The Medicare Part D Prescription Benefit

THE COALITION'S GUIDE FOR PROVIDERS

THE COALITION
OF BEHAVIORAL HEALTH AGENCIES, INC.

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An estimated 43 million Medicare beneficiaries will have drug coverage for the first time under the new Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This law creates a dramatic change to the Medicare program and affects the way you, as providers, help your clients, many of whom live on a fixed income. The purpose of this guide is to educate providers on the changes in Medicare that ultimately affect the vulnerable communities they serve. This guide can help providers assist their clients with making proactive rather than reactive decisions to avoid confusion and anxiety. There are examples provided throughout the chapters to demonstrate possible scenarios that your clients may encounter. An Acronym list, Glossary, and Resource list are provided at the end of this guide. Terms marked with an asterisk (*) are defined in the glossary.

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CHAPTER I

THE MEDICARE MODERNIZATION ACT OF 2003

AN INTRODUCTION TO THE MEDICARE PRESCRIPTION PART D DRUG BENEFIT

THE MEDICARE MODERNIZATION ACT OF 2003

1.1 MMA - What is it?

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA*) adds a new voluntary outpatient prescription drug benefit to Title XVIII of the Social Security Act. This prescription drug benefit, known as Medicare Part D, will affect both Medicare beneficiaries and people on Medicare and Medicaid* (also known as 'dual eligibles'). Medicare beneficiaries include adults 65 and older, and those under 65 years of age who are disabled. Individuals who are on disability are either eligible for Medicare through Supplemental Security Income (SSI) * or Social Security Disability Income (SSDI) *. Those dually eligible beneficiaries lost their Medicaid* drug coverage effective December 31, 2005.

1.2 The Three Categories of Medicare Beneficiaries:

There are three categories of Medicare beneficiaries* mentioned within the Medicare Modernization Act. It is important for providers to distinguish these clients from one another. The three categories are:

1) **Medicare Only Individuals***: a Medicare client who receives **only** Medicare benefits and **no** Medicaid benefits. This group includes adults 65 and older.
2) **Partial Dual Eligible Individuals***: Medicare enrollees who have premiums* and/or deductibles paid for by Medicaid through the Medicare Savings Program* (i.e. QMB, SLMB, or QI program), but receive **no** Medicaid coverage (Refer to Section 4.5).
3) **"Full-benefit" Dual Eligible Individuals***: Refers to a Medicare and Medicaid client with **full** Medicaid benefits. Beneficiaries are eligible for the state Medicaid program, but also Medicare regardless of age because of disability (i.e. persistent mental illness). They used to receive their prescription drugs directly through Medicaid.

1.3 Eligibility for Part D (Technical Requirements):

A beneficiary* is eligible for Medicare Part D if s/he:

- Is entitled to Medicare Part A* and/or enrolled in Medicare Part B*
- Lives in a Part D prescription drug plan service area (which does not include incarcerated individuals but covers the 50 states, U.S. Territories, and the District of Columbia).

1.4 Medicare Part D Providers and Part D Plan Options:

All plans will be referred to as Medicare Part D plans. The prescription drug benefit is provided by private companies that offer either of the following types of plans:

1) **Stand-alone Prescription Drug Plans (PDPs)*:** plans that offer drug-only coverage.
2) **Private Medicare Advantage plans (MA-PD)*:** Medicare Advantage Prescription Drug Plans that offer both prescription drug and health coverage. Private MA-PD plans include Health Maintenance Organization (HMO), Preferred Provider Organizations (PPO), or Private Fee-for-Service (PFFS).
3) **Medicare Advantage Special Needs plans (MA-SNP)*:** plans that can provide prescription drug and health coverage for people with special needs who may suffer from serious and chronic conditions such as mental illness, End Stage Renal Disease

(ESRD), HIV/AIDS, etc. All beneficiaries who wish to enroll in a Medicare Part D plan may join either a PDP, MA-PD, or MA-SNP (if one is available). Below is a breakdown of the new drug plans that are offered.

Prescription Drug Plan (PDP)	Medicare Advantage Plan (MA-PD)	Special Needs Plan (MA-SNP)
Stand-alone, prescription drug coverage only	Managed care program that will replace Medicare+ Choice	Coordinated benefits with full Part D coverage
Beneficiaries have an option of at least 2 plans per region to choose from, 1 of which must be a PDP	New plan options that include regional and local plans	Can be established to offer benefits to institutionalized individuals, dual eligibles, and beneficiaries who have severe or chronic conditions

Source: Bristol-Myers Squibb and Otsuka American Pharmaceutical, Inc: "Medicare Modernization Act (MMA) and Implications for Mental Health," June 2005.

1.5 Possible Medicare Part D Benefit Packages

Medicare Part D plans must offer a standard drug benefit but will be permitted some flexibility to offer an enhanced benefit. This means that there **is no** uniform drug coverage; Medicare plans may offer some version of the standard benefit, as long as the overall value of the benefit is at least as good as the Medicare standard plan.

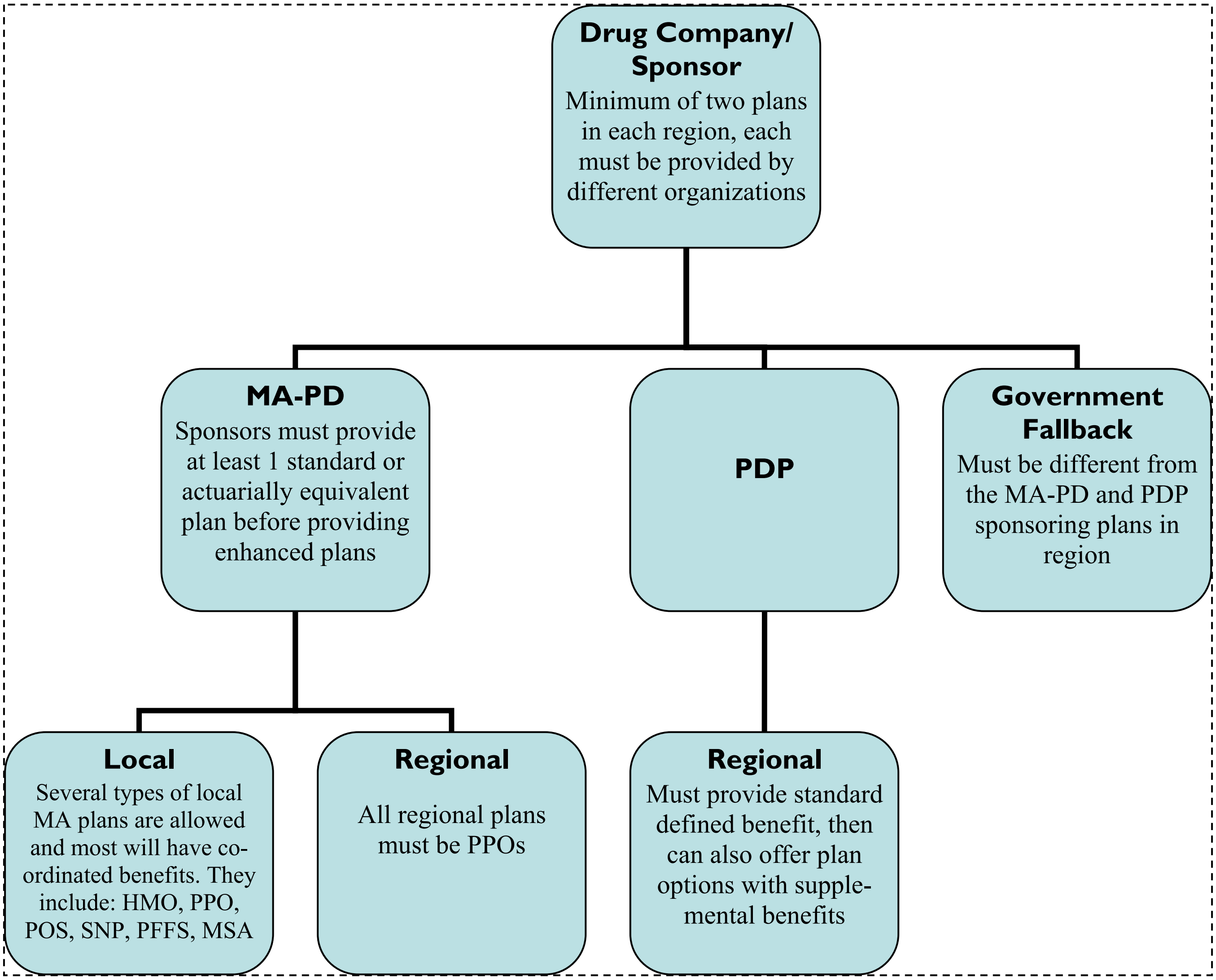
1.6 PDP Regions and CMS Requirements

The Centers for Medicare and Medicaid Services (CMS)* has defined geographic regions to ensure that all Medicare beneficiaries throughout the U.S. have the option of Medicare Part D coverage regardless of geographic location or health status. Nationally, there are 34 PDP regions and 26 MA-PD regions. CMS requires that each region contain at least one state, and that there are at least two plans offered by two different companies within each region. The government will provide a PDP plan if there are not enough plans in an area. To date there have been numerous plans to chose from.

1.7 Prescription Drug Plan Choices

Beneficiaries must have a choice of *at least* two Medicare private drug plans to choose from in their region. At minimum, one of the two plans must be a stand-alone PDP*. Companies that offer multiple Medicare drug plans must provide at least one plan that has the same amount of coverage as the standard Medicare prescription drug plan. The two regional plans must be provided by different organizations. **An individual must reside in a plan's service area (region) in order to enroll.** The following diagram shows the options available.

Demonstration of Coverage Options Under Medicare Part D

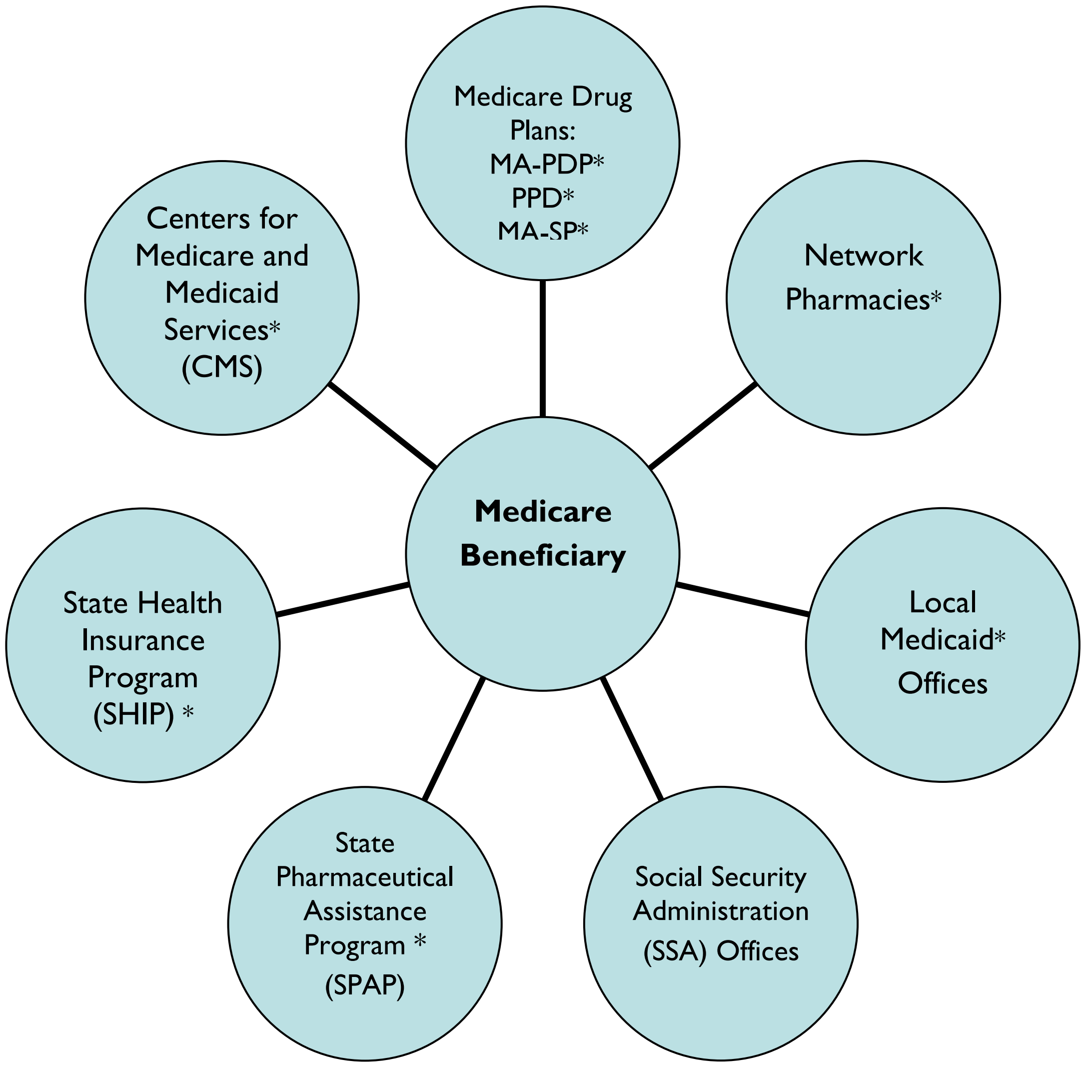


Adapted from Bristol-Myers Squibb and Otsuka American Pharmaceutical, Inc: "Medicare Modernization Act (MMA) and Implications for Mental Health Advocacy," June 2005.

1.8 Key Implementation Entities/ Structures

Beneficiaries will interact with several entities/resources at the local, state, and federal level when managing their new Medicare Part D Prescription coverage.

Below is a diagram illustrating some key players that beneficiaries will be in contact with during their Medicare Part D coverage. Each entity's role is further described throughout this guide and within the glossary.



Adapted from National Council for Community Behavioral Healthcare: "How to Help Consumers Access the Medicare Part D Prescription Drug Benefit," August 16, 2005.

CHAPTER 2

Medicare Part D Enrollment and Disenrollment

INITIAL ENROLLMENT PERIOD AND TIMELINE FOR MEDICARE PART D ENROLLMENT

2.1 Medicare Part D Enrollment - Is it a voluntary program?

Enrollment in Medicare Part D is voluntary for Medicare beneficiaries. **However, it is essentially mandatory for full dual eligible* beneficiaries who wish to continue receiving prescription drug coverage because as of January 1, 2006 Medicaid no longer covers the costs of prescription drugs.** A Medicare only beneficiary* must enroll in a Medicare prescription drug plan to obtain Medicare prescription drug coverage. Although there are some similarities, the Medicare Part D enrollment and dis-enrollment process is different for Medicare only individuals, full dual eligibles*, and partial dual eligibles*. Therefore, the first step is to determine to which of these three categories a beneficiary belongs.

NOTE: Beneficiaries* unsure of whether they are full or partial dual eligible (See also Section 1.2) should contact their state's Medicaid office to find out, or dial the phone number on the back of their Medicaid card. Below is information for the New York State Medicaid Office.

The New York State Office of Medicaid Management
Local: **1-518-486-9057**
Toll-Free: **1-800-541-2831**
Email: Medicaid@health.state.ny.us
Website:
http://www.health.state.ny.us/health_care/medicaid/index.htm

2.2 How does a beneficiary obtain drug coverage through Medicare Part D?

A client may obtain Part D coverage in three different ways:

1) S/he may keep Original Medicare* and enroll in a stand-alone Medicare Part D plan through a private company (that company has the right to charge an additional monthly premium*).
2) S/he may enroll or stay in a Medicare private plan such as a PPO or HMO, which will provide other Medicare-covered services and a drug benefit as a MA-PD or MA-SNP (additional monthly premiums may be charged by private company).
3) S/he may keep Original Medicare but get coverage directly from the government only if no stand-alone Medicare drug plan is made available in his/her region.

2.3 Medicare Part D Enrollment Time Frames

There are three enrollment time periods that beneficiaries should be aware of when considering enrollment into a Medicare Part D plan. The three possible enrollment periods include the Initial Enrollment Period (IEP), Annual Election Period (AEP), and Special Enrollment Period (SEP). Descriptions and time frames for each type of enrollment period are outlined in the chart that follows.

Enrollment Time Frames

Enrollment Period	Time Frame	Description
Initial Enrollment Period (IEP)	Eligibility begins when one is about to turn 65 years of age. There is a seven month enrollment period.	The Initial Enrollment Period is similar to the Initial Enrollment Period for Part B. This includes a seven month enrollment period: three months before eligibility for Medicare Part D, the month of Medicare Part D eligibility, and three months after eligibility for Part D (for example see Section 2.4).
Annual Coordinated Election Period (AEP)	AEP is from Nov. 15 - Dec. 31 of each year	Open enrollment period during which a beneficiary may enroll or switch to a different PDP.
One Time Enrollment 2007	January 1, 2007 through March 31, 2007 2007	This enrollment period is for individuals who received Extra Help in 2006 but no longer qualify for Extra Help in 2007. These individuals are allowed a one time enrollment election in a Part D. All individuals with LIS are given one additional enrollment opportunity through the end of 2007.
Special Enrollment Period (SEP)	Can happen anytime during the year on monthly basis	An enrollment period during which a beneficiary is allowed to enroll in Medicare Part D without having to pay premium* penalties. Special Enrollment Periods are granted to an individual if any of the situations below are met: • A full dual eligible individual • An individual is entering, residing in, or leaving a long-term facility • An individual has involuntary loss, reduction or non-notification of creditable coverage*. One is allowed up to 63 days to sign-up without penalty. • An individual moves out of the plan service area • Other exceptional circumstances (see Section 2.14)

2.4 Enrollment for Medicare Only Individuals

Medicare only individuals must actively enroll in a Medicare Part D plan if they wish to have prescription drug coverage through Medicare Part D. Medicare only individuals who become eligible for Medicare during the year should enroll in a Medicare Part D Plan during the initial enrollment period (IEP) to avoid premium* penalties (See Section 2.8). For subsequent years, enrollment will take place during the annual election period between November 15 and December 31 (See Chart 2.3 for more information). Enrollment in Medicare Advantage plans is during the period of November 15 through March 31.

2.5 Auto-Enrollment for Full Dual Eligibles

Initial enrollment into Medicare Part D is automatic for dual eligibles. This usually happens 2-3 months following the award of dual eligibility status. CMS will **auto-enroll** a full dual eligible into the **lowest premium* prescription drug plan** offered. Dual-eligibles have the option to switch from their assigned plan into another plan should they choose to do so. Dual eligibles may also change plans as often as once a month. As of January 1, 2006, Medicare Part D replaced Medicaid prescription drug coverage for dual eligibles, so dual eligible beneficiaries should make sure that they are enrolled in a plan that best fits their individual needs. **The plan that**

a full dual eligible is auto-enrolled into may not be the plan that best fits his/her individual needs.

