New Medicare Prescription Drug Coverage: An Overview for Pharmacies in Oregon

Note: All material in this manual is intended for people with Medicare who live in Oregon. It is not indicative of what classes of drugs other states will continue to cover or not cover for people with Medicare and Medicaid (dual eligibles). This manual only refers to what classes of drugs that Oregon will continue to cover or not cover for dual eligibles.

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The Medicare Modernization Act (MMA) is the biggest change in Medicare since it began in 1965. MMA was passed into federal law in December of 2003.

There are several parts to this law. The most important is the creation of a new prescription drug coverage program available to all people with Medicare beginning January 1, 2006.

Who is Eligible?

Anyone with Medicare Part A and/or B can enroll in the new prescription drug program. This includes people over age 65 and younger people with disabilities.

Any eligible person who wants to have Medicare prescription drug coverage will need to enroll in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD) that serves the area in which they live. People will need to contact the PDP or MA-PD to enroll. **People are not eligible for services until they enroll in a plan.**

People who want Medicare prescription drug coverage will need to pay a monthly premium to their PDP or the MA-PD and will have other out-of-pocket expenses. There is a federal program to help people with limited incomes cover the out-of-pocket expenses.

If a person has good private health insurance that covers prescription drugs, they may not need to enroll in a PDP or MA-PD. Health insurance companies will send a letter to their customers in the fall of 2005 (or when they first become eligible for Medicare). The letter will say if the insurance is as good or better than Medicare's prescription drug coverage.

Prescription Drug Plans and Medicare Advantage Plans

Unlike most of Medicare, private companies will offer the new prescription drug coverage. Private companies will determine what drugs to cover, what pharmacies to contract with, how to market their materials and how much to charge people. Medicare must approve all prescription drug plans, but each company will have flexibility in designing their plans.

Each plan will have a list of covered drugs called a formulary. The list must include both brand name and generic drugs. People will need to review the plan materials carefully to make sure their drugs are covered and that the plan is contracting with a convenient pharmacy in their area.

These private companies can choose to provide coverage in different ways. They can choose to be:

- A stand-alone **Prescription Drug Plan** (PDP), which only covers the prescription drugs and not other medical costs.
- A **Medicare Advantage Prescription Drug Plan** (MA-PD) that provides all Medicare benefits in one plan, including prescription drugs, or
- A **Special Needs Plan** (SNP) that serves particular groups (such as people with specific diseases or conditions or people with Medicaid).

Prescription coverage can also be offered through an employer or union group. These organizations will notify members whether their drug coverage is as good as Medicare's. People in these plans do not need to enroll in Medicare's prescription drug plan.

Medicare Supplement Insurance Plans (Medigap)

Because Medicare will be providing prescription drug coverage, Medicare Supplemental Insurance Plans (Medigap) cannot sell plans with prescription benefits after December 31, 2005.

People who have these plans (labeled Medigap H, I, or J) will have a choice to make about their prescription coverage.

- They can keep their current plan, but have the prescription coverage removed;
- They can cancel their current plan and enroll in a Medicare PDP and another Medigap Plan A, B, C, F, K, or L;
- They can enroll in a Medicare Advantage plan, or
- They can keep their current Medigap plan with prescription drug coverage and choose not to enroll in a Medicare PDP.

Attention Pharmacies:

-Encourage dual eligibles, people with Medicare and Medicaid coverage, to enroll in one of the Medicare Part D MA-PDs or PDPs.

-Dual eligibles will NOT have any prescription drug coverage if they do not enroll in a Medicare MA-PD or PDP.

-Medicaid will NOT pay for any Medicare Part D covered drugs.

Enrolling in a Plan

Medicare will release the names of the plans offering the prescription drug benefit in October 2005 and will send people the *Medicare & You 2006*. It will list all the plans available in Oregon. Also in October, people can use Medicare's website www.medicare.gov, or call 1-800-633-4227, to learn the plans available in Oregon.

People with Medicare will need to enroll directly with a PDP or MA-PD. Each plan will have different applications. Some may let people enroll on the Internet.

There are different times when someone can enroll in a plan. They are:

- Initial Enrollment Period;
- Annual Enrollment Period; and
- Special Enrollment Period.

Initial Enrollment Period

People who currently have Medicare will have a chance to enroll in a plan from **November 15, 2005** to **May 15, 2006**. During this time period, people can enroll in a plan that fits their needs. People who have prescription coverage from the state Medicaid plan will be enrolled in a Medicare PDP in October and will need to check if this plan meets their needs.

