



Medicare Part D

A Guide For Advocates
and Providers Who
Work With Older Adults
in Southwestern
Pennsylvania



Helpline: 1-800-274-3258 and 1-866-236-6310 (TTY)
www.phlp.org

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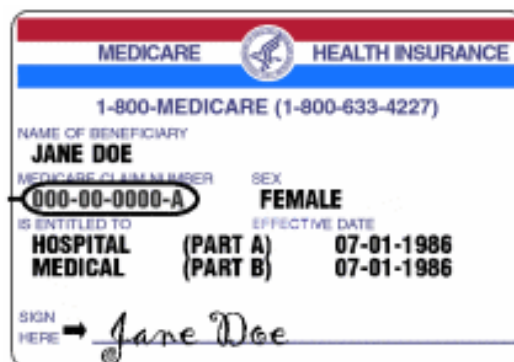
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Medicare Basics

Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services (hereinafter “CMS”), an office within the U.S. Department of Health & Human Services. Medicare is available to:

- Individuals who are age 65 and older;
- Individuals under 65 who have been receiving Social Security Disability Insurance (SSDI) benefits for at least 24 months (except for persons with ALS who get Medicare immediately when SSDI benefits start); *and*
- Individuals of any age (including children) who have End Stage Renal Disease

Medicare has 4 Parts: A, B, C, and D



Medicare Part A

Part A is the Hospital Insurance benefit of Medicare. Most people do not pay for Part A once they become eligible because they (or their spouse, or, in the case of an adult child with a disability, their parents) have worked enough qualifying quarters and have paid into the system via employment taxes.

Persons who have not worked enough qualifying quarters, but who are otherwise eligible for Medicare, can purchase Part A coverage for a monthly premium. The amount of this premium depends on the number of qualifying quarters an individual has worked.



Medical Assistance can purchase Medicare Part A coverage for certain recipients who are eligible for Part A but who have to pay for this coverage (i.e., person over 65 who receives SSI benefits).

The consumer must pay significant deductibles and co-pays for services covered under Medicare Part A unless they have secondary coverage to help pay for these costs.

Medicare Part A covers:

- ✓ **Inpatient Hospital Care**
- ✓ **Skilled Nursing Facility Care (up to 100 days)**
- ✓ **Home Health Care**
- ✓ **Hospice Care**

Medicare Part B

Part B is the Medical Insurance benefit of Medicare. Once a person becomes eligible for Medicare they can choose to enroll in Part B, decline enrollment or delay their enrollment until other insurance coverage (i.e., through her or her spouse's current employment) ends.

Those who enroll in Part B pay a monthly premium for the coverage. The Part B premium for 2007 is \$93.50. Starting in 2007, individuals with higher incomes (over \$80,000 per year for a single person; \$160,000 per year for a married couple) pay a higher premium for Part B. The Part B premium is typically deducted from the person's Social Security or Railroad Retirement benefits.



Low-income Medicare recipients may qualify to have Medical Assistance pay their Part B premium for them. This is referred to as the Medicare Savings Program (MSP).

Medicare Part B coverage includes:

- | | |
|--|---|
| ✓ physician services | ✓ ambulance services |
| ✓ outpatient hospital services | ✓ dialysis services |
| ✓ lab tests | ✓ home health services |
| ✓ x-rays | ✓ vaccines |
| ✓ durable medical equipment and supplies | ✓ medications (e.g. chemotherapy) administered in a doctor's office |

preventive health services such as:

- ✓ annual mammogram (for women 40 and older)
- ✓ pap smear and pelvic exam every 2 years (annually for those in certain high risk situations)
- ✓ annual prostate screening (for men 50 and older)
- ✓ colorectal cancer screening
- ✓ bone mass screening
- ✓ diabetes glucose monitoring
- ✓ cardiovascular screening every 5 years
- ✓ glaucoma testing
- ✓ a one-time "Welcome to Medicare" physical exam for new enrollees

Medicare Part B does not cover:

- × outpatient prescription drugs
- × routine wellness visits
- × routine eye exams and eye glasses (except following cataract surgery)
- × hearing exams and hearing aids
- × long term care
- × dental care
- × medical transportation

As with Part A, Medicare consumers have significant cost-sharing under Part B including an annual deductible and substantial co-pays for all covered services.



Medicare Part C

Part C refers to Medicare managed care. Beneficiaries can choose to get their Medicare through managed care plans called “Medicare Advantage” plans. These types of plans are offered by private companies approved by Medicare.

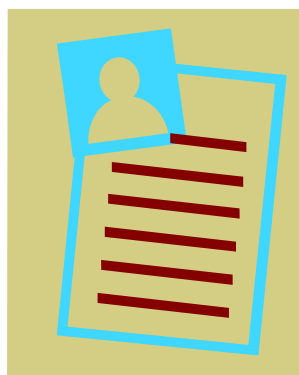
A Medicare consumer can choose get his coverage in one of two ways:

- ❖ **Traditional Medicare (using the red, white and blue Medicare card); or**
- ❖ **Medicare Advantage Plan (using their Plan Identification card)**

When a consumer joins a Medicare Advantage Plan, she gets all of her Medicare Part A and Part B benefits through the Plan. Some Medicare Advantage Plans cover extra services like dental care, eye exams and eyeglasses, and/or hearing exams and aids. Many of the Medicare Advantage Plans have a closed provider network which means the consumer can only get care from providers who are in the network.

Depending on the Plan and the coverage, consumers may be required to pay a monthly premium to the Plan in addition to their Part B premium.

Usually, individuals have lower out-of-pocket costs with Medicare Advantage Plans than they would if they just had coverage through Traditional Medicare. Consumers can join these types of plans rather than buy a Medigap policy (a supplement to help them pay for their cost-sharing through Traditional Medicare).



Medicare Advantage Plans include:

- ❖ Medicare Health Maintenance Organizations (HMOs)
- ❖ Medicare Preferred Provider Organizations (PPOs)
- ❖ Medicare Private Fee-for-Service Plans (PFFS)
- ❖ Medicare Special Needs Plans (SNPs) (enrollment limited to certain Medicare beneficiaries like full dual eligibles or residents of a nursing home)



Q. Can anyone join a Medicare Advantage Plan?

A. A Medicare consumer can join a Medicare Advantage Plan as long as he:

- *lives in the Plan's service area (these types of plans serve a limited geographic location such as a county or group of counties or an entire region);*
- *has Medicare A **and** B coverage; and*
- *does not have End Stage Renal Disease (ESRD) (NOTE: consumers with ESRD who are already in a Medicare Advantage Plan can stay in their current Plan or switch to another Advantage Plan offered by the same company).*

Medicare Part D

Part D is the Medicare Prescription Drug Program that was established through the Medicare Modernization Act (MMA) and went into effect on January 1, 2006.

Essentially, Part D offers Medicare consumers prescription drug insurance through private insurance companies. Consumers can get their Part D coverage through the following types of plans:

- **Medicare-approved stand-alone prescription drug plans (referred to as PDPs)**

OR

- **Medicare Advantage Plans that also include Part D prescription coverage (referred to as MA-PDs).**

Any Medicare consumer can join a Part D plan - this includes those with just Part A coverage, those with just Part B coverage, and those with both Parts A and B.