NOTE: If a dual eligible enrolls in a higher cost plan than the CMS regional benchmark price, s/he must pay for the difference between the government's extra help* and the plan's premium cost (further explained in Chapter 4).

PROVIDER TIP: How to Best Facilitate Your Medicare Client's Enrollment

As a Provider, you can facilitate your Medicare client's enrollment into Medicare Part D by advising that s/he:

1) Keep all letters, records or documentation sent to him/her by CMS, Medicare, Medicaid, Social Security, and/or other health insurance companies (i.e. employer or retiree health insurance)
2) Write or ask pharmacist for a list of his/her medications so that alternatives could be discussed with his/her prescribing physician, and/or a suitable Part D plan be found that covers the individual's medications (See Appendix B for sample form)
3) Assist individual with comparing plans

2.6 Enrollment for Partial Dual Eligibles

Partial dual eligibles should actively enroll in a Medicare Part D plan. However, if a partial dual eligible fails to enroll in a plan within several months, Medicare will 'facilitate' their enrollment by auto-enrolling them into a plan (similar to the process for full dual eligibles).

2.7 Special Concern for the Dual Eligible

Providers should be attentive to dual eligible Medicare recipients because they are most at risk. Dual eligibles are often cognitively impaired, institutionalized, sick, poor and less educated who require more frequent use of prescriptions than other Medicare beneficiaries.

Why should providers and beneficiaries be concerned?

As of January 1, 2006, Medicaid beneficiaries who have Medicare coverage are obligated to obtain prescriptions through Medicare. Their current **Medicaid prescription drug coverage has ceased, with a few exceptions** (see Section 6.8 for more information). This shift in drug coverage from Medicaid to Medicare affects dual eligibles in three ways:

1) Dual-eligibles are responsible for a co-pay
2) Medicaid-covered drugs may not be covered under the new Medicare drug prescription benefit
3) Pre-assigned drug plans may not provide the drugs a recipient needs, AND may not be accepted by that individual's usual pharmacy

This change can cause a lapse in coverage, care, and treatment among vulnerable populations, including beneficiaries suffering from mental illness and the cognitively disabled. Dual eligibles include the following groups:

- All Medicaid beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B
- Medicare beneficiaries who spend-down to Medicaid eligibility (partial dual eligibles)
- Individuals in a Medicare Savings Program (partial dual eligibles)
- Medicare-eligible disabled persons

PROVIDER TIP: How to Advise the New Dual Eligible

Providers should advise dual eligibles of the following:

- **Medicaid will continue to pay for other health costs, so Medicaid beneficiaries should not discard their Medicaid card. Medicaid will offer a partial wrap-around in 2007 of certain medications.**
- They will automatically be assigned to a Medicare Part D plan.
- Their Medicaid card will not work at the drugstore. See Section 6.8 for more exception information.
- Only certain pharmacies will be able to fill their prescriptions depending on which Medicare Part D plan they are enrolled.
- A plan's formulary* (list of drugs covered) may not cover all prescribed drugs.
- They will need to pay new copayments* at the pharmacy.
- What to do in situation where their prescribed drugs are not on their PDP's formulary (See Chapter 5).

2.8 Postponing Enrollment and Premium Penalties

All Medicare beneficiaries are advised to take the initiative to compare plans and enroll in a Medicare Part D plan during the initial enrollment period. Beneficiaries who do not enroll during their initial enrollment period or the annual enrollment period will be subject to a lifetime enrollment premium* penalty (unless an individual is eligible for special enrollment period*). The only exception is when an individual has creditable coverage* from an existing plan (employer, retiree, union, etc). CMS requires that employer and retiree insurance companies mail an annual written notice informing enrollees whether their insurance is considered creditable coverage. If a beneficiary does not receive this letter s/he should contact that insurance company.

Note: Employer insurance plans can change mid-year. Should that plan no longer be creditable, there is a special enrollment period of 63 days in which an individual may enroll in a Part D plan.

What if a Medicare beneficiary chooses not to enroll in a Medicare Part D plan because s/he has other drug coverage?

If a Medicare only beneficiary is receiving drug benefits through another health insurance program and receiving creditable coverage* (benefits that are at least as good as the Medicare drug benefit), then s/he does not have to enroll in the new Medicare drug plan. S/he should receive a letter from the insurance company indicating if his/her plan is creditable. If a beneficiary is receiving drug coverage through insurance (such as a Veterans Program or former employer), s/he should check with the insurance company that the drug coverage is comparable to the Medicare Part D drug benefit. Medicare-only beneficiaries who do not have a drug benefit should consider enrolling during the initial six-month enrollment period to avoid premium penalties.

How does a beneficiary know if s/he will have to pay a premium penalty?

The premium penalty will be 1% (of the Nation Premium average) for every month of delayed enrollment. A beneficiary may incur late enrollment premium penalties if s/he goes without creditable coverage or Medicare Part D for more than 63 days after initial eligibility (2 months). The 63 day count begins the last day of an individual's initial opportunity to enroll in Medicare Part D (or the effective date of disenrollment from a Medicare drug plan). **Late penalties apply to all Medicare beneficiaries and lasts for the duration of their Medicare Part D enrollment. Penalty payments will be reduced for other individuals who qualify for low-income assistance (extra help)*. If**

an enrollment period is missed, the beneficiary will have to wait for the next available annual election period. The beneficiary will be charged 1% per month of delayed enroll-ment. This 1% per month charge is a cumulative penalty and exists for as long as the individual is enrolled in Medicare Part D.

Example: Using the average national premium in 2006 of $32.20 a month, if a beneficiary delays enrollment for seven months, the monthly premium would be increased to $34.44 ($32.20 x 1% = $0.32 x 7 = $2.24 + $32.20 = $34.44).

NOTE: If a beneficiary is receiving the low income subsidy (extra help)* and his/her income is below 135% of the federal poverty level (FPL) paying for Medicare drug costs and his/her income is below $13,230 a year for singles ($17,424 a year for couples in 2007), s/he will be required to pay only 20% of the premium penalty for five years, after which there will be no penalty imposed. This includes all full benefit duals, SSI recipients and those in a Medicare Savings Plan. All other low income subsidy beneficiaries will be subject to the full late enrollment penalty.

What if an existing Medicare beneficiary wants to enroll after the annual enrollment period ends on December 31?

If an enrollment period is missed, the beneficiary will have to wait for the next available annual election period. **The beneficiary will be charged 1% per month for each month of delayed enrollment.**

Individuals who enroll in a Medicare prescription plan who had a drug plan that provided creditable coverage* will not have to pay a penalty if they enroll within 63 days of losing creditable coverage.

NOTE: Beneficiaries should keep their annual letter of creditable coverage on file in case they need to prove creditable coverage once they decide to enroll in Medicare Part D.

What are some examples of creditable coverage?

CMS regulations list several potential sources of creditable coverage in addition to Medicare Part D plans (also refer to Chapter 3). Each year prior to the Medicare Part D election period, these programs must notify enrollees about whether coverage offered is creditable. Examples of programs include:

- State Pharmacy Assistance Programs (SPAPs)
- Group health plans (including church plans)
- The Department of Veteran Affairs (VA)
- Federal and non-federal employment-related plans
- Tri-Care
- Some Medigap Policies (likely most will not be creditable)
- Individual health insurance
- Coverage through the Indian Health Service
- Coverage through Program of All-Inclusive Care for the Elderly (PACE) organizations

2.9 Re-enrollment in Medicare Part D Plans

Do individuals have to re-enroll annually to their Medicare Part D plan?

No, individuals remain in their selected plans unless one of the following occurs:

- They enroll in another Medicare drug plan
- They voluntarily disenroll from a plan
- They are involuntarily disenrolled by the plan

- They are dual eligible in which case CMS may switch them to another plan if the premium* of the plan they are in goes up and exceeds the low-income benchmark
- The plan is no longer offered in their service area (in which case the individual is eligible for a 'special enrollment period')

TIP: While the above is true, plan formularies and costs change every year. It is therefore highly recommended that individuals review their annual notice of change (ANOC)* document, which is sent by their existing plans, to make sure that all their medication needs will be met and that costs will not rise unacceptably.

2.10 The Disenrollment Process for Medicare Part D Plans

Each Medicare Part D plan will develop its own disenrollment process, which may be a paper and/or electronic disenrollment process. CMS must approve all disenrollment processes. CMS has indicated that if an individual enrolls in a second plan, the first plan will automatically process a disenrollment.

When may a beneficiary disenroll?

Individuals may disenroll, or switch plans during the annual election period which is generally between November 15 and December 31. Exceptions will be made for those who meet certain conditions for the special enrollment period. Dual eligibles may change plans at maximum once a month, anytime during the year.

Can a beneficiary be involuntarily disenrolled from a plan?

Yes, plans must disenroll beneficiaries who are no longer living in the plan's service area. Plans may disenroll beneficiaries who:

- Make material misrepresentations to the plan
- Fail to pay monthly premiums* as long as the plan provides "timely notice" to the beneficiary and can show that it made reasonable efforts to collect payment. The plan can refuse future enrollment to beneficiaries disenrolled for this reason, unless the individual pays all premiums owed.
- Display *disruptive behavior*, or behavior that significantly interferes with a plan's ability to provide services to that individual or to other plan enrollees. Plans may not disenroll beneficiaries if the behavior is related to the use or non-use of medical services. The plan must take "serious" efforts to resolve such problems and inform the individual of his/her right to file a grievance, as well as document the behavior and the plan's effort to correct the situation. **Plans must make special accommodations for beneficiaries suffering from mental or cognitive impairments.** Requests to disenroll an individual for disruptive behavior must be submitted to CMS for approval. CMS will determine whether or not the individual should be allowed to enroll in another plan during a Special Enrollment Period (dual eligibles always have the right to a Special Enrollment Period).

What happens if a plan leaves the service area or pulls out of Medicare Part D?

Plans may voluntarily leave the Medicare Part D program at the end of any contract year, but are required to give enrollees at least 90 days' notice before the end of their contact. Individuals may then enroll in another plan during the annual election period.

2.11 Summary Chart & Timeline for Enrollment/Disenrollment for Medicare Part D Plans

	Medicare-Only	Partial Dual Eligible	Full Dual Eligible
Enrollment	**Actively Enroll** in a plan up to 3 months prior to 65th birth month and as late as 3 months after month of birth to avoid premium* penalties. May also enroll or change standalone PDP plans during the Annual Enrollment Period of November 15 through December 31 each year. Medicare Advantage Plan MA-PD annual enrollment is from January 1 to March 31 each year.	**Actively enroll** in a plan when approved for a Medicare Savings Plan. CMS will auto-enroll individuals who do not sign up within several months of eligibility. May change plans monthly.	**Auto-enrolled** in a plan if individual does not actively enroll in a plan of his/her choice at time of eligibility. Individuals may switch into another plan if s/he does not want to remain enrolled in pre-assigned plan. May change plans monthly.
Disenrollment	May actively disenroll from a plan during the Annual Election Period (AEP).	May actively disenroll from a plan anytime during the year, up to once a month. The new plan becomes effective the first day of the month following disenrollment.	May actively disenroll from a plan anytime during the year, up to once a month. The new plan becomes effective the first day of the month following disenrollment.
Timeline & Expected Mailings	**August:** Social Security mails letters to people who applied and qualified for extra help prior to May to see if they qualify for the next year. **October 1:** Next year's PDP marketing begins. **October :** PDPs send Annual Notice of Change (ANOC) to current enrollees, including the next year's premium, summary of benefits, formulary and language for those being reassigned. **Mid to late October:** Medicare prescription drug plan information will be available at 1-800-Medicare and on www.Medicare.gov. The *Medicare* & *You* handbook containing information about prescription drug plans will be mailed. Individuals should read through all plan materials, compare the plans, and decide best choice for him/her. **November 15**: First day of the annual enrollment period. **January 1:** New plan coverage begins.	**September :** CMS, in coordination with Social Security, mailed loss of help notices to people who no longer automatically qualify for extra help as of January 1, 2007 **October 1:** Next year's PDP marketing begins. **October :** PDPs send Annual Notice of Change (ANOC) to current enrollees, including the next year's premium, summary of benefits, formulary and language for those being reassigned **Mid to late October:** Medicare prescription drug plan information will be available at 1-800-Medicare and on www.Medicare.gov. The *Medicare* & *You* handbook containing information about prescription drug plans will be mailed. **Early November:** Plan reassignment letters will be mailed to LIS beneficiaries on blue paper. **January 1:** New plan coverage begins. Beneficiary may switch into new plan if not content with plan.	**September :** CMS, in coordination with Social Security, mailed loss of help notices to people who no longer automatically qualify for extra help as of January 1, 2007 **October 1:** Next year's PDP marketing begins. **October :** PDPs send Annual Notice of Change (ANOC) to current enrollees, including the next year's premium, summary of benefits, formulary and language for those being reassigned **Mid to late October:** Medicare prescription drug plan information will be available at 1-800-Medicare and on www.Medicare.gov. The *Medicare* & *You* handbook containing information about prescription drug plans will be mailed. **Early November:** Plan reassignment letters will be mailed to LIS beneficiaries on blue paper. **January 1:** New plan coverage begins. Beneficiary may switch into new plan if not content with plan.

2.12 Beneficiary Protections and Medicare Part D Plan Marketing

CMS established marketing guidelines that Medicare Part D plans must follow when marketing their health plans. These guidelines are to protect beneficiaries' rights and privacy and to ensure that individuals are receiving accurate information about their drug coverage. Beneficiaries should expect to receive phone calls and mailings from the plans available in their region. **Medicare Part D drug plans will begin marketing their products on October 1 and may not begin enrolling individuals until November 15.**

Information must be provided by mail unless the beneficiary elects to receive the information electronically. The plans must have regular business hours to answer questions. It is the plan's responsibility to provide enrollees with the following information so that individuals can make informed decisions when choosing a plan:

- Service Area
- Premiums*
- Cost-sharing*
- Formulary*
- Participating pharmacies
- How to get drugs at pharmacies that are out of the service area
- Prior authorization requirements
- Ways the plan manages drug costs
- Grievance and appeals information
- Statistics on grievances and appeals filed with plan
- Notice that plan may terminate its contract with Medicare
- Monthly written explanation of benefits that includes information on the enrollee's status in relation to the annual deductible and TrOOP*

PROVIDER TIP: Securing Confidentiality and Beneficiary Information

Providers should advise beneficiaries that they should not provide anyone with their Medicare number or personal information unless they are sure that the person works for Medicare. **Scam phone calls often happen during this marketing period.** Therefore, beneficiaries should be advised that people who are working with Medicare may not:

- Come to an individual's home uninvited to display or endorse Medicare products but they **are** permitted to call and advertise about their plan
- Enroll an individual into a drug plan or ask for payment over the phone
- Ask for payment over the web (bills are printed for individuals who enroll over the internet)

Having this information can protect a beneficiary against fraud and unwanted solicitations. **Beneficiaries should be aware that:**

- They should not provide personal information to plan marketing representatives because plans are not allowed to request this information when marketing their activities. This includes bank account numbers, Social Security Numbers, credit card numbers, etc.
- Plans are not permitted to call before 8 a.m. or after 9 p.m.
- If an individual wishes to stop repeated phone calls, s/he can tell the plan to **"stop"**. Beneficiaries may sign up online for the "Do Not Call" list to prevent all unsolicited marketing calls. They must go to www.donotcall.gov to register. Part D plans are not permitted to call individuals who are signed up on this list
- Beneficiaries may appoint a representative to act on their behalf; providers may be appointed. See section 2.13.

Protection Against Fraud and Abuse

If a beneficiary believes that someone is misusing his/her personal information, s/he may call

- 1-800-MEDICARE
- the Fraud hotline at the HHS Office of the Inspector General at 1-800-447-8477
- the Federal Trade Commission's ID Theft hotline at 1-877-438-4338 to file a report (TTY users dial 1-866-653-4261)

2.13 Comparing and Choosing a Part D Plan

Filing an Enrollment Form

Individuals may apply for Medicare Part D by filing a paper application with the plan directly or apply online using the Medicare Part D Drug Plan Finder Tool.

Appointing a Representative

- A beneficiary may have an appointed representative (AR)* who acts on his/her behalf when dealing with Medicare on Part D enrollment and related issues. This appointed representative may assist the beneficiary with enrollment/disenrollment, or the exception* process (discussed in Chapter 5). A signed agreement/form should be submitted to the Part D plan annually legally appointing the individual who is acting on behalf of the beneficiary. The CMS form 1619 Appointment of Representative should be used. The form may be found in appendix E or on-line at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf

The following are resources that a beneficiary may use to help them compare and choose a plan in their area.

- Family or trusted friend
- Provider, counselor, benefits specialist, or other professional staff
- Senior centers and local organization working with Medicare
- The State Health Insurance Assistance Program
- 1-800-MEDICARE (TTY users dial 1-877-486-2048)
- www.medicare.gov website
- Local health care organization

The Medicare Part D Drug Plan Finder Tool – a Web-Based Comparison Tool

What to Expect:

The Drug Plan Finder Tool provides information about the various drug plans that will begin offering plans the following year. The Plan Finder Tool is updated in Mid-October to reflect the following year's information. Beneficiaries may enroll on-line for the following year as of November 15 online, but must have internet access to use this online tool. This website will allow beneficiaries to:

- Authenticate their identity and view case-specific information regarding his/her level of benefits including costs, level of coverage, and names and addresses of preferred and non-preferred pharmacies in their area. Individuals may also access plan information anonymously
- Enter and save up to 25 medications and preferred drug stores for future use
- Compare plan performance
- Enroll in a drug plan online (the enrollment process online will be the same as if the individual were to complete a paper application)
- Enroll in a drug plan or switch their plan

What will a beneficiary need to apply using the drug plan finder tool? A beneficiary will need the following information to use the online tool:

- Medicare Number (HICN #)
- Last Name
- Effective date of Part A or B
- Date of Birth
- ZIP Code

What additional information will be available to a beneficiary using this Tool?

The Drug Plan Finder Tool provides the following:

- Side-by-side comparisons of up to three different drug plans offered by sponsors/companies in the individual's region
- Specific cost information for each plan being considered by the individual
- Detailed cost breakdowns that take into account the plan selected and the beneficiaries' level of benefits
- Graphic display of annual cost by month
- Location of preferred and non-preferred pharmacies (updated weekly)
- Plan performance scores on 5 topics: telephone customer service, complaints, appeals, information sharing with pharmacist and drug pricing.
- A search tool that allows an individual to input up to 25 of his/her medications in order to search for prescription drug plan that will provide coverage for their medications
- Identification of the best plan for the individual based on his/her specific medications and benefit level

Beneficiaries may call 1-800-MEDICARE for assistance with the enrollment process or plan change process.

