SENIOR HEALTH NEWS

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Medicare Prescription Drug Plan Explained

On December 8, 2003, President Bush signed into law the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003". Here is what the Medicare Act of 2003 includes.

1. Spring 2004-December 2005

Discount drug cards that provide some discount on drugs purchased will be for sale for $30/year to beneficiaries over 135% of the federal poverty level. These will be free to beneficiaries under 135% FPL and will include a $600 credit/year to use towards the cost of drugs, although the consumer will have to pay a 5-10% co-payment on each purchase.

Those enrolled in Medicaid and eligible for Medicaid drug coverage are not eligible for the discount cards. Persons who participate in Medicare Savings Programs but do no get prescription coverage through Medicaid will be eligible for the free discount cards with the $600 annual credit. Persons on PACE or PACENET will also be eligible for the discount drug cards.

Discount Drug Card companies will be able to change their benefits at any time. The consumer can only be enrolled with one of the discount drug cards at a time and will only be able to switch to another company once per year.

2. Beginning in January 2006

In January 2006, Part D of Medicare is scheduled to go into effect.

Here are the basic components of the plan:

Annual Premium – Estimated to be $420/year or $35/month. There is no fixed amount set in the law. Premiums are likely to vary by where you live.

Annual Deductible - $250

Annual Benefits –

Initial Coverage - Part D will pay 75% and you will pay 25% of your drug costs up until your total drug costs reach $2,250

Doughnut Hole of No Coverage - Once you reach $2,250 in drug expenses in a year, your coverage stops and you have to pay all of the next $2,850 in drug expenses you incur

Catastrophic Coverage - Once your total drug expenses reach $5,100, you pay either a flat copayment of $2/generic or $5/brand-name or 5% of each drug's cost – whichever is

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greater – with no limit on total expenditures

Are the costs less for persons who are lower-income? There are 4 levels of subsidy available to lower-income persons. Here are the anticipated costs to beneficiaries under 150% of the federal poverty level:

Income Under 100% FPL and Enrolled in Medicaid:

- No Annual Premium or Deductible.
- Asset Test – State Rules Apply
- Annual Benefits –

Initial coverage - Co-Payment—$1/generics, $3/brand-name
Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

Income Under 135% FPL with some Medicaid and all others enrolled in Full Medicaid (in PA includes people on MAWD, HCBS Waivers, etc.):

- No Annual Premium or Deductible
- Asset Test – State Rules Apply
- Annual Benefits –

Initial coverage - Co-Payment - $2/generics, $5/brand-name
Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

Income Under 135% FPL and NOT Enrolled in Medicaid:

- No Annual Premium or Deductible
- Asset Test – $6,000/individual, $9,000/married couple (SSI rules will be used to calculate)
- Annual Benefits –

Initial coverage - Co-Payment - $2/generics, $5/brand-name
Catastrophic coverage – After total drug expenses reach $3,600, no co-payments.

Income Under 150% FPL and NOT Eligible under other categories:

- Annual Premium – Amount based on income – sliding scale up to $35/mo
- Annual Deductible – $50
- Asset Test – $10,000/individual, $20,000/married couple (SSI rules will be used)
- Annual Benefits –

Initial coverage - Co-Payment – 15% of the cost of drug costs
Catastrophic coverage – After total drug expenses reach $3,600, co-payments go down to $2/generic, $5/brand-name

Are these costs fixed?

No. These are the projected costs at the outset of the program. Premiums may be higher than estimated. In addition, the premiums, deductibles and doughnut hole amounts may change with time, due to increases in drug spending and drug costs. The private plans offering the benefit also have the freedom to raise co-payments, as long as Medicare determines that the overall benefit remains equal to that described above.

Medicare Prescription Plan Explained

How will I enroll in Part D?

This benefit will only be available through **private prescription drug plans or through managed care plans** under contract with Medicare unless there are no plans or only one plan willing to serve an area. In that case, the government will provide a "fall-back" plan that will offer all the same benefits in the private plans. To receive the benefit, you will have to sign up with a plan offering it in your area.

What if I delay enrollment in Part D?

If an eligible person on Medicare does not enroll in the Medicare Part D benefit within the first quarter of 2006, there will be penalties including higher premiums and co-payments. (This is likely to be similar to the penalty imposed on persons who delay enrollment in Medicare Part B).