Q. Are consumers required to join a Part D Plan?

A. No. Medicare Part D is a *voluntary* benefit and consumers can choose not to enroll into a Part D Plan. However, if consumers do not have “creditable coverage”* and do not join a Part D Plan during their Initial Enrollment Period (see p. 13), but later decide they want the benefit, they may have to pay a penalty for delaying their enrollment. The penalty is a 1% increase in the Part D premium for every month they delayed their enrollment.

* **“Creditable coverage”** is other prescription drug coverage that is as good as, or better than, Part D coverage. Individuals who have other prescription drug coverage will be notified each year about whether that other coverage is creditable. If it is, they do not need to join Part D. Should these individuals later lose their creditable coverage, they qualify for a Special Election Period and can enroll in Part D at that time (see page 14).

Part D Coverage Options

Under the Medicare Modernization Act, there are 3 types of plan coverage options that Part D Sponsors can offer. Sponsors can offer a Standard Plan, an Alternative Plan, or an Enhanced Alternative Plan.

Standard Plans

Standard Part D Plans have to meet the following fixed requirements set out in the law. The amount of these standard costs will change every year:

- A monthly premium that differs from Plan to Plan. The national average monthly premium for a standard Plan in 2007 is **\$27.35**.
- An annual deductible that is fixed at **\$265** for 2007.
- An initial coverage period during which the consumer must pay a 25% co-pay for each of her drugs until her total drug costs reach **\$2400** in 2007.
- Once the consumer completes the initial coverage period, she has a coverage gap (also referred to as the “donut hole”) during which she must pay 100% of the cost for her drugs until her total out of pocket expenses* amount to **\$3850** in 2007.
- Upon completion of the donut hole, a catastrophic coverage period that lasts until the end of the calendar year during which a consumer pays only small co-pays for their medications. The co-pays during the catastrophic period are **\$2.15** for generic drugs and **\$5.35** for brand name drugs, or 5% of the drug cost, *whichever is greater*.

Though the monthly premium may be different from one Plan to the next, the benefit structure and cost-sharing is otherwise identical for all Standard Part D Plans.



* “Out-of-pocket” costs are restricted to costs paid for drugs covered by the Part D Plan. If a consumer chooses to buy medications not covered by the Plan those costs do not count toward the “out-of-pocket” threshold. If a consumer gets help paying for their Part D costs, this help may or may not be counted toward the “out-of-pocket” threshold (depending on the source of this help).

Alternative Plans

These are Part D Plans that create their own coverage package and do not meet the fixed requirements described on the previous page. For example, they may have a deductible less than \$265 (or no deductible at all); or these plans may or may not have a “donut hole” coverage gap (i.e., some plans could continue to cover generic drugs during this period).

Once the annual out of pocket threshold is reached (\$3850 in 2007), Alternative Plans cannot impose cost-sharing that exceeds that of a Standard plan.

Although Alternative plans can decide how much to charge during different coverage periods, the overall coverage package must be actuarially equivalent to that of a Standard Plan.

Enhanced Alternative Plans

These are Alternative Part D Plans that choose to offer coverage for drugs that are specifically excluded as Part D drugs—for example, benzodiazepines, barbiturates, and/or over-the-counter medications.

Because these Plans can cover medications that other types of Part D plans cannot cover, they are typically more expensive than Standard or Alternative plans.

By law, the actuarial value of Enhanced Alternative Plans can exceed that of a Standard Plan.

Choosing a Part D Plan

Under Part D, Medicare consumers have many choices to make.

- **Consumers must choose whether to obtain Part D coverage through a Prescription Drug Plan (PDP) or a Medicare Advantage Plan with prescription drug coverage (MA-PD).**
 - **Prescription Drug Plans (PDPs) only** cover prescription medications. The consumer obtains all of their other Medicare-covered services through Traditional Medicare (using the red, white and blue Medicare card).
 - **Medicare Advantage Plans with Prescription Drug coverage (MA-PDs)** offer Part D coverage along with all other Medicare-covered services. See pages 5 and 45 for more information about these types of plans.

- **Medicare consumers must choose among all the various PDPs and MA-PDs offered in their geographic region.**

In the Fall of every year, the Center for Medicare and Medicaid Services (CMS) announces the Part D plans that are approved to offer the Part D benefit in each region. These Plans are listed in the Medicare & You Handbook for that year and can also be found on the Medicare website, www.medicare.gov.

In 2007, Medicare consumers in Southwestern PA have 66 stand-alone PDPs to choose from. In addition, depending on the county they live in, they may have 20+ Medicare Advantage (MA-PDs) available to them!



The Part D region for Pennsylvania consumers includes the entire state of Pennsylvania and the state of West Virginia.

Consumers need to decide which Part D Plan will best meet their needs. To make this decision the consumer should consider the Plan's costs, drug coverage, and pharmacy network.

Costs

When considering whether they can afford a Part D Plan's costs, the consumer should review the amount of the monthly premium, the annual deductible, whether there is any coverage during the donut hole period (for example, some Plans cover generic drugs during the donut hole), and the co-pays charged for the medications they take.

Some of this information can be found in the Medicare & You 2007 Handbook. Information can also be obtained through the "Compare Medicare Prescription Drug Plans" tool on the Medicare website at www.medicare.gov or by calling the Part D Plan directly.

Drug Coverage

Medicare Part D Plans can cover FDA approved prescription drugs, vaccines, insulin and supplies. Plans do not have to cover all prescription drugs. Instead, each Part D Plan has a "formulary" (a limited list of drugs that it covers). The Plan decides which drugs it will cover, but Medicare requires that that plans must include at least two drugs in every therapeutic class or category in its formulary.*

*** Medicare requires that Part D Plan formularies cover "all or substantially all" drugs on the market in the following 6 categories:**

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Anticancer drugs
- Immunosuppressants
- HIV/AIDS drugs

Please note that Medicare has required the Plans to follow this guidance in 2006 and 2007. It is not yet clear if this requirement will extend beyond 2007.

Some drugs on the formulary may only be covered if the consumer obtains a prior authorization or goes through step therapy. A consumer can obtain coverage for a medication not on the Plan's formulary if the consumer (or their prescribing physician) requests a "formulary exception" and gets approval from the plan. *For more information, see p.19.*

When comparing the drug coverage of various Plans a consumer should consider the following:

- ✓ Will the Plan cover all of the medications I take? (check the quantity and dosage too)
- ✓ Does the Plan require that I get prior authorization for any of my medications?
- ✓ Does the Plan have any "transition policies"? (for example, does the Plan have a policy of covering all medications for an initial period of time when a consumer first enrolls?)

This information can be found through the "Compare Medicare Prescription Drug Plans" Tool on the Medicare website, www.medicare.gov. It can also be obtained by calling the Plan directly.

