

MODULE 6: MEDICARE PRESCRIPTION DRUG COVERAGE (MEDICARE PART D)

INTRODUCTION

Medicare Part D is a voluntary prescription drug benefit which has been available to all people with Medicare (Part A and/or Part B) since January 2006. Part D differs from Original or Traditional Medicare in that the Part D benefit is provided **ONLY** through private health insurance companies who work with Medicare to negotiate discounts on drug prices.

Medicare beneficiaries can access this benefit by enrolling in a Medicare-approved private prescription drug (“Part D”) plan. It can be a “stand-alone” prescription drug plan (PDP), which offers only drug coverage, or a Medicare Advantage prescription drug plan (MA-PD), that covers all Medicare benefits, including prescription drug coverage, through a managed care plan.

Like other insurance, Part D plans usually charge a monthly premium, an annual deductible and a share of the cost of prescriptions (copay or coinsurance). Costs vary depending on the individual plan chosen.

All drug plans have to provide at least a standard level of coverage, which Medicare sets. However, some plans offer more coverage and cover additional drugs but may charge a higher monthly premium.

Because drug plans vary in terms of which prescription drugs are covered, how much you have to pay, and which pharmacies you can use, it is important for beneficiaries to choose a plan that best meets their prescription drug needs.

PART D COST-SHARING STRUCTURE

Although Part D plans vary, they each have this *general* overall structure to their standard benefit:

- **Deductible.** Many, but not all, plans charge an annual deductible.
- **Initial Coverage Limit (ICL).** Beneficiaries responsible for 25% of cost sharing; plans pick up 75%.
- **Coverage Gap** (“Donut Hole”). Beneficiary responsible for a much larger share of cost sharing. Up until 2011, beneficiaries paid 100% of the cost sharing during the coverage gap.
 - The coverage gap works like a second deductible. The beneficiary resumes responsibility for most of the cost sharing until **TrOOP (True Out Of Pocket)** limit is reached. TrOOP includes the initial deductible (if any) plus any copayments or coinsurance paid during the ICL; TrOOP does NOT include the monthly premium. Plans cannot change this feature.
 - The coverage gap is being phased out over time as a result of the federal Health Care Reform (HCR) legislation passed in 2010:
 - In 2014, most brand name drugs in the coverage gap were discounted at 52.5%, with generics discounted at 28%.

- In 2015, the brand name drug discount increased to 55%, while the generic discount rises to 35%.
 - In 2016, the brand name drug discount stays at 55%, while the generic discount increases to 42%
 - In 2017, the brand name drug discount increases to 60%, while the generic discount goes up to 49%.
 - By 2020, the coverage gap will be eliminated.
- **Catastrophic Coverage** (After TrOOP limit is reached). Beneficiary responsible for greater of 5% of cost of drug, or copayment of \$2.95 for generics or \$7.40 for brand-name drugs (2016).
 - In 2017, the copayments **increase** to \$3.30/generic and \$8.25/brand name.

SPECIAL INCOME-BASED RULES

People with Medicare with higher incomes who are subject to the Part B income-related premium, also known as IRMAA (“Income Related Medicare Adjustment Amounts”), are also subject to a Part D income-related monthly premium. These individuals are assessed a premium surcharge (an additional amount) for their monthly Part D coverage. The surcharge amount is collected by the Social Security Administration (SSA), not by the Part D plan. And it is paid the same way as the Part B premium, for most beneficiaries, deducted directly from their Social Security check.

In 2016, the Part D income-related surcharge ranges from \$12.70 - \$72.90 per month, depending on the household income as outlined in the charts below¹

Beneficiaries who file an <i>individual</i> tax return with annual income of:	Beneficiaries who file a <i>joint</i> tax return with annual income of:	Monthly premium surcharge amount (2016)
Less than \$85,000	Less than \$170,000	None
Between \$85,000–\$107,000	Between \$170,000–\$214,000	\$12.70
Between \$107,000–\$160,000	Between \$214,000–\$320,000	\$32.80
Between \$160,000–\$214,000	Between \$320,000–\$428,000	\$52.80
More than \$214,000	More than \$428,000	\$72.90

If a beneficiary is married, but files separately, their premium surcharge is determined as follows

Beneficiaries who are <i>married</i> and file a <i>separate</i> tax return from their spouse:	Monthly premium surcharge amount (2016)
Less than \$85,000	None
Between \$85,000–\$129,000	\$52.80

¹ Modified from *Medicare Part D outline* developed by the New York Legal Assistance Group, available at www.nyhealthaccess.org

Beneficiaries who are <i>married and file a separate tax return from their spouse</i>:	Monthly premium surcharge amount (2016)
More than \$129,000	\$72.90

Remember that, just like for the Part B income-related surcharge, SSA relies on the household's most recent tax return. Individuals whose income has decreased since they filed their most recent tax return should bring this fact to SSA's attention; they may be able to get the surcharge removed.

Beneficiaries with *lower incomes* may qualify for the Part D Low Income Subsidy (LIS, also known as "Extra Help"). Qualifying for Extra Help will result in substantially lower out-of-pocket expenses because the Extra Help benefit covers most of the beneficiary cost sharing. Find out more details about Extra Help starting on p. 6-5

SUMMARY OF MEDICARE'S PART D STANDARD BENEFIT

See the chart below for a cost-sharing breakdown of the **standard Part D benefit**. **Note:** This chart is for people who are **not** receiving Part D Extra Help. It will generally apply to beneficiaries with incomes *above* 150% of the Federal Poverty Level (FPL) -- \$17,820 for an individual and \$24,030 for a couple in 2016.

(**Note:** this cost-sharing structure does **not** apply to "Extra Help" (Low Income Subsidy) recipients. See page 6-5 for Extra Help cost sharing.)