2.14 Special Enrollment Periods

There are situations when a beneficiary may be eligible for a Special Enrollment Period (SEP). This is a period of time when one may enroll in or switch plans outside of the annual enrollment period.

Change in residence
Relocation may result in a beneficiary moving out of their PDP.service area. Beneficiaries have a SEP to enroll in a new plan which covers their new residence.

Dual Eligibles
All Beneficiaries who receive both Medicaid and Medicare have an ongoing SEP. Those who lose Medicaid eligibility have a one-time opportunity to switch plans.

Contract violations
Beneficiaries in a PDP plan that violates its contract have a one-time SEP.

Non-renewals or terminations
Beneficiaries in a plan that choose not to renew the following year or the plan terminates.

Involuntary loss of creditable coverage
Beneficiaries whose creditable coverage terminates or whose coverage is reduced and no longer creditable get a one-time SEP within 63 days of the termination.

Not adequately informed about creditable drug coverage
Beneficiaries who were not adequately notified about the creditable status or loss of the creditable status of their coverage may be granted a one-time SEP on a case-by-case basis. This SEP permits one enrollment or disenrollment.

Enroll in or maintain other creditable coverage
Beneficiaries may disenroll in a Part D plan (PDP and MA-PD) if they enroll or maintain other creditable coverage such as PACE, VA or TRICARE coverage.

Institutionalized individuals
Beneficiaries who move in or out of an institution such as long-term care hospital or a skilled nursing facility.

Medicare entitlement determination is made retroactively.
Beneficiaries whose Medicare determination is made retroactively and who should have been provided the opportunity to enroll in a PDP during their initial enrollment period.

Individuals who enroll in Part B during the Part B General Enrollment Period.
For Beneficiaries who pay for Part A coverage and enroll in Part B during the GEP (January -March)

New LIS Eligibles
Beneficiaries who newly qualify for LIS and are not already enrolled in Part D.

SPAP
Beneficiaries who belong to a SPAP* are allowed one enrollment choice during the calendar year.

Full-benefit dual eligibles with retroactive uncovered months.
Full-benefit duals who enroll in a Part D plan before they are auto-enrolled.

2.15 Special Enrollment Periods for 2007

Received Annual Notice of change (ANOC) after November 15, 2006

Beneficiaries in PDPs who received their ANOC after November 15 had a one time enrollment opportunity from January 1, 2007 though February 14, 2007.

LIS re-determination beneficiaries
Beneficiaries who lost their LIS eligibility for 2007 as a result of the re-determination process had a one time enrollment opportunity from January through March 2007.

All LIS
All beneficiaries with LIS have a one time opportunity to switch plans until the end of 2007.

CHAPTER 3

Coordination of Benefits– How the Medicare Part D Benefit Will Coordinate with Other Health Care Coverage

COORDINATION OF BENEFITS WITH MEDICARE PART D PLAN

- Individuals will have to determine how the Medicare Part D benefit will interact with other health care or drug coverage they may have. They will also have to determine if their current secondary health care coverage is considered creditable coverage*. Examples of other coverage include Medigap plans, EPIC, TRICARE, COBRA*, Veteran's Administration benefits, and employer/union/retiree coverage.

3.1 Medigap Plans

- A Medigap* policy is a health insurance policy sold by private insurance companies to provide coverage for care that is not covered under Original Medicare*. Medigap supplemental insurance policies that offer drug coverage ceased to be offered as of January 1, 2006. **Therefore, Medigap plans H, I, and J will no longer be offered beginning 2006.** A Medicare beneficiary will not be able to have at the same time Medicare drug coverage and drug coverage through their Medigap policy. A beneficiary* who had either Medigap plans H, I, or J before January 1, 2006 may choose to do any the following:

1) Keep the Medigap non-drug coverage and enroll in a Medicare drug benefit
2) Switch to another Medigap plan (one that will offer creditable drug coverage)

Two New Medigap Plans:

As of January 1, 2006, there are two new Medigap plans offered (Medigap Plans K and L). These plans have lower premiums since enrollees will be required to pay part of their deductible and co-insurance for most Medicare-covered services until they spend a certain amount of out-of-pocket each year. The out-of-pocket limit is $4,000 for Plan K and $2,000 for Plan L. After a beneficiary reaches the plan's limit, the plan will cover 100% of costs.

3.2 Elderly Pharmaceutical Insurance Coverage (EPIC) Program and other State Pharmacy Assistance Programs (SPAP)

What is it?

EPIC* is a State Pharmacy Assistance Program (SPAP)* for New York State and currently has over 335,000 senior enrollees. The EPIC program provides prescription drug coverage to New York State residents who are 65 years or older and have an annual income of $35,000 or less if single, and $50,000 or less if married. Seniors who have full Medicaid benefits are NOT eligible for EPIC benefits. EPIC is a cost sharing program and enrollees are either enrolled in the annual fee or deductible program. Copayments are between $3 and $20 and the out-of-pocket limit is 8% of an individual's income. The EPIC program provides a comprehensive formulary of generic and brand name drugs, and almost all New York pharmacies are in network.

How will the EPIC Program integrate with the Medicare Part D?

EPIC plan is considered creditable coverage. However, effective July 1, 2007 EPIC requires that it's members join a Part D plan as a condition for EPIC eligibility (some exceptions will apply). EPIC will serve as a secondary payer for EPIC beneficiaries. This means that EPIC will provide coverage for drugs that are on their formulary, but not covered by the beneficiary's other Part D plan. EPIC will also "wrap-around" Part D coverage, filling the gaps in Medicare Part D coverage for beneficiaries who are enrolled in certain types of plans and meet income guidelines.

EPIC will enroll all members into a basic Part D plan as of July 1, 2007, if they are not already enrolled in a plan. They will do an "intelligent" enrollment by reviewing their utilization records for each member and selecting the best plan. Members are free to select their own plan if they contact EPIC within 30 days of receiving the enrollment letter.

EPIC members who are facilitated into a Part D plan by EPIC will be using an SPAP SEP*. Individuals belonging to an SPAP have one opportunity to switch plans before Nov 15, 2007.

In order to discuss specific beneficiaries, please call the EPIC helpline at 1-800-332-3742 Monday through Friday 8:30am to 5pm.

The following is known about the EPIC program:

- For members in the EPIC Free Plan EPIC will pay Part D premiums up to the annual benchmark amount ($24.45 in 2007). Those who chose a more expensive plan will be billed the difference. Members are still responsible for annual and quarterly EPIC fees, unless they are on LIS.
- Members in the EPIC Deductible Plan will receive an annual credit toward their EPIC deductible of the total annual cost of the benchmark Part D premium rate ($24.45 in 2007), at the time of enrollment.
- If an EPIC member is eligible for the LIS they must apply for LIS in order to remain eligible for EPIC. If a senior is approved for Extra Help the EPIC fees will be waived.
- EPIC will provide assistance in applying for Part D
- EPIC and other SPAPs* will be secondary payer to Medicare Part D.
- EPIC will pay for drugs not paid for by the Part D plan if it is on the EPIC formulary
- EPIC will wrap-around Part D copayments.
- Payments made by EPIC will count toward TrOOP*, unless they are for drugs not on plan's formulary or explicitly excluded from Medicare coverage. (See Section 4.2 for more information about TrOOP)

The following are exceptions to Part D enrollment for EPIC members:

- Members not eligible for or enrolled in Medicare Part A or B.
- Members with other health coverage which would be jeopardized by enrolling in Part D.
- Deductible plan members who did not meet their deductible in the previous or current year.

The following resources are available for more information or to request an EPIC application:

- EPIC Helpline: 1-800-332-3742 (TTY 1-800-290-9138) or email epic@health.state.ny.us.
- New York StateWide Senior Action Council, Inc: 1-518-436-1006 (for information on how the new Medicare drug benefit will work with the EPIC program)
- Patient's Rights Helpline: 1-800-333-4374
- New York City Patient's Rights Help-line: 212-316-9393

3.3 Veterans' Health Administration (VA) Benefits

Individuals who receive Veterans' Administration (VA) benefits are not subject to a higher premium* penalty if they decide to join a Medicare Part D drug plan later than their initial enrollment period*. **VA benefits are considered creditable coverage*.** VA drug coverage usually requires that the individual fill his/her prescription through a VA pharmacy in person or by mail through the VA's Consolidated Mail Outpatient Pharmacy Program (CMOP). If an individual chooses to enroll in a Medicare Part D plan in addition to receiving VA benefits, he/she may also apply for the extra help (LIS). When deciding whether to enroll in a Medicare Part D plan, an individual currently receiving medication from the Veteran's Health Administration should consider the following:

- If the VA facility is near individual's home
- If individual resides in a nursing home
- Where individual wishes to get his/her medical care
- Where individual wants to fill his/her prescriptions

Below are scenarios in which a person may decide to enroll in Medicare Part D plan in addition to receiving VA benefits.

Nursing Home Resident:
A nursing home resident may choose to enroll in a Medicare Part D plan (and extra help) if his/her nursing home does not allow use of VA drug benefits.

VA Facility Is Far:
A beneficiary may decide to enroll in a Medicare Part D plan (and extra help) if the nearest VA facility is too far away for him/her to seek routine medical care. Enrolling in a Medicare Part D plan may be more convenient because it allows for flexibility to get prescription filled from local pharmacies and allows beneficiary to see local physician.

Below is a Chart that may help an individual who is deciding whether to enroll in a Medicare Part D Plan.

Comparing VA Benefits and Medicare Drug Benefits

VA Copayments	**Medicare Copayments**
There is a $8 copay for each 30-day or less supply of medication; it does not vary by drug. VA caps patient medication copayment at $960 annually for some veterans. For certain high priority veterans, including those with low incomes (below VA pension thresholds), the VA waives medication copayments*. The VA has no deductible.	If an individual has low income and receives the full Medicare low income subsidy* (also known as extra help), his/her 2007 Medicare copayment will be $2.15 or $5.35 (generally $2.15 for generics and $5.35 for brand name drugs). The Medicare copayment will be paid for each prescription, whether it is for a 30, 60, or 90 day supply of medication (See Chapter 4 for Low Income Subsidy). If an individual is not low income, his/her cost-sharing for a prescription will vary according to the drug plan. After s/he meets the $265 annual deductible, his/her cost-sharing will be 25% of the drug's price until s/he reaches the initial coverage limit of $2,400. The individual's cost-sharing above the initial coverage limit is 100% until s/he spends $3,850 out of pocket after which the cost-sharing is 5% or $2.15/$5.35 copays.
VA Premiums	**Medicare Premiums**
There is no premium* for VA drug benefits.	Beneficiaries with limited incomes and resources will have all or a portion of their monthly Medicare drug plan premium* paid for them. For those who do not receive extra help from Medicare, the monthly national Medicare premium average for a drug plan will be about $27.35.

Source: Centers for Medicare and Medicaid Services: "Veterans' Administration Benefits, New Medicare Prescription Drug Coverage," June 27, 2005.

For more information about VA Health Care Benefits, contact VA Health Benefits Service Center at 1-877-222-VETS (8387) or visit www.va.gov/healtheligibility

NOTE: If an individual is a dual eligible and has VA benefits, s/he will be auto-enrolled in a Medicare Part D plan that may affect his/her VA benefits' creditable coverage. Such individuals should contact his/her VA benefits coordinator to make a decision as to whether to stay enrolled in the Medicare Part D plan.

3.4 Employer or Union Insurance

It is important that individuals, whether employed or retired, know how their employer or union drug coverage will work with the Medicare Part D plan*. Beneficiaries with employer or union coverage should know the following:

Employer and union insurance companies are required to send enrollees information about current prescription coverage no later than November 15 each year. The information should compare current coverage under the employer or union with the standard Medicare prescription drug coverage so that beneficiaries can make informed decisions about whether to enroll in a Medicare Part D plan. An individual's decision to enroll in a Medicare Part D plan will depend on whether the employer or union determines its current coverage to be **on average, at least as good** (creditable) as the standard Medicare prescription drug coverage. **Beneficiaries should contact his/her employer or union's benefits administrator before making any decisions about prescription coverage or if they do not receive this information before November 15 each year.**

What if the employer or union notifies enrollees that current coverage is, on average, at least as good as the standard Medicare prescription drug plan? The individual can keep the employer or union coverage and won't have to pay a premium* penalty if they decide later to join a Medicare prescription drug plan.

What if employer or union notifies enrollees that current coverage will no longer be at least as good as the standard Medicare prescription drug plan?

- The individual may join a Medicare prescription drug plan in addition to, or in place of, his/her current employer or union coverage. S/he should enroll in a Medicare prescription drug plan up to 60 days following the change in benefits to avoid a premium* penalty.
- The individual may keep the employer or union coverage and decide not to enroll in a Medicare prescription drug plan. If an individual decides to enroll in Medicare Part D s/he will have to enroll during the annual enrollment period of any subsequent year, between the time period of November 15 and December 31. In this case, the individual will be subject to a premium penalty.

PROVIDER TIP: Advising Beneficiaries Who Have Employer or Union Coverage

Providers should advise beneficiaries:

- To contact their employer or unions' benefits administrator before making any decisions about prescription drug coverage (especially if a letter is not received).
- To ask the employer or union to send written notice (if one has not already been provided) indicating whether the plan is creditable or not.
- To keep all documentation received in a safe place for future reference.
- **If they drop their employer or union coverage, they may not be able to get it back. Some employer or union coverage may not allow individuals to drop drug coverage without also dropping the entire employer or union health coverage.**

3.5 COBRA – Consolidated Omnibus Budget Reconciliation Act

The Consolidated Omnibus Budget Reconciliation Act (COBRA) * provides insurance coverage that gives former employees, retirees, spouses, and dependent children temporary continuation of health coverage at group rates. This coverage is only available in certain instances and is usually more expensive than health coverage for active employees. Individuals who receive COBRA coverage should find out if their coverage is considered creditable. Companies should provide a letter to enrollees by fall 2005 to notify them of whether their COBRA coverage is at least as good as Medicare's coverage. The premium* penalty rule will apply for individuals who have COBRA coverage that is not considered creditable and who wait until after their initial enrollment period to enroll.

NOTE: Individuals who have both Medicare and COBRA* coverage became eligible for COBRA once they were already on Medicare. Individuals who had COBRA coverage and then became eligible for Medicare lost their COBRA coverage the day they became eligible for Medicare (unless their Medicare entitlement was because of End-Stage Renal Disease (ESRD)).

3.6 TRICARE

Individuals who have TRICARE for LIFE (TFL) coverage will keep the same benefit and do not have to enroll in a Medicare Part D plan. **TFL is considered creditable coverage, so an individual will not incur a premium penalty if s/he drops TFL and decides to enroll in a Medicare Part D plan at a later date (as long as s/he enrolls within 63 days of dropping or losing TRICARE coverage).** Beneficiaries can contact TRICARE for more information.

NOTE: If an individual is a dual eligible and has TRICARE, s/he will be auto-enrolled in a Medicare Part D plan that may affect his/her TRICARE benefits' creditable coverage. Such individuals should contact TRICARE to make a decision of whether to stay enrolled in the Medicare Part D plan.

3.7 Program of All-Inclusive Care for the Elderly (PACE)

Beneficiaries enrolled in a PACE organization that offers drug coverage should **not** enroll in a Medicare Part D plan* (otherwise they will be disenrolled from all PACE coverage). PACE will provide the Medicare drug coverage and the beneficiary will not have to pay for deductibles, copayments*, coinsurance*, or other out-of-pocket drug costs.

CHAPTER 4

Let's Talk Medicare Part D Costs

LET'S TALK COSTS

4.1 Medicare's Standard Drug Benefit (Without Extra Help)

As of January 1, 2006, Medicare offers a standard drug benefit as described below. If no company is offering a drug plan in a beneficiary's area, s/he may see the standard benefit exactly as specified below offered through the government. Private companies may change some of the specifications, but they must offer a drug benefit at least equal in value to the Medicare's standard benefit. Below is a breakdown of how the standard drug benefit will work.

In 2007 Beneficiaries will have to pay:

- The monthly premium* which averages about $27.35 nationwide
- A deductible of $265
- 25% coinsurance for initial coverage up to $2,400 (total $533.75)
- 100% of covered drug costs between $2,400 and $5,451.25 (this gap in coverage is often referred to as the *donut hole* because beneficiaries are responsible for 100% of drug costs within this cost bracket – total $3,051.25)
- 5% of covered drug costs above $5,451.25 **OR** a copayment of $5.35 for covered brand-name drugs and $2.15 for covered generics, whichever is greater (referred to as catastrophic coverage*)

4.2 Calculating a Beneficiary's True Out-of-Pocket Costs (TrOOP)

The term TrOOP* is used to refer to a client's true-out-of-pocket costs. The beneficiary's Medicare plan will keep track of an individuals' TrOOP cost. There are important facts to know about TrOOP:

What Counts Towards a Beneficiary's TrOOP

Only payments made towards drugs on a plan's formulary count towards the out-of-pocket maximum, unless a client received an exception to the plan's formulary. Examples include:

- Payments made by the beneficiary that are not reimbursed by an insurer
- Payments made by individuals on beneficiary's behalf, as long as they are not reimbursed by an insurer (i.e. family or friends)
- Payments made by manufacturer patient assistance programs, charities, state pharmacy assistance programs (SPAP) *, or Health Savings Accounts.
- Coinsurance* or copayments* that are reduced or waived by pharmacies for needy individuals on a case-by-case basis, or for individuals who routinely require extra help

<u>What Does NOT Count Towards a Beneficiary's TrOOP</u>*

Below are examples of drug costs that will not count toward the out-of-pocket maximum:

- Drugs purchased outside the U.S.
- Drugs purchased from an out-of-network pharmacy
- Drugs explicitly excluded from Medicare drug coverage (i.e. over-the-counter drugs) even if the plan has coverage that covers them
- Drugs not on the plan's formulary* (unless beneficiary received an exception to the plan's formulary
- SPAP* payments for excluded Part D drugs or non-formulary drugs **do not** count toward the limit
- Any payments made by the following:

- Government programs such as TRICARE, VA, Indian Health Services, Black Lung, Medicaid Pharmacy Plus Waiver programs
- Group health plans (such as retiree coverage provided by a former employer or union)
- Workers' Compensation.
- AIDS Drug Assistance Programs (ADAPs)
- Automobile, no-fault, or liability insurance
- Any other third-party payment arrangement

NOTE: At the end of every plan's year, the benefit begins over again with a new premium, deductible, initial coverage limit, and out-of-pocket threshold to adjust for drug inflation in the Medicare program.