Annual Enrollment Period

Each year people with Medicare will have a chance to enroll or change plans. This enrollment period will be from November 15 through December 31 each year (starting in 2006). If someone has missed previous opportunities to join a PDP, they can join during this time period. If a person does not enroll when they are first eligible, they may have to pay a penalty.

Special Enrollment Period

A Special Enrollment Period may be given to a person who has prescription insurance coverage as good as Medicare's, or better, and didn't join a Medicare PDP during the initial enrollment period.

This allows a person to enroll in a Prescription Drug Plan without having to pay a penalty for late enrollment. The late enrollment penalty can be as much as 1% of the monthly premium for every month that enrollment was delayed without having coverage as good as Medicare's coverage.

It is possible to disenroll from a plan and join another plan when there has been a change in someone's situation. The events that would allow this are:

- If a person moves out of the plan's service area;
- If a plan has terminated its contract with Medicare;
- If a person misrepresents information to the plan.

The Standard Medicare Prescription Drug Benefit

Medicare has set premiums, deductibles, and co-payment limits as a "benchmark" for prescription drug plans. However, plans can have different premiums, deductibles and co-payment amounts. Some plans may have higher premiums or cost sharing but offer better benefits.

People will be able to choose a variety of ways to pay their premium. These include having the premium taken from their Social Security check, sending the premium directly to the plan, or having the premium taken directly from a bank account.

For 2006, in addition to the $37.00 monthly premium, people can expect to pay:

- A $250 yearly deductible.
- 25% of the cost of drugs between $250 and $2,250.
- 100% of drug costs between $2,251 and $5,100.
- 5% of all drug costs over $5,100 (Catastrophic Coverage).

Attention Pharmacies:

-The Standard Medicare Prescription Drug Benefit is for general Medicare beneficiaries only.

-General Medicare beneficiaries may pay different cost sharing amounts depending on the plan (MA-PD or PDP) they choose.

-Dual eligibles and other low-income people will pay different Medicare cost sharing amounts for drugs.

This may sound confusing but the PDPs and MA-PDs will keep track of this cost sharing for their members. The local pharmacy will know exactly how much a person needs to pay for each prescription. People with limited income and assets may be able to get help for the costs (see "Extra Help for Those with Limited Income" section).

Out-of-Pocket Summary

	Monthly Premium	First $250	Between $251 – $2,250	Between $2,251 - $5,100	After $5,100	Total costs to Catastrophic
You pay	$37	$250	$500	$2,850	5%	$3,600
PDP pays	$0	$0	$1,500	$0	95%	$1,500

Catastrophic Coverage and True Out-of-Pocket costs

Medicare will help those who have paid more than $3,600 for their drugs in any given year. Once a person reaches the $3,600 limit, Medicare will pay 95% of the drug costs for the rest of the year.

This out-of-pocket cost can be paid for by family members, charitable organizations, and from Individual Health Savings Accounts. Payments from other insurance plans, tribal entities, and government entities (including most state programs) do not count toward the true out-of-pocket amount for Medicare's catastrophic coverage.

Alternative or Enhanced Benefit Packages

PDPs can also offer "alternative prescription" drug coverage that is equal to or better than the standard benefit. Cost sharing will vary in these plans but the deductible cannot be more than the amount set by Medicare and the out-of-pocket limit ($3600 in 2006) cannot be higher.

Plans can also offer "enhanced coverage" that might include changes to the deductible and the initial coverage limit. A PDP must offer a standard benefit package if they want to offer an enhanced or alternative coverage plan.

Extra Help for Those with Limited Income

People with Medicare who have limited income may qualify for extra help paying for their prescriptions. The Low-Income Subsidy (LIS) Program provides extra help paying the cost of premiums, deductibles, and cost sharing. Some people with Medicare will be automatically eligible for this help. Other Medicare beneficiaries must apply for this extra help through the Social Security Administration (SSA). SSA provides application forms for people with Medicare who have limited incomes but do not have Medicaid or other forms of help. If a person with Medicare thinks that they might qualify, then they should fill out this form. Remember the adage: "When in doubt, fill it out."

Automatic Eligibility (Deemed Eligible)

People with Medicare and Medicaid and those receiving Supplemental Security Income are automatically eligible for the extra help and are "Deemed Eligible". These people do not need to apply for the extra help.

Changes for those with Medicare and Medicaid

People who have both Medicare and state health benefits-(Medicaid or the Oregon Health Plan)-will not have prescription coverage from the state after December 31, 2005[1]. People with Medicare and Medicaid will be automatically assigned to a PDP serving in their area to make sure they do not lose prescription drug coverage. It will be very important to check the plan's list of covered drugs and its list of pharmacies to make sure that there are no gaps in coverage.