PART D STANDARD BENEFIT - 2016		
Drug Expenses	Beneficiary's Responsibility	Plan's Responsibility
Deductible Cost of drugs from \$0 to \$360	100% of the annual deductible (maximum \$360)	None
Initial Coverage Limit Total cost of drugs (what plan pays plus what beneficiary pays) between \$360 and \$3,310	25% of the cost of the drugs (25% of \$2,950 or \$737.50)	75% of the cost of the drugs (\$2,212.50)
Coverage Gap (also known as the "donut hole") Cost of the drugs between \$3,310 and \$7,062.50... approximately \$3752.50	Beneficiary pays 45% of the cost of brand name drugs. Beneficiary pays 58% of the cost of generics.	5% of the cost of brand name drugs. (50% manufacturer discount applies to brand name drugs.) 42% of the cost of generic drugs.
TrOOP True Out of Pocket expenses (Beneficiary's total cost sharing obligation through end of coverage gap) \$4,850	\$360.00 (deductible) \$737.50 (coinsurance) <u>\$3,752.50</u> (coverage gap) \$4,850.00 (TrOOP)	\$0 (plan costs do not count toward TrOOP)

PART D STANDARD BENEFIT - 2016		
Drug Expenses	Beneficiary's Responsibility	Plan's Responsibility
Catastrophic coverage Cost of the drugs after TrOOP is met (when total drug spending = \$7,062.50)	Greater of 5% or \$2.95 copay for generics, \$7.40 copay for brand names	The remaining expenses, depending on cost of the drugs

PART D STANDARD BENEFIT - 2017		
Drug Expenses	Beneficiary's Responsibility	Plan's Responsibility
Deductible Cost of drugs from \$0 to \$400	100% of the annual deductible (maximum \$400)	None
Initial Coverage Limit Total cost of drugs (what plan pays plus what beneficiary pays) between \$400 and \$3,700	25% of the cost of the drugs (25% of \$3,300 or \$825)	75% of the cost of the drugs (\$2475)
Coverage Gap (also known as the "donut hole") Cost of the drugs between \$3,700 and \$7,425... approximately \$3,725	Beneficiary pays 40% of the cost of brand name drugs. Beneficiary pays 51% of the cost of generics.	10% of the cost of brand name drugs. (50% manufacturer discount applies to brand name drugs.) 49% of the cost of generic drugs.
TrOOP True Out of Pocket expenses (Beneficiary's total cost sharing obligation through end of coverage gap) \$4,950	\$400 (deductible) \$825 (coinsurance) <u>\$3,725</u> (coverage gap) \$4,950 (TrOOP)	\$0 (plan costs do not count toward TrOOP)
Catastrophic coverage Cost of the drugs after TrOOP is met (when total drug spending = \$7,425)	Greater of 5% or \$3.30 copay for generics, \$8.25 copay for brand names	The remaining expenses, depending on cost of the drugs

TRUE OUT-OF-POCKET COSTS (TROOP)

TrOOP stands for "true out-of-pocket" costs. These expenses count toward the threshold that determines the start of catastrophic coverage.

TrOOP eligible expenditures are costs actually paid by the beneficiary, another person on behalf of the beneficiary, a qualified State Pharmaceutical Assistance Program (SPAP or EPIC in New York State), the AIDS Drug Assistance Program (ADAP) or the Indian Health Service.

Part D copays for formulary drugs generally count as TrOOP eligible expenditures, as well as the manufacturer discount portion of the drug (50% for brand name drugs purchased during the coverage gap).

Not all drug costs count, however. Examples of costs not included in TrOOP include the costs of non-formulary drugs; the monthly premium, payments reimbursed by a third party (such as a supplemental insurance plan sponsored by a former employer), costs for Part D-excluded drugs, and most third party assistance, such as that from employers and unions.

EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

Extra Help (also known as the Low Income Subsidy “LIS”) is available for beneficiaries with limited income and resources. This subsidy helps to reduce or eliminate the beneficiary’s Part D premium and significantly lower their cost-sharing requirements. Some beneficiaries receive this Extra Help automatically while others need to apply in order to receive it.

Beneficiaries enrolled in Medicaid (“dual eligibles”) or one of the Medicare Savings Programs receive Full Extra Help automatically, through a process called “deeming.” Others who may be eligible for the Full or Partial Extra Help based on their limited income and resources would need to apply through the Social Security Administration (SSA) for this assistance. Beneficiaries can apply for Extra Help at any time of the year.

Full Extra Help recipients will pay no monthly premium if they are enrolled in a benchmark plan. Benchmark plans are basic Part D plans whose monthly premium is at or below New York State’s subsidy amount (\$39.73 for 2016).

Full Extra Help benefit for Medicaid recipients (dual eligibles)²

Income Up To or At 100% Federal Poverty Level (FPL)

- Individual \$11,880 year/\$990 month (2016)
- Couple \$16,020 year/\$1,335 month (2016)
- No monthly premium (if a benchmark plan)
- No deductible
- Copayment \$1.20 Generic \$3.60 Brand (up to catastrophic coverage limit) 2016 amounts
 - In 2017, the copays will be \$1.20/\$3.70
- \$0 copayments associated with catastrophic coverage limit (when total drug spending reaches \$7,062.50 in 2016/\$7,425 in 2017)

Income Above 100% Federal Poverty Level (FPL)

- Individual \$11,880 year/\$990 month (2016)
- Couple \$16,020 year/\$1,335 month (2016)

² These income figures (FPLs) are the gross income amounts, *before* any allowable deductions.

- No monthly premium (if a benchmark plan)
- No deductible
- Copayment \$2.95 Generic, \$7.40 Brand, up to catastrophic coverage limit (2016 amounts)
 - In 2017, the copays *increase* to \$3.30/\$8.25
- \$0 copayments associated with catastrophic coverage limit (when total drug spending reaches \$7,062.50 in 2016/\$7,425 in 2017)
- **Note:** Institutionalized dual-eligible beneficiaries, individuals in a Medicaid Home and Community Based Services (HCBS) waiver program, *and those in a Medicaid Managed Long Term Care (MLTC) plan or a Fully Integrated Dual Advantage (FIDA) plan*, have \$0 co-pays.

People with Medicare in a Medicaid spend-down (or surplus) qualify for the same low-income subsidy as the full benefit dual-eligible. They continue to receive the Full Extra Help through at least the end of the calendar year **even if they fail to “spend down” for Medicaid in succeeding months.**

Full Extra Help benefit for people not on Medicaid – includes Medicare Savings Program recipients

Income at or below 135% Federal Poverty Level (FPL)

- Individual \$16,038 year/\$1,337 month (2016)
- Couple \$21,627 year/\$1,803 month (2016)
- Asset test \$8,780 (individual) \$13,930 (couple) (2016), if not in a Medicare Savings Program
 - Includes \$1,500 (individual) \$3,000 (couple) for funeral/burial expenses
 - **No asset test for beneficiaries in a Medicare Savings Program**
- No monthly premium (if a benchmark plan)
- No deductible
- Copayment \$2.95 Generic \$7.40 Brand (2016 amount), up to catastrophic coverage limit
 - In 2017, the copays *increase* to \$3.30/\$8.25
- \$0 copayments associated with catastrophic coverage limit (when total drug spending reaches \$7,062.50 in 2016/\$7,425 in 2017)

Partial Extra Help

Income between 135%-150% Federal Poverty Level (FPL)

- Individual \$17,820 year/\$1,485 month (2016)
- Couple \$24,030 year/\$2,003 month (2016)
- Asset test \$13,640 (Individual) \$27,250 (Couple) (2016)
 - Includes \$1,500 (individual) \$3,000 (couple) for funeral/burial expenses
- Sliding scale premium
- Above 135% FPL but at or below 140% FPL, 75% premium subsidy
- Above 140% FPL but at or below 145% FPL, 50% premium subsidy
- Above 145% FPL but below 150% FPL, 25% premium subsidy

- \$74 deductible (maximum) (2016); \$82 maximum in 2017
- 15% coinsurance up to TrOOP (\$4,850 in 2016 and \$4,950 in 2017); \$2.95/\$7.40 copays thereafter in 2016, increase to \$3.30/\$8.25 in 2017

Note: Beneficiaries whose income makes them eligible for Full Extra Help, but whose assets are too high for Full Extra Help, can still receive Partial Extra Help if their assets fall below Partial Extra Help limits. They will receive a mixed subsidy of Full Extra Help with the premium and Partial Extra Help with their drug cost-sharing.

