enrollees:** Part D plan enrollees may disenroll at any time to join a PACE plan. Those who disenroll from PACE have a SEP for up to two months after the disenrollment during which they may join Original Medicare and a PDP or an MA plan.
- **Trial Period SEP:** People who drop a Medigap policy to enroll in an Medicare Advantage plan for the first time are entitled to a guaranteed right to purchase another Medigap policy within the "trial period," usually 12 months. The Trial Period SEP permits them to disenroll from an MA plan at any time during this trial period to return to Original Medicare and to purchase the Medigap policy and a PDP. The SEP begins upon disenrollment from the MA plan and continues for two additional months, with an effective date depending on the situation.

- Retroactive ESRD Entitlement
- Retroactive Medicare Entitlement
- SEP for Institutionalized Individuals: Beneficiaries who move into, reside in, or move out of a long-term care (LTC) facility have a SEP that begins upon moving into the LTC facility and lasts through up to two months after moving out of the facility.
- SEP for Individuals Who Enroll in Part B during the Part B Open Enrollment Period (OEP): Those individuals who are not entitled to premium-free Part A and who enroll in Part B during the GEP (January – March). The SEP begins April 1 and ends June 30, with an effective date of July 1.
- Beneficiaries Losing Special Needs Status: Those enrolled in a Special Needs Plan (SNP) who no longer meet the specific special needs status are eligible for a SEP. The SEP begins upon the change in status and continues for three more months.
- Enrollment in a Chronic Care SNP: A SEP exists for individuals who qualify for a Chronic Care Special Needs Plan (SNP) to enroll in an SNP. The SEP applies to all beneficiaries who qualify for these SNPs and ends upon enrollment in a plan.
- Qualified SPAP Enrollees: Beneficiaries in qualified State Pharmaceutical Assistance Programs (SPAPs) are eligible for a SEP throughout the calendar year. These enrollees may make one additional enrollment election each year. Optional election choices include:
 - from an MA-PD plan to another MA-PD or a PDP
 - from Original Medicare only to Original Medicare and a PDP or to an MA-PD
 - from a PDP to another PDP or an MA-PD; from an MA-only plan to a PDP or an MA-PD
- Non-Dual Eligible Beneficiaries with LIS and Upon Losing LIS: LIS eligible beneficiaries who are not dual eligible have a SEP opportunity that begins upon qualifying for LIS and ends up to two months after losing such eligibility. Because this SEP is continuous, beneficiaries may enroll in or disenroll from a Part D plan, including an MA-PD plan, at any time. The effective date of the change would be the first of the month following the request for the change.
- Disenrollment from Part D to Enroll In or Maintain Creditable Coverage: Any enrollee in a Part D plan (including PDPs and MA-PDs) may disenroll at any time from the plan to obtain or maintain other creditable coverage. The effective date of disenrollment would be the first of the month following the request. This SEP permits those leaving MA-PD plans also to enroll in an MA-only plan.

HOW TO ENROLL

After beneficiaries determine they are eligible for the Part D drug benefit, decide to enroll in a plan during an available enrollment period, and choose an appropriate plan, the next step is to start the process of enrolling. There are several ways to enroll in a Part D drug plan. These include mailing an enrollment form to the plan sponsor, enrolling online, enrolling by phone, and enrolling with a sales representative.

CMS makes it fairly easy for beneficiaries to compare and enroll in Part D plans on the Plan Finder located online at <http://www.medicare.gov>. SHIP counselors who are able to guide clients through the internet enrollment procedure are in a position to provide a warmly welcomed service for those who are not computer savvy.



Part D plans may not enroll beneficiaries on an outbound call from the plan to the beneficiary. CMS allows enrollments by phone only if the beneficiary called the plan to enroll. Plans are not permitted to transfer their outbound calls

Who Can Help a Medicare Beneficiary Enroll?

In most cases a Medicare beneficiary must complete the application to enroll in a Medicare drug plan. CMS's *PDP Guidance on Eligibility, Enrollment and Disenrollment* (online at <http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdateFINAL2010.pdf>) explains that anyone other than the beneficiary who completes an enrollment request must state that she or he has the legal authority under state law to execute the enrollment and that the documentary proof of such legal authority will be made available to CMS or the plan upon request.

SHIP counselors who assist Medicare beneficiaries with enrollment generally do not have the legal authority to make health care decisions on behalf of a Medicare beneficiary. SHIP counselors who assist beneficiaries with Part D plan enrollment are merely facilitating the process. Counselors can avoid problems by making sure that they do not indicate that they represent their clients or sign enrollment forms on a client's behalf unless the client is unable to write. If clients are not able to write, counselors should follow the standard rules for such cases. This means that the client should make an "X" in the signature box and the witness should write "By" and his name and address with a short description of reason the patient cannot sign.

CMS's PDP Guidance on Eligibility, Enrollment and Disenrollment states [w]hen somebody other than the Medicare beneficiary completes an enrollment request, he or she must:

- a) Attest that he or she has the authority under State law (e.g. Power of Attorney) to make the enrollment request on behalf of the individual;*
- b) Attest that proof of authorization, if any, required by State law that empowers the individual to effectuate an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Part D sponsors cannot require such documentation as a condition of enrollment; and*
- c) Provide contact information.*

DISENROLLING AND SWITCHING

Most Medicare beneficiaries who currently are enrolled in a Part D drug plan may only disenroll from that plan during certain periods: the AEP from November 15 through December 31, certain situations during the Medicare Advantage OEP from January 1 through March 31, and applicable SEPs. Generally, once an enrollment choice is effective, most beneficiaries are “locked-in” to their selected plan for the remainder of the plan year.

There are a few ways for a Medicare beneficiary to disenroll from a Part D plan:

- By enrolling in another plan
- By giving or faxing a signed written notice to the PDP sponsor
- By requesting disenrollment online to the PDP sponsor (if the sponsor offers this option)
- By calling 1-800-MEDICARE

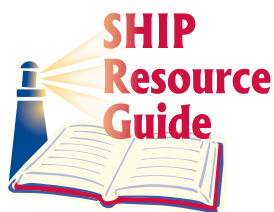
Annual Enrollment Period (AEP) Disenrollment

During the AEP, Medicare beneficiaries can make only one choice among two options affecting their drug plan enrollment. They either can enroll in a different Part D plan (PDP or MA-PD) or disenroll from their current plan. Enrolling in a different Part D plan effectively switches the beneficiary from one plan to the other.

Special Enrollment Period (SEP) Disenrollment

During any applicable SEP, a beneficiary may disenroll from a Part D plan. Beneficiaries need only enroll in a new Part D plan to be disenrolled from a previous one. A disenrollment during the SEP does not prevent a beneficiary from subsequently enrolling in another plan as long as the SEP’s timeframe has not expired. The length of an SEP varies according to the situation. People who move out of their drug plan’s service area, for example, can have a SEP of up to four months. In contrast, people who move out of a certain type of nursing facility have a SEP that lasts up to two months after discharge.

EXAMPLE *Margaret is planning to move to a new area of the country in April. In doing so, she will leave the service area of her Part D drug plan, Canterbury Prime PDP. She notifies Canterbury Prime PDP in February of her impending move, and receives a SEP. The SEP begins in March, the month before her move. It will end in June, two months after her move. If Margaret enrolls in a new plan in March, its effective date is April 1. Her SEP ends when she enrolls in the new plan. She must enroll before the end of June.*



RELATIONSHIP TO MEDICARE ADVANTAGE

This section covers:

- Introduction
- Types of Medicare Advantage (MA) Plans
- MA Plans and Part D

INTRODUCTION

Medicare beneficiaries have the option of receiving their Medicare benefits through the Original Medicare program, also known as fee-for-service Medicare, or through a Medicare Advantage (MA) plan, sometimes called a Medicare Health Plan. Many MA plans offer added benefits, such as routine eye care, that are unavailable in Original Medicare. The monthly premiums of most Medicare Advantage plans can be much lower than those of Medicare Supplement (Medigap) policies. For many people, these features make MA plans an attractive alternative to coverage through Original Medicare and a Medigap policy.

Note: Federal law does not allow Medicare Supplement (Medigap) policies to cover the copayments found in MA plans. People who enroll in MA plans should be prepared to cover these copayments out-of-pocket.

Generally, Medicare beneficiaries may enroll in an MA plan under the following conditions:

- They must have both Medicare Part A and Part B.
- They must live in the MA plan's service area.
- They cannot have end-stage renal disease (ESRD) at the time they enroll, except if enrolling in certain Special Needs Plans (SNPs).
- If enrolling in a Special Needs Plan (SNP), they must meet the eligibility criteria for the SNP.

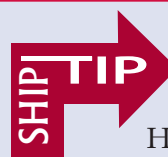
Note: Special Needs Plans (SNPs) are MA plans which are designed for specific subsets of the Medicare population. SNPs may limit enrollment to one of three Medicare beneficiary populations – institutionalized beneficiaries, full dual-eligible Medicare beneficiaries (beneficiaries who have both Medicare and Medicaid), and beneficiaries diagnosed with certain chronic and disabling disease conditions.

TYPES OF MA PLANS

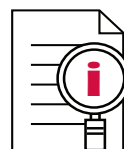
MA plans include a number of plan types. The most prevalent nationally are Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Special Needs Plans (SNPs), and Private Fee-for-Service (PFFS) plans. The common thread among them is that they operate under Medicare Part C and receive a set payment from CMS to deliver Medicare-covered services for each beneficiary they enroll. Other plans include Cost plans, Provider Sponsored Organizations (PSOs), Medicare Medical Savings Accounts (MSAs), and PACE plans.

Some types of Medicare Advantage plans, including HMOs, PPOs, Cost plans, SNPs, and PSOs, are managed care or coordinated care systems. Plans that coordinate the care of enrollees encourage prevention, follow-up on routine and recommended services, and sometimes substitute less expensive alternatives for some procedures. MA plans have different rules for different procedures, and enrollees must follow those rules for the plan to pay for the medical service or product. Also, some MA plans have a network of participating providers, including physicians and hospitals, through which the enrollees typically must get their routine, non-emergency care.

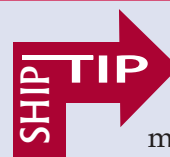
Other plans are not coordinated care plans. The most common of these non-coordinated care plans are PFFS plans and MSAs. In contrast to coordinated care plans, PFFS plans and MSA plans operate on a fee-for-service basis. This means that enrollees go to a doctor or hospital to receive services, and the plan pays for the care. Like Original Medicare (another fee-for-service system), these plans have coverage criteria and will not pay for services received unless they are considered medically necessary. For example, a PFFS plan will not pay for elective surgery or for cosmetic procedures. To contrast these plans with the coordinated care plans, the coordinated care plans might pay for a surgery only if drug therapy fails.



Enrolling in any Health Plan, such as an MA-PD, PFFS, HMO, or PPO, may automatically disenroll a beneficiary from other existing coverage that he may have. CMS has taken steps to prevent this circumstance from occurring.



For more information on PFFS plans and the 2011 changes in plan network requirements, see the "Types of Plans" section of HAP's SHIP Resource Guide: Medicare Advantage, available online at <http://www.hapnetwork.org/medicare-advantage/ship-resource-guide/types-of-plans.pdf>.



In terms of out-of-pocket costs, it's a good idea to keep in mind that beneficiaries in Original Medicare can purchase a separate policy (Medigap) to help pay for cost-sharing, but those in MA plans must be prepared to pay out-of-pocket for their entire cost-sharing amount.

Many managed care plans require a physician’s prior approval as a condition of payment for certain services, including visits to specialists and high-cost diagnostic procedures. Furthermore, cost-sharing requirements for MA plans often differ significantly from those in Original Medicare. For example, Original Medicare fully covers the first 20 days in a skilled nursing facility, but MA plans can charge a copayment or coinsurance for those same days.

MA-PDs are required to pay for emergency or urgent care provided outside of their network of providers. All Part D plans must provide adequate access for enrollees at pharmacies outside of the plan’s network in instances where enrollees could not reasonably be expected to receive coverage within the network. Common examples of such situations include extended travel outside of the service area, emergency room situations that include the administration of Part D drugs, and during federal disasters. Similarly, MA plans (including MA-PDs) are required to provide coverage for all emergency and urgent care, regardless of network and prior authorization rules.

Despite these differences, Medicare rules require MA plans to deliver all the benefits and services that beneficiaries would have in Original Medicare. But the MMA does not require all Medicare Advantage plans to offer Part D prescription drug coverage.

Certain MA plans have rules about who can enroll (e.g., SNPs) or rules about who cannot enroll (e.g., MSAs). For example, Special Needs Plans for people with institutional care (Institutional SNPs or I-SNPs) are designed to serve only the population of Medicare beneficiaries living in long-term care facilities.

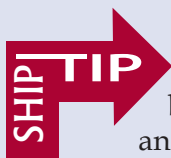
CMS requires coverage for emergency care regardless of the final diagnosis. For example, an enrollee believes he is having a heart attack and goes to the closest emergency room, which happens not to be in his plan’s network. After several tests the physicians diagnose the enrollee with a panic attack. The enrollee’s MA plan must provide coverage for the visit, despite the eventual diagnosis. MA plans must use the “prudent layperson” standard. That is, if a prudent layperson would believe the situation requires emergency or urgent care, then the MA plan must provide coverage.

MA PLANS AND PART D

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must select an MA plan that offers Part D prescription drug coverage (MA-PD). This rule is absolute for all coordinated care plans (i.e., HMOs, Cost plans, PPOs, PSOs, and SNPs). Those beneficiaries enrolled in coordinated care plans who want Part D coverage must enroll in coordinated care plans that have a Part D component – an MA-PD plan. This means that enrollees in coordinated care plans without Part D coverage – MA-only

plans – will not have access to drug coverage through Medicare. Furthermore, Special Needs Plans (SNPs) must provide Part D coverage. Thus, all SNPs are MA-PDs, and enrollees have access to Medicare drug coverage through their SNPs.

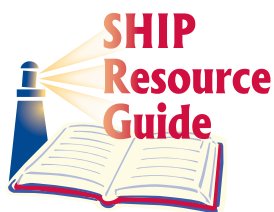
An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not provide drug coverage, including some PFFS plans and all Medical Savings Account (MSA) plans. Private Fee-for-Service plans may or may not have Part D coverage. For those PFFS plans that are MA-PDs, enrollees must take the Part D coverage that comes with the plan. For those PFFS plans that do not offer drug coverage, enrollees may also enroll in stand-alone Prescription Drug Plans (PDPs) to receive Part D coverage. Additionally, MSA plans are not permitted to offer drug coverage, so enrollees in these plans also may enroll in stand-alone PDP plans.



It is important to remember the differences between Original Medicare and Medicare Advantage when working on the Internet with clients. The Medicare Web site has two different online search engines for Medicare plans. People can search for Medicare drug plans using the Plan Finder at <http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/SearchOptions.asp>. The Plan Finder allows users to limit their searches to PDPs, MA-PDs, or both. While the results of these searches are separated by category, it is

critical to keep in mind the differences between Original Medicare and Medicare Advantage as you assist clients in the process of comparing and selecting a Medicare drug plan or health plan with drug coverage. The Medicare Web site also has a second search engine, *Medicare Options Compare*, at <http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp>, which allows users to search for Medigap policies or to compare MA and Original Medicare choices in their area.

Please refer to HAP's SHIP Resource Guide: Medicare Advantage, available online at <http://www.hapnetwork.org/medicare-advantage/ship-resource-guide/medicare-advantage.html>, for more in-depth information about the Medicare Advantage (MA) program.



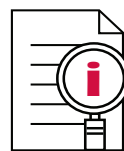
COSTS AND PRICES

This section covers:

- Beneficiary Cost-Sharing
- True Out-of-Pocket (TrOOP) Costs
- Late Enrollment Penalty

Beneficiaries enrolled in both types of Part D plans – PDPs and MA-PDs – will have costs associated with enrollment in those plans. The costs will differ from beneficiary to beneficiary and from plan to plan.

Those who qualify for the low-income subsidy (LIS) receive assistance from Medicare to help cover some or all of these costs that others pay out-of-pocket. Throughout this section, for the sake of simplicity, the costs and prices discussed will apply to those beneficiaries who do not qualify for LIS.



For more information about costs for low-income beneficiaries, see Help for Low-Income Beneficiaries on page 37.