Pharmacy Network:

Every Part D Plan also has its own list of participating pharmacies that is referred to as its "pharmacy network". Generally, consumers who enroll in a Plan must go to a participating pharmacy to obtain their medications. When deciding whether to join a Part D plan consumers should consider the following:

- ✓ Will the Plan let me go to the pharmacy(ies) I go to now?
- ✓ Is there a participating pharmacy near me that is open 24 hours/7 days a week?
- ✓ Will I be able to obtain my medications through a mail order pharmacy?
- ✓ How will I get my medications if I am out of the Plan's service area? (for example, if I am on vacation out of state)

This information can be found through the "Compare Medicare Prescription Drug Plans" Tool on the Medicare website, www.medicare.gov. It can also be obtained by calling the Plan directly.

Enrolling In A Part D Plan

There are certain defined periods during which a Medicare consumer can enroll into a Part D Plan.

Initial Enrollment Period

Every new Medicare beneficiary is given an **Initial Enrollment Period (IEP)** during which she can initially enroll into a Part D Plan. This IEP lasts for 7 months - beginning the 3 months before she is eligible for Medicare and ending 3 months after the month Medicare starts.

If a consumer enrolls into a Part D Plan anytime during that period, the Part D benefit should become effective the first of the following month, or the first day of Medicare eligibility, whichever is earlier.

Example: Ms. Smith turns 65 on September 14, 2007. She is eligible for Medicare Parts A and B on September 1, 2007. Her Initial Enrollment Period for Medicare Part D begins June 1, 2007 and ends December 31, 2007. If she enrolls in Medicare Part D prior to August 30, 2007, her Part D coverage will start September 1, 2007. If she joins any other time after September 1, 2007, her Part D coverage will begin the first of the month after she enrolls in a Part D plan.

If a consumer does not enroll into a Part D Plan during her Initial Enrollment Period, she will not be able to enroll until the Open Enrollment at the end of the year-**unless** she is entitled to a Special Election Period (see next page).

Open Enrollment Period

The **Open Enrollment Period (OEP)** is a six week period at the end of every calendar year (from November 15th through December 31st) during which any Medicare beneficiary can enroll into a Part D Plan or change Plans.

If a consumer enrolls in a plan at any time during this period, her enrollment will be effective January 1st of the next year.

Special Enrollment Periods

Some consumers are given a **Special Election Period (SEP)** that allows them to enroll into a Part D Plan, or change Part D Plans, outside of the Initial and Open Enrollment Periods. Examples of SEPs include (but are not limited to):

- **All dual eligibles** (those on Medicare receiving any help from Medical Assistance) have an ongoing Special Election Period. That means they can enroll into a Plan or change Plans at any time, and even multiple times, throughout the year. Coverage is usually effective the first of the month after they enroll in the new plan.
- **Those who apply for and are awarded a Low Income Subsidy (LIS)** are given a Special Election Period to make one additional enrollment choice (at least through the end of 2007):
 - If they have not yet joined a Part D Plan, they qualify for a one-time chance to enroll outside of the fixed Enrollment Periods.
 - If they do not enroll on their own and CMS auto-enrolls them into a Plan, they are given a one-time chance to change Plans during the year.

Individuals can contact 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 TTY) to find out whether they qualify for a Special Election Period.

There are also certain circumstances that give a consumer a SEP to enroll in a Part D Plan or to change Plans. These include:

- the consumer involuntarily loses their creditable coverage
- the consumer moves in or out of the Part D Plan's region
- the consumer moves into, or moves out of, an institution such as a Skilled Nursing Facility or a long-term care hospital
- the Part D Plan violates its contract or terminates the Plan

Enrolling Into a Part D Plan

Any Medicare consumer can enroll into a Part D plan. A consumer can also have an “authorized representative” enroll him into a Part D plan. An authorized representative includes someone appointed by the consumer to act on his behalf (such as a family member, social worker, or friend) and persons authorized by State law to act for a consumer (such as a Power of Attorney).

There are three ways to enroll into a Part D Plan:

- Contact Medicare: 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 TTY). Enrollment staff will review the person’s other insurance (if any), their medications, and their pharmacy, and help them choose among the Plan options. Medicare representatives will enroll the person into a Part D Plan based on the individual’s choice.
- Contact the Plan: If the consumer has already decided which Part D Plan they want, they can call the Plan directly (phone numbers available at www.medicare.gov and also listed in the Medicare & You 2007 Handbook). Most plans will accept an application over the phone; however, some Plans require the consumer to complete a paper application in order to enroll.
- Enroll online: The consumer or their authorized representative can go to www.medicare.gov and compare the Part D Plans available. Once the consumer chooses a plan, she can enroll directly through the website. When enrolling online, the individual will get a confirmation number. The enrollment information is sent directly from Medicare to the Plan for processing. Some Part D plans also allow individuals to enroll through the Plan’s website.



Once a Medicare beneficiary enrolls into a Part D Plan, the enrollment is to be effective the first day of the month following the month of enrollment.



The earlier in the month a person enrolls the better because it takes at least several weeks to process an application.

If a beneficiary does not enroll until the middle of the month, or later, it is likely that their enrollment will not actually be in place on the 1st of the following month. Therefore, the person may have trouble filling prescriptions or may have to pay out of pocket for medications until the enrollment process is completed.

Once the enrollment is processed, coverage will be effective back to the first day of the month. If individuals had to pay out of pocket for medications before the enrollment was finalized, they should ask the pharmacy to bill their Part D plan and reimburse them their money.



Using the Part D Plan

After a consumer joins a Medicare Part D Plan, she is sent a Member Identification Card that is then presented at the pharmacy when filling prescriptions. The Plan should also send the consumer a Member Handbook that explains how the Plan works, gives details about the consumer's cost-sharing requirements, and provides information about how to appeal and file a complaint.

Each Part D plan has a "formulary"-that is, a limited list of drugs that it covers. Many Part D Plans also place the drugs they cover into different categories (referred to as "tiers"). The plan charges a different co-pay for each tier of drugs. Typically, the higher the tier, the higher the co-pays. This is an example of how a Plan's tiering structure might work:

- **Tier 1** covers most generic medications and has the lowest co-pay
- **Tier 2** covers "preferred" brand name medications with a medium copay
- **Tier 3** covers "non-preferred" brand name drugs with a high co-pay

In addition, some plans have a "**specialty tier**" that includes unique, very high cost medications with very high co-pays.



When a consumer who has Part D needs to have a prescription filled, they go to a pharmacy that accepts their Plan and give the pharmacist their Part D plan identification card and their prescription.

- If the medication is covered by the plan (i.e., on the plan's formulary), the pharmacist fills the prescription and charges the consumer a co-pay based on whether the drug is a generic or brand-name drug and based on which "tier" the drug is placed on (if the plan uses tiers).*
- If the medication is on the formulary but requires "prior authorization" or "step therapy", the pharmacist should tell the consumer that the prescribing doctor needs to contact the plan to request a prior authorization or provide the plan with information about why the drug is medically necessary for the consumer. The plan will have to approve the drug before the consumer can get it filled at the pharmacy. *(Note: plans are required to have a transition plan and provide any medication to the consumer during the first 30-90 days of coverage even if that medication requires prior authorization or has step therapy requirements. Each plan decides the timeframe for their transition policy).*
- If the medication is not on the plan's formulary, the pharmacy will not fill it. The consumer can then either contact their prescribing doctor to see if the doctor can change the prescription to a medication that is covered by their plan, or else the consumer and/or prescribing doctor can request an exception to the formulary. The process for seeking a formulary exception is set out in Example 1 on the following page.