Note: Sometimes Extra Help recipients run into problems at the pharmacy counter, if their Extra Help status fails to display in the pharmacy’s computer system. When this happens they may be charged the “regular” cost sharing amount. The **Best Available Evidence** (BAE) policy can be used to help beneficiaries get their copays adjusted to the correct amount. Check the CMS publication *If You Get Extra Help, Make Sure You’re Paying the Right Amount* (<http://www.medicare.gov/Pubs/pdf/11324.pdf>) for more details.

HOW LONG DOES EXTRA HELP COVERAGE LAST?

Beneficiaries who apply for and receive Extra Help through the Social Security Administration (SSA) don’t have to reapply or recertify every year. Instead, their Extra Help coverage will continue until and unless SSA does a redetermination of their eligibility AND sends them notice that they are no longer eligible.

Those who get Extra Help automatically because they have Medicaid or the Medicare Savings Program will continue to receive Extra Help as long as they keep getting Medicaid or the Medicare Savings Program. If the Medicaid or Medicare Savings Program coverage ends, the Extra Help continues at least until the end of the current calendar year. For beneficiaries who had active Medicaid or Medicare Savings Program coverage during any month between July-December, their Extra Help deemed status lasts until the end of the *following* calendar year. CMS sends letters to beneficiaries who will be losing their deemed status, to let them know that their automatic Extra Help coverage is ending as of December 31st. These individuals can get back on Extra Help by applying through SSA or being re-deemed, if they begin receiving Medicaid or the Medicare Savings Program again.

ENROLLMENT

Enrolling In a Prescription Drug Plan

For many beneficiaries, one of the most challenging aspects of Part D is choosing a plan. Fortunately, Medicare’s website (<http://www.medicare.gov>) makes that process considerably easier. The website has comprehensive information about Part D (PDP only and MA-PD) plans, how well they are rated, what drugs they cover, the cost sharing involved, utilization management requirements (i.e., any special restrictions on covered drugs, such as a prior authorization requirement) and contact information for the plans. The website has a search function that allows the user to find plans that cover specific drugs and then view a detailed comparison of each plan’s coverage.

Medicare's website can be used to enroll into a Part D plan. You can use the Medicare online enrollment tool for MA-PD plans as well as for PDP plans. (There are a few exceptions; you cannot enroll online into a special needs plan or a "low performing plan" – one with a consistently low quality rating.) Beneficiaries can also enroll into a Part D plan by calling 1-800-MEDICARE or by contacting the plan directly.

Note: The *only* Medicare drug coverage option for Medicare Advantage (MA) members who want to stay with their MA plan is their own plan's MA-PD. (Exception: Beneficiaries in Private Fee for Service (PFFS) or Medical Savings Account (MSA) plans **without** Part D can be enrolled in any stand-alone PDP.)

The Part D plan year runs from January 1 through December 31.

Initial Enrollment Period (IEP) for Part D

Beneficiaries who are new to Medicare may enroll in a Part D plan in the same 7-month Initial Enrollment Period (IEP) that they have for Part B, including the month of their eligibility, the three months prior, and the three months after.

Annual Coordinated Election Period (AEP)

Beneficiaries can also enroll, drop, or change plans during the Annual Coordinated Election Period (AEP). The AEP for both PDP and Medicare Advantage enrollment is the same. The AEP is October 15 – December 7, with the change becoming effective January 1.

Special Enrollment Periods (SEP)

In general, beneficiaries not receiving Extra Help (the Low Income Subsidy) can change plans only once each year, during the AEP. However, there are also limited exceptions where a beneficiary would be granted a Special Enrollment Period (SEP) to enroll in, disenroll, or switch plans outside of the AEP. These may include the following situations:

- Change in residence (if you are leaving the Part D plan's service area or moving to another area (county) with new Part D plans available)
- Individual entering, residing in, or leaving a long-term care facility (including a skilled nursing facility)
- Individuals newly released from jail³
- Involuntary loss, reduction, or non-notification of "creditable coverage" (coverage that is at least as good as standard Part D coverage)
- Disenrollment from Part D - to enroll in or maintain creditable coverage (including the VA)
- Loss of employer based drug coverage (including COBRA). This loss may be voluntary or involuntary.
- All EPIC members can choose once per year (at any time during the year) to join a Medicare drug plan for the first time or to change to another plan.
 - You may NOT drop Part D coverage using this SEP.
- All Medicare enrollees can choose once per year (at any time during the year) to join a Part D plan with a quality rating of 5 stars, if a 5 star plan is available in their service area.

³ People who are incarcerated, or who live outside the US, are not eligible for Part D.

- In 2016 in New York State, NO 5 star plans are available.
- Individuals enrolled in plans with overall quality ratings of less than 3 stars for at least 3 consecutive years ("low performing plans") have the opportunity to choose once per year to enroll into a higher quality-rated plan.
- **IMPORTANT:** All Extra Help recipients have a *continuous special enrollment period*, meaning that they can switch plans at any time during the year, to be effective the first of the following month.

Note: CMS recommends that persons change plans early in the month to avoid delays at the pharmacy counter.

Tip: When switching Part D plans, it is NOT necessary to contact the current plan to disenroll. Simply enroll in the new Part D plan to be automatically disenrolled from the current plan because a beneficiary cannot be on two Part D plans at the same time.