Who Will Keep Track of TrOOP? TrOOP tracking will go on automatically, mostly behind the scenes. CMS* requires beneficiaries to report whether they have coverage through a third party (such as a supplemental plan that wraps around the Medicare plan) and will also work with employers and supplemental insurance plans to obtain this information. This will enable CMS, Medicare plans, and third-party payers to coordinate claims. Beneficiaries will see a bottom-line calculation (the beneficiary deductible or copay if any) that remains **after** all the payers have paid their parts. Beneficiaries will receive a statement from their Medicare plan at least monthly showing how much they have spent for the year and where they stand in regard to the TrOOP limit. Beneficiaries will be provided information to keep track of their spending toward the catastrophic coverage. **It is recommended that consumers keep copies of receipts just in case!**

The chart below may assist a beneficiary in determining his/her projective drug costs, or true-out-of-pocket cost (TrOOP), based on annual drug costs for 2007.

Beneficiary's Annual Drug Costs	Beneficiary Pays	Beneficiary's Cumulative TrOOP	Medicare Pays
Up to $265 (annual deductible)	**Monthly premium + $265**	**$265 + monthly premium**	**Nothing**
Between $266 and $2,400 (25% of drug costs)	**Monthly premium + $533.75**	**$98.75** ($265+$533.75) **+ Monthly premium**	**$1,601.25 - 75%** of drug costs within this spending bracket
Between $2,400 and $5,451.25 (donut hole - 100% of costs)	**Monthly premium +$3,051.25**	**$3850** ($265+$533.75+$3,8051.25) **+Monthly premium**	**Nothing**
Over $5,451.25 (catastrophic coverage)	**Monthly premium + $2.15 for generics and $5.35 for brand-name drugs, OR 5% coinsurance for any drug** (whichever cost is greater)	**$3,850 + $2.15 for generics and $5.35 for brand-name drugs, OR 5% coinsurance for any drug** (whichever cost is greater) **+Monthly Premium**	**95%** of drug costs for remainder of calendar year

CHAPTER 5

THE LOW INCOME SUBSIDY
(EXTRA HELP WITH MEDICARE PART D COSTS)

THE LOW INCOME SUBSIDY

5.1 The Low Income Subsidy (LIS) for Medicare Part D

With the implementation of the MMA of 2003, the Federal government makes Low Income Subsidies (LIS)* available to assist eligible individuals with prescription drug costs if they enroll in a Medicare Part D plan. The subsidy provides "extra help" with the premium*, deductible and copayments*. Co-payments are adjusted annually.

5.2 Who is eligible for LIS?

Eligible individuals are those whose income and resources are considered or *deemed* "limited". Medicare recipients who are eligible for more limited drug assistance through programs such as Medicaid and Medicare Savings Programs will be considered for low-income assistance with the Medicare drug benefit. Medicare beneficiaries will be given either **full or partial** assistance depending on their income and/or asset bracket. Income will be compared to the federal poverty level, or FPL (See Appendix A) and based on the applicant's family size to determine eligibility. The premium* and cost-sharing* depend on an individual's institutional status, Medicaid* status, and income and assets. The rules governing the Low Income Subsidy for Medicare Part D and cost-sharing are outlined in the chart below.

5.3 Summary Chart of Cost-sharing with Low-Income Subsidy

General Policy	**Individuals with income between 135% and 150% FPL[1] (PARTIAL HELP)**	**Individuals with income under 135% FPL[2] (FULL HELP)**	**Individuals who are Dual Eligible (FULL HELP)**
Monthly Premium	Sliding scale	None	None
Annual Deductible ($265 person pays in full)	$53	None	None
Copayment (Between $266 and $5,451.25 drug cost range)	15% for drug costs between $53 and $5,451.25	**No Copays* for the institutionalized.** $2.15-$5.35 copays for drug costs up to $5,451.25	**Dual Eligibles with income under 100% FPL:** $1-$3.10 copays for drug costs up to $5,451.25 **Dual eligibles with income above 100% FPL:** $2.15-$5.35 copays for drug costs up to $5,451.25 **No Copays* for the institutionalized.**
Catastrophic Coverage (Threshold, Drug Costs Over $5,451.25)	$2.15-$5.35 Copays	100% Covered	100% Covered

[1] Assets are below $10,210 for individuals and below $20,410 for couples. [2] Assets are below $6,120 for individuals and below $9,190 for couples. Adapted from National Mental Health Association Legislative Alert: "Government Issues Final Rules for Medicare Prescription Drug Benefit," Feb. 16, 2005.

What does the previous chart mean?

- **Full extra help** for individuals with very little income or savings will mean no deductible, no premiums, and continuous coverage through the catastrophic coverage stage.
  - For dual eligibles* with incomes above 100% of the federal poverty level (FPL), there will be copays of $2.15 for generics/ preferred drugs and $5.35 for other drugs up to the out-of-pocket limit, after which there is no copay. For dual eligibles with incomes below 100%, the out-of-pocket copayment is reduced to $1 and $3.10 up to the $3,850 out-of-pocket limit.
  - For those dual eligible beneficiaries who are institutionalized, there will be no copays.
- **Partial extra help** will go to individuals with limited savings and incomes below 150% of the federal poverty level. These beneficiaries will have a sliding scale monthly premium, an annual $53 deductible, continuous coverage up to the out-of-pocket limit of $3,850, coinsurance of 15% up to the out-of-pocket limit, and co-payments of $2.15 and $5.35 beyond the out-of-pocket limit.

NOTE: For dual eligible individuals, the extra help will only cover the premium* of the lowest-cost plan in his/her region. If a dual eligible chooses a higher cost plan, s/he will have to pay the difference between the premium cost covered by the extra help and the actual premium costs of the plan chosen.

5.4 How do I know if my client is eligible for LIS under Medicare Part D?

Some individuals are deemed *automatically* eligible and **will not need to file an application**. This group is referred to as **deemed eligibles*,** and includes individuals who receive:

- Medicare and full Medicaid* benefits (dual eligible*)
- Supplemental Security Income* (SSI) benefit, including those who receive a cash benefit but not Medicaid
- Medicare Savings Program* participants

NOTE: CMS awards deemed eligible subsidies based on state and SSA information and will notify that individual via mail that s/he will not need to file an application.

5.5 What are the Medicare Savings Programs (MSP)?

Medicare Savings Programs are low-income assistance programs that assist Medicare recipients who do not qualify for Medicaid. MSPs pay for Medicare out-of-pocket costs, such as the Part B premium and coinsurance for doctor's visits. Beneficiaries can apply at their local Department of Social Services. Beneficiaries can call their State Health Insurance Assistance Program (SHIP) to find out if they are eligible for MSP (the New York SHIP is the HIICAP at 800-701-0501). Eligibility is based on a beneficiary's income and assets. There are currently three programs available and they are based on different financial eligibility levels that are changed annually:

- **QMB (Qualified Medicare Beneficiary)*:** Pays for Medicare premiums*, deductibles, and coinsurance*. Has income and asset/resource requirement.

- **SLMB (Specified Low-Income Medicare Beneficiary)*:** Pays for Medicare's Part B Premium*. Has income and asset/resource requirement.
- **QI-1 Program (Qualifying Individual Program)*:** Pays for Medi-

care's Part B Premium*. **Has income requirement but no asset/resource requirement.**

PROVIDER TIP: How a beneficiary can become eligible for LIS through MSP.

Potential MSP individuals are hard to identify. since typically there are no records within SSA of a person's assets. Best practice is for an individual struggling to meet Medicare Part D costs and not eligible for LIS to apply for an MSP. An MSP participant is **automatically** eligible for the LIS.

Example:

Clare is 45 years old, receives SSDI of $756 a month and Medicare, her only income. She has been having difficulty paying her Medicare Part D premium and copayments. She requested help and was screened for LIS. Although her income was low enough to qualify, her assets were slightly above the limit. Clare was advised to apply for an MSP*. In New York State the QI1* MSP program has no asset limit.

The application was approved and Clare became eligible for full LIS*, even with her assets. Now her co-payments will be $2.15 (generic) or $5.35 (brand) as long as her medications are covered by the plan. Her deductible and premiums are also eliminated.

More information can be found at http://www.medicarerights.org/payformedicareframeset.html.

5.6 How does a Medicare beneficiary apply for LIS?

The LIS* is administered by the Social Security Administration (SSA). Beneficiaries may apply for the "extra help" through SSA (using the SSA-1020 form) or their local State Medicaid office (using the State application). **If an individual applies through their State Medicaid Office, the State is also required to screen applicants for eligibility in one of the Medicare Savings Programs. If the individual qualifies, s/he will automatically be enrolled in the LIS program.** Should an individual refuse enrollment in an MSP, the state must still process the LIS application. The law requires both SSA and States to accept and process applications for LIS, and States to screen subsidy applicants who apply at the State Medicaid office for eligibility for the MSPs.

NOTE: As of this writing, New York State is not processing LIS applications and is referring applicants to SSA. The SSA's **SSA-1020** application is a scannable document so **photocopies of the document are not permitted.** CMS* has outlined possible application sites and the agency responsible to process an applicant's LIS application (see below). **SSA is currently processing LIS applications for New York State.**

Responsibility for LIS Applications

Application Site	Agency Responsible for the Case
SSA	SSA
State, using SSA application	SSA
State, using State application	State
Deemed Eligible-No Application	CMS (based on State data)

Source: The Centers for Medicare and Medicaid Services: "The CMS Guidance to States on Low-Income Subsidy," May 25, 2005.

The Screening Process - SSA and States' Responsibility: States are required to use Federal rules for subsidy determination and State rules for MSP* determination. States are being encouraged to conduct LIS and MSP screenings simultaneously for those who apply. States **are required to screen** LIS applicants for MSP eligibility, and offer to enroll applicants in an MSP.

Voluntary Enrollment: Applicants found eligible for an MSP* must be offered enrollment into the MSP, but they are allowed to decline if they choose. There are two things that can happen:

1) **Applicant Declines MSP Enrollment:** If the applicant used the State application and declines, the State must continue screening the applicant for LIS.
2) **Applicant Accepts MSP Enrollment:** Beneficiary becomes **deemed eligible** for the LIS. If the beneficiary is eligible for QMB*, the State must continue processing the LIS application to determine eligibility for LIS for months prior to QMB eligibility. If the beneficiary is eligible for SLMB* or QI-1*, the State can close its LIS application.

Enrollment is affected by certain rules governing LIS and Medicare Savings Program*:

- LIS eligibility starts as of the first day of the month of application
- QMB eligibility is effective the first day of the month following the month in which eligibility is determined
- SLMB/QI eligibility begins up to three months prior to the month of application

Does a beneficiary have to apply for LIS in-person?

No, the LIS application can be filed by calling SSA, by mail, or electronically:

1) Original applications can be mailed to the Social Security Administration Wilkes-Barre Data Operations Center
2) Phone calls can be made to the SSA at 1-800-772-1213 (TTY1-800-325-0778)
3) Or an electronic version of the LIS is made available on the internet through the Social Security Administration at https://s044a90.ssa.gov/apps6a/i1020/main.html. Applicants can have someone assist them when filling out the application.

People who can help beneficiaries fill out this form include:

1) Friends, family members or counselors.
2) The Social Security Administration (800-772-1213) or www.ssa.gov.
3) The State Health Insurance Assistance Program (SHIP). The NY SHIP is the Health Insurance Information, Counseling and Assistance Program (HIICAP) office 800-701-0501

5.7 What documentation does the LIS application require when applying through SSA?

Applicants **do not have to submit financial documents** showing their income and assets. An applicant should be advised that their income and assets will be safe and that filling out the questionnaire can potentially save them a lot of money. They should, however, compile their financial records so that they can answer questions on the application to the best of their abilities. The SSA will match financial information with its own records (those from the Internal Revenue Service (IRS) and other government files). Examples of statements include:

- employee payroll
- bank statements
- tax returns
- stocks
- bonds
- life insurance policy.
- pension letters

NOTE: The SSA may request additional documentation to resolve any discrepancies. If a beneficiary uses a State application, the State may require additional documentation verifying financial status since they will not have access to the same data as SSA.

How does a beneficiary determine his/her family size? Family size includes the following:

- applicant
- spouse, **if residing** with applicant
- individuals related to the applicant or spouse **residing in** the applicant's household
- individuals who depend on the applicant or spouse for at least half of their financial support

How does a beneficiary determine his/her income? Income is what an applicant or spouse receive in cash or in-kind that can be used for food or shelter. An applicant's (or his/her residing spouse's) **gross income** will be considered. The following can be considered when evaluating income:

- Earned income
- Wages
- In-Kind Earned Income
- Honororia

NOTE: Dependent family members' gross income is not counted, but they are included in family size calculation.

How does a beneficiary determine his/her resources (assets)? An applicant's and/or his/her spouse's assets will be counted to determine if the applicant is eligible for the Part D LIS. Resources that are counted include:

- Liquid resources that can be converted to cash within twenty days (i.e. savings or checking accounts)
- Property other than the applicant's primary residence, and not attached to the primary residence
- A certain amount of money can be set aside for burial resources and not counted as assets. An individual can have a maximum of $1500, and a couple may have up to $3000 set aside for burial expenses

NOTE: Dependent family members who are Medicare beneficiaries themselves must file their own subsidy application or be deemed eligible individually.

5.8 RE-DETERMINATION and RE-DEEMING

Re-determination and re-deeming refer to the process of reviewing whether beneficiaries who have been receiving the LIS are still eligible to receive the subsidy in the following year.

The **re-determination** process, administered by the Social Security Administration (SSA), reviews beneficiaries who originally applied and qualified for the LIS prior to May 2006. In late August/early September SSA sent letters to LIS beneficiaries. The letters included person-specific information including income, assets and household size. The beneficiary was asked to report back any changes to that information.

If there was no change, the beneficiary did not have to do anything. SSA would then survey other federal agencies to confirm whether the finances and household size had changed or not. If no changes were discovered then the individual would be determined eligible for the subsidy for all of 2007. (No confirmations are sent to the beneficiary.)

If the recipient responds, SSA mails back a re-determination form which the beneficiary must fill out and return within 30 days. If the form is not returned within the 30 days the individual's subsidy will be terminated effective January 1, 2007. Once the form is returned, SSA will reevaluate the individual's eligibility for the LIS. Depending on the extent of change, SSA might approve the same level of subsidy, increase the level, decrease the subsidy or terminate it altogether. In any case the recipient would receive something in writing. The beneficiary has the right to appeal the decision and will continue to receive the subsidy during the appeal process if filed within 10 days of receiving the decision.

Those who qualified for the LIS after May 2006 will be reviewed for continued eligibility in August of 2007.

The **re-deeming** process is administered by the Centers for Medicare and Medicaid Management (CMS) and looks at beneficiaries who were originally **deemed** eligible for the subsidy. Beneficiaries are deemed eligible because they receive Medicaid, SSI, or are enrolled in a Medicare Savings Program* (MSP). Deeming is an automatic process; there are no forms to be filled out.

CMS looks at the State Medicaid eligibility files and SSI files submitted to CMS on a monthly basis. For the 2007 re-deeming process they looked at Medicaid files beginning with July 2006 and SSI files beginning with August 2006. If a beneficiary's name appears on these and subsequent files they are re-deemed and will automatically receive the subsidy for the entire 2007 calendar year.

CMS will send letters to those who will not be redeemed because their names did not appear on the July Medicaid and August SSI files. (CMS estimated that for 2007 over 45,000 people will lose their deemed status in the five boroughs of New York City alone.) If one of these individuals appears on the files in subsequent months they will be deemed eligible for 2007. Beneficiaries who lose their deemed status may apply for the LIS using the SSA application.

In early October, CMS will send notices to those whose individuals whose cost sharing level for 2007 will be altered. Individuals whose cost sharing remains the same will not receive a notice.

5.9 LIS NOTICES, APPEALS, and FAIR HEARINGS

LIS Notices: There are four types of notices that a beneficiary may receive after s/he files an application for LIS. Notices must meet adequate and timely notice requirements. Forms include the approval, denial, termination, and/or change notice. The following must be provided on each type of form:

Approval	Denial	Termination	Change
• application date is regulatory basis for the decision • description of how the subsidy was calculated • premium percentage • effective date of eligibility • who made the decision and how to contact them • appeal rights and procedures • **reminder to apply for a prescription drug plan**	• application date • reason for denial • regulatory basis for decision • description of how denial was calculated • who made the decision and how to contact them • appeal rights and procedures • **depending on denial reason, a reminder to apply for a prescription drug plan**	• reason for termination • regulatory basis for termination • description of how termination was calculated • effective date of termination • who made the decision and how to contact them • appeal rights and procedures • **depending on the termination reason, a reminder that they will still use their prescription drug plan**	• reason for change in subsidy level • regulatory basis for change • new Premium percentage • description of how the change was calculated • effective date of change • who made decision and how to contact them • appeal rights and procedures • **reminder that they will still use their prescription drug plan but that their costs within the plan have changed.**

Source: The Centers for Medicare and Medicaid Services: "The CMS Guidance to States on Low-Income Subsidy," May 25, 2005.

Appeals and Fair Hearings: An LIS applicant can appeal his/her LIS determination. SSA will be responsible for appealing decisions made on SSA applications, and the State will be responsible for appealing of decisions made on Medicaid* State applications.

Initial eligibility determinations are effective the first day of the month of application and remain effective for no more than a year. Redeterminations* will be made annually towards the end of the calendar year. See Section 5.8 for more information.

The subsidy is retroactive, meaning it becomes effective at the beginning of the month of application.

Example 1: Mr. Simons files a subsidy application in October 2005. If he qualifies, his subsidy will begin January 1, 2006.

Example 2: Ms. Jinkins files a subsidy in April 2006. If she qualifies, her subsidy will begin April 1, 2006.

Interim Changes: States can require beneficiaries receiving a subsidy to report changes in their financial status within 10 working days of the change because changes in status can change the level of subsidy or affect eligibility for LIS.

If a beneficiary becomes eligible for Medicaid*, QMB*, SLMB*, or QI-1* after being found eligible for the subsidy, they become part of the deemed population. CMS will notify a beneficiary if s/he becomes deemed. CMS* will also redetermine subsidy eligibility for this population on a yearly basis. See Section 5.8 for more information about the re-deeming process.

Following is a Chart describing what occurs when an applicant files an LIS application with both SSA and/or his/her State Medicaid* office.

5.9 Precedence of LIS Decisions

Scenario	SSA	State	Outcome
1	Denial	Approval	Approval is official determination. Beneficiary may appeal either decision.
2	Approval	Denial	Approval is official determination. Beneficiary may appeal either decision.
3	Denial	Denial	The beneficiary may appeal either decision. If both are appealed and overturned, see scenarios 4 and 5.
4	Approval (Different Month)	Approval (Different Month)	If the subsidy effective dates are in different months, the decision with the earlier effective date is the official determination. The second decision is void.
5	Approval (Same Month)	Approval (Same Month)	If the subsidy effective dates are the same the SSA decision is the official determination. The beneficiary may appeal either decision.