* If the medication is covered by the plan, but the co-pay is higher than the consumer would like, she can request an exception to the Plan's tiering structure in order to get a medication at a lower co-pay. This process is set out in Example 2 on page 20.



Example 1: Seeking Coverage for a Prescribed Medication (or Dosage) not on the Part D Plan’s Drug Formulary

The consumer, their authorized representative, or the prescribing doctor can request an exception to the Plan’s formulary. Regardless of who requests an exception, the prescribing doctor must provide a written or oral statement (depending on the Plan) that the requested medication is “medically necessary” to treat the consumer because one of the following criteria applies:

- ✓ none of the formulary drugs would be as effective as the requested non-formulary drug and/or would have adverse effects on the consumer, or
- ✓ the formulary drugs required to be used under a step therapy regime have been or are likely to be ineffective, or have caused, or are likely to cause, adverse effects for the consumer, or
- ✓ the formulary dosage has been or is likely to be ineffective, or it will have adverse effects on the drug’s effectiveness or patient compliance.

Once the Plan receives the information from the prescribing doctor, it has 72 hours (24 hours in an expedited* case) to make a decision. The Plan must grant an exception for any Part D drug if it determines the drug is medically necessary, consistent with the prescribing doctor’s statement.

- If the formulary exception is granted, the Plan then decides what the tiering/co-pay level will be for that particular medication.
- If the request for exception is denied, that is a “coverage determination” which can then be appealed (see page 21).
- If the Plan fails to decide on the request in a timely manner, it is considered an adverse decision that is forwarded directly to the Independent Review Entity (IRE) appeal stage (see page 23).



* The Plan **must** provide an expedited decision if the evidence provided by the doctor shows that waiting 72 hours for a decision may seriously jeopardize the consumer’s life or health or ability to regain maximum function

Example 2: Seeking an Exception to the Plan’s Tiering Co-Pay Structure

The consumer, their authorized representative, or the prescribing doctor can request a program exception to obtain a “non-preferred” drug at a lower (“preferred drug”) co-pay. The tiering exception process is available for any formulary medication unless the Plan has established a tier for very high cost or unique items (i.e. a specialty tier). Those items can then be excluded from the exceptions process.

The prescribing doctor must provide a written or oral statement (depending on the Plan) that the non-preferred medication is “medically necessary” to treat the consumer because the preferred drug(s):

- would not be as effective as the requested drug, *and/or*
- would have adverse effects on the consumer

The Plan must grant the tiering exception if it finds the “non-preferred” drug is medically necessary consistent with the prescriber’s statement. The Plan has 72 hours (24 hours in an expedited* case) to decide on the request. Failure to decide in a timely manner is considered an adverse decision forwarded to the Independent Review Entity (IRE) stage (see page 23).

- If the exception request is approved, the consumer’s co-pay amount is reduced to the “preferred drug” co-pay level. This decision remains in effect until the end of the year as long as the drug continues to be safe for the consumer and the prescriber continues to prescribe that medication.
- If the request is denied, that is a “coverage determination” which can then be appealed (see the following section).



* The Plan **must** provide an expedited decision if the evidence submitted by the doctor shows that waiting 72 hours for a decision may seriously jeopardize the consumer’s life or health or ability to regain maximum function.

Appeals and Grievances

This section addresses what consumers can do if their request for an exception to a Part D Plan's drug formulary or tiered co-pay structure is denied, if they have been denied coverage of a prescribed medication, or if they are unhappy with how they have been treated by a Plan or with the Plan's policies or practices.

The following individuals can act on a consumer's behalf in pursuing a coverage decision or an appeal from the plan:

- the prescribing physician
- an individual appointed by the consumer to act on his behalf (such as a family member, friend, attorney, social worker, etc)
- persons authorized under State law to act on consumer's behalf which in Pennsylvania includes:
 - those given authority under a Power of Attorney or Guardianship
 - those designated as "substitute health care decision makers" for persons with mental retardation (see DPW OMR Bulletin 00-98-08)

STEP 1: Obtaining a Coverage Determination

The first step in the Part D appeals process is to obtain a "coverage determination". A "coverage determination" is any decision by a Part D Plan about the prescription drug benefits a consumer is entitled to under the Plan. Coverage determinations include:

- ✓ A Plan's decision not to pay for a drug because it is not on the formulary, because the Plan determines it is not medically necessary, or because the drug was obtained from an out-of-network pharmacy.
- ✓ A denial of a request for an exception to the Plan's formulary.
- ✓ A denial of a request for an exception to the Plan's tiered cost-sharing structure.
- ✓ A decision on the amount of co-pay for a drug.
- ✓ The Plan's failure to make a coverage determination in a timely manner when the delay would adversely affect the consumer's health.

STEP 2: Filing An Appeal

If the consumer disagrees with a Part D Plan's coverage determination, she can appeal. There are several levels of appeal that can be pursued. The first level, **Redetermination**, is handled by staff within the Plan. Further levels of appeal, **Reconsideration, Administrative Law Judge, Appeals Council**, are handled by entities outside of the Plan.

The Redetermination Process

- Upon receiving an adverse coverage determination, the consumer has 60 days from the date of the decision to request a Redetermination by the Part D Plan. The request must be in writing unless the Plan has a policy allowing oral requests. The Plan may extend this deadline if a consumer shows good cause why their appeal was not filed on time
- The Plan must provide the consumer and/or prescribing doctor a reasonable opportunity to present, in person as well as in writing, evidence and argument related to the matter in dispute
- The Redetermination must be handled by a Plan representative who was not involved in the initial coverage determination. *Note: If the issue being appealed relates to the consumer's medical need for a medication, the Redetermination decision must be made by a physician with expertise in the appropriate field of medicine involved in the appeal.*
- The Part D Plan must notify the consumer in writing of its Redetermination decision as quickly as the consumer's health condition requires but no later than 7 days* from the date it received the request. *Note: the Plan's failure to issue a Redetermination decision within the timeframe is considered a denial that must be sent within 24 hours to the Independent Review Entity (IRE) for review (see the next page).*
- If the Plan's written decision is adverse to the consumer it must:
 - be in a readable and understandable form,
 - state the specific reasons for the denial,
 - describe the Reconsideration process and further appeal options.



* The timeframe for a decision in an expedited case is 72 hours. The Plan must provide an expedited Redetermination if it determines, or if the prescribing doctor indicates, that waiting 7 days for a decision may seriously jeopardize the consumer's life or health or ability to regain maximum function.

The Reconsideration Process

If a consumer disagrees with the Plan's Redetermination decision, he can request Reconsideration of the decision.