Resource: The Medicare Rights Center has a comprehensive Special Enrollment Period chart at the following link: http://www.medicareinteractive.org/uploadedDocuments/mi_extra/SEP-Chart.pdf

Part D Effective Dates for dual eligibles

- Medicaid recipients newly enrolled into Medicare will have their Part D enrollment become effective the first of the month in which Medicare Part A or B starts.
- Medicare recipients who are not already enrolled in Part D, and who gain Medicaid coverage, will gain Part D coverage effective the first day of the month of Medicaid eligibility.
- Medicare beneficiaries new to Medicaid who do not have an existing Part D plan, and Medicaid recipients who are new to Medicare and have not chosen a Part D plan, can obtain Part D drugs through a special program called LI-NET (Limited Income Newly Eligible Transition). LI-NET provides temporary prescription drug coverage at the point of sale (pharmacy) until the person enrolls in, or is auto-assigned to, a Part D plan.
 - LI-NET webpage: <https://www.humana.com/pharmacy/pharmacists/linet>
- The LI NET Program also provides retroactive coverage for new dual eligibles. Medicare automatically enrolls these individuals into the LI NET Program with an effective date retroactive to the start of their dual-eligible status. Enrollment in LI NET is temporary until Medicare enrolls these individuals in a Part D plan for the future.

Disenrolling From a Prescription Drug Plan

For individuals who want to switch plans during a special enrollment period or the annual open enrollment period, the easiest way to disenroll from the existing plan is to simply enroll into a new PDP or MA-PD plan. The enrollment into the new plan will automatically disenroll the person from their existing plan, effective the last day of the month before the new enrollment takes effect. No additional contact with the "old" plan is needed.

Late Enrollment Penalty (LEP)

Even if a person with Medicare does not take many (or any) prescription drugs at this time, they still should consider enrolling in a Part D plan or seeking creditable coverage from another source. Those who do not enroll in a plan when first eligible, and do not have creditable coverage

(prescription drug coverage determined to be at least as good as standard Part D coverage), will have to pay a penalty for late enrollment. Others with creditable coverage, such as insurance through a former employer or union, the Veterans Administration (VA), TRICARE for Life, or the Indian Health Service, will NOT be subject to a penalty for late enrollment.

The late enrollment penalty (LEP) is equivalent to 1% of the National Base Beneficiary Premium (rounded to the nearest 10 cents) per full month that the person with Medicare was not enrolled in a Medicare Prescription Drug Plan and did not have creditable coverage. In 2016, the National Base Beneficiary Premium is \$34.10 so the penalty would be \$34.10 X 1%, or approximately \$.34 per month. If the Medicare beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and Medicare Part D begins, they will **not** be subject to the penalty.

Tip: Count from the month following the end of the 7-month Initial Enrollment Period for Part D to determine the number of months without creditable drug coverage in order to calculate the Part D LEP, if any.

Note: Beneficiaries who receive Extra Help (either Full or Partial) are NOT subject to the LEP. And beneficiaries currently subject to a LEP would have the penalty end at the point that they qualify for Extra Help; the penalty would not be reinstated even if they subsequently lose their Extra Help in the future.

Facilitated Enrollment

Those beneficiaries in Original Medicare receiving Extra Help – either automatically or through completing the SSA application – who do not choose a Medicare Prescription Drug Plan (PDP) on their own will be enrolled into a random benchmark Medicare PDP. (A “benchmark” plan is a PDP available at zero premium for beneficiaries who receive the Full Extra Help.)

They can then change plans at any time during the year.

Note: Beneficiaries on a Medicare Advantage plan without Part D who later receive Extra Help will be facilitated into their own plan’s MA-PD option.

Exception: Beneficiaries on a Private Fee for Service (or Medicare Medical Savings Account (MSA)) plan without Part D who receive Extra Help will be facilitated into a random Medicare PDP, similarly to those beneficiaries in Original Medicare.

Annual Notice of Change (ANOC)

All Medicare Part D plan members should receive a combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) notice from their plan each year by September 30. The ANOC details all changes for the following year including premiums, cost-sharing (deductibles, copayments, coinsurance, and coverage gap), cost utilization tools, and formularies. The ANOC is NOT plan member specific, so beneficiaries would have to identify which changes may apply to them.

WHAT DRUGS ARE COVERED

Each Part D plan has its own formulary, which lists all the drugs it covers and the tier the drugs are in. While plans are not obligated to cover all drugs, every plan has to follow certain basic

requirements so that beneficiaries will have access to drugs for any medical condition they have or develop.

Plans must cover at least two different types of prescription drugs in each therapeutic category and each drug class. Plans are required to cover all or substantially all drugs in these six categories:

- 1) Antidepressants
- 2) Antipsychotics
- 3) Anticonvulsants
- 4) Anti-neoplastics (cancer)
- 5) Immunosuppressant (for organ and tissue transplant patients) and
- 6) Antiretroviral (for treatment of HIV/AIDS).

Plans must obtain CMS approval of their formularies, and must make their formularies publicly available. You can find plan formularies on Medicare's website (<http://www.medicare.gov>) and also on the individual plan websites.

Excluded Drugs

Certain drugs *cannot* be covered as part of the basic Part D benefit. Enhanced Part D plans may include certain excluded drugs as part of their enhanced plan benefit, but the cost of Part D-excluded drugs cannot be counted toward TrOOP.

Barbiturates and benzodiazepines used to be excluded, but have been covered for any medically indicated limitation since 2014.

Here are some of the drugs that are not covered under Part D:

- Drugs for anorexia, weight loss, or weight gain
- Fertility drugs
- Cosmetic or hair growth drugs
- Cold medicine
- Prescription vitamins and minerals
- Over-the-counter drugs
- Drugs for treatment of sexual or erectile dysfunction
- Drugs covered under Medicare Part A or Part B
- Drugs prescribed "off-label" (i.e., for treatment of a condition other than the one indicated on the drug's FDA-approved labeling, and for an indication not approved in one of three Medicare-approved pharmaceutical compendia)
- DESI drugs deemed less than effective -- older drugs determined to be as safe but "less than effective" by the FDA's Drug Efficacy Study Implementation (DESI) evaluation
- Drugs not covered under a signed manufacturer agreement with CMS.

Compounded drugs

Sometimes a pharmacist or physician will combine, mix or alter ingredients of a drug to create a medication tailored to the needs of an individual patient. This type of medication is called a compounded drug. Part D will only cover compounded drugs that contain at least one ingredient that is a Part D drug, and that do not contain any Part B ingredients.

Prescriber enrollment requirement (new for 2017)

There is a new policy which may affect beneficiaries who get prescriptions from doctors who don't participate in Medicare. Beginning in February 2017, CMS is planning to limit payment for Part D drugs to prescriptions written by doctors enrolled in Medicare in an approved status or who have a valid opt-out agreement with Medicare. A 3 month provisional supply will be dispensed, with individualized written notice, if a beneficiary presents a prescription written by a non-approved, non-opt-out doctor. After the 3 month provisional supply period, if the doctor hasn't corrected his/her status with Medicare, the Part D plan will deny payment for refills or other prescriptions written by that doctor. More information about these new requirements is available on CMS' website at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html>.