Attention Pharmacies:

-All dual eligibles will pay co-payments beginning January 1, 2006 unless they are institutionalized.

-Dual eligibles in home and community based care (e.g. adult foster homes) will pay drug co-payments.

-Medicaid will NOT pay for any Medicare Part D covered drugs or co-payments.

People who are changing from state prescription coverage to Medicare prescription coverage will have to pay co-payments from $1.00 to $5.00 for each prescription, except for those in an "institution." Medicare defines institutions as nursing facilities, psychiatric hospitals, or the Eastern Oregon Training Center.

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[1] Medicaid will continue to pay for a few drug classes such as benzodiazepines, barbiturates and over-the-counter medications.

The amount a person pays depends on their income and whether they use generic or brand name drugs. People who have both Medicare and full Medicaid benefits fall into 2 categories for assistance. Those individuals with incomes less than 100% of the federal poverty level ($798/ month for a single person in 2006) fall into LIS Category 1. Medicaid clients with incomes above 100% of FPL fall into LIS Category 2.[2] (See LIS Categories on Page 22).

If a person with Medicare loses their state medical assistance eligibility, they will remain eligible for this extra help until the end of the calendar year. For the following calendar year after their state medical assistance has expired, the individual must apply for the extra help with the Social Security Administration (SSA).

Others with Limited Income

Other Medicare beneficiaries with limited income will need to apply for the extra help through the Social Security Administration (SSA). Throughout the summer of 2005, SSA will mail letters and application forms to people with Medicare who may be eligible for the extra assistance. The letter tells individuals that they may qualify for extra help. Individuals will need complete the application form by providing information regarding their income, resources, and family size.

- Income includes all earned and unearned income (e.g., federal benefits, interest, pensions, wages, annuities, rental income, etc).
- Resources include cash and liquid assets that can be converted to cash within 20 days (e.g., real estate, bank accounts, stocks, bonds, etc.)

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[2] If a person has Medicare and only a Medicare Savings Program or Supplemental Security income, then they will fall into LIS Category 2, regardless of income level.

- Family size includes the individual, his or her spouse, and any relatives living with the individual, and who receive at least half of their financial support from the individual.
    - Relatives are people related to the individual by blood, marriage, or adoption.

Not all people with Medicare who receive the application will qualify for extra help but they should apply anyway. If the Social Security Administration determines that someone is eligible for the extra help, then this individual will fall within one of the following groups:

LIS Category 1

Who?: Individuals with both Medicare and Medicaid coverage whose income is below 100% of the federal poverty level not living in an institution.

Benefit: No monthly premium and no deductible
Co-payments limited to $1 for each generic drug and $3 for each name brand drug.

LIS Category 2

Who?: Individuals with Medicare and Medicaid whose income is above 100% of Federal Poverty Level, or

Individuals with Medicare whose income is below 135% of Federal Poverty Level and who have limited resources.

Benefit: No premium and no deductible
Co-payments limited to $2 for each generic drug and $5 for each name brand drug.

LIS Category 3

Who?: People with Medicare whose income is between 135% of FPL and 150% of FPL and who have limited resources.

Benefit: A subsidy covering up to 75% of the monthly premium, and -.

Out of pocket expenses limited to:

$50 annual deductible,
15% of the prescription costs up to $5,100 ($757.50 per year).
Co-payments limited to $2 for each generic drug and $5 for each name brand drug after the annual prescription costs exceed $5,100.

Attention Pharmacies:

-Pharmacies <u>can</u> waive and/or reduce co-payments for dual eligibles and low-income subsidy (LIS) clients.

-Pharmacies <u>can</u> waive or reduce these clients' co-payments on a <u>routine</u> basis.

-Pharmacies <u>cannot</u> advertise that they will waive or reduce co-payments.

-Co-payment waivers/reductions <u>do</u> count toward TrOOP. [3]

[3] Per Medicare's final Part D Coordination of Benefits Guidance: "…for low-income subsidy recipients only, pharmacies do not need to ensure that the waiver or cost-sharing reduction is non-routine and provided only after ascertaining financial need. However, they cannot in any way advertise the provision of the waiver or cost sharing reduction…such waivers or reductions of Part D cost sharing by pharmacies would count toward a beneficiary's TrOOP." **Source:** http://www.Medicare.hhs.gov/pdps/cobguidancefinal.pdf, page 24-25.

SSA will review eligibility at the end of each calendar year. If someone loses eligibility during the calendar year, they will not lose the benefit until the end of the calendar year.