- Reconsiderations are handled by an Independent Review Entity (IRE) under contract with Medicare (In 2007, the IRE is Maximus).
- The consumer must file a written request for Reconsideration within 60 days of the date of the Part D Plan's Redetermination decision. *Note: In order for a consumer to request Reconsideration of a Plan's refusal to cover a drug not on its formulary, the prescribing doctor must have determined that the drug is "medically necessary".*
- The IRE must request the opinion of the prescribing doctor either orally or in writing in order to make their decision. *Note: If the issue on appeal relates to the consumer's medical need for a medication, the Reconsideration decision must be made by a physician with expertise in the appropriate field of medicine involved in the appeal.*
- The IRE must conduct the Reconsideration and notify the consumer in writing of its decision as quickly as the consumer's health condition requires but no later than 7 days* from the date it received the request.



* The timeframe for decision is 72 hours in an expedited case. The IRE must provide an expedited Reconsideration if it determines, or if the prescribing doctor indicates, that waiting 7 days for a decision may seriously jeopardize the consumer's life or health or ability to regain maximum function.

- The Reconsideration decision must:
 - state the specific reasons for the decision in understandable language,
 - tell the consumer of her right to an Administrative Law Judge (ALJ) hearing if the amount remaining in controversy* is at least \$110, and
 - describe the process to obtain an ALJ hearing.



* The "amount remaining in controversy" is the projected value of the denied drugs for the year. The projected value includes any costs the consumer could be charged for the drug(s) in question based on the number of refills prescribed during the plan year.

Administrative Law Judge Hearing:

If the consumer disagrees with the Reconsideration decision, and the amount remaining in controversy (see previous page) meets the threshold requirement established annually by the Secretary of HHS (\$110 in 2007), the consumer can appeal further by requesting a hearing before an Administrative Law Judge (ALJ).

To request an ALJ hearing the consumer must file a written request within 60 days of the date of the Reconsideration decision. If the ALJ decides that the amount in controversy is less than the threshold requirement, the appeal is dismissed. If the threshold requirement is met, a hearing will be scheduled. The consumer and/or the prescribing doctor will have the opportunity to make an argument and present evidence. A written decision will be issued by the ALJ.

Medicare Appeals Council

If the consumer disagrees with the ALJ's decision she can request review by the Medicare Appeals Council (MAC). The request for review must be made in writing within 60 days of the date of the notice of the ALJ's decision.

Federal Court Review

If the consumer disagrees with the MAC decision she can seek review by the Federal District Court if the amount in controversy (see previous page) meets the threshold requirement established annually by the Secretary of HHS. In 2007, the amount in controversy for Federal Court Review is \$1,130.



Q. Can the consumer request a formulary exception or appeal the Part D Plan's denial of any drug?

A. The exception and appeals processes can be used for most prescription drug denials. However, they are not available if the consumer is requesting coverage for drugs that are not Part D drugs. These include:

- *medications already covered under Medicare Part A or Part B*
- *benzodiazepines, barbituates or over-the-counter drugs (unless the consumer is enrolled in an Enhanced Alternative Part D Plan that offers coverage for these drugs)*

Filing a Grievance

Part D plans must have a Grievance process for any consumer complaint or dispute (other than a coverage determination - see page 21) expressing unhappiness with any aspect of a Part D Plan's behavior, operations or activities.

To file a grievance with a Part D Plan the consumer:

- can make the grievance either orally or in writing (depending on the Plan's requirements)
- must file request no later than 60 days after the event or incident being grieved

Once the Plan receives the Grievance:

- it has 30 days to respond with a decision (unless the consumer or the Plan requests a 14 day extension)
- it must issue its decision in writing if a written grievance was filed.

The Medicare Modernization Act does not provide for any appeal mechanism if the consumer disagrees with the Plan's grievance decision.



Low Income Subsidy (Extra Help)

Consumers who enroll in Part D have significant out-of-pocket costs. These costs include a monthly premium, an annual deductible, and co-pays on most, if not all, prescriptions. To help consumers with low incomes and limited assets afford Part D, the Medicare Modernization Act provided for “extra help” from Medicare to help pay these out-of-pocket costs. This extra help is also referred to as the Low Income Subsidy or “LIS”.

There are actually two levels of help available- a **full** subsidy and a **partial** subsidy. Qualifying for either of these subsidies depends on a consumer’s income and assets.

Counting Income for LIS Eligibility:

When applying for a subsidy, individuals have to report their income from all sources. However, some of the consumer’s income will not count when determining eligibility for a subsidy.

- If a consumer has **unearned income** (such as Social Security or pension benefits): \$240/year will not be counted as income for LIS eligibility
- If a consumer has **earned income** (such as wages) : the first \$65 and one-half of the remainder of earned income will not be counted for LIS eligibility.

Example: A Medicare consumer is receiving Social Security income and is working part-time. She receives a total of \$15,000/year from Social Security. She earns \$4000/year from her part-time job (this is the gross amount of her earnings). Her total annual income is \$19,000.

When applying for the low-income subsidy, her countable unearned income is \$14,760/year (\$15,000 minus \$240) and her countable earned income is \$1967.50 (\$4000 minus \$65=\$3935; \$3935/2=\$1967.50). Therefore, her total countable income for purposes of LIS eligibility is \$16,727.50.

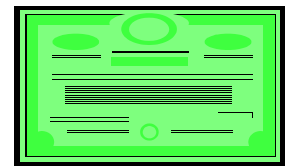
Counting Assets for LIS Eligibility:

Not all of a consumer's assets will count in determining eligibility for LIS. Specifically, Medicare will not count:

- the value of the consumer's home
- motor vehicles
- up to \$1500 each for the consumer and their spouse in assets designated for burial expenses
- burial plots

Medicare will count the following types of assets when determining eligibility for the LIS:

- any real property that is not the consumer's primary residence
- any liquid asset (stocks, bonds, IRAs, etc) that can be converted to cash within 20 days



Full Subsidy

Eligibility

To be eligible for a **full subsidy**, consumers must either:

- be receiving some benefit from Medicaid (Medical Assistance), even if the only benefit they get is help paying for their Medicare Part B premium (these individuals are called dual eligibles—see page 42)

or

- have income below 135% of the federal poverty level and have limited assets

2007 Full LIS Guidelines		
	<u>Income</u>	<u>Assets</u>
Single Person	Less than \$1,149/month or \$13,788/year	Less than \$6,120
Married Couple	Less than \$1,540/month or \$18,480/year	Less than \$9,190

Benefits of Full Subsidy

Once a consumer is determined eligible for a full LIS, the LIS benefits cover almost all of the costs of Part D. Specifically, individuals who qualify for the full subsidy:

- **Have NO monthly premium** (as long as they join a standard plan with a premium at or below the “benchmark premium” for that year-this amount is \$28.45 for 2007). These plans are called “**zero-premium plans**”. If the consumer chooses to enroll in a higher premium plan, the LIS will pay for part of the premium (up to the benchmark premium) and the consumer will have to pay the difference).
- **Have NO annual deductible**
- **Have NO “donut hole” or coverage gap**
- **Pay only small co-pays*** for their medications during the **initial coverage period**. The co-pay amounts these consumers have to pay depends on income and will change every year. For 2007, the co-pays are as follows:
 - For persons with income at or below 100% of the Federal Poverty Level (FPL), their co-pays are: \$1/generics and \$3.10/brand name
 - For persons with income over 100% FPL , their co-pay will be \$2.15/generics and \$5.35/brand name
- **Pay NO co-pays** once he/she reaches **catastrophic coverage** (Consumers reach catastrophic coverage in 2007 when the combined total of their out-of-pocket costs and the help they get from the subsidy equal \$3850)

In 2007, 100% FPL is:

Single Person: \$851/mo
or \$10,210/year

Married Couple: \$1,141/mo
or \$13,690/year



* persons approved for the full LIS who are residents of medical institutions like nursing homes and ICF-MRs have **no** co-pays under Medicare Part D.