DETERMINING WHETHER DRUGS ARE COVERED UNDER PART A OR PART B

Drugs administered in a hospital or other inpatient setting

Prescription drugs administered in an inpatient hospital or skilled nursing facility (SNF) setting are usually covered by Medicare Part A. However, these drugs can be covered under Part B if the person does not have Part A coverage, Part A coverage of the hospital or SNF stay has run out, or if a stay is not covered.

Prescription drugs administered in a hospital outpatient setting (i.e., the Emergency Room or people considered to be under "observation status") are usually not covered by Medicare Part A or B, but may be covered under Part D.

Hospice patients

Most drugs administered to hospice patients are covered under Part A; however, drugs unrelated to the terminal illness can be covered under Part D. CMS clarified in 2014 that because "drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances," Part D plans are supposed to impose prior authorization (PA) requirements on all drugs for beneficiaries who have elected hospice to determine whether the drugs are coverable under Part D. More information on Part D coverage of hospice drugs is available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Part-D-Payment-Hospice-Final-2014-Guidance.pdf.

Part B vs. Part D

There are certain drugs that may be covered under either Part B or Part D. As a general rule, any drugs that were previously covered under Part B prior to the start of Part D (January 2006) are still covered under Part B today. Medicare Part D did not change Medicare's limited coverage for drugs under Part B. As a general rule, Part B coverage is usually - but not always! - limited to medications that are infused or injected in a doctor's office or hospital outpatient setting. Here are some examples of drugs that may be covered either by Part B or Part D, depending on the situation.

- **Antigens**

- Part B – Can be covered
 - Part D – NOT covered
 - **Erythropoietin (EPO)**
(**Examples:** Aranesp, Epogen, Procrit)
 - Part B – End Stage Renal Disease (ESRD) – for treatment of anemia
 - Part D – Other than for ESRD
 - **Immunosuppressive Drugs**
(**Examples:** Cyclosporine, Methotrexate, Prednisone)
 - Part B – following a Medicare-covered transplant
 - Part D – if Medicare did not cover the transplant
 - **Drugs Furnished “Incident To” a Physician’s Services**
(Not Usually Self-Administered) (Example: Avonex for multiple sclerosis)
 - Part B – drugs purchased by doctor and administered at the office
 - Part D – drugs purchased at pharmacy (that may be administered at the office)
 - **Oral Anti-Cancer Drugs**
(**Examples:** Busulfan, Cyclophosphamide, Methotrexate)
 - Part B – For cancer treatment
 - Part D – For any other condition
 - **Parenteral Nutrition**
 - Part B – Non-functioning Digestive Tract
 - Part D – All other situations
 - **Drugs Administered Through Part B Covered Durable Medical Equipment (DME) (such as Infusion Pump or Nebulizer)**
(**Example:** Insulin administered through Insulin Pump or Proventil (Albuterol) through a Nebulizer)
 - Part B – Administered Through Part B Covered DME
 - Part D – All other situations
 - **Vaccines**
 - Part B – Influenza, Pneumococcal and Hepatitis B (if at high risk only)
 - Part B – Vaccines given directly related to the treatment of an injury or direct exposure to a disease or condition
 - Part D – All other vaccines and Hepatitis B (if NOT at high risk)
- Note:** Besides knowing how Medicare covers a drug, you may also want to know how it is billed to Medicare. How the same drug is billed to Medicare may vary depending on the form of the drug, where it is purchased and how it is administered. For instance, a drug in tablet form may be covered under Part D and billed to the Part D plan. However, if you are receiving higher dosage injections of that same drug at the doctor’s office that may be covered under Part B. If you are purchasing the injectable drug at the pharmacy and then

bringing it to the doctor, the pharmacy would bill Part D. But if the doctor is purchasing the drug, the doctor would bill Part B for the cost of the drug, as well as its administration.

Note: The shingles vaccine (Zostavax) is billed to Part D for both the vaccine and its administration.

For further guidance on Part B vs. Part D issues, check the CMS publication:

<http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11315-P.pdf>

and chart from the Medicare Rights Center:

http://www.medicareinteractive.org/uploadedDocuments/mi_extra/B-vs-D-chart.pdf

COST UTILIZATION TOOLS

In an effort to control costs, many Part D plans employ “utilization management” tools, the most common of which are the following - prior authorization, step therapy and quantity limits. Additionally, plans use tiers to further control costs.

Tiers

Most Part D plans divide their formulary into “tiers” and encourage the use of drugs covered under the lowest tiers, by assigning different copayments or coinsurance for each tier. For instance, drugs covered under a lower tier, such as for generics, would require less cost sharing than those covered under a higher tier, such as for brand name medications.

Note: A plan may utilize one specialty tier. Only drugs with a cost greater than \$600 (\$670 in 2017) may be placed in the specialty tier. Coinsurance in the specialty tier is limited to 33% maximum and exceptions are not allowed for the cost sharing amount. (Remember that Extra Help recipients can’t be charged more than the maximum LIS copay, even for drugs in specialty tiers.)

Prior Authorization (PA)

Prior authorization means that the person’s doctor must request permission ahead of time from the plan to get the drug covered, and the beneficiary may have to meet specific criteria before the plan will approve the request.

Step Therapy (ST)

Step therapy is a type of prior authorization where a Part D plan will require a beneficiary to try less expensive drugs for the same condition before they will pay for a more expensive or brand name medication. Beneficiaries who have already tried the less expensive drugs should speak to their doctor about contacting the plan to request an **exception** (explained below).

Quantity Limits (QL)

For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. For instance, a plan may only cover up to a 30-day supply of a drug at a time. However, regardless of the quantity they approve, the same copayment applies.

In 2017, plans will have a new option. For formulary drugs that are provided on an extended supply basis (longer than 30 days), the plan may choose to impose a 30 day limit on the initial fill. CMS is allowing this change to limit drug waste when a new therapy is not working for the patient or has adverse effects.

Note: Tiers, prior authorization, step therapy and quantity limits, are all indicated on the www.medicare.gov Web site, when searching for particular drugs covered under a Part D plan.

PROTECTIONS – TRANSITIONS, EXCEPTIONS AND APPEALS

Formulary changes

A Part D plan’s formulary can change from year to year. Within the plan year itself (between January 1st and December 31st), plans are also allowed to make changes to their formulary. These are known as “midyear” formulary changes.

Plans who remove a drug from their formulary midyear or change its cost sharing are supposed to give 60 days’ notice in advance to affected members, their prescribing doctors and pharmacists. If the plan doesn’t provide advance notice to affected members, the plan must provide a 60-day supply of the drug at the time of refill, as well as written notice at that time. Plans will exempt existing members from the formulary change for the remainder of the year.

Plans should post midyear formulary changes on their website.