Medicare Prescription Drug Plan Coverage and Exclusions

PDPs and MA-PDs are required to cover certain drugs commonly called "Part D covered drugs." There are also certain drugs that are excluded. Plans are not allowed to pay for the costs of excluded drugs.

Medicare Part D Covered Drugs

Medicare will pay for the following:

- Prescription Drugs;
- Biological Products (e.g. Procrit, Raptiva);
- Vaccines (e.g. Hepatitis B vaccine for low risk individuals);
- Smoking Cessation drugs;
- Insulin (insulin injection supplies: syringes, needles, alcohol swabs, and gauze), and
- Compounded Drugs (two or more drugs added together by a pharmacy).

Attention Pharmacies:

-Medicare Part D plans (MA-PDs and PDPs) must coordinate benefits with all other payers.

-Pharmacies should make sure they can bill multiple payers, otherwise contact their software vendors.

-Medicare Part D should be billed as the primary payer for most circumstances.

-Do NOT bill Medicaid for Medicare Part D covered drugs.

-Medicaid will still coordinate benefits with Medicare **Part B**.

Medicare Part D Excluded Drugs

Medicare will not pay for the following:

- Drugs for anorexia, weight gain or weight loss;
- Fertility drugs;
- Drugs for cosmetic purposes or hair loss;
- Prescription Vitamins (except for prenatal vitamins and fluoride preparations);
- Drugs for the relief of cough and cold symptoms;
- Over-the-counter (OTC) drugs;
- Barbiturates, and
- Benzodiazepines.

Medicaid Covered Drugs

For eligible Medicaid clients, who also have Medicare, the state will continue to provide coverage for the following categories/classes of drugs as long as there is a covered diagnosis including:

- Drugs for anorexia, weight gain or weight loss;
- Prescription vitamins (except for prenatal vitamins and fluoride preparations);
- Prescription cough and cold drugs;
- Barbiturates (e.g. Barbital, Phenobarbital);
- Benzodiazepines (e.g. Ativan, Klonopin, Valium, Xanax), and

- Over-the-counter Medications (OTCs).
    - Medicaid will cover these drugs according to the Oregon Health Plan (OHP) funding criteria and limitations currently in place.

Formularies and Formulary Tools

A formulary is a list of drugs that a health plan will cover. Each PDP and MA-PD will have different formularies. Some drugs may be on one plan's formulary but not on another. Individuals will need to carefully compare each plan to see if it will meet their needs.

Additionally, plans may use different strategies to control the use of expensive or unnecessary drugs. These are usually called Formulary Tools. They include:

Prior Authorizations (PAs) - A process to determine if a specific drug is medically necessary for a specific individual.

- *Why?* - Plans usually use a prior authorization process because a specific drug is expensive or has health risks.
- *How?*
    - Plans maintain a list of drugs that require a PA.
    - When the pharmacy receives a prescription that requires a PA, they submit information about the patient's condition.
    - The plan may contact the doctor to get more information.
    - If the plan approves the drug, the pharmacy will fill the prescription.
    - If a PA is not approved, then the drug will not be covered and the patient may need to get a different prescription, file an exception, or pay the entire costs of the prescription out of their own pocket.

Quantity Limits (QLs) - A limit on the quantity of the drug that is covered.

- *Why?* - Plans usually use quantity limits because the drugs are expensive or have health risks. They may also use QLs when someone is starting a new prescription.
- *How?*
    - Plans maintain a list of drugs with quantity limits.
    - When the pharmacy receives a prescription that has a Quantity Limit, they submit a request to the plan.
    - The plan reviews the information and either:
    - Approves the request for the higher quantity or
    - Allows the prescription to be filled at the lower quantity.

Step Therapy - Trial of one or more less costly alternative drugs prior to allowing coverage of the more expensive drug. (*Example: A patient must try Prilosec before coverage of Nexium is allowed*.)

- *Why?* - Drugs requiring step therapy are usually high cost and there are other drugs that are cheaper.
- *How?*:
    - Plans require pharmacies to contact doctors to see if a less expensive drug can be substituted. Sometimes a PA can bypass step therapy if medical necessity is proven
    - If step therapy is not completed, the more costly drug may not be covered.

- Plans will usually cover the more expensive drug if the step therapy is unsuccessful. Step therapy is unsuccessful if:
    - Adverse side effects occur, or
    - Treatment is not effective.

Cost Sharing Tiers (The majority of plans use prescription drug formularies to determine the co-payment amounts).