If my income is under 150% of the Federal Poverty Level, how will I enroll to get reduction in costs?

You will be able to enroll either through your local Social Security Office or through your local County Assistance Office. If you are denied, you will be able to appeal. The appeal process will differ whether you enroll through the SSA or through the CAO.

Will my drugs be covered?

It will depend on the plan you choose. While Medicare is required to contract with at least 2 plans in every area or provide "fall back" coverage on its own, there is no requirement to cover all available prescription drugs. Plans will be required to cover at least one drug in each "therapeutic class" but are not required to cover all drugs. We do not understand there to be any exception process through which you could get an off-formulary drug. Medicare may define what amounts to a therapeutic class. Consumers will want to check the drugs that a plan covers before enrolling.

For those who also have full Medicaid coverage, the drug coverage would be significantly less than what they have under full Medicaid. For more information, see page 4.

Can I have other drug coverage?

Yes and no. You may have other private coverage but, it will not be counted towards your out-of-pocket costs. You must pay out-of-pocket for all the co-payments, premiums, and deductibles for which you are responsible and the full cost of drugs (in the doughnut hole) or your catastrophic coverage will not kick in. You

Medicare Prescription Drug Plan Explained—Continued

may not have other Medicare coverage –meaning you cannot be in two Part D plans at once.

Must out-of-pocket costs be incurred on particular drugs?

Yes. Out-of-pocket costs will have to be spent on prescription drugs that are available through your drug plan. If you incur costs on uncovered drugs, you cannot use these costs to reach your deductible or catastrophic cost level.

Information compiled from resources at: Families USA – www.familiesusa.org; Center for Medicare Advocacy – www.medicareadvocacy.org; and Kaiser Family Foundation – www.kff.org .

Impact of Medicare Drug Plan on Persons with Full Medicaid

Persons who have Medicare AND full Medicaid will be significantly impacted by the new Medicare Law. It is unclear whether they can be or will be required to enroll in Medicare Part D, as the new prescription drug benefit is called. What is clear is that Medicaid prescription drug coverage for persons on Medicare will end on January 1, 2006 for all Part D covered therapeutic classes of drugs. It is also clear that prescription drug coverage under Medicare Part D will be significantly less than coverage persons have received under full Medicaid.

Will persons with Medicare AND FULL Medicaid still be able to get the drugs that are medically necessary for them?

Not necessarily. For those enrolled in the Medicare drug plan, they will be able to access only the drugs that their drug plan covers.

If the Medicare drug plan doesn't cover what the person with Medicare AND FULL Medicaid needs, will Medicaid cover it?

Not likely. The Medicare law prohibits Medicaid from "wrapping around" or filling the gaps in Medicare drug coverage. Thus if the Medicare drug plan does not cover a drug at all but covers something else in the same therapeutic class, or if it covers a drug but doesn't think it is medically necessary for the consumer to have, Medicaid would not be able to cover it for the consumer.

Medicaid will only be able to cover drugs in therapeutic classes that the consumer's Medicare plan does not cover. However, Medicare plans will have to cover at least one drug in all therapeutic classes so we do not foresee that there will be any therapeutic classes that Medicaid could cover.

If the person with Medicare and FULL Medicaid is denied a drug (that the plan covers), will she be able to appeal the denial?

Maybe. The appeals process will be through Medicare (not Medicaid) and the appeal rules for Medicare apply. Under Medicare law, there are rules governing whether an appeal can proceed that relate to how much money is in controversy. Thus, a person may not be able to appeal if they have been denied a prescription for a medication that costs $5 while they may be able to appeal if they have been denied a

Impact of Medicare Drug Plan on Persons with Full Medicaid

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prescription for a medication that costs $100.

If a person with Medicare and FULL Medicaid appeals a denial of a medication, will she be able to get a 72 hour supply of the medication while she tries to document her need for the medication?

Although this is currently allowed under the Medicaid program, the Medicare bill does not provide for this.

If a person with Medicare and FULL Medicaid appeals a termination of a medication, will she be able to get continuing benefits pending the outcome of the appeal?

The Medicare bill does not expressly call for this. However, the Supreme Court has previously held that due process requires this.

If a person has Medicare and FULL Medicaid and her prescriptions have been free under Medicaid, will she now have to pay co-payments?