Source: The Centers for Medicare and Medicaid Services: "The CMS Guidance to States on Low-Income Subsidy," May 25, 2005.

5.10 Medicaid/Medicaid Spend down* and LIS – How Does It Work?

Medicaid eligibility that is based on income will not be affected by Medicare Part D extra help. However, Medicaid eligibility based on the Medicaid spend down program* (where income is adjusted for medical expenses) may be affected, especially if a beneficiary's medical spending is no longer high enough to receive Medicaid benefits because the extra help is assisting with drug expenses. **Beneficiaries receiving Medicaid benefits in the late summer and winter will automatically qualify for Medicare Part D extra help for the following calendar year even if their drug spending is no longer high enough to spend down to the Medicaid eligibility that year.** Individuals who "spend down" to Medicaid because of high prescription drug costs will notice that Medicare will cover much of their drug spending and they will no longer spend down as quickly to become Medicaid-eligible. The spend down program allows individuals who have incomes higher than Medicaid maximum income level to qualify for Medicaid benefits by spending down, or deducting medical expense from their income. For instance, medical expenses can include eyeglasses and prescription drugs.

Someone with Medicare prescription drug coverage who qualifies for extra help will be left with more available income and have less need for Medicaid since LIS will help pay for out-of-pocket costs. Individuals will not lose the ability to rely on Medicaid in months that medical expenses may be higher and will still receive Medicaid benefits during those months.

NOTE: Medicare does not anticipate that LIS eligibility will affect Medicaid coverage for people in nursing homes since they will have nursing home expenses that will be deducted from income as high medical costs each month.

In order to automatically receive the low income subsidy in subsequent years, the beneficiary must meet his/her spend down in the fall of each year to qualify for the following calendar year. If s/he no longer meets his/her spend down, s/he will have to apply in order to continue to qualify for the subsidy.

PROVIDER TIP: LIS and Medicaid/ Medicaid Spend Down*

Providers should advise beneficiaries of the following:

- If an applicant qualifies for the LIS, s/he will not lose Medicaid coverage.
- If an applicant is spending Medicaid spend down in the same month s/he applies for a subsidy, the State will continue with LIS determination but will use gross income prior to spend down.
- If an applicant meets Medicaid eligibility during the month of the subsidy application, s/he is a deemed eligible and will not have to file an LIS application.
- If a beneficiary meets Medicaid spend-down requirements, **s/he will be "deemed eligible" and will have extra help or LIS for the full calendar year even if s/he does not qualify for Medicaid (i.e. doesn't reach Medicaid spend-down amount) in later months** because s/he has lower medical expenses.

Example: Qualifying for Extra Help Through the Medicaid Spend Down Program

Carol has Medicare and received $900 in Social Security. Her income is above the maximum income level to qualify for Medicaid in her state. Her state's Medicaid income limit is $600 a month, which means she must spend at least $300 a month in medical expenses to spend down to the state's limit. Carol pays $200 dollars a month in out-of-pocket costs for nine medications, and $150 a month in doctors visits for a total of $350 in medical experiences per month. After she spends $300 on medical costs, she qualifies for Medicaid, which will pay for the additional $50 of her medical expenses. She is left with $600 for other expenses. **Once Carol receives Medicaid, she automatically qualifies for LIS and is deemed eligible for the full 2006 calendar year, even if she does not meet Medicaid spend down requirements in later months because of lower medical costs.**

Carol begins receiving extra help through LIS, and pays no premium*, no deductible*, and pays small copayments* of $1 for each of her nine generic prescriptions for a total of $9. When added to her doctor visit expense this totals $159 in medical expenses. Her medical bill no longer qualifies her for Medicaid since she does not exceed the $300 limit under spend down. The extra help increases Carol's available income to $600 for other expenses.

Carol will be "deemed eligible" for LIS for the entire 2006 calendar year once she meets her Medicaid spend down requirement for a month. Furthermore, she will not lose her ability to rely on Medicaid in months when she has higher medical bills. Below is a chart outlining Carol's medical expenses and how this affects her Medicaid eligibility and LIS status.

Carol will have to meet her spend down requirements each following year to be eligible for LIS.

Carol's Medical Expenses

	TODAY	WITH LIS PAYING FOR PRESCRIPTION DRUG COSTS
	Months with High Medical Expenses	Months with Low Medical Expenses
Monthly Income	$900	$900
Medicaid spend down requirement = $300 in medical bills to reach $600 in monthly income		
Carol's Drug Spending	$200	$9
Other Medical Costs	$150	$150
Carol's Total Medical Costs	$350	$159
Meets spend down requirement and qualifies for Medicaid?	Yes	No
Carol's Out-of-Pocket Spending for Medical Care	$300 (Medicaid pays the additional $50)	$159
Carol's cash available for other expenses	$600	$741

Adapted from the Centers for Medicare and Medicaid Services: "Information Partners Can Use on: Medicaid Spend Down, New Medicare Prescription Drug Coverage," May 25, 2005.

5.11 LIS and Other Federal Means-Tested Programs

Food Stamps and LIS

Beneficiaries who receive food stamps and the Medicare Part D extra help (LIS) may see their food stamp benefits decrease as they spend less on drugs. This is because an individual receiving extra help will have more cash to spend on food and other household costs that used to be spent on prescription drugs. **Therefore, individuals with high drug spending will see their food stamps benefit lowered due to the lower drug spending if they receive extra help for prescription drug costs.**

Food stamps offset income with medical expenses over $35 a month, but according to CMS, the reduction in food stamps will be more than offset by the value of the extra help received for Medicare prescription drug costs. Individuals who receive the $10 minimum food stamp benefit may lose their food stamp benefit because their income will no longer be enough to qualify for food stamps as their drug spending goes down. For every $1 increase in adjusted income (due to drug spending), there will be a $0.30 decline in food stamp benefits.

HUD – Housing Assistance and LIS

Similar to the food stamp benefit, HUD housing assistance may be reduced for individuals who receive extra help paying for Medicare Part D drugs because of lower drug spending. The portion of rent may be increased as drug spending goes down. **However, any housing assistance reduction will be offset by the value of the extra help received.** This is because the amount of extra help is greater than the decrease in rental help. For every $1 increase in adjusted income (due to lower drug costs), there will be a $0.30 decline in HUD assistance. Individuals may notice their part of the rent increases and housing assistance decreases when they no longer have high drug spending. Individuals will **not** lose their housing assistance eligibility. A beneficiary* is not worse off because he receives extra help paying for prescription assistance. Beneficiaries should discuss how their rent will be affected with the agency that handles their rent determination once they learn about the amount of extra help they will receive. This information will help with recertification information.

Example: How Will Sam's Rent and Food Stamps Be Affected If He Qualifies for Extra Help (LIS)?

Sam gets Medicare's extra help: his monthly prescription drug bill is $200. He has Medicare, lives alone, and received $798 per month in Social Security benefits. He doesn't receive Medicaid. Sam receives food stamps and HUD housing assistance. He usually pays $250 a month for medical expenses, $200 of which is for three prescriptions and $50 for other medical expenses. His HUD subsidized rent is $162 a month.

Under the Medicare prescription drug plan, Sam will pay no monthly drug plan premium*, no deductible*, and his copayments* for his three prescription drugs will total $9 ($3 x 3 drugs). His monthly medical spending is now $59 ($50 for other medical expenses + $9 for drug copays) for a monthly savings of $191. Because Sam's out-of-pocket medical costs have decreased, his food stamps will be $5 less than they were when he paid for all of his medications out-of-pocket and his HUD subsidized rent will increase by $57 to $219 a month. Sam still has $129 more cash in his pocket each month despite the decrease in food stamps and increase in subsidized rent.

Sam's Expenses

	Without Extra Help	With Extra Help	
Income	$798	$798	
Medical Spending	$250	$59	(medical spending declines by $191)
Food Stamps	$15	$10*	(food stamps decrease by $5)
Rent Payment**	$162	$219	(rent increases by $57)
Net Impact	$401	$530	(bottom line: $129 more cash in Sam's pocket)

* $10 is the minimum monthly food stamp benefit for eligible people living alone.
** Rent payment reflects rent as 30% of adjusted income.

Source: Centers for Medicare and Medicaid Services: "Food Stamps, New Medicare Prescription Drug Coverage," May 20, 2005.

Supplemental Security Income (SSI) and LIS

Supplemental Security Income (SSI)* provides monthly income to individuals who are 65 or older, blind or disabled, and have limited financial resources or income. SSI benefits are **not** based on adjusted income, and are based on income without regard to medical expenses. Some individuals who are disabled and going back to work may be affected by the new Medicare Part D benefit if their current prescription drug out-of-pocket spending allows them to meet the SSI program's work requirement. In most cases, an individual's out-of-pocket drug expenses can be used to reduce an individual's countable income, thereby increasing their SSI. Therefore, if a beneficiary's out-of-pocket drug expenses are reduced because of extra help (LIS) eligibility, the individual's income exclusion will also be reduced. Individuals should call Social Security at 1-890-772-1213 or visit www.ssa.gov for more information regarding how LIS will affect their SSI.

Low Income Home Energy Assistance Program (LIHEAP) and LIS

The home energy assistance program does not adjust for medical expenses. As a result, an individual receiving extra help for Medicare Part D will notice that the extra help will not affect his/her LIHEAP benefits.

CHAPTER 6

Medicare Drug Coverage, Formularies, and Pharmacies

MEDICARE DRUG COVERAGE

6.1 What Is and Is Not Considered a Medicare Part D Drug

A Medicare Part D drug is a medication covered by Medicare through the new drug benefit. There are approximately 209 therapeutic categories of drugs covered under Medicare Part D. Each plan may limit the number of drugs they cover (See Section 6.2). **Medicare Part D drugs include:**

- Vaccines
- FDA approved prescription drugs that must be covered by all states that provide Medicaid drug coverage and that are used for medically accepted indications
- Insulin supplies
- Smoking cessation drugs (these drugs are currently an optional drug under Medicaid)

NOTE: CMS* provides comparative information on benefits and plan formularies*, quality and performance (after two or three years), premiums*, cost-sharing*, and results of consumer satisfaction surveys. Medicare has a Medicare Part D Drug Plan Finder Tool that shows a beneficiary what s/he can expect to pay at the pharmacy for a specific drug. Go to www.medicare.gov and select Compare Medication Prescription Drug Plans.

Medicare Part D excludes non-Medicare Prescription Drugs*:

- Drugs that are optional under Medicaid (excluding smoking cessation agents).
- Drugs covered under Medicare Parts A* or Part B* (these include drugs that are administered through hospitals or under a physician's supervision, doctor's office, dialysis center, or other health care setting. Excludes most drugs that are administered by patients themselves). Medicare Part A or B will continue to cover these drugs, not Part D.
- Drugs that are excluded from Medicare coverage by law such as drugs used for anorexia, weight loss or weight gain, cosmetic purposes, fertility, hair growth, relief from cold symptoms, prescription vitamins and minerals, over-the counter drugs, and some anti-anxiety and anti-seizure drugs.

NOTE: Some plans may offer additional coverage that includes some of the excluded drugs. Payments for these drugs, however, will not count towards a beneficiary's TrOOP* because they are considered excluded drugs from the Medicare benefit.

For 2007, CMS will continue to require that **"all or substantially all"** drugs in the following categories be covered by plans under the Medicare Modernization Act (MMA) *:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Anticancer
- Immunosuppressants
- Antiretrovirals including treatments for HIV/AIDS

These include generic and older branded drugs available as of Jan. 1, 2006. **Drugs made available after this date are subject to the Pharmacy and Therapeutic committee review process.**

How does CMS* explain its focus on the inclusion of these six drug categories in the formulary?

- To avoid formulary discrimination of clinically needed medications
- To provide uninterrupted access to drugs for seniors and people with disabilities
- To avoid negative outcomes that may result from change in treatment
- To provide access to highly demanded drugs that are already included on state Medicaid formularies

CMS is imposing the following rules regarding management techniques:

- Plans should not require prior authorization or step therapy for patients already stabilized on any drugs within the six categories
- <u>Plans may use prior authorization or step therapy for patients beginning treatment for any of these drugs except HIV/AIDS drugs</u>

Below are **exceptions*** to the "all or substantially all" guideline. **This is not a list of exclusions from Part D coverage. In each case, a prescription drug plan's Pharmacy and Therapeutics committee should make a determination about the appropriate treatment of these drugs for their population.**

- Iressa is not required on formularies*
- Fuzeon must be listed on formularies but may have prior authorization for new users
- All formularies must include either Escitalopram or Citalopram
- Fosphenytoin may be left off formularies
- CMS does not require that multi-source brands of the identical molecular structure be included, that extended release products be included, or that all dosages be included

6.2 Drug Plan Formularies and Prescription Drug Plans

Drugs plans do not have to cover all Part D drugs. Medicare will provide plans with a list of drugs that the plans must cover (plans must cover at least what the Medicare stand-alone plan would cover). Plans may cover additional drugs that Medicare excludes as an extra benefit.

How will a beneficiary know what drugs his/her drug plan covers?

Each PDP* has its own list of covered drugs, or a *formulary**. A plan's formulary must cover at least two drugs from each therapeutic class. A therapeutic class is a group of drugs that is similarly classified based on the disease treated or on the way they affect the body. Beneficiaries can call their PDP, visit their plan's website, or visit www.medicare.gov to find out which plans cover their needed medications within their area. The Medicare website will allow a beneficiary to search for a plan that covers his/her drug, as well as network pharmacies if the beneficiary types in his/her ZIP code.

PROVIDER TIP: Compiling a list of your patient's medications

Providers assist a Medicare beneficiary* by obtaining a list of medications that s/he currently takes in order to find out if the individual's Medicare Part D plan will cover his/her drugs. Providers can advise a beneficiary to either:

1) Request a copy of his/her medications and dosages at the pharmacy (the pharmacy is required to give such information), or
2) Ask his/her physician for a list of current medications and dosages

Formulary Requirements:

- Plans must provide "adequate" access to drugs used most frequently by Medicare beneficiaries
- Plan formularies cannot discriminate against a group of beneficiaries (i.e. by income, health status, ethnicity, or disease)
- Each plan must cover **at least** two different drugs in every therapeutic class or category (if there are more than two FDA approved drugs available in that class or category)

How will plans decide which drugs to cover?

All plans that have formularies have a Pharmacy and Therapeutics (P&T) Committee that review and choose which drugs will be on a plan's formulary. The P&T committee will consist of practicing physicians or pharmacists.

6.3 How does a beneficiary know how much s/he will pay for drugs?

Some Medicare private drug plans may choose to organize their formularies to contain multiple cost-sharing tiers, referred to as a *tiered formulary*. A beneficiary's out-of-pocket cost will depend on which "tier" the drug is found. Lower tiers will have lower out-of-pocket drugs costs and may have more generic versions of a drug. Higher tier drugs will cost more. Brand name drugs will cost more than generic drugs, so patients should ask their physicians if generic substitutes are possible. A beneficiary can see his/her out-of-pocket cost by going to the plan's benefits website or by calling the plan's toll-free customer service. The www.medicare.gov website will also provide this information. In addition, the pharmacist can tell the beneficiary of his/her out-of-pocket costs.

NOTE: The plan is required to keep track of a beneficiary's TrOOP*. When a beneficiary enrolls in a PDP*, s/he will be provided a card that should be used at the pharmacy. This is how the plan will keep track of the beneficiary's TrOOP. The plan is required to send a statement every month showing how much the beneficiary has spent in TrOOP for the year, and provide this information on its website. A beneficiary can request this information at any time.

6.4 What information is a drug plan required to share with beneficiaries?

A Medicare drug plan is required to share the following information with their enrollees and prospective enrollees. The information must be provided in writing at the time of enrollment and annually thereafter, and must be available on the plan's website and upon an enrollee's request. The plan is required to have a toll-free number during normal business hours with representatives to provide information. Plans and pharmacists are required to inform an individual about generic equivalents if they are available. Information required includes:

- plan's service areas (geographic areas it serves)
- the benefits offered under the plan
- formularies*
- cost-sharing* amounts
- pharmacy network*
- other aspects of coverage

In addition plans are required to send beneficiaries an Annual Notice of Change* (ANOC) by October 31 each year. The ANOC contains specific information about Medicare and benefit plan changes such as premium costs, plan rules, and formularies.

6.5 Can a plan place additional restrictions on the coverage of certain drugs?

Yes, a plan can require that a beneficiary get *prior-authorization*, or permission from the plan before a specific drug prescription may be filled. The physician must make the request to the plan. The plan may also have *fail first or step therapy* requirements* that allow a beneficiary to get coverage for a drug only after s/he has tried the plan's preferred drug (generally a lower price or generic drug) which is not found effective for him/her.

Plans may impose a *quantity* or dosage limit* which limits the amount of certain medications which are dispensed over a particular time frame.

Finally plans may have *off-label usage** restrictions on drugs which are routinely used to treat conditions which have not been approved by the FDA.

6.6 What if a beneficiary's new Medicare prescription drug plan does not cover the medications that s/he currently takes?

The PDP* is required to have a transition process for cases like this. The processes may differ. For example, a plan may offer a one-time refill or the plan can explore substitutions with the beneficiary's physicians before the new coverage kicks in. Plans are required to explain the transition process to beneficiaries upon request and to include their transition process on their website. If a beneficiary wants to obtain long-term coverage for medication, s/he will most likely need to file an *exception**. See Chapter 7 for more transition information.

6.7 Can a plan change its formularies?

Yes, a plan can change its formularies* (i.e. remove a drug from its list), but must adhere to the following conditions:

1) A drug plan may not change its formulary during the months of January and February, or from the beginning of the annual election period* until 60 days after the end of the election period. There may be exceptions to this policy such as additions made to formulary for newly approved drugs, FDA approved changes in drug use, or FDA removal of drugs from market for safety reasons.
2) If a plan changes a formulary they must give pharmacists, physicians and the patient taking the drug *at least* 60 days written notice before removing the drug from the formulary or changing the cost-sharing amount. The plan must also post formulary changes on its website 60 days *before* the formulary change. The notice must include the reason for the formulary change, alternative drugs that are covered and their costs, and information on how to appeal the drug change. If a plan fails to provide 60 days notice in advance, the patient is allowed a 60-day supply at the time of the first refill after the formulary change.
3) A plan may expand their formulary by adding drugs, reducing copayments or deleting utilization management* requirements any time of the year.

6.8 How will Medicare Part D affect dual eligibles* in particular?

The selection of drugs made available to beneficiaries through the Medicare Part D benefit will be **restricted** by each plan's formulary, so individuals will not have the same comprehensive drug coverage as offered through the Medicaid benefit. **Furthermore, New York State Medicaid <u>will</u> continue to cover certain excluded drugs such as benzodiazepines and barbiturates. New York State Medicaid* implemented Preferred Drug List* (PDL) on June 28, 2006 and PDL appeals process will coordinate with Medicare Part D. The PDL will determine which medications Medicaid will choose to cover. Non-preferred drugs will require a prior-authorization. A list of preferred medi-**

cations may be found at https://newyork.fhsc.com/.