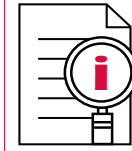
BENEFICIARY COST-SHARING

Beneficiaries enrolled in Part D plans almost always have cost-sharing responsibilities. These costs generally include the monthly premium, an annual deductible, and copayments or coinsurance for each prescription filled. Above a certain level of out-of-pocket spending, beneficiaries also will have costs in the coverage gap, also known as the “doughnut hole.” Once beneficiaries have spent to another set level, costs are minimal as there is a level of catastrophic coverage in the Part D plan design.

Monthly Premiums

A premium is a set amount of money beneficiaries must pay each month to a Part D plan in order to be enrolled in a plan. Monthly premium amounts range widely. Depending on the region of the country, PDPs in 2010 have premiums anywhere from \$10 to \$120; the premiums for MA-PDs range from \$0 to several hundred dollars in 2010. Plans with higher premiums sometimes offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for some drugs in the coverage gap.

Stand-alone Prescription Drug Plans (PDPs) typically have higher monthly premiums than Medicare Advantage Plans with Prescription Drug Coverage (MA-PD) plans. Since MA-PD plans can offset the costs of the Part D premium from savings on Part A and Part B coverage, many MA-PD plans have a low or \$0 monthly Part D premium. As counselors, you may notice that beneficiaries sometimes gravitate to plans with low or \$0 premiums; to make a well-informed decision, beneficiaries should examine more than a plan's premium, or even a plan's total costs. Since the annual cost to those enrolled in Part D plans varies, the monthly premium is not the only cost consideration beneficiaries should weigh when comparing plans.



For more information about PDP and MA-PD plans, see Types of Drug Plans on page 5.

Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check or money order. Another option is to have the premium deducted directly to the plan from a savings or checking account. Additionally, some plans allow beneficiaries to make an electronic payment by phone or through the Internet by using credit cards. Beneficiaries may also elect to have the premium deducted from their Social Security checks. However, data transfers from the drug plans to CMS and then to SSA can take a few months to process, which can result in several months of premiums taken out of a Social Security check at once.



Due to errors, some beneficiaries have had erroneous premium deductions taken from their Social Security checks. Many SHIPs have begun to advise beneficiaries to avoid having payments deducted from their Social Security checks because of this issue.

Annual Deductible

A deductible is the amount a beneficiary owes out-of-pocket before the drug plan starts to pay for medications on its formulary. The maximum annual deductible in 2010 is \$310. The allowed deductible amount increases each year. Plan deductibles range from \$0 to \$310 (2010), depending on the type of plan. Some plans have a structure in which certain tiers of their formularies are exempt from the deductible. For example, a plan could allow enrollees to pay reduced cost-sharing for generic drugs, but brand-name drugs are full price until the enrollee reaches the deductible.

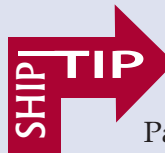


SHIP counselors should note that plans with no deductible are not necessarily more affordable than plans with a deductible. It is important for your clients to consider other cost and coverage factors as they make enrollment decisions.

Copayments and Coinsurance Amounts

After plan enrollees spend the full amount of a plan's deductible, they enter the period of coverage known as the "initial coverage period." During the initial coverage period, Part D plans charge either a copayment or coinsurance amount for each medication that enrollees fill at pharmacies. Each plan sponsor sets the copayment or coinsurance amount, and the amount differs according to the drug plan's design. Typically, beneficiaries pay this out-of-pocket cost at the time they receive each filled prescription.

Copayments are a flat-rate amount, such as \$5 or \$25, charged to beneficiaries for each prescription. Coinsurance charges are based on a percentage of the total negotiated price of a prescription, such as 25 percent (as in the case of a basic standard plan). Negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer. In effect, the negotiated price is the amount paid by Part D plans to pharmacies for each prescription drug filled by a plan enrollee.



For budgeting purposes, beneficiaries may find that Part D plans that use a copayment structure may be more "user-friendly" for calculating expected yearly drug costs.

TRUE OUT-OF-POCKET (TRROOP) COSTS

True Out-of-Pocket (TrOOP) costs are those that a beneficiary incurs in the course of paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Plans calculate these costs for each enrollee in order to determine which level of coverage to provide (i.e., deductible, initial coverage period, coverage gap, or catastrophic coverage). TrOOP includes the total amount of any annual deductible paid plus the price paid for each formulary prescription filled. Note that the monthly premium does not count towards TrOOP costs.

It is important for SHIP counselors to understand the relationship between TrOOP costs and the initial coverage limit and catastrophic coverage. As beneficiaries incur costs under their Part D plans, they move closer to the initial coverage limit.

Using the standard design basic plan to illustrate, a beneficiary enters the coverage gap after incurring \$2,830 in total drug spending. (\$2,830 is the initial coverage limit in 2010.) The total drug spending amount includes the \$940 (in 2010) in TrOOP costs paid by the beneficiary plus about \$1,890 in plan spending. The TrOOP costs of \$940 include the \$310 annual deductible and \$630 spent in coinsurance (in 2010).

Note:

Plans may not use the term TrOOP but may call it "Your Costs" or "Your Spending."



The monthly premium does not count towards the TrOOP costs that beneficiaries must spend to get catastrophic coverage from their Part D plans. Similarly, out-of-pocket payments for drugs that are not on a plan's formulary do not count towards TrOOP.

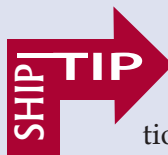
After plan enrollees reach the initial coverage limit of \$2,830 (in 2010) measured by total drug spending, they enter the coverage level known as the coverage gap. During the coverage gap, beneficiaries must pay the entire negotiated price for covered drugs. All formulary drug expenses in the coverage gap count as TrOOP. When beneficiaries have incurred \$4,550 in TrOOP costs (2010), they reach the catastrophic coverage threshold. Beneficiaries with catastrophic coverage pay the greater of five percent of the plans' negotiated drug costs or copayments of \$2.50 for generics and preferred brand-name drugs and \$6.30 for other brand-name drugs for the remainder of the calendar year. The Part D plan covers 95 percent or the balance of the cost.

Beneficiaries with LIS also incur TrOOP costs. Their TrOOP includes the amount Medicare pays for formulary drugs for LIS beneficiaries in Part D plans. For those with LIS, Part D plans use TrOOP to determine the point when beneficiaries enter catastrophic coverage. The catastrophic limit is the same for all enrollees in Part D plans.

A plan must send a statement, called an "Explanation of Benefits," to every enrollee at the end of each month showing how much the plan and the enrollee have paid in TrOOP costs. Part D plans are responsible for calculating and reporting TrOOP costs. (See Appendix A for CMS's *Model Explanation of Benefits*.)

TrOOP costs for each Part D enrollee follow enrollees throughout the plan year. If a beneficiary switches Part D plans, his TrOOP costs are transferred to the new Part D plan. For this reason, beneficiaries cannot switch Part D plans to "reset" their TrOOP costs and avoid the coverage gap. Because TrOOP follows Part D enrollees from plan to plan, there is no way to "game the system."

Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket spending does not count. See the chart on page 33 for a detailed list of costs.



The most important thing is for your clients to receive their medications. If they can do so less expensively outside of the plan benefit, and their expenses do not count towards TrOOP costs, this is perfectly acceptable. Your clients need to understand that they may not reach the catastrophic coverage benefit during the year if they do not use their plans.

Enrollees who switch plans during a calendar year may want to refer to their monthly statements from their old Part D plan and their new Part D plan to check their TrOOP spending. It's important to make sure the plan is accurately calculating spending through the enrollment switch. When the new plan has a different cost structure than the old plan, the plan must calculate how TrOOP spending in the old plan will work in the new plan.

For example, an enrollee in a plan with a \$310 deductible changes plan in January. She has already spent \$100 to her plan's deductible in January. Her new plan has a \$0 deductible. The new plan must calculate how her \$100 affects her level of benefit.

TrOOP Includes	TrOOP Does NOT Include
Out-of-pocket expenses including the annual deductible and all coinsurance and copayment amounts for drugs on the plan's formulary	Monthly premiums paid to the plan
Spending from health savings accounts (HSAs), flexible spending accounts (FSAs), and medical savings accounts (MSAs)	Amount paid by other insurance plans in addition to the beneficiary's Part D coverage (e.g., an employer or retiree group plan's drug benefit, VA, or TRICARE)
Contributions or payments for drugs on the plan's formulary paid by friends or relatives on a beneficiary's behalf	Amount paid by Medicaid or by state programs that receive federal or public funds, such as AIDS Drug Assistance Programs (ADAPs) that help cover the beneficiary's costs
Contributions or payments for drugs on the plan's formulary paid by certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are non-Part D drugs or that are not on the plan's formulary (unless the enrollee received a formulary exception for a drug)
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to a beneficiary's inability to pay	Amount spent for prescription drugs that are purchased from a pharmacy that is not in the pharmacy network of the plan (except for drugs received due to a plan's out-of-network policy)
Payments by Qualified State Pharmaceutical Assistance Programs (SPAPs)*	Total cost of a drug that a private Patient Assistance Program (PAP) provides to a beneficiary
Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are on their plan's formulary	Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are not on their plan's formulary

* As of February, 2009, 24 states and territories offer qualified SPAPs. More information is available from CMS at <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAP2.17.09.pdf>.

EXAMPLE *Alma is in the coverage gap of her basic benefit plan. She's paying approximately \$600 per month for all of her prescriptions. After approximately eight months in the coverage gap (\$600 per month x 8 months = \$4,800), she will have spent enough to reach the catastrophic coverage portion of the benefit for 2010. For the remainder of 2010, she will pay no more than 5% of the cost of her prescribed drugs.*

See Appendix B for the chart, *Medicare Drug Coverage: Beneficiary Cost-Sharing (2010)*, which details the cost-sharing structure for the MMA's standard plan with a basic benefit.

LATE ENROLLMENT PENALTY

The late enrollment penalty (LEP) affects those without Part D or creditable coverage who delay enrolling in a Medicare drug plan. Creditable coverage is insurance coverage that is at least equal to or better than the coverage in the Part D basic benefit. Generally all beneficiaries without creditable coverage for more than 63 days will face an LEP if they decide to enroll in a Part D plan at a later date.

Most beneficiaries who do not have creditable coverage and delay enrolling in a Part D plan will owe an

LEP. The penalty is added to their plan's monthly premium. The penalty will continue as long as they are enrolled in a Part D plan and, for many, this means that they will pay the penalty for the rest of their lives. Plans are not permitted to charge an LEP to beneficiaries with LIS.



For more information about creditable coverage, see Eligibility and Enrollment on page 11.

The penalty is calculated as 1 percent of the Part D base beneficiary premium (\$31.94 for 2010) for each month the beneficiary does not have creditable coverage and is not enrolled in Part D plan.

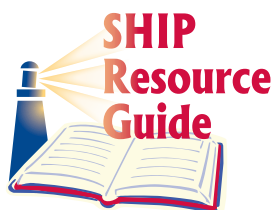
Another category of beneficiaries will not face an LEP, in one specific situation. The under-65 Medicare population, like all Medicare beneficiaries, who are not enrolled either in Part D or in creditable coverage for more than 63 days have an LEP if they later choose to enroll in Part D. These beneficiaries receive a new Initial Enrollment Period (IEP) upon turning 65. With the new IEP comes an exemption from past or current LEP. The exemption is in effect for beneficiaries who were paying an LEP as well as those who never enrolled in Part D and otherwise would have an LEP. The subsequent IEP, in effect, erases any previous record of months without creditable coverage.

Penalty Calculation

The LEP is not calculated as a percentage of the premium of the enrollee's chosen drug plan. The penalty amount will change each year because CMS calculates the penalty based on the Part D base beneficiary premium for a current calendar year. This amount is added onto the premium of the plan that the beneficiary selects. See the chart below for information on calculating the LEP.

(18%)	x	\$31.94	=	\$5.75	+	\$20.80	=	\$26.55
1% x 18 months (the number of months without creditable coverage)		Base Beneficiary premium		Penalty amount		Monthly premium		Total Monthly premium including the penalty

EXAMPLE *Ivan did not want to sign up for Part D when he was first eligible. Ivan decided to enroll in a PDP during the most recent Annual Enrollment Period. He chose Complete Choice PDP, and his Part D coverage began on January 1, 2010. His penalty is equal to one percent of the Part D base beneficiary premium (\$31.94) for 2009 multiplied by the 18 months he was without creditable coverage. His plan will collect a penalty of \$5.75 plus the \$20.80 monthly premium, making his total premium amount \$26.55 for 2010.*



HELP FOR LOW-INCOME BENEFICIARIES

This section covers:

- Eligibility
- Levels of Low-Income Subsidy
- Applying for the Low-Income Subsidy
- Eligible for Low-Income Subsidy: What Happens Next
- Medicaid's Role with Non-Part D Drugs
- Redeterminations and Redeeming
- Part D Plan Reassignment by CMS
- Prescription Drug Assistance Programs and Medicare Part D

ELIGIBILITY

Medicare beneficiaries with limited income and resources have access to substantial financial help with the costs of Part D. A program called the low-income subsidy (LIS), or “Extra Help,” provides this assistance to beneficiaries with limited means. The subsidy helps to pay a portion of Part D plans’ costs – including the monthly premium, the annual deductible, and copayments or coinsurance amounts for covered drugs. The MMA sets forth several subsidy levels that differ based on the amount of a beneficiary’s income and resources (or assets).

The Social Security Administration (SSA) manages the following processes related to the low-income subsidy:

- Provides general information to the public about LIS
- Supplies applications for LIS
- Makes LIS eligibility determinations for Medicare beneficiaries who apply for LIS

SSA works in conjunction with CMS on the LIS program. In short, CMS is responsible for administering the program, while SSA makes determinations about who is eligible for the program.

In general, LIS is available to Medicare beneficiaries whose:

- Income is **below** 150% of the federal poverty level (FPL)
 - In 2009, 150 percent of FPL for a single person is \$1,354 per month and \$1,821 per month for a married couple living in the 48 contiguous states or the District of Columbia. Income amounts are higher for those living in Hawaii and Alaska. (The new FPL is announced each year in the first few months of the year.)
- Resources (sometimes called assets) are at or below \$12,510 for an individual and \$25,010 for a married couple (2010).

Please note these income amounts do not take into account any income exclusions or disregards. Federal poverty levels for 2009 are available at <http://aspe.hhs.gov/poverty/09poverty.shtml>. Also note that SSA does not count all sources of income and resources when determining eligibility for LIS. Federal poverty levels become available each year in January. These figures will be updated upon receipt of 2010 information.

SSA and CMS also work with state Medicaid agencies to determine LIS eligibility for another group of Medicare beneficiaries – individuals who qualify for Medicaid or for a Medicare Savings Program (MSP). These beneficiaries are considered “deemed eligible” and will automatically receive the subsidy. All other individuals must apply in order to receive the subsidy (see Appendix C). Except in limited circumstances, those who are eligible for LIS receive the subsidy at least throughout the calendar year.

Note: There are special rules for some low-income nursing home residents. See the section on Levels of the Low-Income Subsidy on page 40.

Countable and Excluded Income

The degree of help available to low-income beneficiaries depends in part on the amount of income they receive. In general, SSA uses Supplemental Security Income (SSI) rules to calculate countable income in determining if beneficiaries meet the income limits for the low-income subsidies. Common sources of countable income are:

- Social Security benefits
- Railroad Retirement benefits
- Pensions or annuities (including veterans’ pensions)
- Alimony
- Rental income (net)
- Workers compensation
- Wages (gross) or earnings from self-employment (net)

If beneficiaries receive Social Security benefits for a disability or blindness and have work-related expenses that are not reimbursable by their employers, these expenses will be deducted before earned income is counted. Some sources of income do not count in LIS eligibility determinations. They include food stamps, home energy assistance, stipends paid to ACTION program volunteers (e.g., Senior Companion Program workers), some victim compensation payments (e.g., war reparations), and some tribal payments to Native Americans. More details about countable income are available in the Social Security booklet, *A Guide to SSI for Groups and Organizations* (see Appendix D).

Countable and Excluded Resources

The amount of help available to low-income beneficiaries also depends on their resources or assets. Only certain resources count in determining eligibility for the Extra Help program.