Transition Process

Each Part D plan must have a transition process in place during the first 90 days of coverage for new enrollees. The transition process ensures that new members can continue to access any non-formulary drugs they had been taking before they joined the plan. The transition process also applies to drugs that are on the Part D plan’s formulary but have a prior authorization or step therapy requirement. This transition process provides a one-time refill (a 30-day supply, unless the prescription is for less than 30 days).

Transition fills must also be made available to *current members* at the beginning of a new plan year that are affected by negative formulary changes (meaning that a drug they were taking last year was removed from this year’s formulary or became subject to prior authorization or step therapy in the new plan year).

Plans are required to send a written notice to each enrollee within 3 business days of the transition fill, explaining that the transition fill is temporary and advising beneficiaries to contact their health care providers. During the transition, beneficiaries should be speaking to their doctor about either switching to a formulary drug, requesting an exception (below), or considering switching to a different plan if they have the option to do so.

Exceptions and Appeals

In addition to the transition process, Part D plans must have procedures that provide enrollees with the opportunity to challenge the exclusion of a particular drug from a plan's formulary, the placement of a drug on a higher cost-sharing tier (tier exceptions), or the imposition of utilization management tools (prior authorization, step therapy, quantity limits). These procedures include the *coverage determination* process (sometimes called the "exception" process) and the *appeals* process.

Note: These processes are not available for drugs that are excluded from the standard Medicare Part D drug benefit.

Note: Tier exceptions may only be requested for brand name drugs covered under a non-preferred instead of a preferred tier. Tier exceptions cannot be requested to have brand name drugs covered under a generic tier, or to have specialty drugs covered at a lower tier.

Coverage Determinations/Exceptions Process

As an initial step, enrollees can file a *coverage determination request* with their plan if a particular drug is not on the plan's formulary, or is subject to utilization management, or the enrollee is seeking a tier exception for the drug.

The terms "coverage determination" and "exception" are generally used interchangeably, although an exception is one type of a coverage determination request. For simplicity's sake, CMS has developed a model form which beneficiaries and their physicians can use for most types of coverage determination/exception requests, available at <http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminationsandExceptions.html>.

Plans often have their own coverage determination request forms, although they cannot *require* beneficiaries or their physicians to use a specific form. CMS mandates a uniform exceptions and appeals process, meaning that, among other things, there is one standardized form to be used by all plans.

Physicians and appointed representatives (such as a family member) may assist enrollees in requesting a coverage determination. Plans must make their determinations as expeditiously as an enrollee's health condition requires, but no later than 24 hours for expedited decisions involving enrollees who suffer from serious health conditions, and 72 hours for standard decisions. The timeframe generally begins with the plan's receipt of the physician's supporting statement that the Part D preferred drug for treatment of the condition would not be as effective or would have an adverse effect for the enrollee. If a plan does not make a coverage determination or redetermination within the appropriate timeframes, the decision is automatically forwarded to the Independent Review Entity (IRE) (see Appeals section below) for review.

Generally, plans must approve coverage determination/exception requests when they determine that it is medically appropriate to do so. If the request involves a plan's tiered cost sharing issue, the drug being prescribed may be covered if the prescribing physician determines that the preferred drug for treatment of the same condition would not be as effective as the non-preferred drug or would have an adverse effect for the enrollee, or both. If the enrollee is requesting coverage of a non-formulary drug, the drug may be covered if the prescribing physician determines that all of the drugs on the formulary would not be as effective as the non-formulary drug or would have adverse

effects for the enrollee, or both. In both cases, the plan would have to agree with the physician’s determination.

Appeals Process

If a plan makes an unfavorable coverage determination such as denying an exception request, the enrollee, or his or her appointed representative, may appeal the plan’s decision. The Medicare Prescription Drug appeals process is modeled after the Medicare Advantage appeals process. An appeal must be filed within 60 calendar days of a plan’s decision to deny coverage.

Level	Standard Appeal	Expedited Appeal
1 Redetermination by Medicare Part D plan	If the Part D plan’s initial coverage determination is unfavorable, an enrollee may request a redetermination and the plan has up to 7 days to make its decision.	Same as standard except the timeframe is up to 72 hours for the plan to make its decision.
2 Reconsideration by Independent Review Entity (IRE)	If the Part D plan’s redetermination is unfavorable, an enrollee may request a reconsideration by an IRE, which is a CMS contractor that reviews determinations made by a plan. The IRE has up to 7 days to make its decision.	Same as standard except the timeframe is up to 72 hours for the IRE to make its decision.
3 Administrative Law Judge (ALJ)	If the IRE’s reconsideration is unfavorable, an enrollee may request a hearing with an ALJ if the amount in controversy is at least \$150 (in 2016). ALJ generally has 90 days to make a decision.	10 day time limit.
4 Medicare Appeals Council (MAC)	If the ALJ’s decision is unfavorable, an enrollee can request MAC review. MAC generally has 90 days to make its decision.	10 day time limit.
5 Judicial review	If the MAC decision is unfavorable, an enrollee can appeal the decision in federal court, if the amount in controversy is at least \$1,500 (in 2016).	Not applicable.

Note: The beneficiary may be held responsible for the cost of a drug during the exception/appeals process but if the final decision is favorable, they can receive retroactive reimbursement from the plan at the rate that the plan would have paid.

HELP! The Medicare Rights Center’s www.medicareinteractive.org website can help you through the appeals process. Also, MCCAP-funded agencies can provide help with Part D appeals, including representing individual beneficiaries in the appeals process. For a list of MCCAP agencies, go to <http://www.aging.ny.gov/HealthBenefits/MCCAP.pdf>

Note: If a Part D plan is not following Medicare rules, and efforts to resolve the problem directly with the plan have failed, a formal complaint can be filed with the CMS regional office. CMS regional office staff will investigate and attempt to resolve the complaint. HIICAPs should use the Complaint Tracking Module (CTM) system to file such a complaint.

END OF MEDICAID “WRAP-AROUND”

Before Medicare Part D, dual eligibles previously received coverage for most of their prescription drugs through Medicaid. After Medicare Part D began, Medicaid provided some “wrap around” coverage to pay for drugs that dual eligible beneficiaries were unable to get covered by their Medicare Part D plan.

However, the Medicaid wrap for Part D drugs ended in the fall of 2011. Medicaid no longer covers or “wraps” around any Part D drug.

Medicaid continues to pay for a few drugs excluded from the Medicare prescription drug benefit. These drugs include select prescription vitamins and certain nonprescription drugs (over the counter medications).