6.9 How do pharmacies work with PDPs and MA-PDs so that a beneficiary can get his/her prescription filled?

Each PDP or MA-PDP is contracted with various pharmacies within a beneficiary's service area to form a "network." A pharmacy can be either an in-network pharmacy* or an out-of-network pharmacy. A beneficiary* must use a pharmacy in his/her Medicare prescription drug plan's network (in-network pharmacy) to get Medicare to pay for drugs. If a beneficiary uses an out-of-network pharmacy, s/he may be required to pay more up-front costs for the prescription at the pharmacy, and should ask for reimbursement from his/her private plan. If a plan charges more for using out-of-network pharmacies, the cost to the beneficiary will most likely be the difference between the out-of-network pharmacy's price and the plan's allowed cost for the drug. Beneficiaries may obtain coverage from an out-of-network pharmacy and receive reimbursement from his/her plan if **both** of the following conditions are met:

1) The beneficiary cannot get drugs from an in-network pharmacy, and
2) The beneficiary does not obtain drugs from an out-of-network pharmacy on a regular basis

- Similar rules apply to beneficiaries who live in nursing homes. These beneficiaries should use a private drug plan that works in–network with their nursing home.
- If a beneficiary spends many months out of the year in another state, s/he should enroll in a national drug plan that networks with pharmacies all around the country.

6.10 What should a beneficiary know about cost-sharing and pharmacies?

If a beneficiary is receiving LIS*, s/he will not pay more than $5.35 for drugs purchased from an in-network pharmacy. However, beneficiaries not receiving LIS may have drug costs that vary depending on how the plan arranges its network. For instance, a private plan can organize its in-network pharmacies into preferred and non-preferred network pharmacies. A beneficiary may pay less for drugs purchased at a preferred in-network pharmacy versus a non-preferred in-network pharmacy. Another way a plan can organize its pharmacies is into mail-order pharmacies and retail pharmacies. A beneficiary may pay less for drugs purchased through a mail-order pharmacy orders versus purchasing from a network retail pharmacies. It will depend on the plan.

Certain Circumstances

Scenario 1: A beneficiary is out of a drug plan's coverage area and needs to get prescription filled

Action 1: The beneficiary should call his/her Medicare private drug plan. The plan may allow him/her to get coverage from an out-of-network pharmacy if the individual cannot obtain the drugs at a network pharmacy and s/he does not get drugs at an out-of-network pharmacy on a regular basis. It is likely that such a request will be approved if the beneficiary does not ask for exceptions often.

Scenario 2: A beneficiary is traveling outside U.S. and needs an emergency prescription when traveling

Action 2: A beneficiary can obtain medication if s/he shows that s/he cannot reasonably get the medication from a network pharmacy and does not routinely use out-of-network pharmacies. The individual may need to pay upfront for the prescription at the pharmacy and then ask the plan for reimbursement afterwards. The plan is allowed to charge the individual for using an out-of-network pharmacy (the difference between the out-of-network pharmacy price and plan's allowance for drug).

6.11 Are Medicare private drug plans responsible for managing what prescription drugs an individual is taking?

Yes, a Medicare private drug plan must provide therapy management programs to its enrollees who are taking multiple medications, have multiple chronic illnesses, and/or who have high drug expenses. Such programs will pay pharmacists to spend time counseling enrollees to maintain overall good health status and prevent adverse drug effects.

6.12 Filing an Exception

Medicare will only pay for drugs that a plan has on its formulary or a drug that a plan approves through its appeals and exception process. An exception* is a beneficiary's request for his/her plan to cover a medically necessary drug that is not on the drug plan's formulary. A beneficiary may file an **exception** in the following situations:

1) A beneficiary is using a medication covered by his/her plan, but the drug is taken off the plan's formulary* (if not removed for safety reasons).
2) A plan issues coverage restrictions such as a dosage limitations or substitution requirements that are inappropriate for the beneficiary.
3) A physician prescribes a medication that is not on the plan's formulary because s/he does not believe that the drugs on formulary will work for the beneficiary.
4) A beneficiary is using a medically necessary drug that is in a high cost-sharing tier and s/he cannot afford it. A beneficiary may file an exception if s/he is currently using the medication and the drug plan raises the copayment* for the drug, or if the doctor prescribes a drug that has a higher copayment because s/he believes the drugs offered by the beneficiary's plan from the lower cost-sharing tier will be harmful or not work for the patient. (**NOTE:** A plan can exclude a "high cost or unique drug" from the exceptions process)

Important facts about exceptions:

- Exceptions **may not** be requested for drugs specifically excluded from Medicare Part D coverage.
- **A beneficiary is allowed only one exception* per drug.** For example, if s/he files an exception for a nonformulary drug and is granted coverage, s/he may not file an exception to have the same drug moved to a lower costing tier.
- In conjunction with exceptions, doctors are required to provide scientific/clinical evidence to support a patient's need for a drug.

A model exception form (see appendix D) has been approved by CMS and may be used with any plan. The plan reserves the right to ask for additional information that may pertain to the specific drug in question.

How to File an Exception:

A beneficiary should contact his/her plan to request an exception as soon as any of the above-mentioned situations is encountered. The beneficiary will need to submit oral or written supporting requests from the doctor that prove his/her need for the drug. The plan is required to grant an exception when medically necessary. Two initial types of exceptions may be requested:

- A beneficiary may submit a **regular request** in which the plan is required to respond within 72 hours, or

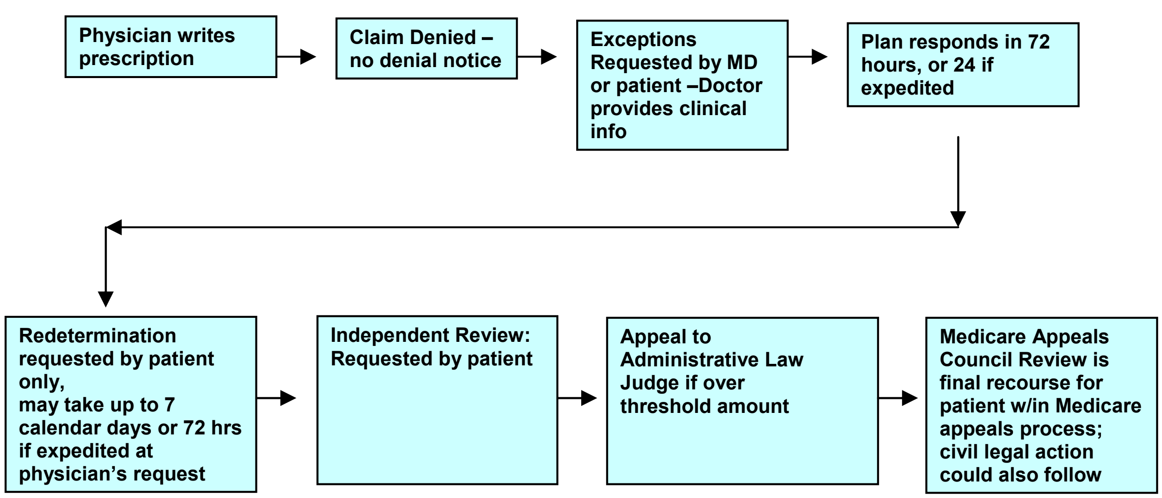
- A beneficiary may submit an **expedited request** in which the plan must respond within 24 hours. An expedited request is granted when a beneficiary's life, health or ability to regain maximum function is threatened.

What happens once the plan makes a decision on a request for an exception request?

A plan makes a coverage determination* and either of two things can happen. Either the plan grants the request to cover the drug, or the plan denies coverage for the drug:

1) If a plan grants the request, it will cover the refills for the beneficiary's drug as long as the drug is safe, the doctor continues to prescribe the drug, and the calendar year has not ended
2) If the plan denies the request, the beneficiary may appeal* the plan's decision (See Appendix C). A prescribing doctor or representative can act on a beneficiary's behalf. A representative is someone authorized under state law to act on behalf of a beneficiary (i.e. health care proxy) or someone appointed in a written document sent to Medicare.

Exceptions/Appeal Process



Source: Linda Schofield, Schofield Consulting: "The Medicare Drug Benefit," August 17, 2005.

CHAPTER 7

Annual Transitions

ANNUAL TRANSITIONS

7.1 Issues to Anticipate

Low Income Subsidy:

Low Income Subsidy (LIS) beneficiaries transferred to another plan within the same company (because the old plan was no longer a LIS plan) may be charged premiums and higher copayments.

LIS individuals who switch plans may no longer be recognized as LIS eligible.

LIS individuals were mistakenly listed as no longer eligible for LIS during the re-determination or re-deeming process earlier in the year.

Some beneficiaries may not be aware that they no longer qualify for the LIS.

Enrollment:

Pharmacies may not know how, or are unwilling, to enroll a dual eligible in a Part D plan using the point of service provider WellPoint.

Existing Part D beneficiaries may not have received the required Annual Notice of Change (ANOC) in early November which describes changes to the plan's costs and formulary. Or, they may have received it very late which did not allow sufficient time/information to make a plan change during the annual enrollment period.

Beneficiaries do not understand that Part D plans may change from year to year and therefore do not understand the importance of reading and understanding the ANOC. They end up stuck in a plan.

Beneficiaries are enrolled incorrectly in a Medicare Advantage plan, usually because of improper marketing by the plan.

Cost Sharing:

Some beneficiaries are being told they may have to pay money back to their drug plan. Some drug plans are reconciling their records and may discover they are used the wrong cost-sharing for some LIS beneficiaries.

Some LIS beneficiaries are not recognized as LIS eligible and are being charged premiums and higher copayments.

Misinformation:

1-800-Medicare customer service represent-tatives give out incorrect information

Formulary Coverage:

Pharmacists do not advise beneficiaries to contact their plans for a coverage determination (exception) when a particular drug is not covered. See section 6.12 for more information about filing an exception.

Some issues have been adapted from the Center for Medicare Advocacy, "Weekly Alert" January 11, 2006.

7.2 Actions to Minimize Problems

Bring any new prescriptions or refills to the pharmacy before the end of the year.

January is a very busy month for pharmacist as most insurance policies have changes that take place in January.

If the beneficiary switched or signed up for a new plan:

- Have the beneficiary bring their new insurance card, the confirmation letter (or welcome letter or acknowledgement letter) or the enrollment confirmation number received from the plan to the drug store. (Note: confirmation numbers from www.medicare.gov enrollment is not the same thing.)

- If approved for Extra Help, have the beneficiary bring a copy of the yellow enrollment letter from Medicare, the approval letter from the Social Security Administration or other proof of qualification for extra help.
- CMS has created a tip sheet for the first 2007 pharmacy visit which can be found in Appendix E available or on-line at http://www.cms.hhs.gov/States/Downloads/2007pharmacyvisit.pdf

If the beneficiary did not receive new enrollment materials the pharmacist should:

- be able to check by submitting an "E1 query", or calling the dedicated pharmacy enrollment/ eligibility helpline (1-866-835-7595) or
- call 1-800-MEDICARE to identify the plan in which the consumer was enrolled.
- Be able to verify dual eligibility status by examining the LIS notice from Medicare or SSA, Medicare and Medicaid cards, award letters with effective dates or a copy of a Medicare Summary Notice and a recent history of Medicaid billing in the pharmacy's patient profile. They may also check Medicaid status by using the state's eligibility verifications system and Medicare status by calling the Medicare pharmacy eligibility line 1-866-835-7595
- Refer to the CMS tip sheet for pharmacists. Beneficiaries can hand a copy to the pharmacist if the pharmacist doesn't know what to do. The first two pages of the tip sheet can be found in Appendix E. The full version is available online at http://www.cms.hhs.gov/States/Downloads/NoMembershipCard.pdf

If the beneficiary remained in their current plan:

- bring current insurance card to the drug store.
- If the beneficiary is a dual eligible, s/he should carry both Medicare and Medicaid cards in case there is a need to prove eligibility for Extra Help.

If a qualified low-income beneficiary finds him/herself not enrolled in a Part D plan in January the WellPoint Point-of Sale Facilitated Enrollment process will still be available.

CMS has improved the process so that pharmacists should be more willing to try it. If the pharmacist has any questions they can refer to the CMS tip sheet attached. It can also be found online at http://www.cms.hhs.gov/States/Downloads/pos4steps.pdf

7.3 Plan Transition Requirements

New Enrollees on January 1

New enrollees into a drug plan must be provided a temporary 30-day refill (or less based on prescription) of a medication which they were taking prior to enrollment but is not on the new plan's formulary. This includes medications which are on the plan's formulary but require prior authorization or step therapy. This temporary supply may be provided anytime during the first 90 days of coverage under the new plan.

New Enrollees Mid-year

Plans are also required to provide this temporary 30-day fill when a beneficiary is newly enrolled in a Part D plan because they reached Medicare eligibility during the year or they switched plans during the year

Enrollees Remaining in Current Plan

Beneficiaries who remain in the same plan for the following year but will experience a negative formulary change may be contacted by the plan PRIOR to the beginning of athe new year and encouraged to seek an appropriate alternative medication, which is covered by the formulary, or seek an exception from the plan to continue taking the current medication. If this happens the plan is required to complete requests for formulary or tiering exceptions prior to 1/1 of the new year. If the plan fails to issue a timely decision then CMS expects the plan to continue to provide the medication on a case-by-case extension of the transition period, if the exception or appeal has not been processed by the end of the minimum transition period.

Or, the plan may give the same transition as new enrollee would get and provide him/her with a notice that they must switch to another appropriate medication or get an exception from the plan in order to continue taking the current medication.

Enrollees Who Had Exceptions in Prior Year

Plans have the option of honoring the exception granted the year before. If the plan is NOT going to honor the exception they must notify the beneficiary in writing at least 60 days before the end of the year, and offer to process another exception prior to the start of the next year. They must provide a temporary supply at the beginning of the year as well as informing the beneficiary that they must seek an appropriate alternative or obtain another exception in order to continue to take the same medication.

Enrollees Who Change Treatment Settings

CMS does not require but encourages plans to allow for transition supplies to be provided to beneficiaries whose level of care changes during the year. If no transition is available beneficiaries must seek an exception from the plan.

APPENDIX A

2007 Federal Poverty Level Guidelines
(Excludes Alaska and Hawaii)
Income Guidelines as Published in the Federal Register on February 24, 2007

Annual Guidelines

Family Size	Percent of Poverty				
	100%	135%	140%	145%	150%
1	10,210.00	13,783.50	14,294	14,804.50	15,315
2	13,690.00	18,481.50	19,166	19,850.50	20,535
3	17,170.00	23, 179.50	24, 038	24,896.50	25,755
4	20,650.00	27,877.50	28,910	29,942.50	30,975
5	24,130.00	32,575.50	33,782	34,988.50	36,195
6	27,610.00	37,273.50	38,654	40,034.50	41,415
7	31,090.00	41,971.50	43,526	45,080.50	46,635
8	34,570.00	46,669.50	48,398	50,126.50	51,855

For family units of more than 8 members, add $3,480 for each additional member.

Monthly Guidelines

Family Size	Percent of Poverty				
	100%	135%	140%	145%	150%
1	850.83	1,148.63	1,191.17	1,233.71	1,276.25
2	1,140.83	1,540.13	1,654.21	1,654.21	1,711.25
3	1,430.83	1,931.63	2,003.17	2,074.71	2,146.25
4	1,720.83	2,323.13	2,409.17	2,495.21	2,581.25
5	2,010.83	2,714.63	2,815.17	2,915.71	3,016.25
6	2,300.83	3,106.13	3,221.17	3,336.21	3,451.25
7	2,590.83	3,497.63	3,627.17	3,756.71	3,886.25
8	2,880.83	3,889.13	4,033.17	4,177.21	4,321.25

APPENDIX B

Sample Form to Assist Beneficiary with Plan D Comparisons and Enrollment

IMPORTANT CONTACTS:

Your Doctor(s)' Names and Phone Numbers:

Doctor(s):	Phone Number:
____________________________	(_____)_________-_____________
____________________________	(_____)_________-_____________
____________________________	(_____)_________-_____________
____________________________	(_____)_________-_____________
____________________________	(_____)_________-_____________

Your Case Manager's Name and Phone Number:

____________________________ (_____)_________-_____________

Medications:

Drug Name	Dosage:	Frequency:	Brand or Generic (Circle One)
_____________________	_______	__________	Brand or Generic
_____________________	_______	__________	Brand or Generic
_____________________	_______	__________	Brand or Generic
_____________________	_______	__________	Brand or Generic
_____________________	_______	__________	Brand or Generic

Medicaid Office Location and Number (if applicable):

Medicaid Office Address:	Medicaid Office Phone Number:
____________________________	(_____)_________-_____________

Type of Medicare Beneficiary:

Check one:

( ) Full Dual Eligible
( ) Partial Dual Eligible
( ) Medicare Only Eligible

Extra Help Eligibility (Low Income Subsidy):

( ) Eligible, Full Dual Eligible
( ) Eligible, Partial Dual Eligible
( ) Eligible, doesn't have Medicaid coverage, but receives **SSI benefits**
( ) Maybe Eligible, has low income

Current Pharmacy:

Pharmacy Name and Address: Pharmacy Phone Number:

______________________ (_____)________-____________
____
____

New Medicare Prescription Drug Plan:

Plan Name: Plan Phone Number:

______________________ (_____)________-____________

Network Pharmacy:

Network Pharmacy Name and Address: Pharmacy Phone Number:

__________________________ (_____)________-____________
____
____

Other Health Insurance Coverage or Prescription Drug Program:

Name of Insurance/Program:	Primary/Secondary Insurance (circle one)	Creditable Coverage (circle one)
__________________	Primary or Secondary	Yes or No
__________________	Primary or Secondary	Yes or No
__________________	Primary or Secondary	Yes or No

Other Information:

____
____
____

Adapted from the National Mental Health Association: "Medicare Prescription Drug Benefit, Getting Enrolled Consumer Workbook," 2005.