Some examples of countable resources are:

- Bank accounts (checking, savings or certificates of deposits or CDs)
- Stocks, bonds, savings bonds, mutual funds, individual retirement accounts (IRAs)
- Cash at any other financial institution or at home
- Life insurance policies (cash value: If you turned in your policy right now, how much money would it be worth?)
- Real estate other than a primary home

Other resources, such as the beneficiary's primary home or a car, do not count in determining one's eligibility for LIS. These excluded resources include:

- Up to \$1,500 (for single persons) or \$3,000 (for married couples) of the cash value of life insurance policies, often called "whole life" or "universal life" policies. Term life insurance policies and whole life or universal life policies with a face value (death benefit) of less than \$1,500 are excluded.
- Cash value of a life insurance policy, beginning in 2010
- Property one needs for self-support, such as rental property
- Jewelry and home furnishings
- Burial spaces owned by a beneficiary and spouse

Note: Beginning in 2010, SSA will no longer use the cash value of life insurance when calculating eligibility for LIS. This change is due to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Beneficiaries can exclude from their countable resources up to \$1,500 (for single persons) and \$3,000 (for married couples) that they designate for funeral and burial expenses. Added to the \$11,010 (\$22,010 for married couples) of countable resources that beneficiaries can have and still qualify for the LIS, this resource exclusion effectively lifts the resource limit to \$12,510 for an individual and \$25,010 for couples (2010).

LEVELS OF LOW-INCOME SUBSIDY

There are different levels of subsidies that depend on eligible beneficiaries' income and resources. The descriptions below use the standard federal poverty level (FPL) for individuals living in the 48 contiguous states and the District of Columbia. Income amounts are slightly higher for those living in Alaska and Hawaii. Income charts are available at <http://aspe.hhs.gov/poverty/09poverty.shtml>. Federal poverty levels become available each year in January. These figures will be updated upon receipt of 2010 information.

The descriptions below refer to the benchmark premium. CMS calculates the benchmark premium each year using premium and enrollment information for all plans with enrollment in the past year. CMS uses the following premium amounts for plans:

- The total monthly premium for standard plans
- The portion of enhanced plans' premiums attributed to standard Part D coverage
- The monthly prescription drug beneficiary premiums for MA-PD plans

CMS calculates the average of these amounts and uses actual enrollment information to weight the average. This weighted average is called the "benchmark subsidy." Each year, CMS calculates the benchmark for each plan region. Those with the full premium subsidy do not have to pay a monthly premium if they enroll in standard plans with premiums below this benchmark amount.

Note: The following information is available as a chart. See Appendix E, *Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2010)*.

Full Dual-Eligible (Medicare and Full Medicaid) with Income up to 100% FPL

In 2009, 100 percent of the FPL equals \$902.50 per month for an individual and \$1,214.17 per month for a married couple. These beneficiaries do not have to apply for LIS because they are deemed eligible for the program. Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay any annual deductible
- Pay \$1.10 for generic and preferred brand prescription drugs and \$3.30 for all other drugs on the plan's formulary (2010)
- After beneficiaries in this group reach the out-of-pocket threshold, all prescription drugs on the plan's formulary are free

Full Dual-Eligible (Medicare and Full Medicaid) with Income above 100% FPL

In 2009, 100 percent of FPL equals \$902.50 per month for an individual and \$1,214.17 per month for a married couple. Most beneficiaries in this group qualify for full Medicaid benefits through an income spend-down or through a Medicaid Home and Community-Based Services (HCBS) waiver. These beneficiaries do not have to apply for LIS because they are deemed eligible for the program. Full dual-eligible beneficiaries who reside in the community and have income within these requirements receive the following subsidies:

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Do not pay any annual deductible
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary (2010)
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold

Income up to 135% FPL

In 2009, this income bracket includes those with monthly income up to \$1,218.38 for a single person and below \$1,639.13 for a married couple. This group generally includes beneficiaries enrolled in the Medicare Savings Programs (MSPs)—including Qualified Medicare Beneficiaries (QMBs), Specified Low-income Beneficiaries (SLMBs), and Qualifying Individuals (QIs). Those in MSPs sometimes are known as partial dual-eligibles. Many of these beneficiaries do not have to apply for LIS because they are deemed eligible for the program. This group also includes SSI recipients who automatically receive full Medicaid benefits.

There are two subsidy levels available for beneficiaries within this income range depending upon the amount of their countable resources.

• Fewer Resources

Beneficiaries in this income group with resources assets less than \$8,100 for an individual or less than \$12,910 for a married couple (2010):

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark amount must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits

- Do not pay any annual deductible
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary (2010)
- Pay nothing for all prescription drugs on the formulary, after reaching the out-of-pocket threshold
- **More Resources**

Beneficiaries in this income group with countable resources (assets) between \$8,100 and \$12,510 for an individual or between \$12,910 and \$25,010 for a married couple (2010):

- Pay no monthly premium if they choose a standard plan with a premium at or below the benchmark premium for their region
 - Those who enroll in a standard plan with a premium above the benchmark must pay the balance out-of-pocket
 - Those who enroll in an enhanced plan must pay the portion of the plan's premium that is attributed to the enhanced benefits
- Have a \$63 annual deductible (2010), unless their plan has a deductible less than \$63. In that case, they would pay the plan's deductible, which could be as low as \$0
- Pay a coinsurance of 15 percent for each prescription drug on the plan's formulary
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan's formulary, after reaching the out-of-pocket threshold (2010)

Income between 135% FPL and 150% FPL

Beneficiaries whose countable income is between 135 percent and 150 percent of FPL (see chart below) and who have countable resources (assets) of no more than \$12,510 for an individual or \$25,010 for a married couple are eligible for a subsidy (2009). In 2009, this income bracket includes those with monthly income between \$1,218.38 and \$1,353.75 for a single person and between \$1,639.13 and \$1,821.25 for a married couple. Beneficiaries who meet these income and asset requirements receive the following subsidies:

- Medicare pays a portion of the monthly premium based on their income:
 - Those with income between 135 percent and 140 percent FPL receive a premium subsidy of 75 percent of the benchmark premium (see the table on page 43)
 - Those with income between 140 percent and 145 percent FPL receive a premium subsidy of 50 percent of the benchmark premium (see the table on page 43)
 - Those with income between 145 percent and 150 percent FPL receive a premium subsidy of 25 percent of the benchmark premium (see the table on page 43)
- Have a \$63 annual deductible (2010), unless their plan has a deductible less than \$63. They would pay the plan's lower deductible, or \$0 in plans with no deductible

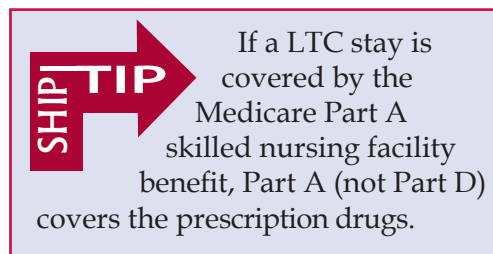
- Pay a coinsurance of 15 percent for each prescription drug on the plan’s formulary
- Pay \$2.50 for generic and preferred brand prescription drugs and \$6.30 for all other drugs on the plan’s formulary, after reaching the out-of-pocket threshold (2010)

Monthly Income by Percent of the 2009 FPL

Federal Poverty Level (FPL)	Single	Married
135% to 140% FPL	\$1,218.38 to \$1,263.50	\$1,639.13 to \$1,699.83
140% to 145% FPL	\$1,263.50 to \$1,308.63	\$1,699.83 to \$1,760.54
145% to 150% FPL	\$1,308.63 to \$1,353.75	\$1,760.54 to \$1,821.25

For more information on the levels of the low-income subsidy, see Appendix E, *Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2010)*.

Special LIS rules apply for full-duals who reside in certain long-term care (LTC) facilities including: skilled nursing facilities, nursing facilities, inpatient psychiatric hospitals, and intermediate care facilities that are residential facilities for developmentally disabled adults (called “ICF/MRs”). Regardless of their income, Medicare beneficiaries who receive full Medicaid benefits and reside in these LTC facilities receive maximum subsidies, and therefore do not incur any out-of-pocket costs for prescription drugs on their plans’ formularies. They do not pay monthly premiums, annual deductibles, or copayments for their prescriptions.



Residents of assisted living facilities, group homes, and board and care homes may qualify for LIS but are subject to some cost-sharing in line with their income and resources.

APPLYING FOR LOW-INCOME SUBSIDY: WHO NEEDS TO APPLY AND WHO DOES NOT?

Some low-income beneficiaries do not need to apply for LIS (Extra Help) because they are “deemed eligible.” Other low-income beneficiaries **must apply**.

Individuals who are deemed eligible for the Extra Help and do not need to apply are those Medicare beneficiaries who receive Medicaid benefits, including full and partial benefits. Individuals with Medicare and full Medicaid benefits are referred to as “full duals,” in that they are enrolled in both programs and are eligible for Medicaid’s full set of benefits. Full-duals also include residents of nursing facilities who are on Medicare and Medicaid and Medicare beneficiaries who reside in the community and are enrolled in a Medicaid Home and Community-Based Services (HCBS) waiver program.

Medicare beneficiaries who are enrolled in one of three Medicare Savings Programs (MSPs) sometimes are referred to as “partial duals.” The state, through its Medicaid program, pays at least the Part B premiums for beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB), Specified Low-income Beneficiaries (SLMB), and Qualified Individuals (QI) programs. For those in the QMB programs, the state also covers Medicare’s deductibles and coinsurance costs.

SHIP TIP Generally, those who need to apply for the subsidy have incomes above 135 percent of the FPL. Those with incomes below 135 percent are often eligible for a Medicare Savings Program, and therefore are deemed eligible for LIS and do not need to apply.

Medicare beneficiaries who must apply for the extra help are those with limited financial means but who are not a full or partial dual. All beneficiaries who think they may be eligible for the extra help can apply, but only those who meet the income and resource limits will be found eligible.

EXAMPLE *Mary, a retired widow, has an annual income of \$10,000 and resources that amount to \$13,000. Although her resources are just over the limit for the subsidy, her income is below the maximum. She thinks it is worthwhile to apply for the subsidy, and completes an application. She is thrilled to find out that she is indeed eligible because some of her resources, including the \$600 cash value accumulated in a whole life insurance policy with a \$2,000 death benefit, along with \$1,500 that she can earmark for burial expenses, are excluded from the eligibility decision.*

How Do Beneficiaries Apply?

Those beneficiaries who are not deemed eligible and want to apply for Extra Help must complete an application in order for SSA to make an eligibility determination. Beneficiaries can access the SSA application in four ways:

- Go to the SSA website at <http://www.ssa.gov> and complete the application **online**
- Call SSA at 1-800-772-1213 and ask a customer service representative to send an application through the mail
- Call SSA at 1-800-772-1213 and ask a customer service representative to help them complete the application over the phone
- Go to a local SSA office and pick up an application form SSA Form 1020 (see Appendix C)

Once paper applications are complete, they must be mailed to the Social Security Administration. The application comes with a self-addressed, postage-paid envelope.

SSA verifies elements of eligibility (e.g., income, resources, residency, and Medicare entitlement) by comparing the information on the application form to Social Security records and records from other federal agencies, including CMS. SSA asks applicants to submit proof of income or resources in limited circumstances. Two examples of such instances are if there are discrepancies between the information on the application and the government records or if applicants report ownership of non-home real property.

Beneficiaries also can go their local Medicaid offices and speak with an eligibility specialist. These offices are required to help beneficiaries complete the SSA application for extra help. The Medicaid office can send the applications in to SSA, or the beneficiaries can mail the application on his own. (The applications come with self-addressed, postage paid envelopes.) While Medicaid offices are required to provide this assistance for beneficiaries, reports indicate most beneficiaries receive help applying for LIS elsewhere.

Who Can Help Beneficiaries Complete the Application?

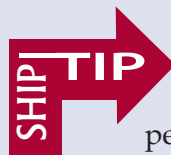
Three categories of helpers, called personal representatives, may act on behalf of beneficiaries for the purpose of applying for LIS. These include:

- Those asked to help (such as a family member or friend)
- Those authorized by state or other law
- Someone acting responsibly on behalf of an “incapacitated” beneficiary

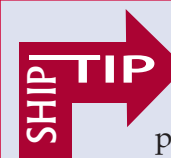
CMS expressly declined to limit “acting responsibly” in any way, stating that it assumes the good intentions of everyone who wants to help get people into the LIS program. Also, SHIP counselors are able to help beneficiaries complete applications.

How Long Does SSA Take to Process an Application?

The law does not require the SSA to process applications and notify applicants about subsidy determinations in any particular time frame. The SSA states only that applications remain “in effect” until a decision is reached regarding subsidy eligibility, and has further indicated that it expects routine processing time to be two to three weeks.



Beneficiaries need to complete the SSA paper application using a black pen or a No. 2 pencil, or the SSA scanning system is not able to process the application. Also, advise beneficiaries not to write additional information on the application – the automatic system that processes the applications cannot detect it.



Eligibility specialists at Medicaid offices are required to screen LIS applicants for the Medicare Savings Programs. Remember that MSP enrollees are deemed eligible for LIS and do not need to apply.

What Rights Do Beneficiaries Have if Their Subsidy Applications Are Denied?

The SSA has an appeals process that low-income beneficiaries can use if they disagree with a decision to deny, reduce, or discontinue the LIS. Beneficiaries who wish to appeal a decision by SSA must complete a form called *Appeal of Determination for Help with Medicare Prescription Drug Plan Costs* (see Appendix F).

ELIGIBLE FOR LOW-INCOME SUBSIDY: WHAT HAPPENS NEXT

Beneficiaries who qualify for LIS must be enrolled into Part D plans to receive the subsidy. An automatic system processes enrollments for all beneficiaries with LIS (those who are deemed and those who apply) into Part D plans if they do not enroll in plans on their own. This system turns a two-step process (LIS application and Part D enrollment) into one step for those who apply and automatic eligibility and enrollment for those who are deemed. While these systems may not operate flawlessly, they are critical to the success of Part D and LIS. If all beneficiaries had to apply for LIS and subsequently enroll in Part D, it is quite likely that enrollment would be far lower than it is.

Most beneficiaries who are deemed eligible are automatically enrolled into a Part D plan if they do not enroll on their own. They receive a yellow letter (see Appendix G) from CMS notifying them of the auto-enrollment process, unless they have creditable coverage through a retiree plan. If they do have creditable coverage through a retiree plan that is receiving a credit from CMS for their enrollment, these beneficiaries will not be automatically enrolled in a Part D plan. They will receive a white letter explaining this process (see Appendix H).

Note: Remember that CMS enrolls nearly all beneficiaries with LIS into random Part D plans. It is still a good idea to help those with LIS find the most appropriate plans for them. While costs will not vary much from plan to plan, formularies and pharmacy networks will differ. These distinctions may make the assigned plan worth far less than a chosen plan.

Limited Income Newly Eligible Transition (LI NET) Program

The Limited Income Newly Eligible Transition (LI NET) program is administered by Humana and offers those with the low-income subsidy (LIS) immediate, but temporary, access to prescription drug coverage. LI NET provides this coverage for beneficiaries who qualify for Extra Help and go to a pharmacy to have a prescription filled, but are not enrolled in Medicare drug plans.

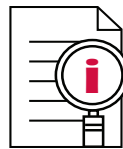
The LI NET program serves three functions:

1. When full dual-eligible beneficiaries have some period of retroactive eligibility with no Part D plan, the LI NET plan through Humana provides retroactive coverage of their prescription drugs. The LI NET program then auto-enrolls these beneficiaries prospectively into a standard Part D plan with a premium below the regional benchmark. Keep in mind that the LI NET auto-enrollment process applies to full benefit dual-eligible

bles and to Medicare beneficiaries and people with SSI who do not have Medicaid but who are entitled to retroactive Part D coverage.

2. All beneficiaries with the low-income subsidy (LIS) who are not enrolled in a Part D plan are eligible to use the LI NET plan for immediate coverage of their prescription drugs at the pharmacy. Beneficiaries must provide evidence of their eligibility for the LIS. Other than the group eligible for LI NET auto-enrollment, all other beneficiaries with LIS will still have access to the existing facilitated enrollment process.

3. Finally, the LI NET program also provides retroactive reimbursement for out-of-pocket expenses paid by beneficiaries with LIS who were not enrolled in a Part D plan at the time of the expenses.