- Different levels of co-payments amounts depending on the type of drug.
- Generic drugs have the lowest co-payment amount.
- Formulary drugs have the next lowest co-payment.
- Non-formulary drugs have the highest co-payment.

Attention Pharmacies:

-Medicare Part D plans (MA-PDs and PDPs) must cover a minimum of two drugs per every category and/or class of drugs.

Medicare Part D plans must cover the majority of:

-Anti-convulsants (seizure drugs);

-Anti-depressants;

-Anti-neoplastics (cancer drugs);

-Anti-psychotics;

-Anti-retrovirals (HIV/AIDS drugs), and

-Immunosuppressants (transplant drugs).

Drug Plan Guidelines

- Medicare has told the PDPs and MA-PDs that they must meet the needs of the Medicare population. This includes special instructions on working with long term care facilities and providing transition coverage for people who are new to their plans. Medicare has also told the plans that they must cover the majority of drugs in six categories/classes.

This mandate was designed to protect seniors and people with disabilities who may be the most at risk if they are forced to change prescriptions. The plans cannot discriminate against groups of people because of income, health status, or ethnicity. A plan must ensure its formulary does not discourage enrollment in its plan for any of these reasons.

Plans can change their formularies throughout the year by adding or removing drugs. Before a drug can be removed from the formulary, the plan must contact clients to advise them of the change. Plans must notify clients at least sixty days prior to the drug's removal from the formulary. Plans might cover some of the Medicare Part D exclusions as part of a step therapy program at no additional cost to the client.

Appeals and Exceptions

If a patient's drug is not one of the drugs on the plan's formulary, then the client can contact the plan to ask for an exception. If the exception is approved, the client can receive or continue to receive the drug, but may have to pay a higher co-payment.

Individuals can also ask for a co-payment exception. This means that if an exception is approved the person only has to pay the standard co-payment rather than a higher amount.

Exception Timeframes

- Standard: 72 hour turnaround, and

- Expedited: 24 hour turnaround.

Attention Pharmacies:

-If an exception is denied the client can:

- Pay out-of-pocket (OOP) for the drug;
- Choose a formulary/alternative drug;
- Appeal the exception denial, or
- Switch to a different drug plan, if the client is a dual eligible.

If an exception is granted, then it remains in place for the calendar year. If the exception is denied, the individual can appeal that decision. Appeals follow the normal Medicare appeals process.

- Re-determination by the plan;
- Reconsideration by an independent company contracted with Medicare;
- Review by an administrative law judge;
- Review by Medicare Appeals Council;
- Review by Federal District Court.

The affected individual, or their representative, must state the appeal at all stages. Appeals beyond the reconsideration stage may take a very long time.

Medicaid Client Information

Plan formularies and pharmacy networks will be available to the public in October 2005. Medicaid clients who have an “open card” or who are in a Medicaid managed care plan that does not have a Medicare plan will be randomly enrolled in a PDP. Medicaid clients in a managed care plan will stay in that managed care

plan. Clients will receive a letter from Medicare telling them which plan has been chosen for the clients.

Clients must decide if the plan they have been assigned to meets their needs. This means clients should make a list of the drugs they are currently taking or request a print out from their pharmacy, and then compare the list to the plan's formulary. Clients need to make sure those drugs are on the formulary. Also, clients must make sure that their pharmacy is listed as one of the plan's network pharmacies.

If a client's drugs are not on the formulary, then the client should look at formularies from other plans. Another plan's formulary might better meet the client's needs. The same is true for pharmacy networks. If clients cannot find their current pharmacy in a plan's network, they should look for their pharmacy in other plan networks.

DHS will be contacting Medicaid clients impacted by the change. Local offices and volunteers will be available to help those that need assistance in evaluating and choosing a plan.

Federal Poverty Levels-FPL		
Federal Poverty Level	**Family Size**	**Monthly Income (2005)**
100%	Individual	$798
	Couple	$1,069
135%	Individual	$1,076
	Couple	$1,443
150%	Individual	$1,196
	Couple	$1,604

***LIS Resource Limits**		
LIS Category	**Family Size**	**Resource Limit (2005)**
1	Individual	$2,000
	Couple	$3,000
2	Individual	$7,500
	Couple	$12,000
3	Individual	$11,500
	Couple	$23,000

**Other resource limits may apply.*

LIS Group 3 Premium Subsidy Amounts		
Income levels	**Premium Subsidy**	**Individual Pays**
135 – 140% FPL	75%	25% Coinsurance
140 – 145% FPL	50%	50% Coinsurance
145 – 150% FPL	25%	75% Coinsurance