Partial Subsidy

Eligibility

To be eligible for a **partial subsidy**, individuals must have income between 135% and 150% of the federal poverty level and limited assets. These are the partial subsidy guidelines for 2007:

	<u>Income</u>	<u>Assets</u>
Single Person	\$1,149-\$1,276/mo OR \$13,788-\$15,312/year	Less than \$10,210
Married Couple	\$1,540-\$1,711/mo OR \$18,480-\$20,532/year	Less than \$20,410

Benefits of Partial Subsidy

Consumers who are determined eligible for the partial LIS get the following benefits:

- **Help with their monthly premium**-the amount of help someone receives is on a sliding scale depending on their income. (Medicare covers 25-75% of their premium up to the benchmark premium-\$28.45 in 2007)
- **Have their annual deductible reduced** to \$53 (in 2007)
- **Have NO “donut hole” or coverage gap**
- **Pay reduced co-pays** during both the initial coverage and catastrophic coverage periods:
 - 15% co-pays on all medications until their total out-of-pocket expenses reach \$3850 in 2007.
 - After they reach this amount in spending, co-pays will be \$2.15/generics and \$5.35/brand names for the rest of the year.

Applying for the Low Income Subsidy

To receive the LIS, Medicare beneficiaries (other than dual eligibles) must complete and submit a subsidy application. **Consumers can apply for a LIS at any time throughout the year** - there are no deadlines or time limits. An application can be made in one of 3 ways:

1. Submit an original written application to the local County Assistance Office (DPW); or
2. Submit an original written application to the Social Security Administration (SSA); or
3. Apply on-line through the Social Security Administration website at www.ssa.gov/prescriptionhelp.

Once the application is processed, consumers will receive a notice from Social Security (SSA) or DPW telling them the following information:

- whether or not they qualify for a subsidy
- how much help they will get (full or partial)
- how to appeal if they disagree with the LIS decision.



This notice is important so consumers should keep it in a safe place in case there is any question later about their entitlement to an LIS.

Appealing an LIS Determination

If a consumer disagrees with an LIS determination she can appeal. **The appeal process is different depending on whether SSA or DPW made the initial determination.**

- **If DPW made the decision** to deny, reduce or terminate an LIS:
 - The consumer is notified in writing.
 - The notice will contain the reason(s) for the decision and will tell the person how they can appeal.
 - The consumer has 30 days from the date of the decision to appeal in writing and request a Fair Hearing with the Bureau of Hearings and Appeals (BHA). The individual can request a telephone or in-person hearing (based on consumer's preference). Generally, a decision will be issued within 90 days of when the appeal is received.
 - If the person disagrees with the BHA decision, he can appeal further by requesting Reconsideration of the Secretary of DPW and/or appeal to Pennsylvania Commonwealth Court.

- **If SSA made the decision** to deny, reduce or terminate an LIS:
 - The consumer is notified in writing and told how she can appeal.
 - The consumer has 60 days from the date she received the decision to request an appeal. Individuals can appeal by completing an appeal form which can be obtained by calling SSA (at 1-800-772-1213 or 1-800-325-0778 (TTY)) or from the SSA website at www.socialsecurity.gov. Individuals can also appeal by calling, writing, or visiting their local SSA office.
 - Individuals can choose to have a telephone hearing or have a paper review of their case (called a "hearing by case review"). After the hearing is conducted, the consumer is sent a written notice of decision with appeal information.
 - If the consumer disagrees with the hearing decision, she can appeal further by filing suit in federal district court.

Redetermining Eligibility for LIS

On a regular basis, Social Security and DPW must review the cases of those who have been previously determined eligible for an LIS. Both SSA and DPW will conduct redeterminations of eligibility to make sure the individuals continue to qualify and that they are getting the correct subsidy amount.

SSA and DPW will contact individuals via mail at certain designated times to conduct the redetermination of eligibility. Individuals will be asked about their income, assets and household size to determine whether any changes have taken place. The redetermination paperwork will provide instructions for the consumer to follow. It is important for the consumer to pay attention to these instructions, especially the timeframes for returning the information requested!

- If the decision of the redetermination process is that the consumer continues to qualify for an LIS, no notice is sent and LIS eligibility is continued for the entire next calendar year.
- If the decision of the redetermination process is that the consumer no longer qualifies for an LIS, or if their LIS level is changed, the consumer will be notified in writing and given appeal information if she wishes to contest the decision. The notice will also state when the decision will take effect.



Dual Eligibles and the LIS

“Dual eligibles” are Medicare beneficiaries who also receive some help from Medicaid (Medical Assistance). This includes those who only get Medical Assistance to help them pay their Part B premium (see page 42 for more information about dual eligibles).

Pennsylvania’s Department of Public Welfare (DPW) sends data files to Medicare on a monthly basis notifying Medicare which beneficiaries are also receiving help from Medical Assistance and are therefore dual eligibles.

Once Medicare is notified about an individual’s dual eligible status, they “deem” the individual eligible for a full LIS by Medicare for at least the rest of that calendar year. “Deeming” means they **automatically qualify** for a full LIS and do not need to apply for it.

Medicare sends a notice to these individuals after they are notified about their dual status. This notice explains that the individual automatically qualifies for the Full Subsidy.



This notice is important so consumers should keep it in a safe place in case there is any question later about their entitlement to an LIS.

“Re-Deeming” Dual Eligibles

Medicare must annually review the data files it receives from the State to determine if individuals continue to be dual eligible and therefore continue to automatically qualify for the full LIS. This process is referred to as “re-deeming”.

Between the middle and end of every year, Medicare checks to see whether an individual who was previously identified as a dual and deemed eligible for a full LIS continues to be listed as a dual in recent data files from the state:

- If the person is still listed as a dual, she is “re-deemed” for the full LIS and sent a notice that her LIS will continue throughout the entire next calendar year.
- If the person is **no longer listed** as a dual, he is sent a notice that his deemed LIS status will end on the last day of that year. There are two important things to remember here:
 - This notice does not mean the person is not LIS eligible, it simply means he is no longer identified as a dual and therefore does not **automatically** get the LIS. He can then file an application with SSA or DPW to see if he financially qualifies for a full or partial LIS.
 - If the person goes back onto Medical Assistance at a later date and therefore becomes a dual eligible again, he will again be deemed automatically eligible for an LIS.