For more information about the LI NET program, see the following publications:

Limited Income Newly Eligible Transition (LI NET) Program, Four Steps for Pharmacy Providers at <http://apps.humana.com/marketing/documents.asp?file=1285050>

Limited Income NET for People at the Pharmacy Counter at <http://www.cms.hhs.gov/partnerships/downloads/11328-P.pdf>

Limited Income NET Program for People with Retroactive Medicaid & SSI Eligibility at <http://www.cms.hhs.gov/partnerships/downloads/11401-P.pdf>

Humana has established a toll-free number for assistance with the LI NET program. This number is 1-800-783-1307.

MEDICAID'S ROLE WITH NON-PART D DRUGS

The MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs that are covered by Medicare Part A or Part B, such as some chemotherapy drugs. Other drugs that are generally excluded from Part D coverage are listed in the section on formularies. Some Part D plans with enhanced benefit designs, however, may provide coverage for some of the drugs in these categories.

A state's Medicaid program may cover some of these excluded drugs or Part D drugs that are not on Medicare drug plan formularies. Some Medicaid programs provide this coverage for full dual-eligible beneficiaries, including residents of nursing facilities and recipients of HCBS waivers. To access specific information about which non-Part D drugs state Medicaid programs are covering for full-dual beneficiaries, please check the CMS website at <http://www.cms.hhs.gov/States/EDC/list.asp>, or check with your state Medicaid agency.

EXAMPLE *Edna is a full dual-eligible beneficiary who receives home and community-based services through a Medicaid waiver program. She is enrolled in a standard PDP. She was recently diagnosed with breast cancer and has been prescribed a brand-name drug to help relieve the side effects of radiation. The formulary of her PDP does not cover that drug. However, her state's Medicaid program does provide coverage for the drug. Through Medicaid, Edna is able to get the drug she needs and will pay a minimal copayment for it.*

REDETERMINATIONS AND REDEEMING

Agencies reassess eligibility for the LIS on a regular basis. This process involves three agencies: the SSA, CMS, and state Medicaid agencies. The agency that initially determined a beneficiary's eligibility for the LIS is responsible for reassessing her eligibility for the following calendar year.

- Redetermination: SSA uses a process called "redetermination" to assess the continued eligibility of LIS recipients who applied for and were found eligible for LIS through the SSA.
- Redeeming: CMS reviews the eligibility status of all beneficiaries who were deemed eligible for LIS (in the previous calendar year) because they receive Medicaid benefits (full or partial) or Supplemental Security Income (SSI) benefits.
- State Medicaid agencies must redetermine eligibility for any beneficiary who applied for and was found eligible for the LIS through his state Medicaid agency. Note that this, however, is not a common method for LIS eligibility.

SSA Redeterminations

The Social Security Administration (SSA) conducts three types of redeterminations:

- Initial
- Cyclical
- Subsidy changing events (SCE)

The following SSA redetermination processes only pertain to beneficiaries who applied for the LIS (or Extra Help) through the SSA.

- **Initial Redeterminations**

To redetermine eligibility for 2010, the SSA selected a group of beneficiaries who were eligible for Extra Help in 2009 **and** who the SSA believes have experienced a change in their circumstances that may have affected their eligibility for extra help. These beneficiaries receive a redetermination form (see Appendix I) in the mail in September. The form, *Social Security Administration Review of Your Eligibility for Extra Help* (SSA-1026), must be completed and returned within 30 days of receipt, even if nothing has changed. If a beneficiary does not complete and return the form, SSA may terminate his eligibility for Extra Help, effective January 1 of the following year.

- **Cyclical Redeterminations**

Each year the SSA also will select a random group of Extra Help recipients for redetermination to redetermine their eligibility for 2010. These beneficiaries receive a redetermination form in the mail in September. The form is the same form sent to those selected for the initial redetermination (see Appendix I). Beneficiaries must respond to

the form within 30 days of receipt, **even if nothing has changed**. If a beneficiary does not complete and return the form, SSA may terminate their eligibility for Extra Help, effective January 1 of the following year.

- **Subsidy Changing Event (SCE) Redeterminations**

Beneficiaries with LIS who experience subsidy-changing events — including marriage, divorce, separation, annulment, and death of spouse — must report the event to SSA. Upon notification, SSA sends these beneficiaries a special SCE redetermination form. Beneficiaries are required to complete and submit the form within 90 days of receipt. Beneficiaries who do not respond will no longer receive Extra Help. For those that do respond, their Extra Help status will reflect the change the month after SSA receives the completed form. More information about SCEs is available from the SSA *Program Operations Manual System* or *POMS* at <http://policy.ssa.gov/poms.nsf/links/0603050011>.

Beneficiaries may appeal a reduction or termination of their subsidy. According to SSA, “It may be more advantageous to the individual to file an appeal than to file a new application. This is because the individual may lose one or more months of Part D subsidy by filing a new application. An appeal would preserve the retroactivity of the subsidy while a new application would not” (20 CFR 418.3605 - 418.3680). Beneficiaries should use the SSA appeals form (see Appendix F) for this process.

More information on the Social Security Administration’s updated redetermination processes and procedures are detailed in the *POMS* at <http://policy.ssa.gov/poms.nsf/links/0603050011>. SSA has also prepared a beneficiary fact sheet with more information, available online at <http://www.ssa.gov/pubs/10111.pdf> (see Appendix J).

Redeeming

Based on data that state Medicaid agencies send to CMS, individuals with Medicare and Medicaid are deemed eligible for the LIS. These beneficiaries automatically qualify for LIS, and therefore, do not need to complete an application. CMS redeems for the following year all individuals who were full or partial duals in or after July of the current year.

Starting each year in July, state Medicaid agencies begin sending transmissions to CMS containing data on all dual-eligible beneficiaries. Individuals whose data is transmitted to CMS automatically are redeemed eligible for LIS for the following year.

If their LIS status has not changed, they will not receive any notice informing them that they will continue to receive Extra Help in the following year. If they remain LIS eligible, but a change in their finances requires a change to their subsidy amount, they will receive an orange letter (see Appendix K) from CMS. The letter explains that although they still qualify for the Extra Help in 2010, their costs will change as of January 1.

Some people who were deemed eligible for LIS in the current year will not be deemed eligible for the following year because they no longer qualify for Medicaid. These beneficiaries receive a grey letter (see Appendix L) from CMS in September. The letter explains that they will not automatically receive Extra Help to pay for their Part D costs effective January 1. The letter explains they can apply for the LIS through the SSA. It also contains an application for the LIS with a postage-paid envelope.

SHIP TIP State Medicaid agencies are required to screen individuals for eligibility for the Medicare Savings Programs (MSPs). Anyone found eligible for a MSP would be deemed eligible for the LIS. The recent MIPPA law requires SSA and states to work together to screen and identify those who might be eligible for MSPs.

Individuals who receive this letter include Medicare beneficiaries who:

- No longer qualify for full Medicaid benefits
- Are no longer eligible for a Medicare Savings Program (MSP)
- No longer receive Supplemental Security Income (SSI) and do not qualify for Medicaid

Anyone who receives the grey letter and subsequently re-qualifies for Medicaid would thereupon be redeemed for the LIS for the following year. More information on the redeeming process is available from CMS at <http://www.cms.hhs.gov/limitedincomeandresources>.

SHIP TIP Beneficiaries who receive grey letters in error but are still full or partial dual-eligible should call their Medicaid offices to correct the mistake as soon as possible.

PART D PLAN REASSIGNMENT BY CMS

In the fall of each year, CMS reassigns certain groups of Medicare beneficiaries who are eligible for LIS into Part D plans for the coming year. Typically, CMS reassigns two groups of Medicare beneficiaries who were deemed eligible for the Extra Help in the past year and will continue to be deemed eligible in the following year:

- Medicare beneficiaries with the full subsidy who stayed in the plan into which they were auto-assigned by CMS, **and** their plan premium for the following year is more than the regional low-income premium subsidy benchmark.
- Medicare beneficiaries with the full subsidy whose plans are leaving the Medicare program in the following year.

Some Part D plans that were LIS benchmark plans in the past year will have a premium above the following year's regional LIS benchmark. As a result, full LIS recipients would be responsible to pay a portion of the plan premium if they remain in such plans. Therefore, CMS reassigns certain LIS-eligible individuals to different Part D plans with premiums that are at or below the regional LIS benchmark for their area. Specifically, CMS reassigns only those full subsidy LIS beneficiaries who accepted their auto-assigned plans.

By early November, reassigned Medicare beneficiaries should receive blue letters from CMS with information about their reassignment. Those who are reassigned because their plan is leaving the Medicare program will receive Version 1 of the blue letter (see Appendix M). Those who are reassigned because their current, assigned plan's premium will be above the next year's regional LIS benchmark will receive Version 2 of the blue letter (see Appendix N).

Notably absent from those reassigned are all full subsidy LIS beneficiaries who enrolled in plans other than the one to which they were auto-assigned. CMS will not reassign these Medicare beneficiaries who were deemed eligible but switched plans. CMS refers to this group of beneficiaries as "choosers." CMS does not reassign one other group of LIS beneficiaries – those with partial LIS subsidy (which includes those with LIS who are charged a deductible).

These beneficiaries, the "choosers," should receive a tan letter (see Appendix O) from CMS by early November informing them that they will owe a portion of the premium if they remain in their plans.

Information from CMS on plan reassignment is available online at <http://www.cms.hhs.gov/limitedincomeandresources>.

PRESCRIPTION DRUG ASSISTANCE PROGRAMS AND MEDICARE PART D

Generally two types of prescription drug assistance programs are available to help Medicare beneficiaries with limited financial resources access their medications:

- State Pharmaceutical Assistance Programs (SPAPs)
- Private Pharmaceutical Assistance Programs (PAPs)

Beneficiaries must meet certain eligibility criteria to qualify for the benefits offered under these programs. These programs coordinate their benefits with Part D in different ways.

State Pharmaceutical Assistance Programs (SPAPs)

State Pharmaceutical Assistance Programs (SPAPs) provide assistance with prescription drug costs to some beneficiaries with limited financial resources. Eligibility criteria vary from program to program. The MMA allows SPAPs to wrap-around Medicare Part D coverage and fill in coverage gaps for medication that are either:



Tip 1: It is important for beneficiaries to show their pharmacist all of their drug benefit membership cards at the point-of-sale to ensure proper sequential billing.

Tip 2: SPAPs that wrap-around Part D plans must meet certain criteria set forth under the MMA. These SPAPs are referred to as qualified SPAPs. More information on qualified SPAPs is available from CMS at http://www.cms.hhs.gov/States/07_SPAPs.asp.

Tip 3: An SPAP is always the payer of last resort. In the event of a coverage denial, beneficiaries need to pursue all avenues of getting coverage with the plan before asking the SPAP to pay.

- Not covered by an individual's PDP or MA-PD plan
- Excluded by law
- Cost prohibitive while someone is in the coverage gap ("doughnut hole")

Beneficiaries may still pay a portion of the cost for each of their medications even with Part D and SPAP coverage.

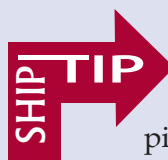
All other forms of drug coverage, including Part D, are primary to coverage provided by an SPAP. That is, an SPAP will only cover medications after any other drug coverage is applied to the cost of that drug. Additionally, payments made by some SPAPs to cover drugs that are on the plan's formulary, but are needed during the coverage gap, count towards TrOOP for the Part D plan. Only payments from qualified SPAPs count towards TrOOP.

The 24 states and territories that offer qualified SPAPs include: Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, Missouri, Montana, Nevada, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Texas, U.S. Virgin Islands, Vermont, Virginia, Washington, and Wisconsin. Some states offer more than one qualified SPAP. A specific list of qualified SPAPs is available from CMS at <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAP2.17.09.pdf>.

Private Pharmaceutical Assistance Programs (PAPs)

Some private pharmaceutical companies offer their products to low-income individuals for free or reduced prices through pharmaceutical assistance programs (PAPs) and drug discount programs. These programs also have been called "indigent patient programs." Due to Medicare Part D coverage, many of these programs either no longer offer their services to Medicare beneficiaries who are eligible for or enrolled in a Medicare Part D plan, or require some attempts to have the Part D plan pay for a medication before they will assist a beneficiary. There is a separate application process for each medication. This process varies from company to company.

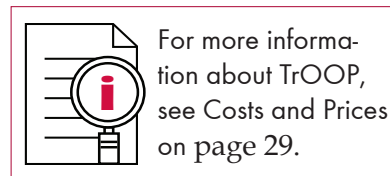
PAPs are not comprehensive insurance plans and therefore are not considered creditable coverage. Some programs may provide only one free sample or supply of a medication; others may provide ongoing assistance. The application process sometimes requires the participation of a physician who will receive and administer or deliver the drug to her patient.



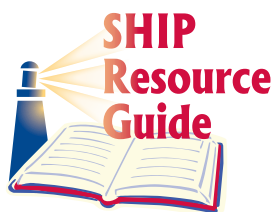
To streamline the application process, CMS has a dedicated website that compiles detailed information about all of the PAPs available through every drug manufacturer. The site lists medications by name to find out whether the companies offer them free or at low cost. Go to <http://www.medicare.gov/pap/index.asp>.

It is important to know that the total cost of the drug that a PAP provides to a beneficiary in the coverage gap does not count towards True Out-Of-Pocket costs (TrOOP).

Therefore, assistance from a PAP extends the time that a beneficiary spends in the coverage gap, and, hence, delays the Part D catastrophic benefit. However, if a beneficiary must pay a copayment or coinsurance amount to receive a PAP-provided medication, the copayment or coinsurance amount counts towards TrOOP if the medication is on the plan's formulary.



EXAMPLE *Susanna takes Procrit, a very expensive cancer medication. Her Part D plan does cover this as a specialty drug; however, she is now in the coverage gap and cannot afford to pay \$986 for a month's supply. She is also on a fixed income and also receives a partial in-kind stipend to pay her monthly rent. After speaking with her doctor, he applied for her to receive Procrit directly from the manufacturer where she will pay a \$125 copayment, which will count towards her TrOOP with the plan.*



ACCESS TO DRUGS AND FORMULARIES

This section covers:

- Pharmacy Networks
- Formularies
- Cost-Containment Strategies
- Medication Therapy Management Programs (MTMPs)
- Transition Policies

Each Part D plan has a network of pharmacies from which enrollees routinely can access their Part D drugs. Additionally, each Part D plan covers the prescription drugs that it places on a formulary, or list of covered drugs. Formularies may vary greatly among the plans. Plans also may encourage enrollees to use certain drugs on their formularies in an effort to control costs. All of these factors may affect a beneficiary's access to prescription drugs, and thus are important to consider when selecting a plan.

PHARMACY NETWORKS

The Part D plans vary in the extent of their pharmacy networks. A pharmacy network is a group of pharmacies under contract with a Part D plan to provide its enrollees access to prescription drugs. In a June 2007 report, the Office of Inspector General for the Department of Health and Human Services (HHS) found that 97 percent of retail pharmacies participate in at least one stand-alone PDP (available online at <http://www.oig.hhs.gov/oei/reports/oei-05-06-00320.pdf>). At the same time, 70 percent of these participating retail pharmacies were members of the pharmacy networks of all the available PDPs in their region.

In addition to network pharmacies, some drug plans also designate preferred pharmacies that offer the lowest prices and out-of-pocket costs among all the plan's network pharmacies. The Plan Finder lists all network pharmacies by name and location and further notes those that are preferred pharmacies. It is important to learn if a beneficiary's pharmacy of choice is in the plan's network, and if it is not, to make sure that convenient alternatives exist. Because the drug plans renew their contracts annually, network pharmacies may change from year to year.

Note: Pharmacies in a Part D plan's network charge lower cost-sharing than other non-network pharmacies. For non-routine situations and emergencies, beneficiaries may be allowed to use non-network pharmacies. Each Part D plan has an out-of-network policy for such coverage issues.

A Medicare drug plan may not pay for prescriptions at pharmacies that are not in the plan's network. Exceptions apply, however, in emergencies and some other situations. CMS requires Part D plans to ensure that their enrollees have adequate access to covered drugs at out-of-network pharmacies when someone "cannot be reasonably expected to obtain covered drugs at a network pharmacy, or when such access is not routine." Thus, CMS expects the drug plans to cover prescriptions filled at out-of-network pharmacies when a plan enrollee loses his or her covered drugs or becomes ill, needs a covered drug, and cannot get to a network pharmacy.