Note: Check the NYS Department of Health Medicaid Updates at the following link for the latest information on Medicare Part D and Medicaid.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_transition/

MEDICARE PART D AND OTHER DRUG COVERAGE

Employer/Union

People with Medicare who have coverage for prescription drugs through a former employer or union should receive an annual notice from that organization stating whether or not their coverage is creditable. Creditable coverage is determined to be at least as good as the standard Medicare Prescription Drug Coverage. If it is creditable coverage, the beneficiary may want to keep that coverage and not enroll in a Medicare Prescription Drug Plan. If the beneficiary loses their creditable drug coverage from their former employer or union, **either voluntarily or involuntarily**, they will be granted a Special Enrollment Period (SEP) in which to sign up for the Medicare Prescription Drug Coverage without having to wait for the next enrollment period or pay a penalty for late enrollment.

Note: Employer-based drug coverage includes coverage through the beneficiary, their spouse, or other family member’s current employment, retiree coverage or even through COBRA.

EPIC

Medicare Prescription Drug Coverage and EPIC is covered in Module 8.

ADAP (AIDS Drug Assistance Program)

ADAP, administered through the NYS Department of Health, provides free medications for the treatment of HIV/AIDS and opportunistic infections. There is an income and resource test for ADAP (Income cap is 435% of the Federal Poverty Level (in 2016 \$51,678 annually for a household of one and \$69,687 for two; liquid assets must be less than \$25,000.) ADAP does not have a citizenship/immigration status requirement.

For beneficiaries who have both ADAP and Medicare Part D, Medicare Part D will generally be the primary payer for HIV-related medications. ADAP can help with Medicare Part D copayments and

deductibles, and will pick up the cost of HIV-related medications during the Part D coverage gap). ADAP expenditures during the coverage gap count toward TrOOP.

Additionally, ADAP can be billed as primary payor in order to meet a Medicaid spenddown obligation (i.e., if the person needs Medicaid or Extra Help coverage).

For more information about how ADAP and Part D work together, go to <http://www.health.state.ny.us/diseases/aids/resources/adap/medicarefaqs.htm>

Medigap

Medigap plans stopped offering prescription drug coverage in 2006. However there may be some beneficiaries who were enrolled in Medigap plans H, I, or J with prescription drug coverage prior to 2006 that are still enrolled in the same Medigap plan today. (Plans H, I and J no longer exist in the current standardized Medigap plans; they were eliminated in June 2010.)

Note: These plans were **never** considered to be creditable drug coverage.

If a beneficiary kept their existing Medigap plan H, I or J with drug coverage and later decided to enroll in a Part D plan, they will be subject to a late enrollment penalty.

Other Sources of Copay Assistance

There are various other programs, including charitable organizations, drug discount cards and pharmaceutical drug assistance programs, which can help pay for prescription drugs. These programs may be able to assist individuals with no drug coverage at all, people who need help paying for a specific drug (i.e., off-label medication), as well as beneficiaries who have drug coverage but can't afford their cost sharing obligation.

The “Needy Meds” website (www.needymeds.org), administered by a national nonprofit organization, has a comprehensive listing of national and state resources to help pay for prescription medications, including:

- Pharmaceutical patient assistance programs
- Disease-based assistance programs
- Free/low-cost clinics
- Drug discount cards.

Other cost control tactics for prescription drugs include generic substitution, mail order pharmacy purchase, and comparison-shopping. Studies reveal substantial price differences between pharmacies, including independents, chains, and supermarket drugstores.

Sources of Assistance

NYS OFA HIICAP Hotline

1-800-701-0501

1-800-MEDICARE

www.medicare.gov

1-800-633-4227

New York State Office for the Aging Senior Hotline

(NY Connects)

1-800-342-9871

Independent Review Entity (IRE)

MAXIMUS Federal Services

1-877-456-5302

Part D QIC

Fax: 866-825-9507

860 Cross Keys Office Park

Fairport, New York 14450

<http://www.medicarepartdappeals.com/>

Publications:

- *Your Guide to Medicare Prescription Drug Coverage* (CMS 11109)
<https://www.medicare.gov/Publications/Search/results.asp?PubID=11109&PubLanguage=1&Type=PubID>
- *If You Get Extra Help, Make Sure You're Paying the Right Amount* (CMS 11324)
<http://www.medicare.gov/Publications/Pubs/pdf/11324.pdf>
- *Closing the Coverage Gap – Medicare Prescription Drugs Are Becoming More Affordable* (CMS 11493) <http://www.medicare.gov/Publications/Pubs/pdf/11493.pdf>
- *Getting Medical Care & Prescription Drugs in a Disaster or Emergency Area* (CMS 11377)
<http://www.medicare.gov/Pubs/pdf/11377.pdf>
- *How Medicare Drug Plans Use Pharmacies, Formularies, and Common Coverage Rules* (CMS 11136)
<https://www.medicare.gov/Pubs/pdf/11136.pdf>
- *Medicare Drug Coverage under Medicare Part A, Part B, Part C, & Part D* (CMS 11315-P)
<http://www.cms.hhs.gov/partnerships/downloads/11315-P.pdf>
- *How income affects your Medicare prescription drug premiums* (CMS 11469)
<http://www.medicare.gov/Pubs/pdf/11469.pdf>
- *How Medicare Prescription Drug Coverage Works with a Medicare Advantage Plan or Medicare Cost Plan* (CMS 11135)
<https://www.medicare.gov/Pubs/pdf/11135.pdf>

These publications are available in English and other languages via the Medicare publications website:

<http://www.medicare.gov/Publications/Search/SearchCriteria.asp?version=default&browser=Firefox|20|WinXP&Language=English&pagelist=Home&comingFrom=13>