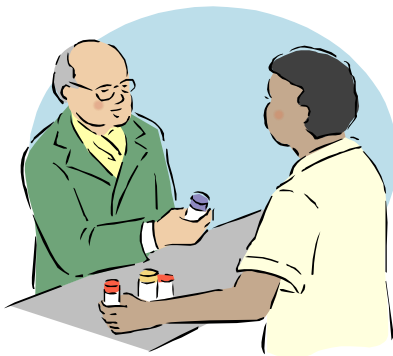
PACE/PACENET Enrollees and Part D

Medicare beneficiaries who are enrolled in PACE or PACENET are already considered to have “creditable coverage” (that is, prescription coverage as good as, or better than, Medicare Part D). Therefore, consumers with PACE or PACENET can simply remain with that coverage and choose not to enroll into a Part D plan. If the person later loses PACE/PACENET coverage, he qualifies for a Special Election Period and can enroll into a Part D Plan without being subject to a delayed enrollment penalty.



Pennsylvania created the PACE Plus Medicare program in 2006 to encourage those enrolled in PACE or PACENET to also enroll into a Medicare Part D Plan.

Under PACE Plus Medicare, PACE/PACENET becomes the person’s secondary drug coverage (the Part D Plan will be primary). This saves PACE/PACENET money that could be used to cover additional consumers.



How Does PACE Plus Medicare Work?

PACE/PACENET contracts with a number of Medicare Part D Plans that it refers to as “partner plans”. For a list of the 2007 partner plans go to the PACE website (www.aging.state.pa.us) or PHLP’s website (www.phlp.org).

As of September 1, 2006, PACE and PACENET began auto-enrolling many of their members into one of the “partner plans” based on the consumer’s medications and pharmacy. The Program sends these consumers letters telling them about their enrollment into a Part D Plan. PACE/PACENET then automatically enrolls the consumer into the designated plan unless the consumer contacts PACE within 10 days to decline enrollment or to choose a different plan.

Not all PACE/PACENET enrollees will be enrolled into Part D or receive a Part D assignment letter. Consumers who are already enrolled in Medicare Advantage Plans (i.e., Medicare HMOs or PPOs) or in a retiree plan with prescription coverage should not be assigned to a Part D Plan by PACE.



If those consumers do get a Part D assignment letter they should contact PACE immediately to notify them that a mistake has been made. Otherwise, if PACE enrolls these consumers in a Part D Plan it will result in a disenrollment from their Medicare Advantage Plan or a loss of their retiree prescription coverage!

If the consumer declines to be enrolled into a Part D Plan, the PACE/PACENET programs will continue to pay for drugs as they have in the past:

- **PACE enrollees** will be able to obtain their drugs and pay a \$6 co-pay for generic drugs and a \$9 co-pay for name brands.
- **PACENET enrollees** will pay a \$28.45 monthly premium/deductible at the pharmacy (in 2007) and then will be able to obtain their drugs through the program paying a \$8 co-pay for generics and a \$15 co-pay for name brands.

If the consumer agrees to be enrolled into a Medicare Part D Plan, PACE Plus will work a little differently depending on whether the consumer is in PACE or PACENET. See the next page for details!

PACE PLUS MEDICARE FOR PACE MEMBERS

Those who were auto-enrolled into a “partner” Plan by PACE:

- ✓ do not have to pay a Part D Plan premium (as PACE will cover the cost).
- ✓ use both their Part D Plan card and their PACE card at the pharmacy.
- ✓ should not pay more than their current PACE co-pays (\$6 generic/\$9 brand) for any medication covered by the PACE program. If the Part D Plan co-pay is lower, the consumer pays the lower amount.
- ✓ have their Part D Plan deductible covered by PACE.
- ✓ have PACE coverage for prescriptions through the Plan’s “donut hole” (period of non-coverage during which the person must cover 100% of their drug costs).
- ✓ have PACE coverage for medications that are not on the Part D Plan’s formulary as long as the medication is one covered by PACE.

If a PACE enrollee has Medicare Part D coverage through a Medicare Advantage Plan or through a Prescription Drug Plan that is **not** one of PACE’s “partner plans”, PACE will still help them with some of their Part D costs:

- PACE will pay up to the annual benchmark premium (\$28.45 in 2007) toward the Plan’s Part D premium.



In order for PACE to help pay the premium for the Part D plan, the plan has to have an agreement with the Program. Individuals in Part D Plans that are not “partner plans” should check with PACE to see if they have an agreement with the plan to help them pay their premium.

- PACE will also cover other Part D costs such as deductibles, co-pays above \$6/generics and \$9/brands, and coverage during the donut hole as described above. In addition, PACE will also cover non-formulary medications as long as the medication is covered by the PACE Program.

PACE PLUS MEDICARE FOR PACENET MEMBERS

Consumers who have PACENET and who are enrolled into a Part D Plan by the PACENET program:

- ✓ will have to pay their Part D plan premium directly to the plan (instead of the \$28.45 PACENET deductible/premium at the pharmacy).
- ✓ use both their Part D card and their PACENET card at the pharmacy.
- ✓ should not pay more than their current PACENET co-pays (\$8 generic/\$15 brand) as long as their medication is covered by the PACENET program. If the Part D Plan co-pay is lower, the consumer pays the lower amount.
- ✓ have their Part D Plan deductible covered by PACENET.
- ✓ have PACENET coverage for prescriptions through the Plan's "donut hole" (period of non-coverage during which the person must cover 100% of their drug costs).
- ✓ have PACENET coverage for medications that are not on the Part D Plan's formulary as long as the medication is one covered by PACENET.

If a PACENET enrollee has Medicare Part D coverage through a Medicare Advantage Plan, or through a Prescription Drug Plan that is **not** one of PACE's "partner plans", she will continue to pay the Part D premium and the PACENET \$28.45 deductible will be eliminated. PACENET will then cover other Part D costs such as deductibles, co-pays above \$8/generics and \$15/brands, coverage during the donut hole, and medications that are not currently on the Part D plan's formulary as described above.

For other information about the PACE *Plus* Medicare program see the Department of Aging's website at <http://www.aging.state.pa.us/aging/cwp/view.asp?a=293&q=253193&PM=1>.

Chronic Renal Disease Program (CRDP) and Part D

The Chronic Renal Disease Program (hereinafter “CRDP”) is run by the PA Department of Health. CRDP is a program that helps those with end stage renal disease by covering medications and certain other costs for services related to an individual’s renal disease (i.e. dialysis).

For Medicare beneficiaries, the CRDP Program is **not** considered “creditable coverage” (prescription coverage as good as, or better than, Medicare Part D). This is because the CRDP is a very limited prescription benefit and only covers medications used to treat renal disease. **Therefore, Medicare consumers who are enrolled in CRDP should also enroll into a Medicare Part D Plan when it is offered or they will be subject to a delayed enrollment penalty when they seek to enroll at a later time.**

Like those in PACE/PACENET, the State decided to auto-enroll CRDP members into a Part D Plan if they have not already joined one on their own. The State sent out notices to certain CRDP members telling them they would be auto-enrolled into one of the State’s Medicare Part D “partner plans” for coverage starting October 1, 2006. Individuals who already had Part D coverage (either through a stand-alone PDP or a Medicare Advantage Plan) or who had other “creditable coverage” (i.e., through a retiree plan) should not have received this notice and should not have been auto-enrolled into a Plan by CRDP.