Similarly, drug plans should cover prescriptions that a hospital or clinic-based pharmacy fills when someone is an emergency or outpatient surgery patient. Since Medicare Part B covers these types of hospital and clinic visits, Part D covers the prescriptions received during those visits. Many hospital-affiliated pharmacies are not in the network of Part D plans, so this type of coverage would be provided by the plan's out-of-network policy. Since the plan's negotiated price for a drug is often less than the price charged by a hospital pharmacy, beneficiaries should keep in mind that they will have to pay the difference between the two prices.

It is also important to know that the MMA allows pharmacies to waive or reduce the cost-sharing amount (i.e., copayment, coinsurance) for beneficiaries who are otherwise unable to afford their prescription drugs. Pharmacies, however, cannot do this on a routine basis. The amount the pharmacy pays counts toward the beneficiary's true out-of-pocket costs (TrOOP).

EXAMPLE *For the past 20 years, Charlie has been going to the ABC Pharmacy, which is exactly 2 miles from his house. He will be turning 65 in one month, and consequently will lose his retiree coverage. He takes three prescription drugs and has decided to enroll in a Part D plan. He is currently deciding between two PDPs. Both plans cover all three of his prescriptions; however, only one plan lists the ABC Pharmacy as a preferred pharmacy in its pharmacy network. Because Charlie wants to get the lowest price at his favorite pharmacy, he decides to enroll in that plan.*

FORMULARIES

Medicare drug plans use formularies – that is, comprehensive lists of the drugs they cover – to define their drug benefits. The MMA allows each drug plan to develop its own formulary within certain limits. CMS reviews formularies to make sure that they comply with federal law. It evaluates the formularies to ensure adequate access to medically necessary drugs and to make sure that no formulary excludes drugs in such a way as to discourage particular groups from joining a plan. For example, CMS would not approve a formulary if it did not include insulin and oral anti-glycemic agents, as such a formulary would discriminate against people with diabetes.

The MMA requires all Part D drug plans to provide access to medically necessary medications including generic and brand-name drugs. Plans' formularies must include at least two drugs in each treatment category and class that a drug plan sponsor designates, although CMS may require plans to include more than two drugs for some categories and classes. Medicare rules require the plans to cover "all or substantially all" drugs in six categories. CMS refers to these classes as "classes of clinical concern."

- Anti-neoplastics (anti-cancer drugs)
- Anti-convulsants
- Antidepressants
- Antipsychotics
- Immunosuppressants
- Anti-retrovirals

Note: Many plans cover more than two drugs in each class, though most plans do not have open formularies that cover all Medicare Part D allowable drugs.

CMS established the "all or substantially all" requirement for plans to cover all drugs and dosage forms within these six classes with only limited exceptions. Those exceptions include:

- Multi-source brands of the identical molecular structure
- Extended release products when the immediate-release product is included
- Products that have the same active ingredient or moiety
- Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals)



More information about this "all or substantially all" rule can be found in CMS's *Medicare Prescription Drug Benefit Manual*, Chapter 6, Section 30.2.5, available online at <http://www.cms.hhs.gov/Transmittals/Downloads/R2PDB.pdf>.

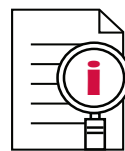
Drugs Excluded from Part D Coverage

Aside from requiring coverage for drugs in certain categories, the MMA specifically excludes some drugs from Part D coverage. Part D plans do not cover prescription drugs when they are covered by Medicare Part A or Part B, including some chemotherapy drugs. Other drugs that the law generally excludes from Part D coverage are:

- Drugs prescribed for anorexia, weight loss, or weight gain (except drugs used to treat AIDS wasting and cachexia due to chronic disease)
- Drugs prescribed to relieve the symptoms of coughs and colds. This exclusion does not include medications used to treat a cough that results from a medical condition that is not a cold or cough.
- Prescription vitamins and minerals, with the exception of prenatal vitamins and fluoride. Vitamin D analogs such as calcitriol, doxercalciferol, paricalcitol and dihydrotachysterol are not considered prescription vitamins. Also, prescription niacin products, such as Niaspan and Niacor are Part D drugs and are not considered vitamins.

- Over-the-counter drugs, with the exception of insulin
- Prescription drugs to promote hair growth
- Fertility drugs
- Cosmetic drugs. Drugs taken to treat psoriasis, acne, rosacea, or vitiligo are not considered cosmetic.
- Drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications
- Barbiturates (drugs used to control seizures or used for sedation or anesthesia such as Phenobarbital or Nembutal)
- Benzodiazepines, often referred to as minor tranquilizers, used to treat anxiety or insomnia (such as Xanax, Valium, and Ativan)
- Sexual or erectile dysfunction (ED) drugs, when prescribed for the treatment of sexual or erectile dysfunction

Note: For Contract Year (CY) 2006 Erectile Dysfunction (ED) drugs met the definition of a Part D drug and were available on Plan Sponsor formularies. On October 26, 2005, Section 1860D-2(e)(2)(A) of the Social Security Act was amended to exclude ED drugs when prescribed for the treatment of sexual or erectile dysfunction for CY 2007 and beyond. Please see the CMS Q&A on ED drugs for more information available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/QAEDDrugs_07.06.06.pdf.



The state Medicaid program may cover some Part D excluded drugs for full dual-eligible beneficiaries. For more information, see Help for Low-Income Beneficiaries on page 37.

Formulary Changes

Part D plans can change their formularies within certain limits. Medicare drug plans may only change the therapeutic categories and classes in their formularies once each year. These changes must occur between plan years. That is, a 2010 plan can change the categories and classes on its formulary for the 2011 plan year, but the change cannot be effective prior to January 1, 2011.

Medicare drug plans typically may not remove drugs from their formularies at any time during the plan year. A few exceptions to this general rule exist. First, Part D drugs may be removed from formularies when the Food and Drug Administration (FDA) pronounces a Part D drug unsafe. Plans may also remove drugs from formularies if the manufacturer removes the Part D drug from the market.

Medicare drug plans also may not make any change in cost-sharing status of formulary drugs from the start of the Annual Enrollment Period to 60 days after the beginning of the plan year. Plans also must provide a 60-day notice to affected beneficiaries including those who are currently taking a drug that is removed from the formulary or whose costs are changing because of a shift in a drug's tier placement. If the plan does not provide prior notice, it must authorize a 60-day fill of the drug and provide notice at the point of sale.

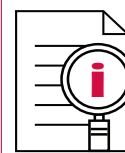
Part D plans usually must follow these general rules about mid-year formulary changes:

- Plans may remove or place in a higher tier brand-name drugs when generic or multi-source brand name equivalents enter the market.
- Plans may remove non-Part D drugs included on their formularies by mistake.
- Plans may add utilization management tools based on new FDA warnings.
- Plans may remove drugs based on new FDA market withdrawal notice.
- Plans may remove or place in a higher tier drugs based on new clinical guidelines or recommendations. An example is following CDC’s recommendation against using older antivirals for treatment and prevention of the flu.
- Plans may add utilization management tools in the following cases:
 - To respond to other approved formulary changes. One example is adding prior authorization to a brand name drug when a generic version is on the market.
 - To help determine B vs. D coverage
 - To promote the safe utilization of a Part D drug based upon new clinical guidelines or information

Medically Accepted Indications and Off-Label Use

Part D plans must ensure that physicians and other health providers prescribe Part D covered drugs for medically accepted indications. In some cases, providers prescribe drugs for a purpose other than the one originally approved by the FDA. This is called an “off-label use” of the drug. Sometimes physicians prescribe a drug to treat a medically accepted indication that is an off-label use. CMS does not require Part D plans to approve off-label use, but does expect them to refer to common medical practice in determining that a prescribed drug effectively deals with a medically accepted indication.

Because plans can differ in their decisions about medically accepted indications, it is important to check with a plan about its policies for approving off-label use. One plan, for example, may consider peer-reviewed literature in deciding on an acceptable use, while another may limit its consideration to the uses described in a CMS-approved drug compendium. Plans may deny coverage for off-label drug use for lack of medical necessity. If the client’s physician is willing to help make the case that an off-label use is within common medical practice, SHIPs can assist their clients to appeal these coverage denials.



For more information on coverage determinations, see Coverage Determinations and Appeals on page 67.

COST-CONTAINMENT STRATEGIES

The Part D program relies on competition among drug plans and limits on the use of some covered drugs, often called utilization management tools, to help contain costs and control government spending on the prescription drug program.

Price Competition

The federal government does not regulate the drug prices that plan sponsors charge in the Medicare Part D program. Part D plan sponsors individually negotiate prices with drug manufacturers. Thus, drug prices vary from plan to plan. The plans' negotiated drug costs affect the length of time it takes enrollees to reach the initial coverage limit, as well as the full prices they pay for drugs once in the doughnut hole.

Utilization Management Tools

Along with price competition, the MMA allows drug plans to control costs through drug utilization management systems that may have an impact on a beneficiary's ability to access prescribed medications. The common elements in these utilization management systems are:

- Cost tiers
- Prior authorization
- Step therapy
- Quantity limits

As a SHIP counselor, keep in mind that even though a drug plan lists a client's medication as a covered drug on its formulary, a utilization management tool may restrict access to that drug. It may be necessary to ask the prescribing physician to make the case to the plan that your client's medical condition creates a medical need for the drug. When a Part D plan uses a utilization management tool to deny coverage for a formulary drug that your client needs, SHIPs can play an important role in assisting through the exceptions or redetermination appeals processes.



It is a good idea for beneficiaries to fill all of their medications at the same pharmacy to better predict their drug spending as well as to benefit from the pharmacist's expertise about avoiding drug interactions.



For more information about exceptions, see Coverage Determinations and Appeals on page 67.

Cost Tiers

Many plan sponsors assign the covered drugs on a plan's formulary to different cost-sharing tiers. The MMA allows plan sponsors to design plans with as many as six tiers, though plans more commonly have three or four. Plans usually assign generic drugs to a low cost-sharing tier. For example, a plan's copayments for generic furosemide and brand-name Lasix might be \$5 and \$40, respectively. The smaller copayment in the lower tier works as an incentive for beneficiaries to select less costly drugs instead of the more expensive alternatives placed in higher tiers.

EXAMPLE Bernard was enrolled a PDP plan, while his neighbor, Kyle was enrolled in a different PDP plan. Both take diabetic medication and use the same local pharmacy. Bernard takes the brand-name drug Avandia, and Kyle takes the generic form metformin. Bernard's medication is on the fourth tier, and his copayment is \$120 for a month's supply. Kyle's medication is on the second tier as a generic drug, and costs only \$22 per month.

Prior Authorization

Prior authorization requires an added step in filling a prescription. Plans typically use prior authorization requirements to control the use of higher cost medications. The MMA gives plan sponsors considerable latitude to design their prior authorization systems. The plans can use different forms, and may ask physicians to provide more or less documentation to establish the need for a drug. Thus, it may be easier for prescribing physicians to secure prior authorization in one plan as opposed to another. SHIP counselors may be in a position to help clients with information about the exceptions and appeals process following an unsuccessful request from the plan for prior authorization.

EXAMPLE Bernard's physician has prescribed a brand-name blood pressure drug, Zestril. The plan covers the generic form of the drug, lisinopril, but requires prior authorization for Zestril. Bernard's doctor contacted the plan and provided documentation, through notes in his medical record, that Bernard had tried the generic form in the past and that it caused him to feel dizzy. He also provided information from clinical trials to tie Bernard's reaction to a proven side effect. The drug plan approved the physician's request for coverage. This approval by the plan applies only to Bernard; it does not change its policy about covering Zestril for other enrollees who cannot take the generic form.

Step Therapy

Step therapy is a cost-control method that requires beneficiaries to use a less expensive medication, long-established as effective in treating a condition, before moving on to the next "step" in the process, involving a higher cost or newer, brand-name drug. Drug plans that require step therapy for a particular drug will not pay for the more expensive drugs, in the second and third steps, until the beneficiary tries the less expensive first step, and it proves to be ineffective or harmful. When beneficiaries have already tried the less expensive drug unsuccessfully, the doctor should contact the drug plan to request an exception.

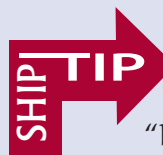
EXAMPLE Carmen's doctor prescribed Prevacid to treat symptoms of acid reflux disease. The cost for a 30-day supply of the 15mg tablets is \$135. Carmen's drug plan required her to first try Omeprazol at \$25 per month. The pharmacist contacted her doctor to ask if she could take Omeprazol instead of Prevacid. Because Carmen had a history of negative reactions to the less expensive drug, her doctor contacted the plan to ask it to cover the brand-name drug. The plan would not pay for the Prevacid until the doctor described in writing the poor results Carmen had with Omeprazole.

Quantity Limits

Plans may limit the amount of medication that they pay for over a certain period of time. The Kaiser Family Foundation reported that quantity limits are the most common utilization management tool that national PDPs use with ten frequently prescribed brand-name drugs (<http://www.kff.org/medicare/upload/7749.pdf>). It is not unusual to find plans only paying for a limited supply of a brand-name medication, even though a physician prescribes more.

EXAMPLE *Ethel takes Imitrex, a medication for migraine headache. She has done well on this drug. Her doctor wrote a prescription for 15 doses, but her drug plan will only cover a supply of 10, under a quantity limit restriction. To overcome the restriction, Ethel will need to request an exception to the 10-dose quantity limit.*

The MMA allows Part D plans to use any of these cost-containment strategies. SHIP counselors can expect that their clients will encounter one or more of them as potential road-blocks to access their prescribed drugs. Thus, it is important for clients to understand their rights, and know how to exercise them, when a drug plan's cost-control requirements impede needed care.



Our health is unpredictable; therefore, it is impossible to predict the “best” plan for the unforeseeable future. It's usually best to encourage beneficiaries to choose a plan that meets their needs at that point in time.

MEDICATION THERAPY MANAGEMENT PROGRAMS (MTMPs)

All Part D plans (including MA-PD plans) must offer a Medication Therapy Management Program (MTMP) to eligible enrollees. MTM programs are intended to reduce the risk of adverse medication events and improve medication use by participants.

Beginning in 2010, CMS has established new rules for MTMPs. CMS has defined certain criteria for these programs. Plans must:

- Enroll beneficiaries using an opt-out method
- Target enrollment at least quarterly during the plan year
- Enroll beneficiaries who
 - Have multiple chronic conditions
 - Programs cannot require more than three chronic diseases as a minimum, and they must target at least four of the following chronic conditions:
 - Hypertension
 - Heart Failure
 - Diabetes
 - Dyslipidemia
 - Respiratory Disease

- Bone Disease-Arthritis
 - Mental Health
- Are taking multiple Part D drugs
 - Programs cannot require a minimum of more than eight drugs
- Are likely to spend at least \$3,000 annually out-of-pocket for covered drugs
- Offer the following services
 - Interventions for beneficiaries and prescribers
 - An annual comprehensive medication review, including review of drugs, consultation, and a written summary
- Report extensive details on the activities of the program

TRANSITION POLICIES

All Part D drug plans have transition policies through which enrollees sometimes can obtain a temporary fill of their prescription drugs. Transition policies cover new Medicare beneficiaries' enrollment in Part D plans, a switch from one Part D plan to another, level of care changes affecting long-term care facility residents, and formulary changes from one contract year to the next affecting current plan enrollees.

When a transition policy is in effect, a Part D plan must cover an enrollee's prescription drugs even if they are not on the plan's formulary. While CMS has set forth minimum transition policy requirements to address the needs of new and current drug plan enrollees, the agency allows plans to craft their own transition policies. Because the policies may vary from plan to plan, with some exceeding the minimum requirements, it is important for your clients to check with their drug plans to learn how the transition policies might affect them.

New Enrollees

Under the MMA, Part D plans must offer a transition process for beneficiaries who are either enrolling in a Part D plan for the first time (i.e., new Medicare beneficiaries and beneficiaries who recently lost creditable coverage) or are enrolling in a different plan. This includes beneficiaries who are joining a Part D plan through a Special Enrollment Period (SEP). Under the transition process, plans must provide new enrollees with a temporary, 30-day supply of a non-formulary drug, including a drug dispensed under a utilization management restriction (e.g., prior approval) that they were taking before enrolling in new Part D plans. Plans may choose to extend the 30-day supply for new enrollees, but at a minimum they must provide a 30-day supply. Plans must cover this temporary supply, or transition fill, when beneficiaries go to pharmacies to fill prescribed medications within 90 days of drug coverage becoming effective.