APPENDIX C

Appeal Process for Exception Denials

STAGES	SCENARIO
Redetermination by Medicare Private Drug Plan	A beneficiary may request a second review within 60 days of receiving a denial from the plan (the 60-day rule has exceptions including sickness, illness or death of family member, incorrect information from the plan and destroyed records). The plan must respond within seven calendar days from the date it receives appeal from beneficiary (72 hours for an expedited appeal). Plans are required to expedite appeals if a beneficiary's physician certifies that the medication is needed for patient's health.
Reconsideration by Independent Review Entity (IRE)	If a beneficiary's plan denies drug coverage after a redetermination request, the beneficiary can appeal to an IRE within 60 days of receiving the redetermination notice of denial. The notice will explain how to appeal to the IRE. The IRE is an independent agency (not associated with Medicare) that is contracted with Medicare to handles exception appeals. The IRE must receive supporting evidence from the prescribing doctor orally or in writing and respond no more than seven calendar days after receiving the request (72 hours for an expedited appeal).
Administrative Law Judge (ALJ) Hearing	A beneficiary can request an ALJ hearing within 60 days of the IRE decision if s/he disagrees with the IRE's decision or the IRE does not respond. The cost of the drug must meet the minimum amount that Medicare posts annually (for example, the minimum drug cost will be $100 in 2005). A beneficiary may add multiple appeals to meet this amount (i.e. s/he can predict the cost of the drug to include all the refills needed for the calendar year). The ALJ has 90 days to make a decision, but this period may be extended for different reasons not yet specified.
Medicare Appeals Council (MAC)	If a beneficiary disagrees with an ALJ decision, s/he can appeal within 60 days to the Medicare Appeals Council (a division of the Department of Health and Human Services that reviews ALJ decision).
Judicial Review	A beneficiary can disagree with the MAC's decision and request a Judicial Review if the cost of the drug meets the minimum amount set by Medicare annually (for example, the minimum amount will be $1,050 in 2005). A beneficiary may request a Judicial Review in federal court.

APPENDIX D

Provider Check List
Facilitating the Medicare Part D Process

Providers should anticipate that Medicare clients will require more physician time for consultation. Medicare patients will need physicians to help with prescriptions, formulary compliance, drug substitutions and the exception/appeals process. Caseworkers should anticipate a higher number of crisis calls because of Medicare Part D transitions.

To minimize the problems that will accompany the Medicare Part D transition, providers should follow the steps provided in the list below.

Provider should…

STEP 1:
Identify Medicare Clients: Review caseloads as soon as possible to determine which consumers are Medicare beneficiaries.

STEP 2:
Determine Type of Medicare Client: Those Medicare clients should fall into 3 categories: Medicare-Only Individuals*, Partial Dual Eligible*, and Full Dual Eligible*. Identify who falls into each category because each category will require different handling.

Step 3:
Develop Relationship With Client: Meet with Medicare client to assist in choosing Medicare Part D options that support his/her prescription drug needs. Providers should advise clients to save and bring in any information they've received about Medicare Part D or Low Income Subsidy (extra help).

STEP 4:
Complete Medicare Appointed Representative Forms: When necessary, fill out an Appointed Representative Form if you are acting directly on the client's behalf for Medicare Part D decisions. Refer to Section 2.13 for more details.

STEP 5:
Assess Client's Current Medications: Identify a client's current prescriptions, prescribing physicians, and pharmacies. Contact physicians with questions about a client's current medications. Use the form provided in Appendix B to collect this information so that it is readily available when choosing an appropriate Medicare Part D Plan for your client. Utilize the Medicare Part D Drug Plan Finder Tool to find an appropriate Medicare PDP within the client's region and identify in-network pharmacies. Refer to Section 2.13 for more details. *Ensure that the client has received his/her new pharmacy card once he/she is signed up for plan, and that client will have appropriate transportation to access pharmacy.*

STEP 6:

Assess Client's Current Health Care Coverage: Review a client's current health care coverage to see how other insurance will coordinate with Medicare Part D and if a client's current insurance provides "creditable" prescription coverage. Other types of health care coverage which may include prescription coverage are TRICARE, Medigap, VA benefits, COBRA, Union and Employer/Retiree Insurance. Refer to Chapter 3 of this Guide for more details.

Step 7:

Help Medicare Client's Apply for Extra Help: Advise clients with considerably low incomes and assets to apply for extra help and enroll in a Medicare prescription drug plan when appropriate. Refer to Chapter 5 of this Guide for more details.

STEP 8:

Assess Client's Eligibility for Other Federal Means-Tested Program: Determine if a client is receiving benefits from other programs and how this will affect extra help eligibility and benefits. Other Federal Means-Tested Programs include Food Stamps, Housing Assistance (HUD), Social Security Income (SSI), and Low Income Home Energy Assistance Program (LIHEAP). Refer to Section 5.11 of this Guide for more details.

Step 9:

Assist Client with Prescription Drug Plan Enrollment: Advise those clients who qualify for the Low Income Subsidy (extra help) but will not be auto-enrolled (dual eligibles are auto-enrolled) in a Medicare prescription Drug Plan that they must enroll in a drug plan on their own. (If clients receive SSI or have a Medicare Savings Plan and do not choose a plan, their enrollment in a Part D plan will be facilitated by CMS.)

STEP 10:

Use Available Resources: Become familiar with available resources to learn more information about the Medicare Part D benefit and Low Income Subsidy. Refer to our "Resource" list at the end of this Guide for helpful resources.

Additional TIPS for Counseling…

Medicare-Only Individuals

- COMPLETE STEPS 1-10
- Advise Medicare-only clients that they will not be auto-enrolled in a Medicare Prescription Drug Plan and they should enroll in a prescription drug plan during their eligible period (3 months prior to 65th birth month, their birth month and 3 months following their birth month to avoid premium penalties.
- Determine if client's current health care coverage provides "creditable" prescription coverage. Reminder: Some employer/union plans will be considered creditable.
- Providers should identify beneficiaries within Medicare Advantage HMO, PPO, or SNP plans to see if they are receiving prescription drug coverage and if not, consider signing them up for Medicare Part D.
- Review Medicare Part D with client and contact The Coalition Provider Help line 212-742-8173, the New York SHIP 800-701-0501 or 1-800-MEDICARE for more information if necessary.
- Advise Medigap policy holders that as of January 1, 2006, Medigap policies H, I and J will not provide "creditable" prescription drugs.
- Review client's current plan and compare it to the PDPs available to ensure that client is enrolled in the best plan for him/her.
- Providers should assist clients who utilize non-formulary drugs with appeal and grievance procedures once Medicare prescription drug coverage begins.
- Review the Low Income Subsidy with possible eligible clients and assist with filling out the application. Review the results once the LIS application is approved so the client knows his/her drug plan costs.

Partial & Full Dual Eligible

- COMPLETE STEPS 1-10
- If a client is on Medicaid Spend-down, be aware that s\he must reach their spend down level once between July 1 and December 31 to be eligible for the low income subsidy for the following year.
- Meet with dual eligibles:
  - to see if their auto-assigned PDP plan has been switched because their original plan is not offered in 2007. Check the plan to be sure that the formulary covers all of their medications. Switch plans if necessary.
  - to see if their plan has increased premium costs above the annual benchmark amount. A basic plan whose month premium amount is $2 above the benchmark is still considered a benchmark plan. Anticipate helping them switching plans to a benchmark plan, if the new basic plan rates are above $26.45.
- Meet with dual eligibles to confirm they have meet spend down. If not, help them apply for the LIS or a Medicare Savings Plan which will keep their prescription costs down. Review their PDP to ensure that it still covers their needs and is affordable. If not anticipate helping them switch plans. They are allowed a special one-time opportunity to switch to another plan.

- Providers should assist clients who utilize non-formulary drugs with appeal and grievance procedures once Medicare prescription drug coverage begins.
- Review the Low Income Subsidy with possible eligible clients and assist with filling out the application. Review the results once the LIS application is approved so the client knows his/her drug plan costs.

APPENDIX E

Annual Transition Checklist
(Things to do between October to December)

Every year providers will need to verify that clients still have the best possible coverage at the lowest cost. Do not assume that if this year is working well things will remain the same next year. Each year plans are allowed to change formularies and costs effective January 1. Plans may drop out and new plans may become available; the benchmark LIS value is recalculated, and Federal Poverty Levels (FPL) change. All these factors impacts LIS eligibility criteria.

1) Check to see if your client is eligible for the Low Income Subsidy (extra help):

- S/he may be automatically deemed eligible if s/he recently became a dual eligible or was approved for a MSP;
- S/he may qualify for LIS because of low income and assets;

2) Check to see if your client is no longer eligible for the Low Income subsidy

- S/he may have lost his/her deemed LIS eligibility during the re-deeming process;
- S/he may have lost their LIS eligibility or the level of subsidy during the re-determination process;

  What you can do:
  - If s/he has lost his/her deemed status they may still be eligible for the LIS, so submit an application.
  - If s/he is no longer eligible for LIS, check prescription assistance programs for free or discounted programs.
  - S/he may be eligible for a Medicare Savings Program which will automatically deem them eligible for LIS.

3) Check to see if his/her plan is still available next year

- Plans may drop out.
- If the client was auto-enrolled in an LIS plan s/he may be reassigned to another plan if the current plan will not be available next year and s/he remained in his/her original plan

4) Check to see if their plan is still a benchmark plan

- Plan prices increase.
- The benchmark LIS value is recalculated annually and his/her current plan may no longer be a benchmark LIS plan.

5) Check to be sure that the current plan

- Still covers all their medication needs
- Still offers an acceptable cost share
  - Some plans will increase cost or no longer be a bench mark plan

6) Check to see if a new plan is available

- A new plan may cover more medications.

Remember, November 15th through December 31st is the only time Medicare only beneficiaries may switch standard Part D plans. One can apply for the LIS anytime during the year and if awarded eligibility may apply or switch plans once before the annual election period. The annual election period for Medicare Advantage plans is January 1st through March 31st.

Troubleshooting Problems Arising at the Pharmacy
(What to do when things don't go smoothly in January)

1) The pharmacist says that the individual is not eligible for LIS and/or asks for higher co-payment. It could be that in switching plans the LIS eligibility was not transferred to the new plan or a change in LIS coverage not recognized.

- Bring proof of LIS eligibility.
- In the case of a dual, bring Medicare and Medicaid cards, summary of recent billing history from your pharmacists, Medicare summary notice, Medicaid award letter.
- In the case of LIS application, bring a copy of the approval letter from Social Security.
- Pay full price, keep receipt and work with your plan for reimbursement.

2) Specific medication not available

- An exception granted in the previous year may not apply for the following year.
  Need to request an exception.
- The formulary changed, medication no longer covered.
  Ask for transition supply (one 30 day fill in the first 90 days).
  See if Doctor can substitute another medication.
  Request an exception.
- Prior approval is required.
  Ask for transition supply.
  Request doctor process the prior approval request with the plan.
- NY State Medicaid wrap ended 12/31/2006 and no longer covering medications not in plan formulary.
  See if Doctor can substitute another medication.
  Request an exception.
- Client was re-assigned to a new plan because the auto-assigned plan for the previous year was no long a LIS plan.
  Ask for transition supply (one 30 day fill in the first 90 days).
  See if Doctor can substitute another medication.
  Request an exception.

Reminder: Dual eligibles are allowed to change plans up to once a month. Another plan may be another alternative.

3) Pharmacist unable to confirm client enrollment in a Part D plan. This could be a result of a first time enrollee or a LIS individual who was re-assigned.

- Show pharmacist any enrollment material from the plan, if available.
- If LIS, bring proof of eligibility (see above.)
- If the client is a full dual eligible s/he may ask pharmacist to enroll him/her into the safety-net Wellpoint system.

4) Client mistakenly enrolled in a Medicare Advantage Plan.

- A special enrollment period allows a one-time switch to original Medicare and a standalone Part D prescription drug plan during the Medicare Advantage open enrollment period of January 1 through March 31. This is available for existing MA-PD enrollees and newly enrolled individuals.

APPENDIX F

CMS TIP SHEETS

Beneficiary Fact Sheet: Using Your Medicare Drug Coverage In 2007

Using Medicare Prescription Drug Coverage Before Receiving a Drug Plan Membership Card

Point-of-Sale Facilitated Enrollment (POS FE) Process
Four Steps for Pharmacists

Beneficiary Fact Sheet: Using Your Medicare Drug Coverage In 2007

If you've just joined a Medicare drug plan for the first time, or you switched to a new Medicare dug plan during the open enrollment period, there are some things you can do to make sure your first visit to the pharmacy in 2007 goes smoothly.

The first time you use your new Medicare drug plan, you should come to the pharmacy prepared with as much information as possible, especially if you need to use your new coverage before you receive a plan ID card. Here's what you should bring to the pharmacy:

- Your Medicare and/or Medicaid card
- A photo ID
- Your plan ID card, if you have one
- If you don't have a plan ID card, you can bring an acknowledgement or confirmation letter from the plan if you have one, or an enrollment confirmation number from the plan. (**Note**: Only confirmation numbers from the plan will work, not those from Medicare's Online Enrollment Center at www.medicare.gov.)

If you haven't received a plan ID card or any plan enrollment materials, you should let the pharmacist know the name of the Medicare drug plan you joined, so that the pharmacist can confirm your plan enrollment and get the information necessary to bill your plan. Since the pharmacist may have to search for your plan information, it could take extra time to fill your prescription.

If You Have Medicare and Medicaid or Qualify for Extra Help

If you have both Medicare and Medicaid or have been approved for extra help with your drug plan costs, you should bring proof of enrollment in both programs to the pharmacy, along with a copy of the yellow automatic enrollment letter from Medicare, an approval letter from the Social Security Administration, or other proof that you qualify for extra help.

Proof of Medicare may include
- Medicare card
- Copy of a Medicare Summary Notice

Proof of Medicaid may include
- Medicaid card
- A recent history of Medicaid billing in your pharmacy's patient profile
- Copy of a current Medicaid award letter

The pharmacist will use this information to confirm your Medicare drug plan enrollment and/or Medicaid status, to make sure you get the prescriptions you need.

What If the Pharmacist Can't Confirm My Drug Plan?

In some rare cases, the pharmacist may not be able to confirm your plan enrollment or Medicaid eligibility status. As a last resort, you can pay out-of-pocket for the prescription, save the receipts, and work with your Medicare drug plan to be reimbursed.

Using Medicare Prescription Drug Coverage Before Receiving a Drug Plan Membership Card

New Medicare Prescription Drug Coverage As of March 2006

If a person enrolls or switches drug plans late in the month, they may need to fill prescriptions before they receive their drug plan membership card. If this is the case, they should let the pharmacist know the name of the Medicare drug plan they have joined, and they may substitute other information for their card if necessary. They should be aware that since the pharmacist will have to search for their membership information, it may take a little longer than usual to fill their prescription.

The following may be used as a temporary substitute for a drug plan membership card.

- An acknowledgement letter, or
- a confirmation letter, or
- a welcome letter, or
- an enrollment confirmation number received from the plan. (Note: Only confirmation numbers from the plan will work, not those from www.medicare.gov's "Online Enrollment Center.")

For people with Medicare and Medicaid who haven't received their drug plan membership card

If the person has both Medicare and Medicaid or has been approved for the low-income subsidy (extra help paying for prescriptions), they should bring proof of enrollment in both programs to the pharmacy.

Proof of Medicare may include:
- their Medicare card, or
- a copy of a Medicare Summary Notice.

Proof of Medicaid may include:
- their Medicaid card, or
- a recent history of Medicaid billing in the pharmacy's patient profile, or
- copy of a current Medicaid award letter

The following may be used by people with Medicare and Medicaid as a temporary substitute for a drug plan membership card.

- The automatic enrollment letter from Medicare on yellow paper, or
- an approval letter from Social Security, or
- other proof that they qualify for the low-income subsidy.

Point-of-Sale Facilitated Enrollment (POS FE) Process
Four Steps for Pharmacists

1. Request Patient's Part D Plan ID Card

Alternatively, if an individual does not have an ID card, he or she may have a plan enrollment "acknowledgement letter" or "confirmation letter" that should contain the 4Rx data—Bank Identification Number (BIN), Processor Control Number (PCN), Group ID for the patient's specific plan (GROUP), and Member ID information.

2. Submit an E1 Transaction to the TrOOP Facilitator

If the individual has no proof of enrollment, their plan's billing information may be available through the Part D eligibility and enrollment online system, the TrOOP Facilitator, which can be accessed with an E1 query—in 2007 called an "enhanced E1." The enhanced E1 will provide effective dates for Part D plan enrollment within 90 days. If you are uncertain about how to submit an E1 query, please contact your software vendor. If the E1 query returns a BIN/PCN indicating the individual has current drug plan coverage, do NOT submit a claim to the POS FE national plan. If the E1 query returns a help desk telephone number, this indicates the individual has been enrolled in a plan, but the 4Rx data is not yet available. Please contact that plan for the proper 4Rx data.

3. Identify a "Dual Eligible (Medicare and Medicaid)" Individual, or Those Eligible for the Low-Income Subsidy (LIS)

Verify the individual's Medicare and Medicaid eligibility (or LIS status) using one of the items listed below. If the individual cannot provide evidence of current eligibility for Medicare and Medicaid or the LIS, the claim should NOT be submitted to the POS FE national plan. The following options are available to verify an individual's dual eligibility/LIS eligibility:

Medicaid
- Medicaid ID Card
- Copy of current Medicaid award letter with effective dates
- State eligibility verification system (EVS) queries (interactive voice response, online)

Medicare
- Submit an E1 query to determine Medicare Part A eligibility and/or Part B enrollment
- Medicare ID Card
- Medicare Summary Notice (MSN)
- Medicare pharmacy eligibility line—1-866-835-7595

Low-Income Subsidy
- LIS Notice from Medicare or SSA

4. Bill the POS FE National Plan

WellPoint/Anthem/Unicare will again be the Contractor for the POS FE process for 2007. Anthem is the Pharmacy Benefits Manager (PBM) for WellPoint, and Unicare is the plan into which POS FE beneficiaries will be enrolled if they use the POS FE process. Please note that

POS FE is considered temporary drug coverage until enrollment can be facilitated into one of WellPoint/Unicare's Part D plans. The BIN/PCN for POS FE will remain the same in 2007.

There will be new edits at the Point-of-Sale, implemented through Per-Se Technologies, Inc. on behalf of WellPoint, which will give you real-time data on the validity of the individual's HICN, other Part D plan enrollment, and Low-Income Subsidy status. You may receive the following reject codes:

• Code 65—Patient Not Covered: This code will be returned when there is no match of the HICN entered on the claim to a HICN in CMS' systems (invalid HICN), the individual is not eligible for Part D or has opted out of Part D, or a retiree drug subsidy (RDS) is being paid on the individual's behalf. Please read the text that accompanies the rejection code to get more specific information on the reason for the rejection. If the HICN is returned as invalid, check the HICN entered on the claim to verify its validity. If it appears that you entered the HICN correctly but it is still being returned as invalid, call 1-800-MEDICARE for eligibility and enrollment information.
• Code 41—Other Part D plan enrollment**:** Individual is enrolled in another Part D plan, and therefore, NOT ELIGIBLE for POS FE. The new, enhanced E1 will also give effective dates of coverage.
• Code 81—Claim Too Old: Claims submitted later than 30 days from the date of service, as of January 1, 2007, will be rejected.