The State will continue to enroll certain new CRDP members into Part D plans if they have not joined a plan on their own. They should not enroll individuals who currently have coverage through a Medicare Advantage Plan or who have other creditable prescription drug coverage.



If those consumers do get a Part D assignment letter they should contact the State immediately to notify them that a mistake has been made. Otherwise, if CRDP enrolls these consumers in a Part D Plan it will result in a disenrollment from their Medicare Advantage Plan or a loss of their retiree prescription coverage!

CRDP Plus Medicare Part D

- CRDP will pay up to the annual benchmark premium (\$28.45 in 2007) toward an individual's Part D Plan premium (if the Part D plan has an agreement with the State).
- Medicare Part D will be the individual's primary prescription coverage and CRDP her secondary coverage.
- CRDP will help pay the Part D Plan costs for drugs that are currently covered by CRDP (even during the deductible and donut hole phases of the Part D Plan) so that consumers pay no more than their normal CRDP co-pay for those medications (\$6/generic; \$9/brands). If the Part D Plan's co-pay is less, the consumer pays the lower co-pay.
- If the consumer is taking prescriptions not covered by CRDP, then she will pay whatever the Part D Plan charges for those particular medications.

For more information on the CRDP Plus Medicare program go to the PA Department of Health's website at:
http://www.dsf.health.state.pa.us/health/CWP/view.asp?A=179&QUESTION_ID=232459.

Dual Eligibles and Part D

“Dual eligibles” are Medicare beneficiaries who also receive some help from Medicaid (Medical Assistance).

- **“Full duals”** are persons who receive full health care coverage from Medical Assistance and have an ACCESS card they use for medical services. This includes those who qualify for Medical Assistance under Healthy Horizons, Medical Assistance for Workers with Disabilities (MAWD), and the Aging Waiver (a/k/a the PDA waiver).
- **“Other duals”** are those who receive limited benefits from Medical Assistance. This includes those who are in the Medicare Savings Program and who only get help from Medical Assistance to pay their Medicare Part B premiums.

Effective January 1, 2006, the Department of Public Welfare decided that any adult who is a dual eligible cannot be enrolled in a Medical Assistance Physical Health Managed Care Plan (i.e., Gateway Health Plan, Unison, or UPMC for You). Therefore, as soon as a consumer with Medical Assistance becomes eligible for Medicare (becomes a dual eligible), they will be disenrolled from the MA Physical Health MCO and transitioned back to the Medical Assistance fee-for-service system. These consumers will then use their ACCESS card along with their Medicare card to obtain health care services.

As of 2007, if an individual only receives Medical Assistance Benefits, the ACCESS card they use is yellow. If the individual also receives food stamp benefits in addition to medical, the ACCESS card they use is green.

Because dual eligibles are Medicare beneficiaries with the lowest income and assets, they have some protections under Medicare Part D that do not apply to other beneficiaries.

All dual eligibles are:

- “deemed eligible for a full Low Income Subsidy (LIS);
- are auto-enrolled into a Part D Plan if they do not choose on their own; and
- can enroll into/change plans at any time.



Dual Eligibles and Deemed Eligibility for the LIS

All dual eligibles are “deemed” eligible for an LIS. That means they ***automatically qualify*** and ***do not need to apply*** for the LIS (as discussed on page 34).

- **All duals also qualify for the full LIS, even if their income or assets exceed the LIS guidelines.**
- **Once Medicare recognizes a consumer as a dual and deems her eligible for a full LIS, she is entitled to receive the LIS at least through the end of the calendar year—even if the consumer subsequently loses Medical Assistance (and thus their dual status) during that year.**

Auto-Enrollment Into Part D Plans

Before the Medicare Modernization Act, full dual eligibles had prescription coverage through Medical Assistance. However, Part D changed that. Since January 1, 2006, full dual eligibles must enroll into a Part D Plan for prescription drug coverage because they no longer have prescription coverage through their ACCESS card (except for some very limited drug coverage described on the next page).

To ensure duals do not go without prescription coverage, Medicare will auto-enroll all dual eligibles into a Part D Plan if they do not choose one on their own. Medicare sends the consumer a notice telling them they have been assigned to a Part D Plan and will be auto-enrolled on a specified date. Medicare’s Plan assignment is random and is not based on a consumer’s drugs or pharmacy preference. If the consumer does not want to be enrolled in the Plan Medicare has assigned him to, he must choose a different Plan and enroll before the effective date of the auto-enrollment.



Please Note: Sometimes dual eligibles lose their Medical Assistance drug coverage before they have had a chance to enroll (or be auto-enrolled) into a Part D plan. If a full dual eligible experiences such a gap in prescription drug coverage, Medicare has created a back-up plan known as “Wellpoint” that pharmacies can use so that these full dual eligibles only have a small co-pay for their medications. Pharmacists can find out how to bill Wellpoint by calling the Wellpoint Helpdesk at 1-800-662-0210 or by downloading instructions from <http://www.cms.hhs.gov/States/Downloads/pos4steps.pdf>.

Ability to Enroll In Or Change Plans At Any Time

All dual eligibles have an ongoing Special Election Period. That means they can enroll into a Part D Plan, or change Plans, at any time throughout the year. They can even change plans multiple times during a year.

If a dual initially enrolls into a Plan, or changes Plans (by enrolling into a new Plan), the new enrollment is effective the first day of the following month.

ACCESS Card As Back-Up Prescription Coverage

Though full dual eligibles are required to obtain prescription coverage through a Medicare Part D Plan, there are some drugs Part D Plans do not cover. For example, Part D Plans do not cover barbiturates, benzodiazepines or over the counter drugs. If they have a prescription, dual eligibles can use their ACCESS card at the pharmacy to obtain many of these drugs not covered by Part D.

Please note: Medical Assistance uses a Preferred Drug List so consumers may have to obtain prior authorization before the ACCESS card will cover a prescribed drug.

Medicare Advantage Plan Enrollees and Part D

Medicare beneficiaries can choose to obtain their Medicare coverage through Traditional Medicare (using their red, white and blue Medicare card) or through a Medicare Advantage Plan (i.e. a Medicare HMO or PPO).

If a consumer enrolls into a Medicare Advantage Plan, she uses the Plan's identification card to obtain coverage for all services covered by the plan. Most Medicare Advantage Plans require their members to obtain care from providers in their network and may require the member to obtain a referral to see a specialist.

Some Medicare Advantage Plans offer Part D prescription coverage (referred to as MA-PDs) and some do not.

If a consumer is enrolled in a Medicare Advantage Plan without prescription coverage and she wants to enroll into Part D, she should contact her insurer to enroll into a different Plan within the same company that does include Part D coverage. The consumer could also choose to enroll into a Medicare Advantage Plan with a different company, or join a stand-alone prescription drug plan.



Important Note: A consumer cannot be enrolled in a Medicare Advantage Plan and a stand alone Part D Plan (PDP) at the same time. If the consumer enrolls into a PDP she will be disenrolled from her Medicare Advantage Plan and placed back into Traditional Medicare.