Clients may want to check the plan's transition policy before deciding to enroll in or switch to a plan.

The transition process also is an opportunity for enrollees to work with their physicians to find alternative drugs on the plan's formulary or to file an exception to request coverage for the drug. Medicare rules require plans to give new enrollees a written notice that states that they must either switch to a therapeutically equivalent drug that is on formulary or request an exception from the plan to continue taking the drug for the remainder of the calendar year. Plans work with pharmacies to distribute the notice to enrollees when they receive a transition fill. In the event that a prescription is not filled and such a notice is not distributed, it is best to contact the plan for further information on the plan's reasons for denying coverage and the appropriate next steps. For 2010, CMS has provided plans with a model transition letter, available online at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/PartDMMM/list.asp>. The transition letter should explain the reason that the plan is providing a temporary fill, e.g., that the drug is not on the formulary or that the plan places a utilization management restriction on the drug.

Current Enrollees

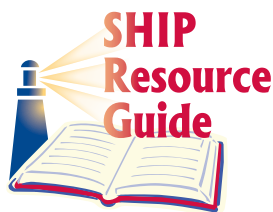
CMS expects Part D plans to have a meaningful transition process in place for current plan enrollees whose drugs are no longer on the plan's formulary in the change from one contract year to the next. CMS expects plans to select one of two options.

1. Plans can provide for current enrollees a transition process that is consistent with the process for new enrollees. Under this option, CMS requires plans to provide enrollees with a temporary supply of the requested prescription drug (where it is not medically contraindicated) and with written notice that states how they must either switch to a drug that is on the plan's formulary or request an exception to continue taking the drug.
2. Alternatively, plans can establish and implement a transition process for current enrollees prior to the start of a new contract year (January 1, in most cases). This option requires plans to prospectively transition current enrollees to a therapeutically equivalent drug on the formulary or complete requests for formulary and cost-sharing exceptions before prior to the start of a new contract year. If a plan does neither, it must provide a temporary fill until the beneficiary has transitioned to a new drug on the formulary or until it has granted an exception.

EXAMPLE *Mary joined a Part D plan in February of 2009, and decided to remain in the same PDP for 2010. In 2009, she paid \$25 for a brand-name drug for her arthritis. In November 2009, she learned in the plan's Annual Notice of Change (ANOC) that her share of the cost would increase to \$50 in 2010. Because Mary lives on a fixed income and takes six other prescription drugs, she cannot pay the extra \$25 per month. She checked with her prescribing physician about switching to another drug, but he advised against it. Mary filed an exception to the cost-sharing amount on December 30, but as of January 2 she had*

not heard from the plan. When she went to fill her prescription on January 2, the pharmacist provided a transition fill. On January 3, she heard from the plan that she had been granted an exception to the higher cost-sharing amount. As a result, she will continue to pay \$25 for her drug in 2010.

Chapter 6 of the Medicare Prescription Drug Benefit Manual provides details on plan transition requirements as they currently exist, available online at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/R2PDBv2.pdf>.



GRIEVANCES, COVERAGE DETERMINATIONS, AND APPEALS

This section covers:

- Grievances
- Coverage Determinations (Including Exceptions)
- Appeals

Because each Medicare drug plan has a different formulary, as well as different rules regarding access to drugs, some enrollees may have problems getting all of their prescriptions filled through their Part D plans. The MMA establishes specific rules and processes for beneficiaries who are having difficulty obtaining their prescriptions. Understanding the reasons for the plan's denial of coverage and learning what to do about it are important steps in obtaining a drug from the Part D plan.

GRIEVANCES

All Medicare drug plans must have processes in place to hear and resolve grievances filed by Part D plan enrollees. Here are several examples of situations that Part D plans should process as grievances:

- Complaints about copayment amounts
- Complaints about an enrollee's enrollment or disenrollment
- Complaints about a change in premiums or cost-sharing amounts from one contract year to the next
- Complaints about wait times on the plan's toll-free number for members
- Complaints about the quality of care or benefits provided
- Complaints about the plan's written communications
- Complaints about timeliness of services provided

CMS requires that Part D grievance procedures include the following elements:

- Plans must accept information and evidence about grievances orally and in writing up to at least 60 days after the event.
- Plans must accept any information or evidence concerning the grievance.
- Plans must respond within 24 hours to expedited grievances related to a plan's refusal to grant a request for an expedited coverage determination or an expedited redetermination if the enrollee has not yet received the drug at issue
- Plans must transmit in a timely manner all grievances to the appropriate decision-makers

- Plans must take prompt, appropriate action, including a full investigation of complaints
- Plans must notify results of their investigations to all concerned parties, as expeditiously as the enrollee's case requires, but no later than 30 days after the plan receives the oral or written grievance
- Plans must inform enrollees of the results of the grievance as follows:
 - Plans must respond in writing to those grievances submitted in writing
 - Plans may respond either orally or in writing to grievances submitted orally, unless the enrollee requests a written response.
 - Plans must be responded to in writing to all grievances related to quality of care, regardless of how the grievance is filed. The response also must include information about the enrollee's right to file a written complaint with the QIO.
- Plans must have procedures for tracking and maintaining records about the receipt and disposition of grievances. They also must disclose grievance data to Medicare enrollees upon request.

All enrollees in Part D plan are entitled to receive written materials about the plan's grievance procedures. Plans must make written information available about enrollees' right to file expedited grievances when plans deny the enrollees' requests for expedited appeal or organization determination or when the Part D plan takes an extension on a coverage determination or appeal.

EXAMPLE *Susan recently called her SHIP office to talk about a problem she had with her Part D plan's customer service call center. She reports that she was on hold for 30 minutes and that a service representative was rude and unable to answer her questions. Susan is upset and wants to know what she can do.*

Susan has the right to file a grievance (i.e., a complaint) with her Part D plan within 60 days of the incident. She can refer to her plan's Evidence of Coverage booklet for instructions on how to file a grievance. After submitting her grievance, Rachel should receive a response from the Part D plan within 30 days.

COVERAGE DETERMINATIONS

A coverage determination is a decision by a Medicare drug plan about whether or not to cover a prescribed medication under the Part D program. In most cases, drug plans determine that prescribed medications are medically necessary and approve coverage. But a plan may decide not to cover a drug for several reasons:

- The drug is not on the plan's formulary.
- The plan determines the drug to be not medically necessary.
- The plan restricts coverage to a specific dosage of the drug.

- The drug is subject to prior authorization, step therapy, or another utilization management restriction.
- The drug is covered under Medicare Part A or Part B.
- An out-of-network pharmacy furnishes the drug.
- The plan sponsor determines that the drug is excluded from Part D coverage.

These types of coverage determinations are generally made by the plan behind the scenes, and do not require an enrollee to take action to receive a coverage determination. There is, however, a type of coverage determination – called an exception – that only occurs after an enrollee takes action. When a beneficiary files a request for a formulary exception with the plan, the plan’s decision about whether to grant the exception is also a coverage determination.

If a plan denies coverage for a prescription drug at the pharmacy counter, the beneficiary, an appointed representative, or the beneficiary’s physician may request a coverage determination. An appointed representative is a person asked by a beneficiary to assist in the coverage determination process. To become an appointed representative, this person can complete a standard CMS form (<http://new.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>). The form is valid for one year after it is signed, and must be submitted with each request for a coverage determination. Because the MMA gives physicians the authority to request a coverage determination on behalf of a beneficiary, it is not necessary for the physician to be an appointed representative.

EXAMPLE *Aretha went to the pharmacy with a prescription for the antibiotic Keflex. When the pharmacist entered the drug into his computer system, the plan indicated that this brand-name drug is not on the plan’s formulary. But the drug’s generic form, cephalexin, is on the formulary. The pharmacist called Aretha’s prescribing physician about dispensing the generic instead of the brand-name drug. If the doctor does not approve the generic substitution, Aretha can talk to her SHIP about getting help to request a formulary exception from the plan. The plan’s decision on the exception request is a coverage determination.*

Medicare drug plans make coverage determinations on standard and expedited time frames. When someone requests a standard coverage determination, the Part D plan must make its decision and respond to the beneficiary and the prescribing physician (if the physician requested the coverage determination) within 72 hours after receiving the request. If the plan denies coverage for the prescribed medication, the plan must give the beneficiary a written notice describing the reason for the denial along with instructions to appeal the adverse coverage determination.



If an enrollee is requesting payment for drugs already received, the plan must authorize the payment and send written notice of the decision within three calendar days of issuing an oral notice.

A drug plan will make an expedited coverage determination if the physician believes that a delay will place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests are completed according to the plan's rules, usually by phone or fax. The plan must respond to the beneficiary and physician within 24 hours.

SHIP TIP Plans are not required to fill prescriptions for most enrollees while an exception is pending. Long-term care residents, however, must receive their drugs while awaiting a plan's decision.

EXAMPLE *Wilson is enrolled in a PDP. Until recently, the plan covered all of his prescribed drugs. Last month, Wilson's doctor prescribed a new brand-name drug for his arthritis. Wilson went to a preferred pharmacy to fill the prescription, but the pharmacist told him that the plan denied coverage for the drug because it has a prior authorization. Wilson should work with his pharmacist and doctor to fulfill the prior authorization requirement of the plan to receive coverage. Wilson's doctor faxed in his relevant medical records, and his PDP began to provide coverage within three days.*

Exceptions

A significant portion of coverage determinations are requests for exceptions. Part D plan enrollees have the right to request two different types of exceptions from their drug plans, one for coverage of a non-formulary drug (formulary exception) and the other for a reduction in the cost-sharing amount for a formulary drug (tiering exception). If the plan decides to cover the drug or reduce the cost-sharing amount, the exception lasts for the remainder of the plan year. If an enrollee remains in the same plan for the next year, the plan can decide anew about an exception for the drug. The plan may require the enrollee to submit a new exception request for the coming plan year. Note that Medicare rules do not require the drug plans to process an enrollee's exception request until the prescribing physician provides the plan with an oral or written supporting statement.

SHIP TIP Beneficiaries may not request both types of exceptions for the same drug.

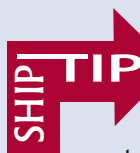
Formulary Exceptions

Exceptions that fall under this category include requests for:

- A drug that is not on the plan's formulary
- A drug that is on the plan's formulary, but not in the dosage or form prescribed by the physician
- A drug with a utilization management restriction (i.e., step therapy, prior approval, quantity limit)

Cost-Sharing (Tiering) Exceptions

Beneficiaries may request exceptions to lower their cost-sharing amounts for non-preferred, brand-name drugs. Plans with cost-sharing tiers assign some medications to a more costly non-preferred drug tier and others to a more affordable, preferred status tier. Beneficiaries who cannot take the preferred drug in a class or category may request an exception to lower the cost-sharing amount of their non-preferred drug to that of the preferred group.



If a plan has a separate tier for generic drugs, an enrollee cannot request an exception to reduce the copayment of a brand-name drug to that of a generic drug.

EXAMPLE *Otis was discharged from the hospital on a Friday afternoon. While in the hospital, he received prescriptions for three new drugs. His daughter went to the pharmacy that evening to fill the prescriptions, and learned that one of the drugs was not on his Part D plan's formulary. The daughter immediately called the attending physician to ask if there was an alternative drug that her father could take. The physician said no, but agreed to call Otis's plan to request an expedited exception for his non-formulary drug. The physician also spoke with the pharmacy to arrange for a two-day supply of the drug. On Saturday afternoon, the physician received notice of the plan's favorable coverage determination, granting a formulary exception. As a result, Otis was able to fill his prescription with coverage through his drug plan. The exception lasts for the remainder of the plan year, provided that Otis stays with the same plan.*

APPEALS PROCESS

When a coverage determination is unfavorable, or “adverse,” the enrollee may appeal the drug plan's decision. There are five steps in the appeals process. In each step, beneficiaries must make their request for further action within 60 days of receiving notice of the prior, unfavorable response.

Step 1. Redetermination

A redetermination is a request for the Part D drug plan to revisit an unfavorable coverage determination. A request for a standard redetermination must be decided by the plan within seven days. If the beneficiary's request must be expedited, the plan must make a decision within 72 hours of receiving the request.

Step 2. Reconsideration

When the drug plan gives an adverse decision on a redetermination request, reconsideration is the next step in the appeals process. This step is a request to the Part D Qualified Independent Contractor (QIC), a Medicare contractor also known as an Independent Review Entity (IRE), to review the Part D plan's adverse redetermination decision. The Part D QIC must decide on standard reconsideration requests within seven days and within 72 hours of receiving an expedited reconsideration request.

The Part D QIC is Maximus Federal Services. For details on reconsideration procedures, see the Part D Reconsideration Manual at the Part D QIC's appeals website at <http://www.MedicarePartDAppeals.com>. The QIC's office in King of Prussia, Pennsylvania handles reconsiderations coming from the stand-alone PDPs, while its office in Victor, New York reconsiders denial decisions by MA-PDs.

In 2007, the last year for which a report is available, the Part D QIC received 11,033 reconsideration requests. Thirty-eight percent of these appeals involved a utilization management tool dispute including, for example, step therapy restrictions. In some types of appeals, the Part D QIC reversed the drug plan's adverse decision—and ordered coverage for the drugs—at fairly high rates. It reversed drug utilization management tool denials in 59 percent of the cases and out-of-network coverage denials at a 47 percent rate. With respect to exceptions requests, the Part D QIC overturned 48 percent of the off-formulary exception request denials, and 26 percent of denials for tiering exception requests.

Step 3. Administrative Law Judge (ALJ) Hearing

When the request for reconsideration is unfavorable, the next step in the process is a hearing with an Administrative Law Judge (ALJ), who will review the case thus far. However, the amount in controversy must be at least \$130 (2010) to request an ALJ Hearing. The amount in controversy is defined as the projected amount of money that a beneficiary would spend during the plan year directly related to the Part D drug in question. ALJ Hearings generally must be decided within 90 days. It may take longer than 90 days for in-person hearings.

Step 4. Medicare Appeals Council (MAC)

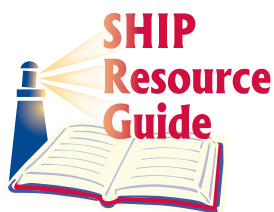
When the request for an ALJ Hearing is unfavorable, the next step is the Medicare Appeals Council (MAC). The MAC reviews the ALJ decision. The MAC must make a decision within 90 days in most cases.

Step 5. Federal District Court

The Federal District Court is the final step in the appeals process. To request a review by the Federal District Court, the amount in controversy must be at least \$1,260 (2010). The amount in controversy is defined as the projected amount of money that a beneficiary would spend during the plan year directly related to the Part D drug in question.

As this section illustrates, there are specific rules and processes set forth by the MMA for beneficiaries who are having difficulty obtaining their prescriptions. Some beneficiaries may be able to resolve their access issue relatively easily, while others may need to take a series of steps to hopefully resolve their issue.

See Appendix P for *Part D: Appeals Process* flowchart.



MARKETING

This section covers:

- Overview
- Marketing Materials
 - Advertising
 - Pre-Enrollment Materials
 - Post-Enrollment Materials
 - Low-Income Subsidy (LIS) Issues
- Marketing Review
- Special Guidelines
- Promotional Activities
- Employer/Union Sponsored Group Plans for Retirees

OVERVIEW

CMS issues “Marketing Guidelines” for Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs), available online at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/Chapter%202%20Medicare%20Marketing%20Guidelines.pdf>. Providers, such as pharmacies, and all other entities that contract with Medicare drug plan sponsors and MA plans, must also follow a set of Marketing Guidelines. Congress took steps in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 to address several problematic marketing activities. MIPPA and related CMS rules and guidance deal with unsolicited contacts with Medicare beneficiaries, providing meals to prospective enrollees, and the use of unlicensed sales agents. CMS also issued new guidance on co-branding, appointments to market Medicare drug plans and MA plans to prospective enrollees, and agent and broker compensation.

It is important for SHIP counselors and Medicare beneficiaries to be able to recognize and report activities or behaviors that do not meet the Marketing Guidelines. See Appendix Q for the HAP’s, *MA and PDP Marketing Fact Sheet*, summarizing the Marketing Guidelines.

The materials and methods organizations use to promote and sell Medicare drug plans to eligible beneficiaries must follow standards established by CMS. Unless otherwise specified, this section addresses all Medicare drug plans. This section does not focus specifically on the marketing of Medicare Advantage plans with Prescription Drug coverage (MA-PD) plans though many rules governing the marketing of both types of plans are identical.