2016 MEDICARE PART D SUMMARY CHART

COMMUNITY SERVICE SOCIETY - RSVP/ACES

	Dual Eligibles (Medicare and Medicaid ⁱ)	Medicare Savings Program (MSP)	Income 100-135% FPL	Income 135-150% FPL	Income above 150% FPL
Income limit (monthly)ⁱⁱ	Varies	Below QMB: \$1010 single/1,355 married SLMB: \$1,208/1,622 QI: \$1,357/1,823	Up to \$1,356 single/ 1,822 married	Up to \$1,485 single/ 2,002 married	Above \$1,485 single/2,002 married
Resource limit	\$14,850 single/ 21,750 married	QMB, SLMB, QI: no resource test	\$8,780 single/ 13,930 married including \$1,500 burial expenses per applicant and spouse	\$13,640 single/ 27,250 married including \$1,500 burial expenses per applicant and spouse.	N/A
Eligibility for Extra Help	Deemed eligible (no need to submit application).	Deemed eligible when approved for MSP.	Submit application to Social Security to be determined Low Income Subsidy (LIS) eligible; EPIC may submit. This information is sent to states for MSP screening.	Not eligible.	
Timeline for enrollment	Automatically enrolled for 2016 if had Medicaid any month after 7/15.	Facilitated enrollment if had MSP any month after 7/15, if plan not chosen.	If approved for Extra Help, facilitated enrollment if plan not chosen.	Unless first eligibility for Medicare or use EPIC or other SEP, only during Annual Coordinated Election Period to be effective 1/1.	
Late enrollment Penalty	No penalty if enrolled in Part D with Extra Help.				If no creditable coverage, 1% of current base premium (in 2016 base premium is \$34.10), per month eligible but not enrolled.
Switching plans	Once monthly, change effective first of following month.				Only during Annual Coordinated Election Period (10/15-12/7) for coverage effective 1/1, unless extenuating circumstances give a Special Enrollment Period. ⁱⁱⁱ May disenroll from a Medicare Advantage plan, with or without drug coverage, and get Original Medicare and may join a Stand Alone Part D from 1/1-2/14, effective on the first day of the following month.
Monthly Premium	\$0 ^{iv}	\$0 ^{iv}	\$0 ^{iv}	Sliding scale based on income. Subsidy based on % of benchmark premium (\$39.73). EPIC will pay up to additional \$39.73 for members. ^{iv}	Pay full premium, which in NYS is \$0-143. Additional surcharge of \$12.30 to \$70.80 per month if income two years before is above \$85,000 single/170,000 couple.

	Dual Eligibles (Medicare and Medicaid ⁱ)	Medicare Savings Program (MSP)	Income 100-135% FPL	Income 135-150% FPL	Income above 150% FPL
Annual Deductible	\$0	\$0	\$0	\$74, or less if in plan with lower deductible.	Varies from \$0-360.
CO-PAY^v	\$1.20 generic/\$3.60 brand (\$2.95/7.40, if over 100% FPL) maximum \$7,062.50 in drug costs ^{vi} ; no co-pays thereafter. No co-pay for nursing home residents or MLTC/FIDA or HCBS.	\$2.95 generic/\$7.40 brand, until either \$7062.50 in drug costs (per 1/21/05 CMS guidance and issue brief) or \$4,850 “true out-of-pocket” costs (per Federal Regulation at 423.782(b) (3)) ^{vii} . No co-pays thereafter.		15% of drug costs until either \$7062.50 total drug costs or \$4,850 “true out-of-pocket” costs ^{vii} ; \$2.95 generic/ \$7.40 brand thereafter.	Varies by plan. Gap starts at \$3310. After “true out-of-pocket” costs ^{vii} reach \$4,850, co-pays are 5% of drug costs, or \$2.95 generic/ \$7.40 brand, whichever is more. During gap, brand drugs discounted 55% and generics subsidized 42%.
Interaction with EPIC	Not eligible for EPIC, except those with spend down.	No EPIC fee. EPIC pays only when Part D has paid first except for prescription cough, cold, and vitamins not covered by Part D. With Extra Help the co-pay is maximum \$7.40, so with EPIC the maximum co-pay will be \$3.00. EPIC will pay up to \$39.73 additional for higher premium or enhanced coverage plans.		EPIC pays only when Part D has paid first except for prescription cough, cold, and vitamins not covered by Part D. Must pay EPIC fee but EPIC will pay up to \$39.73 additional for higher premium plans.	EPIC pays only when Part D has paid first so not during deductible period or when drug restrictions, except for dugs excluded by law. Must pay EPIC fee or deductible but EPIC does pay max \$39.73 premium up to income \$23,000 single/\$29,000 couple, or gives \$477 annual credit on EPIC deductible.
Advocacy Tips	Confirm that client has plan with fewest restrictions. Enroll in an MSP unless a bigger spend down is worse than paying the Part B premium.	Confirm that client has plan with fewest restrictions. Also submit Extra Help application to receive LIS assistance more quickly.	Confirm that client has best plan. Beneficiaries with incomes within this limit can also get an MSP.	Try to spend down to Medicaid at least once using drug costs paid in the previous three months by EPIC, ADAP, or medical costs to obtain full Extra Help until 12/31/16. If have EPIC, consider a Part D with no deductible.	Consider enrollment in EPIC if income below \$75,000 single/ \$100,000 married. Try to spend down to Medicaid at least once using drug costs paid in the previous three months by EPIC or ADAP, or other medical costs to obtain full Extra Help until 12/31/16. Use EPIC SEP to join a Part D or switch to better plan. If have EPIC, consider a Part D with no deductible.

Thanks to Bethene Trexel, RSVP/ACES volunteer, for table concept and updates, and Eric Hausman, DFTA, for checking.

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- ⁱ Anyone with Medicaid (including those with spend down who have spent down or paid in at least one month, Buy-In, or through a Supplemental Needs Trust) should be deemed eligible. All dual eligibles should be continued in or changed to a benchmark plan for 2016 unless they voluntarily changed from the plan originally assigned to them for 2015. Medicaid doesn't cover drugs when the Part D plan won't pay, except for select prescription vitamins and cough and cold medications, for duals only.
- ⁱⁱ Income considerations: Income limits are higher for Social Security LIS if there are additional dependent household members, such as minor children. Non-Medicare spouse is counted in all cases for Medicare spouse's income eligibility for MSP. There are monthly earned income disregards (\$65, then 50% disregard). If disabled or blind, can deduct impairment related work expenses. Medical insurance premiums are deductible for MSP.
- ⁱⁱⁱ Extenuating Circumstances that give a Special Enrollment Period include moving outside or possibly within a plan service area, going to or from an employer group health plan, change in institutionalized care living arrangement, or loss of an LIS. Joining EPIC also gives a SEP. Use one change given to enroll in a new plan, not disenroll from old; disenrollment is automatic when enroll in new.
- ^{iv} Clients opting for a higher premium plan or enhanced coverage will be required to pay the difference between their plan and the benchmark amount (\$39.73 in 2016) or an additional premium unless they also have EPIC which will pay up to \$39.73 more for up to income \$23,000 single, \$29,000 couple.
- ^v All co-pays, including those after drug costs reach catastrophic coverage, refer to drugs on the plan formulary and purchased at a participating pharmacy.
- ^{vi} \$7,062.50 is total drug costs (Example: if a person pays a \$1 co-payment for a drug and the drug plan pays \$90, \$91 is counted toward the total annual drug costs).
- ^{vii} "True out-of-pocket" costs, or TrOOP, are costs actually paid by the beneficiary, another person on behalf of the beneficiary, the 50% paid by drug companies during the gap, ADAP, or EPIC, and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer). The TrOOP amount counts toward reaching catastrophic coverage. Neither excluded drugs, nor the 42% generics subsidy nor 5.0% not rebated for brand names in the gap, count toward TrOOP.