Other edits include those for safety, duplication, Part B covered drugs, and Part D excluded drugs. Electronic overrides will not be available in 2007, but manual overrides can be obtained through the Anthem Customer Service Line at 1-800-662-0210. If you have questions about claims reversals from 2006, you may call the Anthem Pharmacy Benefits Line at 1-800-957-5147.

Enter the claim through your claims system (even if your pharmacy does not have a contract with Per-Se) in accordance with the WellPoint/Anthem payer sheet available at: http://www.anthem.com/prescription/noapplication/f1/s0/t0/pw_ad066429.pdf. The payer sheet is also provided below.

Please note that it is critical that you submit both the Medicare HICN and the Medicaid ID number to validate the individual's dual eligibility status. There may be a small number of individuals who have LIS but not Medicaid. If the LIS status is indicated in CMS' systems, the claim should be adjudicated properly.

ACRONYM LIST

ALJ	Administrative Law Judge
ANOC	Annual Notice Of Change
AR	Appointed Representative
CMS	Centers for Medicaid & Medicare Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
EOB	Explanation of Benefits
EPIC	Elderly Pharmaceutical Insurance Coverage – a New York SPAP
FPL	Federal Poverty Level
HMO	Health Maintenance Organization
IRE	Independent Review Entity
LIS	Low Income Subsidy (extra help)
MAC	Medicare Appeals Council
MA-PDP	Medicare Advantage Prescription Drug Plan
MA-PD SNP	Medicare Advantage Special Needs Plan
MMA	Medicare Modernization Act
MOD	Mail Order Drug
MSP	Medicare Savings Program
OOP	Out-of-Pocket
OTC	Over the Counter
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PDL	Preferred Drug List
PDP	Prescription Drug Plan
PPO	Preferred Provider Organization
Rx	Drug
QI-1	Qualifying Individual Program
QMB	Qualifies Medicare Beneficiary
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SLMB	Specified Low-Income Medicare Beneficiary
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TrOOP	True Out-of-Pocket Costs
VA	Veterans' Health Administration

GLOSSARY

Annual Election Period (AEP): Open enrollment period during which a beneficiary can enroll or switch to a different PDP. For the first year Part D goes into effect, Initial Enrollment Period is from November 15, 2005-May 15, 2006. In 2006 and after, the AEP is from November 15 - December 31 of each year.

Annual Notice Of Change (ANOC): PDPs are required to send this document to beneficiaries on an annual basis. It must be received by October 31. The ANOC is to inform beneficiaries about what is new with the plan and allow them to compare the current year benefits with the coming year benefits. It should also include a formulary, or list of drugs, either abridged or in full.

Appeal: A formal process by which a beneficiary can request a review and reversal of a coverage determination (i.e. exception decision), if s/he is dissatisfied with the decision. The appeal levels are 1) redetermination, 2) reconsideration, 3) ALJ hearing, 4) Medicare Appeals Council, and 5) federal court/judicial review (See Appendix B).

Appointed Representative (AR): Someone who acts on a Medicare beneficiary's behalf when dealing with Medicare. A signed agreement/form should be submitted to the Part D plan annually legally appointing the individual who is acting on behalf of the beneficiary.

Benchmark: Benchmark refers to an actuarial averaging of the costs for Part D basic coverage premiums. There is a regional benchmark and a national benchmark. The National benchmark premium cost is used to determine the penalty assessed for those who sign up late. The regional benchmark (NY State is its own region) premium cost determines which plans are premium and deductible free for those who qualify for the low income subsidy.

Beneficiary: An individual who has insurance coverage such as Medicaid, Medicare, or private insurance.

Catastrophic Coverage: Comprehensive coverage that an individual receives after spending a pre-determined maximum out-of-pocket costs. The catastrophic coverage protects Medicare recipients who require a large amount of prescriptions. The out-of-pocket cost maximum is $3600 in 2006. Once someone spends that maximum, the out-of-pocket costs drop to 5% or either $2 and/or $5.

CMS: The Centers for Medicare and Medicaid Services, formerly referred to as Health Care Financing Administration (HFCA). CMS is the federal agency responsible for administrating Medicare and the prescription drug benefit.

COBRA: The Consolidated Omnibus Budget Reconciliation Act (COBRA) is insur-ance coverage that gives former employees, retirees, spouses, and dependent children temporary continuation of health coverage at group rates. This coverage is available in certain instances and is usually more expensive than health coverage for active employees.

Co-insurance: A percentage of a prescripttion drug cost.

Copayment (copays): A certain dollar amount that a beneficiary is required to pay out-of-pocket for a specific service at the time the service is rendered.

Cost-sharing: The out-of-pocket payments a beneficiary make towards his/her cost of care.

This includes deductibles, premiums, co-insurance, and cop-payments.

Coverage Determination: A Medicare Part D Plan's decision to either cover or deny coverage for a beneficiary's drug(s).

Creditable Coverage: Drug coverage that CMS considers equal to or better than the Medicare Part D standard benefit. If someone has creditable coverage, they can avoid Medicare's late enrollment penalties for the drug benefit.

Deductible: A flat dollar payment a beneficiary must pay before Medicare will cover his/her prescription drug costs.

Deemed Eligible: Term used to refer to Medicare beneficiaries who will automatically qualify for LIS and do not have to apply. This includes full-benefit dual eligibles, SSI recipe-ents, and MSP participants.

Donut Hole: The gap in Medicare prescript-tion drug coverage where the beneficiary pays 100% of the cost for all prescription drugs. (From $2,250 to $5,100 of total drug costs.)

Dual Eligible: Term used to refer to a client who receives benefits from both the Medicare and Medicaid programs. Dual eligible individuals may be either "full" dual eligible or "partial" dual eligible (see definitions below).

EPIC: The Elderly Pharmaceutical Insurance Coverage (EPIC) Program is a State Pharmacy Assistance Program (SPAP)* for New York State and currently has over 335,000 senior enrollees. The EPIC program provides prescription drug coverage to New York State residents who are 65 years or older and have an annual income of $35,000 or less if single, and $50,000 or less if married.

Exception: A Medicare drug plan's formal decision to either cover a beneficiary's medication or reduce the co-payment for a drug. If an exception is granted, it will last for one year and the beneficiary will have to request an exception again when the time has elapsed. If the plan denies the exception, the beneficiary may appeal the plan's decision (see Appendix B).

Extra Help: See LIS.

Facilitated Enrollment: If a Medicare Savings Plan beneficiary has not selected and enrolled in a Part D plan by May 15, 2006, they will automatically be enrolled.

Formulary: A prescription drug plan's list of covered medications. Prior author-ization may be required from the Medicare prescription drug plan for coverage. A plan will not pay for drugs not on its formulary, unless an exception is granted.

"Full" Dual Eligible: Term used to refer to a Medicare and Medicaid client with **full** Medicaid benefits. Beneficiaries are eligible for state Medicaid program, but also Medicare because of age or disability (i.e. persistent mental illness).

HMO (Health Maintenance Organization). A private managed care plan that covers only the care received from doctors, hospitals, and other health care providers that are in the HMO network. HMO members must choose a primary care doctor who coordinates their care and refers them to a specialist.

Initial Enrollment Period (IEP): Initial Enrollment Period is similar to the Initial Enrollment Period for Part B. This includes a seven month enrollment period: three months before eligibility for Medicare Part D, the month of Medicare Part D eligibility, and three months after eligibility for Part D.

LIS (Low Income Subsidy): LIS is extra help in which the Federal government pays subsidies to the drug plan in which the eligible Medicare beneficiary enrolls. The government pays for part or all of the Medicare prescription drug premiums for Medicare beneficiaries (including all dual eligibles) who are below 135% of the federal poverty level (FPL) and part of the premium for individuals between 135% and 150% of the FPL. The subsidy exempts beneficiaries under 150% of FPL from the gap in drug coverage known as the doughnut hole. Dual eligibles do not need to apply for the subsidy, but other possibly eligible individuals are encouraged to apply.

Low Income: Under the MMA, low income refers to an individual who is below 150% of FPL. In 2006, this will be equivalent to an individual's yearly income of $14,700 and a couple's yearly income of $19,800, with assets below $10,000 for individuals and below $20,000 for couples.

MA-PD (Medicare Advantage Prescri-ption Drug Plans): Plans that offer both prescription drug and health coverage. Private MA-PD plans include HMOs, PPOs, or PFFS.

MA-PD SNP (Medicare Advantage Special Needs Plans): Plans that may be available in certain regions. These plans provide prescription drug and health coverage for people with special needs who may suffer from serious and chronic conditions such as mental illness, ESRD, HIV/AIDS, etc.

Medicaid: A federal government program that is administered by the states to help pay medical costs for financially needy people. Each state has its own definition of "need" based on the federal poverty level. Medicaid operates in addition to Medicare to help pay for some of the medical costs that Medicare does not cover, but will no longer cover prescription drugs for dual eligibles as of January 1, 2006.

Medicaid Spend Down: The spend-down process allows an individual who has too much income to qualify for Medicaid to "spend down" to Medicaid eligibility by having medical expenses deducted from their income. Once the individual meets the level directed by his/her state's Medicaid plan, s/he will receive Medicaid benefits and also be "deemed eligible" for LIS.

Medicare Only Beneficiary: Term used to refer to a Medicare client who receives **only** Medicare benefits and **no** Medicaid benefits. This group contains mostly older adults over the age of 65.

Medicare Part A: Medicare coverage that pays for inpatient hospital care, hospice care, skilled nursing care, and some home health care.

Medicare Part B: Medicare coverage that pays for outpatient hospital care, doctor services, and services not covered under Part A such as occupational and physical therapy and some home health care.

Medicare Part C: Medicare Advantage Plans

Medicare Part D: Medicare Prescription Drug benefit, effective January 1, 2006.

Medicare Savings Program (MSP): Assistance programs that help low income Medicare recipients who do not qualify for Medicaid. MSPs pay for Medicare out-of-pocket costs, such as the Part B premium and coinsurance for doctor's visits.

Medigap: A Medigap policy is a health insurance policy sold by private insurance companies to provide secondary coverage for care that is not covered under Original Medicare.

MMA (The Medicare Prescription Drug Modernization Act of 2003): This legislation adds a prescription drug benefit to the Medicare Program, also referred to as Medicare Part D.

Network Pharmacy: A pharmacy that is contracted with a Medicare PDP or MA-PD, where beneficiaries with coverage under that plan must get their prescriptions filled. Medicare prescription drug plans can organize their in-network pharmacies as they wish, for example delineating preferred versus non-preferred pharmacies.

Non-Medicare prescription drug: Under the law, drugs that are excluded from Medicare coverage, including barbiturates, benzodiazepines, and prescription vitamins.

Off Label Usage: The practice of prescribing a drug or medical device for a purpose different from one of the indications for which the product is approved by the Food and Drug Administration (FDA).

Original Medicare: A federal health insurance program, created in 1965, which the pays providers directly for each service a person receives (on a fee-for-service basis). Also referred to as Traditional Medicare.

Partial Dual Eligible: Medicare enrollees who have premiums and/or deductibles paid for by Medicaid through the Medicare Savings Program (i.e. QMB, SLMB, or QI program), but receive **no** Medicaid coverage.

PDP: "Stand-alone" Prescription Drug Plans that will offer drug-only coverage. The Centers for Medicare and Medicaid Services will define a service area for each PDP.

PPO (Preferred Provider Organization): A private managed care plan that partially covers the care received from out-of-network providers. Enrollees must use network providers.

Preferred Drug List (PDL): This list determines which medications Part D plans may choose to cover.

Premium: A beneficiary's regular monthly payments made to his/her health plan for health care coverage.

Prior Authorization: A requirement used by some PDPs, for some drugs, in which the PDP must approve the drug your doctor prescribed before you will be able to get your prescription filled. If the plan does not provide approval, you may not be able to receive this particular drug.
In pharmacy, a cost-containment procedure that requires a prescriber to obtain permission to prescibe a medication prior to prescribing it. Also called prior approval.

QI-1 Program (Qualifying Individual Program): A Medicare Savings Program that pays for the Medicare Part B Premium. Has income requirement but no asset/resource requirement.

QMB (Qualified Medicare Beneficiary): A Medicare Savings Program (MSP) that pays for Medicare premiums, deductibles, and coinsurance. Has income and asset/resource requirement.

Quantity Limits: Limits applied by some PDPs, for some drugs to the amount of the drug that the plan will cover. The limit may be on the number of pills dispensed per prescription, number of pills per month or number of pills per year.
Plans impose limits on the number of dosages allowed per month for certain drugs to ensure that the medication is being used correctly and other treatments are not appropriate.

Redetermination: A process of evaluating whether beneficiaries who are currently receiving the LIS will be eligible to receive the subsidy for the following year

State Health Insurance Assistance Program (SHIP): A federally-funded program within each state that answers questions about Medicare free of charge.

State Pharmacy Assistance Program (SPAP): A state program that provides pharmaceutical coverage or assistance usually to low-income elderly or people with disabilities who do not qualify for Medicaid. Most programs use state funds to subsidize a portion of drug costs, but many use discounts or bulk purchasing options. In New York State, the SPAP is the EPIC program.

Special Enrollment Period (SEP): An enrollment period during which a beneficiary is allowed to enroll in Medicare Part D without having to pay premium penalties. SEPs can occur at anytime during the year if certain situations are met (see section 2.3 for details). Special Enrollment Periods are granted to an individual if any of these situations are met.

SLMB (Specified Low-Income Medicare Beneficiary): A Medicare Savings Program (MSP) that pays for the Medicare Part B Premium. Has income and asset/resource requirement.

Social Security Disability Income (SSDI): SSDI is a benefit paid to people who have worked for at least 5 of out of the past 10 years. The rules are different for individuals under 31 years of age since they have not been in work force long enough.

Step Therapy: The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

Supplemental Security Income (SSI): Supplemental Security Income. This benefit is paid to people who are disabled and receive lower income, regardless of their work history. SSI children's disability benefits are for children younger than 18 years, who are disabled, and whose parents receive lower income.

Tier - The plan's drug formulary is split into multiple tiers (for example, Tier 1 Generic drugs; Tier 2 Preferred brand name drugs; Tier 3 Non-preferred brand name drugs, etc.). The tier that your drug is in will affect the amount of your co-payment. Dual eligibles will have co-payments of $1 or $3 for each prescription depending on whether a brand name or generic version of the drug is prescribed.

TrOOP (True-Out-of-Pocket Expenditures): TrOOP this is the out-of-pocket threshold that a beneficiary must pay before his/her out-of-pocket costs are reduced substantially. The TrOOP will increase on a yearly basis. After the threshold is met, the government will pay for most of the beneficiary's drug costs for the rest of the year. See Guide for costs that do and do not count toward the out-of-pocket threshold.

Utilization Management (UM): Utilization management includes special requirements like prior authorization, step therapy or quantity limits to better manage how prescription drugs are provided to people in the plan.
Used by PDPs, utilization management techniques control access to certain medications and when possible reduce costs.

RESOURCES

The Centers for Medicare and Medicaid Services (CMS)

- http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Provides full text of the Medicare Program; Medicare Prescription Drug Benefit; Final Rule and links to other sources of information regarding Medicare Part D.

- http://www.cms.hhs.gov/Partnerships/PDI/list.asp#TopOfPage

Provides resources materials to help promote and understand Medicare Part D.

The Coalition of Voluntary Mental Health Agencies, Inc.

- 212-742-1873 Coalition Provider Help Desk
- http://www.cvmha.org/medicare_ptd/index.html

The Coalition Provider Help Desk provides information and assistance to providers who have Medicare Part D questions regarding the client's they serve. The Coalition's Medicare Part D Prescription Drug Plan website provides an extensive list of Medicare Part D Resources.

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

- 1-800-332-3742 (1-800-290-9138 TTY) EPIC Helpline
- epic@health.state.ny.us

Provides information about the EPIC Program and how EPIC will coordinate with Medicare Part D Prescription Drug Coverage.

Health Insurance Information Counseling and Assistance Program (HIICAP) – NY SHIP

- (800) 701-0501 Toll Free 9:00 - 4:00 Monday - Friday
- www.hiicap.state.ny.us

The Henry J. Kaiser Family Foundation Kaiser Commission on Medicaid & the Uninsured

- http://www.kff.org/medicare/

Provides information and publications about the Medicare Part D benefit and dual eligibles.

Low Income Subsidy Application

- http://www.socialsecurity.gov/prescriptionhelp/

An electronic version of the LIS application is made available on the internet through the Social Security Administration. Applicants can have someone assist them when filling out the application.

MEDICARE

- 1-800-MEDICARE (1-800-633-4227; 1-877-486-2048 TTY)
- http://www.medicare.gov/
- Medicare & You Handbook
- http://www.medicare.gov/medicarereform/drugbenefit.asp

Website provides Medicare plan comparison tool, provider information, and Medicare coverage information. You can also view, print, or order publications online (such as the ***Medicare&You 2006*** *Handbook) using the search tool or you can call 1-800-MEDICARE (1-800-633-4227). If you order online or through 1-800-MEDICARE, you will receive your order within 3 weeks.*

- http://questions.medicare.gov/

Provides answers for Medicare Part D Frequently Asked Questions

The Medicare Rights Center

- www.medicarerights.org/maincontentapptips.html

Website provides tips on filling out the Low Income Subsidy (LIS) application.

Mental Health Part D

- www.mentalhealthpartd.org

Provides Medicare Part D information of particular interest to the Mental Health Community

National Council in Community Mental Health

- http://www.nccbh.org/MEDICARE/INDEX.HTM

Provides resources to assist providers in preparing their practices and consumers for this upcoming change.

The National Mental Health Association (NMHA)

- 1-800-969-NMHA (6642)
- http://www1.nmha.org/federal/MedicarePrescriptionDrugBenefit.cfm#facts
  http://www.nmha.org/affiliates/directory/index.cfm – listing of local Mental Health Associations

Provides fact sheets for consumers, tools for advocates, news and resources about Medicare Part D.

New York StateWide Senior Action Council, Inc:

- 1-518-436-1006
- http://www.nysenior.org/

Provides information on how the new Medicare drug benefit will work with the EPIC program.

The New York State Office of Medicaid Management

- 1-800-541-2831
- Medicaid@health.state.ny.us - email

Provides information on beneficiary Medicaid status and answers questions regarding Medicaid benefits.

Social Security Administration

- http://www.socialsecurity.gov/
- 1-800-772-1213 (1-800-325-0778 TTY)

Provides answers to Medicare and Low Income Subsidy questions and information about prescription drug costs and Social Security Office locations.

State Health Insurance Assistance Programs (SHIPs)

- https://www.shiptalk.org

Website provides listing of all SHIPs by state.

Veterans' Administration (VA) Health Benefits Service Center

- 1-877-222-VETS (8387)
- www.va.gov/healtheligibility

Provides information about Veteran's Health Administration (VA) Health Care Benefits.