Marketing for the next plan year may not begin until Medicare drug plan sponsors receive notice from CMS that they have an approved contract to offer in the coming year, but not before October 1 of the current year. Prior to this marketing period, plans may only provide educational material or presentations (that is, with no intent to enroll potential members) to eligible Medicare beneficiaries.

Medicare drug plan sponsors may not market a plan outside of the plan's service area (unless it is unavoidable). In unavoidable situations, the organization must disclose the plan's service area in a clear manner.

If a SHIP counselor or a beneficiary believes that a plan or provider is not following the guidelines, he can report such activities to the following places:

CMS Regional Offices

Region 1- Boston:

PartDComplaints_RO1@cms.hhs.gov

Region 2- New York:

PartDComplaints_RO2@cms.hhs.gov

Region 3- Philadelphia:

PartDComplaints_RO3@cms.hhs.gov

Region 4- Atlanta:

PartDComplaints_RO4@cms.hhs.gov

Region 5- Chicago:

PartDComplaints_RO5@cms.hhs.gov

Region 6- Dallas:

PartDComplaints_RO6@cms.hhs.gov

Region 7- Kansas City:

PartDComplaints_RO7@cms.hhs.gov

Region 8- Denver:

PartDComplaints_RO8@cms.hhs.gov

Region 9- San Francisco:

PartDComplaints_RO9@cms.hhs.gov

Region 10- Seattle:

PartDComplaints_RO10@cms.hhs.gov

Counselors should not usually report issues directly to the plan. CMS encourages counselors to submit cases to the appropriate Regional Office for tracking and follow up through a central process.

Counselors who help beneficiaries file grievances with their plans need to contact the plan or 1-800-MEDICARE to do so.

EXAMPLE *One example of an unavoidable situation is television advertising. A commercial for a Medicare drug plan may be broadcast from a television station that broadcasts across PDP regions. The Medicare drug plan may be available in one of the PDP regions and not the other. In this case, the Medicare drug plan cannot avoid marketing to those who live outside the plan's service area.*

Plan Names

CMS has specific rules about names for Medicare drug plans. Medicare drug plan sponsors may not use a plan name that discourages certain beneficiaries to enroll in the plan. For example, a sponsor cannot use the word “senior” or “seniors,” because it may mislead Medicare beneficiaries under age 65 to think they are not eligible to enroll in the plan. Also, Medicare drug plans generally may not suggest an ethnic or religious group in their names. The exception to this rule is plans that are affiliated with a group named as such. Finally, while Medicare drug plan names may not include the words “Medicare endorsed,” they may contain the word “Medicare.”

Co-Branding

Medicare drug plan sponsors may coordinate with a separate entity in a business arrangement to offer a Medicare drug plan. Because of this relationship, the plan may use the name of the co-branded entity in the plan’s marketing materials. CMS prohibits, however, the use of the co-branded entity’s name on enrollees’ membership cards.

Because of confusion in past years, marketing materials that include the name of the co-branded entity now must clarify that the plan has a larger provider network than those of the co-branded entity alone. CMS requires that these materials include the following language, “Other pharmacies are available in our network.”

The co-branded entity also may market the Medicare drug plan during appropriate marketing and enrollment periods.

EXAMPLE *Humana offers Medicare drug plans that are co-branded with Wal-Mart. Humana may not use the name, Wal-Mart, on their membership cards. Humana’s marketing materials may include the name, Wal-Mart, but they also must say, “Other pharmacies are available in our network.”*

Cross-Selling

Starting on September 18, 2008, a CMS rule now prohibits MA and Medicare drug plans and their representatives from marketing non-health care related products (such as annuities and life insurance) to prospective plan enrollees during sales activities or presentations. The rule’s purpose is to prevent confusion that Medicare drug plans and non-health related financial products are part of the same package. Plans may, however, sell non-health related products on inbound calls when a beneficiary asks for information about them.

Note: *State insurance departments typically approve marketing materials for health insurance policies sold in their states. With the Medicare Drug Coverage program, federal law pre-empts state regulation of drug plan marketing materials. The states, however, still license and regulate the agents and brokers who work for, and contract with, MA plans.*

MARKETING MATERIALS

All materials used in promoting and selling a Medicare drug plan and for enrollment are subject to CMS-established rules and restrictions on marketing. Separate CMS rules govern the materials that plans use for different phases of the marketing process.

Advertising

Advertising, as governed by CMS rules, includes the following methods:

- Television ads
- Radio ads
- Banner ads
- Outdoor advertising
- Print ads
- Internet advertising
- Direct mail (including enrollment forms or materials)

There are specific rules about certain aspects of Medicare drug plan advertising, including the following features:

- **Disclaimer:** Except for banner ads and outdoor advertising, all ads must state the organization contracts with the federal government
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”
- **Hours of Operation:** When ads include phone numbers, they also must include the hours of operation of the customer service department.
- **TTY/TDD Numbers:** Generally, when ads include plan phone numbers, they also must include TTY/TDD numbers in the same font size and style.
- **Pharmacies:** Medicare drug plans may advertise the number of network pharmacies but must distinguish between preferred and non-preferred pharmacies, if applicable.
- **Formatting Requirements:** Footnotes must be the same size font as the majority of text in a piece of written advertisement. Brochures and direct mail may not use a font size smaller than Times New Roman 12-point font. The font of any Internet advertising must not be smaller than 12-point Times New Roman font or its equivalent.
- **Logos/Tag Lines:** Medicare drug plan organizations may use unproven claims about their plan in advertising, but may not make superlative remarks about the Medicare drug plan being advertised. That is, ads may not state that a plan is better than all other plans in delivering services or care.

- **Drawings/Prizes/Giveaways:** Free gifts and prizes offered by a Medicare drug plan during marketing must be made available to all those at an enrollment event and may not be used to obligate a beneficiary to enroll. The value of any gift or prize must be less than \$15 retail. The gift or prize may not be cash or a cash equivalent, like a gift card.

Pre-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials that Medicare drug plan organizations use prior to enrollment. These are called “pre-enrollment materials.”

- **Language Requirements**

Medicare drug plans must include certain statements in all pre-enrollment materials. These language requirements fall into the following specific categories:

- **Enrollment Limitations:** Sponsors must include a statement indicating that beneficiaries may enroll in a plan only during specific times of the year.
- **Network Limitations:** Medicare drug plans must explain the requirement that enrollees use network pharmacies, except under non-routine circumstances when they could not reasonably use network pharmacies.
- **Alternative Formats:** Pre-enrollment materials must indicate when a Medicare drug plan has beneficiary materials in alternative formats (e.g., Braille, languages other than English, audio, or large print).
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”

- **Formatting Requirements**

All pre-enrollment materials for Medicare drug plans must follow specific formatting requirements to ensure their readability. These formatting requirements fall into the following specific categories:

- **Member Materials:** Printed pre-enrollment materials must use 12-point or larger font.
- **Materials on the Internet:** Information on the Medicare drug plan’s website must be written in a minimum of 12-point Times New Roman font, or another font with same point size.
- **Footnotes and Subscripts:** Footnotes and subscripts on notices must be written in a minimum of 12-point Times New Roman font, or another font with same point size.

- **Eligibility Requirements**

Pre-enrollment materials must describe the eligibility requirements for enrollment into a Medicare drug plan. The materials must include the following specific eligibility information:

- An individual must be entitled to Medicare benefits under Part A or enrolled in Part B.
- An individual must reside in the service area of a Medicare drug plan.
- An individual may be enrolled in only one Part D plan at a time.
- Individuals enrolled in a private fee-for-service plan (PFFS) that does not include Medicare prescription drug coverage or a Medicare Medical Savings Account (MSA) plan may enroll in a stand-alone Medicare drug plan.
- Individuals enrolled in a MA coordinated care (HMO or PPO) plans or PFFS plan that include Medicare prescription drugs may not enroll in a stand-alone Medicare drug plan unless they disenroll from the HMO, PPO, or PFFS plan.

- **Other Requirements**

CMS has established other requirements for pre-enrollment materials that include:

- Logos/Tag Lines: Medicare drug plan organizations may use unproven claims about their plan in pre-enrollment materials, but may not make superlative remarks to promote the Medicare drug plan. That is, ads may not state that a plan is better than all other plans in delivering services or care.
- Online Enrollment Center: Medicare drug plan sponsors may choose to allow enrollment into Medicare drug plans through CMS's Online Enrollment Center (Plan Finder).
- Low-Income Subsidy: All Medicare drug plan sponsors offering drug plans must include the following language, "You may be able to get extra help to pay for prescription drug premiums and costs." The statement must include contact information for 1-800-MEDICARE, the Social Security hotline, and a reference to the state Medicaid office.

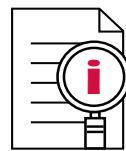
- **Summary of Benefits**

The Summary of Benefits (SB) is the main mechanism a Medicare drug plan sponsor uses to provide current enrollees and eligible individuals wide-ranging information about a the plan's structure, coverage, benefits, and costs.

The SB is a standardized document with four sections:

- An introduction and beneficiary information: This section includes standard language that applies to all Medicare drug plan sponsors (as well as organizations offering MA plans) and must be included verbatim in the SB.

- A benefit comparison matrix: This section of the SB includes a chart of benefits offered by the Medicare drug plan. The benefits included on the chart are pulled from a list of commonly available benefits.
- An optional free-form text area: This section includes information about the plan's benefits not included elsewhere in the SB.
- Beginning in January 2010, Special Needs Plans (SNPs) for dual-eligible beneficiaries must provide each prospective enrollee a written statement describing
 - Benefits the individual is entitled to under Medicaid
 - Cost-sharing protections the individual is entitled to under Medicaid
 - Which of these benefits and cost-sharing protections are covered under the SNP



For more information about Special Needs Plans, see HAP's SHIP Resource Guide on Medicare Advantage, available online at <http://www.hapnetwork.org/medicare-advantage/ship-resource-guide/medicare-advantage.html>.

Post-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials a Medicare drug plan sponsor uses after enrollment. These are called “post-enrollment materials.”

- **Language Requirements**

All post-enrollment materials, when used to market Medicare drug plans, must follow the same language requirements that apply to pre-enrollment materials, described above.

- **Formatting Requirements**

All post-enrollment materials for Medicare drug plans must follow the same formatting requirements that apply to pre-enrollment materials, described above.

- **Other Requirements**

CMS has established other requirements for post-enrollment materials. Post-enrollment marketing materials must meet the following requirements:

- **Logos/Tag Lines:** Medicare drug plan sponsors may use unproven claims about their plan in post-enrollment materials, but may not make superlative remarks to promote the Medicare drug plan. That is, ads may not state that a plan is better than all other plans in delivering services or care.
- **Media Type:** Medicare drug plan sponsors may offer post-enrollment materials, including the SB, EOC, and Provider/Pharmacy Directory, in different formats (e.g., hard copy, CD-ROM) provided the alternative formats are available in the required time frame.

• **Specific Guidance**

CMS has established guidance to govern certain post-enrollment materials. Plans must provide the following documents to enrollees at the time of enrollment and annually thereafter:

- Annual Notice of Change (ANOC): This document describes Medicare drug plan changes for the following plan year. The ANOC must be delivered to enrollees by October 31 each year. Current plan enrollees receive the ANOC and EOC in one envelope each fall.
- Evidence of Coverage (EOC): Medicare drug plans must mail this document to new Medicare drug plan enrollees by January 31 of the plan year. The EOC must describe rules for accessing health services, emergency and urgent care rules, appeal rights, benefits and plan premiums, and low-income subsidy information (if applicable).
- Comprehensive or Abridged Formulary
- ID Card: Must be mailed to all enrollees within ten days after CMS confirms enrollment.
- Pharmacy Directory
- Explanation of Benefits (EOB): Medicare drug plan sponsors must mail this document to plan enrollees each month in which plan enrollees utilize their prescription drug benefits. The EOB must include all items and charges from the month, information about exception and appeal rights, and total cumulative spending by both the plan and the enrollee on drug costs.

Low-Income Subsidy (LIS) Issues

All Medicare plans that offer Medicare drug coverage (including Medicare drug plans and MA-PDs) must provide information to all enrollees about the low-income subsidy (LIS) program that provides Extra Help to beneficiaries with limited income and resources. Each of the following marketing materials must include information about LIS program eligibility:

- Member Letters
- Direct Mail
- Telephone Scripts
- Pre-Enrollment Packet
- Websites

While CMS does not require it, these plans may conduct outreach to a portion or all enrollees about the LIS program. For those who do not respond to this outreach, plans may follow up to provide information and assistance in applying for LIS. Medicare drug plans' marketing materials may provide alternatives for LIS application, including referring enrollees to SHIPs to receive help with the application process.

Medicare rules prohibit Medicare drug plans from storing and sharing financial information about enrollees with any entity not involved in the LIS outreach. These plans also may not imply to enrollees that the plan has the right to screen enrollees for eligibility.

MARKETING REVIEW

With few exceptions, Medicare drug plan sponsors must submit all of their marketing materials to CMS for review and approval prior to use. Most marketing materials and enrollment forms are submitted to CMS for a 45-day review. When Medicare drug plan sponsors submit model language for materials without modification, CMS has 10 days to review the materials. One of these four outcomes may result from submission of such materials: approval, disapproval, deemed, or withdrawn. A status of “deemed” occurs when CMS neither approves nor disapproves materials within the appropriate time frame.

SPECIAL GUIDELINES

Requirements for Marketing to Populations with Special Needs

Sponsors offering Medicare drug plans must make marketing materials available in any language spoken as a primary language by more than 10 percent of residents within a plan’s service area. Medicare drug plans also must provide a service through their toll-free call centers to assist beneficiaries who speak a language other than English.

Medicare drug plans must accommodate enrollees with visual impairment by providing appropriate basic enrollee information materials. Any Medicare beneficiary eligible to enroll in a drug plan, including those with disabilities, must have appropriate assistance from the plan to access information.

Plans must submit materials in languages other than English (including Braille) with an English translation as well as a signed and certified letter to demonstrate that the translation is suitable.

Anti-Discrimination

The law prohibits Medicare drug plan sponsors from discriminating on the basis of:

- Race
- Ethnicity
- Religion
- Gender
- Sexual Orientation
- Health Status
- Geographic Location

With a few exceptions, a Medicare drug plan's services must be offered to all enrollees in the plan. A few examples of these exceptions include gender-specific items or services and certain items for those with specific diagnoses.

PROMOTIONAL ACTIVITIES

CMS has established specific rules about many aspects of Medicare drug plan promotion. It is important to note that CMS guidance issued in September 2008 clarified a distinction between "educational events" and "marketing (or sales) events." Several important restrictions on sales activities apply to Medicare drug plans involved in educational events. CMS's marketing rules, designed to protect beneficiaries from undue sales pressure and misleading information, apply to the following activities:

Nominal Gifts

Medicare drug plans may provide small gifts of nominal value (\$15 retail) to potential enrollees who attend a marketing or sales presentation. Plans must provide any nominal gift to any eligible beneficiary and cannot make the gift conditional on enrollment in the plan. Plans advertising any free gifts must include disclaimers that there is no obligation to enroll in the plan. Medicare rules prohibit plans from using cash, charitable contributions, gift certificates, and gift cards as nominal gifts.

Drawings/Prizes/Giveaways

Any prize offered to potential enrollees at marketing or sales presentations may not be used to coerce beneficiaries to enroll in a specific Medicare drug plan. A plan may offer a larger drawing, prize, or giveaway with a value greater than \$15, but any attendee of the function (not only beneficiaries) must be eligible to win.

Hold Time Messages

A Medicare drug plan may use health-related information as part of the messages played while on hold with the plan's toll-free call center. Information may not be presented during these messages about non-health related services, for example, other lines of insurance.

Referral Programs

Medicare drug plans may offer small, nominal gifts to plan members who refer potential enrollees to the plan. The rules limit these gifts to one per year for any plan member, and are subject to the same limitations as other nominal gifts (e.g., retail value less than \$15). Medicare drug plans may solicit such referrals from their enrollees during the year.

Educational Events

Starting on September 18, 2008, Medicare drug plans cannot engage in sales activities, including the distribution of marketing materials or the collection of plan applications, at educational events. Typically, educational events include health information fairs and other state or community-sponsored events that the sponsors promote as being educational in nature. Medicare drug plans and other organizations may sponsor educational events. According to CMS, the purpose of an educational event is to provide objective information about the Medicare program and issues such as wellness and prevention. CMS guidance says that the plans should not use educational events to steer or attempt to steer beneficiaries “to a specific or limited number of plans.”

Organizations that sponsor or participate in educational events must add a notice on advertising materials saying that the event is “educational only and information regarding the plan will not be available.” In contrast to educational events, sales events are those that have the purpose of marketing to potential members or steering potential members to a specific or limited number of plans.

Health Fairs and Health Promotion Events

Medicare drug plan sponsors may take part in health fairs either as a sole-sponsor or as a co-sponsor. At sole-sponsor events, such plans may offer door prizes, or similar items, with a value less than \$15. At multiple-sponsor events, Medicare drug plans may exceed the \$15 limit if they contribute to a larger prize offered by multiple contributors. CMS prohibits sales presentations and enrollment at health fairs and events and health promotion events.

CMS-Sponsored Health Information Fairs

CMS is required to sponsor informational events about Medicare drug plans and MA plans. The agency permits Medicare drug plans (as well as MA plans) to participate. At these health fairs, Medicare drug plans may assist in planning, distribute information and applications, have a booth, distribute nominal gifts, contribute funding to the costs of the fair, and market multiple lines of business. CMS does not, however, permit them to make sales presentations, collect enrollment forms, collect names or addresses of beneficiaries, compare benefits to other plans, use third-party materials, or provide gifts larger than \$15.

Meals and Light Snacks

Starting on September 18, 2008, CMS rules prohibit Medicare drug plans and MA plans from providing or subsidizing meals for potential enrollees and current enrollees at marketing events, that is events at which someone discusses plan benefits or distributes plan materials. The prohibition on subsidizing meals means that plans cannot give restaurant gift cards or gift certificates to beneficiaries, regardless of the gift’s value.

Plans and their representatives may, however, provide refreshments and light snacks at marketing events. CMS guidance suggests that foods such as fruit, nuts, cookies, crackers, and cheese, are acceptable as light snacks. In addition, the rules allow plans to provide meals to beneficiaries at educational events.

Provider Promotional Activities

Providers may be involved in some activities to promote Medicare drug plans. This section refers to providers, including pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

• **Providers in the Health Care Setting**

- Providers may have general discussions with beneficiaries about potential plan options.
- Providers may make available marketing materials to their patients as long as they make them available for all Medicare drug plans with which a provider participates.
- Providers cannot accept enrollment applications
- Providers may not persuade beneficiaries to join an Medicare drug plan.
- Providers may not offer anything to a beneficiary in return for enrolling in an Medicare drug plan.
- Providers may refer their patients to other sources of information, including SHIPs.

• **Plans in the Health Care Setting**

- Medicare drug plans may not conduct sales activities in health care settings, except in common areas such as hospital and nursing home cafeterias, community or recreational rooms, or conference rooms.
- Plans cannot conduct sales presentations and distribute or accept enrollment applications in areas where patients primarily receive health care services, including waiting rooms, exam rooms, hospital patient rooms, dialysis center, and pharmacy counter areas.
- Plans may not mislead or pressure beneficiaries into participating in the presentation.
- Plans may only schedule marketing appointments with long-term care nursing facility residents when a beneficiary requests it.

• **Provider Affiliations**

- Providers may announce new affiliations for specific Medicare drug plans through general advertising.
- Any materials found within the provider's location that list a provider's Medicare drug plan affiliations must include all such plans.

- **Health Fairs**

- Providers may distribute marketing materials (not including Medicare drug plan enrollment applications) at health fairs.
- Providers may present general education about Medicare drug plans at health fairs.

Agent and Broker Guidance

People employed by or contracting with a Medicare drug plan sponsor are governed by a set of rules concerning their behavior and activities. The Medicare drug plan sponsor employing or contracting such sales agents are responsible for the activities of these agents. State insurance departments also regulate agents and brokers. This means that agents are subject both to plan and state oversight. One drawback of this arrangement is that oversight often depends on the strength of a state's insurance department.

No person marketing a Medicare drug plan may choose to market to or selectively enroll healthier beneficiaries. This discriminatory practice is called “cherry picking” and is not allowed in the marketing of either MA or Medicare drug plans.

- **Licensed and Trained Marketing Representatives**

CMS requires Medicare drug plans to use only those agents, brokers, and sales representatives who are licensed, certified, or registered under state law to market their products. CMS further expects plan sponsors to follow a state's appointment process to inform the state insurance regulators of the representatives they have appointed to market Medicare drug plans on their behalf, as well as to report the termination of any agents or brokers. In addition, starting with plan year 2009, Medicare drug plan sponsors must ensure each year that brokers and agents who sell Medicare products are trained on Medicare rules, regulations, specific plan details, and that they pass a test with a score of at least 85 percent.

- **Agent and Broker Compensation**

CMS is aware that Medicare drug plans offer compensation to agents and brokers who market these plans to beneficiaries, and that some plans' compensation structures have led to “churning,” a prohibited sales practice in which an agent or broker enrolls a beneficiary in a new Medicare drug plan each year to take advantage of higher first year commissions. While compensation structures may differ among types of plans (e.g., stand-alone PDP versus MA-PD), Medicare law now requires plans to create compensation systems that create incentives for agents and brokers to enroll beneficiaries in the Medicare drug plan that best meets their health care needs. In short, compensation systems that create incentives for agents or brokers to move beneficiaries between different PDP (and/or MA) plans are prohibited.

CMS rules that took effect with the 2009 plan year limit agent or broker compensation for a beneficiary's annual renewal in a Medicare drug plan to half the compensation paid for the beneficiary's first year as a Medicare drug plan member. The rule also requires that compensation paid to agents and brokers reflect fair market value based on commissions paid in past years (with inflation adjustments allowed). CMS will review the plans' compensation structures annually, and plans cannot change their commission rates or compensation structures without CMS approval.

- **Scope of Appointments (Sales Meetings) with Beneficiaries**

Medicare drug plans' sales representatives, including agents and brokers, may not market any health care related product during an individual marketing appointment beyond the scope of topics that the beneficiary agrees to discuss. This rule, in effect with the 2009 plan year, requires plans and their sales representatives to document, in advance of a personal sales meeting, the scope of the beneficiary's interest in discussing different Medicare drug plan options (see Appendix R for CMS's *Model Sales Appointment Confirmation Form*). The rule applies to marketing appointments with both current and prospective Medicare drug plan members. CMS expects plans to confirm that a beneficiary wants to talk about stand-alone Medicare drug plans or Medicare Advantage plans, or both. Medicare drug plans may document a beneficiary's consent through a signed appointment form, a recording, and other verifiable means.

Note:

SHIPs continue to report to CMS that Medicare drug plan and MA plan sales agents market their products improperly. Some agents receive an invitation from one resident of a senior housing facility and then go door-to-door within the facility. SHIPs also report agents who offer rides to visit family and friends to encourage them to enroll in MA or PDP plans. Counselors can report all of these "bad agent" behaviors to both:

- CMS Regional Offices
- 1-800-MEDICARE (The SHIP Medicare hotline is 1-888-647-6701.)

1-800-MEDICARE (or the SHIP hotline) will enter information into the Complaints Tracking Module (CTM). CMS uses the CTM to track the number and type of complaints made about MA and PDP plans. CMS also uses the CTM when they must use corrective action against plans.

Marketing through Unsolicited Contacts

Starting on September 18, 2008, CMS rules prohibit Medicare drug plans from making unsolicited contact with prospective enrollees outside of advertised educational or marketing events. The rules apply both to door-to-door and telephone marketing activities.

- **Door-to-Door Solicitation**

Medicare drug plan sponsors cannot market their plans door-to-door without a beneficiary's invitation to do so. Similarly, agents and brokers cannot visit or call beneficiaries who attended an event unless the beneficiary gave permission for the follow-up contact at the event.

- **Unsolicited Email Policy**

Generally, Medicare drug plan sponsors may not send unsolicited emails to beneficiaries. If beneficiaries request email from an Medicare drug plan, the sponsor is permitted to do so.

- **Outbound Marketing Calls**

Rules that took effect for the 2009 plan year prohibit Medicare drug plans and their sales representatives from making outbound calls to potential enrollees, without the beneficiary first initiating the contact. Medicare drug plans may not conduct or allow unsolicited contacts under the guise of selling another product such as Medicare Medigap policies (i.e., Medicare Supplement policies), a needs assessment, or a review of Medicare coverage options to which CMS's unsolicited contact rules do not directly apply. The prohibition on outbound calls does not apply, however, to Medicare Supplement marketing. Thus, the Medicare drug plan sponsors must walk a fine line because the rules allow sales representatives to make outbound calls specifically to market Medicare Supplement policies and to discuss MA products if the beneficiary expresses an interest in them.

CMS, however, allows plans to contact beneficiaries **who are already plan members** to discuss other products. In the same way, agents and brokers may contact beneficiaries that they enrolled in a Medicare drug plan to discuss plan issues and to market other Medicare drug plan options. Agents also can initiate phone calls to confirm an appointment to which a beneficiary has already agreed. Otherwise, agents cannot make unsolicited phone calls to other beneficiaries or plan members, and plans cannot make unsolicited contacts with former plan members who have disenrolled or with current members who are in the process of disenrolling voluntarily.

Informational Inbound Telephone Scripts

Medicare drug plans must have scripts for customer service representatives who answer the toll-free hotlines. A Medicare drug plan must have prepared a minimum set of topics for such calls:

- Pre-enrollment information
- Post-enrollment information
- Benefits
- Cost-sharing
- Formulary
- Network pharmacies
- Out-of-network coverage
- Claims submission

- Formulary transition process
- Grievances, coverage determinations, and appeals
- Claims processing
- Benefit coverage
- Extra Help or LIS
- Claims payment
- TrOOP status
- Obtaining forms
- Replacing membership cards

During inbound pre-enrollment calls, plans may not request beneficiary identification numbers or payment information. During post-enrollment calls, plans may request a member ID number. Plans may not direct the caller to enrollment unless requested to do so.

Enrollment via Inbound Telephone

Medicare drug plan sponsors may not enroll beneficiaries during outbound calls (telemarketing). Furthermore, they cannot transfer outbound calls to inbound lines to proceed with enrollment. During an appropriate enrollment call, the Medicare drug plan may not collect (or request) credit card or bank account numbers.

Beneficiaries who would like to enroll in a Medicare drug plan during an appropriate enrollment period may call the plan directly to do so.

If a SHIP counselor or a beneficiary believes that a plan or provider is not following the guidelines, he can report such activities to the following places:

CMS Regional Offices

Region 1- Boston:

PartDComplaints_RO1@cms.hhs.gov

Region 2- New York:

PartDComplaints_RO2@cms.hhs.gov

Region 3- Philadelphia:

PartDComplaints_RO3@cms.hhs.gov

Region 4- Atlanta:

PartDComplaints_RO4@cms.hhs.gov

Region 5- Chicago:

PartDComplaints_RO5@cms.hhs.gov

Region 6- Dallas:

PartDComplaints_RO6@cms.hhs.gov

Region 7- Kansas City:

PartDComplaints_RO7@cms.hhs.gov

Region 8- Denver:

PartDComplaints_RO8@cms.hhs.gov

Region 9- San Francisco:

PartDComplaints_RO9@cms.hhs.gov

Region 10- Seattle:

PartDComplaints_RO10@cms.hhs.gov

Counselors should not usually report issues directly to the plan. CMS encourages counselors to submit cases to the appropriate Regional Office for tracking and follow up through a central process.

Counselors who help beneficiaries file grievances with their plans should contact the plan or 1-800-MEDICARE to do so.

EMPLOYER/UNION SPONSORED GROUP PLANS FOR RETIREES

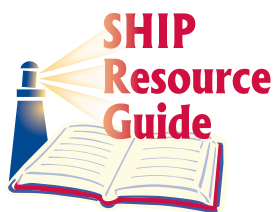
Medicare law allows plan sponsors to offer Medicare drug plans exclusively for employer and union retiree groups. Because a group plan sponsor typically is dealing directly with a plan administrator – not beneficiaries – to market plan options, some of the marketing rules for these plans differ from those in effect for Medicare drug plans sold on an individual basis.

The marketing rules above that apply to employer and union group plans include those for:

- Nominal gifts
- Marketing in health care settings
- Marketing at educational events
- Co-branding
- State licensing, appointment, and reporting
- Training

The marketing rules that do not apply to employer and union group plans include those for:

- Unsolicited contacts
- Cross-selling
- Scope of marketing appointments
- Providing meals
- Agent and broker compensation
- Testing



MEDICARE PART D RESOURCES

Additional resources on the Medicare Prescription Drug program, including the low-income subsidy, are available from a variety of sources including governmental agencies and non-profit organizations.

Federal Government

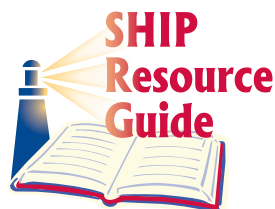
- Centers for Medicare & Medicaid Services: <http://www.cms.hhs.gov>
- Medicare: <http://www.medicare.gov>
- Social Security Administration: <http://www.ssa.gov/medicareoutreach2/index.htm>
- United States Department of Health and Human Services: <http://www.hhs.gov>

Non-profit Organizations

- AARP: <http://www.aarp.org>
- Center for Medicare Advocacy: <http://www.medicareadvocacy.org>
- Families USA Foundation: <http://www.familiesusa.org>
- Health Assistance Partnership: <http://www.hapnetwork.org>
- Kaiser Family Foundation: <http://www.kff.org>
- Medicare Rights Center: <http://www.medicarerights.org>
- National Senior Citizens Law Center: <http://www.nsclc.org>
- National Council on Aging: <http://www.ncoa.org>
- SMP Technical Resource Center: <http://www.smpresource.org>

Other

- Medicare Part A: <http://www.ahsmedicare.com>
- Medicare Part B: <http://www.medicarenhic.com>
- The American Health Quality Association (represents Quality Improvement Organizations or QIOs): <http://www.ahqa.org>



MEDICARE PART D APPENDICES

Appendix A: *Model Explanation of Benefits*

<http://www.hapnetwork.org/assets/pdfs/cms-model-eob.pdf>

Appendix B: Medicare Drug Coverage: Beneficiary Cost-Sharing (2010)

<http://www.hapnetwork.org/assets/pdfs/standard-part-d-costs-2009.pdf>

Appendix C: Application for Extra Help

<http://www.socialsecurity.gov/i1020/>

Appendix D: *A Guide to SSI for Groups and Organizations*

<http://www.ssa.gov/pubs/11015.html>

Appendix E: Medicare Drug Coverage: Extra Help for Low-Income Beneficiaries (2010)

<http://www.hapnetwork.org/assets/pdfs/2010-aep-toolkit/lis-costs-2010.pdf>

Appendix F: SSA Appeals Form (*Appeal of Determination for Help with Medicare Prescription Drug Plan Costs*)

<http://www.ssa.gov/online/ssa-1021.pdf>

Appendix G: Yellow Letter

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11154.pdf>

Appendix H: White Letter/FBDE RDS Letter

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11334.pdf>

Appendix I: *Social Security Administration Review of Your Eligibility for Extra Help*

<http://www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf>

Appendix J: SSA Beneficiary Fact Sheet, *Review of Your Eligibility for Extra Help With Medicare Prescription Drug Plan Costs: Some Things You Should Know*

<http://www.ssa.gov/pubs/10111.pdf>

Appendix K: Orange Letter

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11199.pdf>

Appendix L: Grey Letter

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11198.pdf>

Appendix M: Blue Letter - Version 1

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11208.pdf>

Appendix N: Blue Letter - Version 2

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11209.pdf>

Appendix O: Tan Letter

<http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11267.pdf>

Appendix P: Part D Appeals Process flowchart

<http://www.hapnetwork.org/assets/pdfs/part-d-appeals.pdf>

Appendix Q: MA and PDP Marketing Fact Sheet

<http://www.hapnetwork.org/assets/pdfs/ma-tools/2010-aep-toolkit/marketing-fact-sheet.pdf>

Appendix R: *Model Sales Appointment Confirmation Form*

<http://www.hapnetwork.org/assets/docs/ma-tools/revised-model-sales-appointment-confirmation-form.doc>

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