Yes. Under the Medicare law, she will be required to pay the $1/generic and $3/brand-name co-payments that are imposed under the Medicare bill. That co-pay is expected to rise as drug costs go up. States cannot use Medicaid to pay these co-payments for consumer.

Can a person with Medicare and FULL Medicaid participate in more than one Medicare Drug Plan to try to maximize coverage?

No. A person cannot be in more than one plan at a time. In addition, once the Medicare Drug Plan takes effect in January 2006, Medigap policies that include prescription drug coverage will no longer be available.

Other Pieces to the New Medicare Law

QI-1 Benefit Reauthorized until September 2004. Reauthorization of this program was widely supported. It is surprising to see that it was only reauthorized for 6 additional months (as a Continuing Resolution already authorized it until March 2004). Come summer, discussions are likely to resume as to the future of the QI-1 benefit.

Part B deductible changes. As we know, the Part B premium rises every year. Under this new Medicare Law, the Part B deductible—which is currently fixed at $100/year—will rise annually. Starting in 2005, the Part B deductible will go up to $110 and is expected to increase annually by the same percentage that the Part B premium increases. Although, persons with SLMB and QI-1 coverage receive state payment of their monthly Part B premiums, they do not receive any assistance with the Part B deductible amount. Some are concerned about the impact the annual increase will have on lower-income persons in SLMB and QI-1, especially as the years pass and the amount continues to increase at a significantly higher rate than does the cost of living increase consumers receive in their Social Security checks.

What is the Pennsylvania Health Law Project?

The Pennsylvania Health Law Project (PHLP) is a non-profit public interest law firm that provides free legal services, community education, and advocacy for lower-income persons, seniors, and persons with disabilities who are having trouble accessing healthcare coverage or services. PHLP staff provide direct assistance to consumers, presentations to the community, trainings for advocates, and informational materials for anyone. Check out our website including our other free newsletters at www.phlp.org!

Consumers who are having trouble getting eligible for programs or getting services once they are in programs may obtain free assistance by calling the Pennsylvania Health Law Project Helpline toll-free at (800)274-3258.

Community Education Corner

Staff of the Pennsylvania Health Law Project are available to come speak to your group. Whether it is consumers at a senior center or advocates that collaborate to help seniors, we can talk on publicly funded healthcare program topics of your choice.

Our presentations are free. Some suggested topics:

1. How do I get help paying my healthcare costs?
2. How do I get my healthcare services if I have Medicare and Medical Assistance?
3. How do I get prescription drug coverage?

And more….

To schedule a training, call the Pennsylvania Health Law Project at (800)274-3258.

"Community Choice" Waiver Pilot Off To a Promising Start

"Community Choice" is the name of the Home and Community Based Services (HCBS) Waiver Pilot Project jointly initiated by the state's Office of Health Care Reform, Department of Public Welfare and Department of Aging.

The goals of the Pilot are to help elderly consumers and persons with disabilities access home and community based services as fast as possible to prevent their having to go to a nursing facility at all, or to expedite a consumer's discharge from a nursing facility to return to their own community. The Pilot seeks to address many of the barriers that have kept consumers from applying for the state's HCBS waiver programs, as well as to speed up the application and assessment process so that eligible consumers can begin to receive home and community-based services quickly. To that end the State has, among other things:

- Simplified and streamlined the MA waiver application, reducing it from 12 pages to 4 pages
- Simplified the functional assessment form used by the waiver programs, reducing it from 23 pages to 4 pages
- Increased the asset limit for the Waiver Programs from $2,000 to $8,000 for an individual and allows applicants to "self declare" their income and assets
- Streamlined the application process so that a consumer can be determined eligible for MA and put into a waiver program within 24 hours of their application being received by the CAO

The "Community Choice" Pilot Project began in three rural SW counties beginning October 31, 2003 (Fayette, Greene and Washington counties). It includes most of the states HCBS Waiver programs (except for the Mental Retardation waivers and the COMMCare [traumatic brain injury] waiver). So far, the Pilot has gone very well. In the first two months, over 100 consumers had applied and been assessed and 40 persons had begun receiving home and community based services. A Community Choice Implementation Group made up of agencies, providers, advocates and consumers from the 3 counties has been meeting regularly to share information and experiences, address problems that arise, and discuss how to work together more effectively in carrying out the Pilot.

Building on the work being done in the SW, the State is now planning to pilot Community Choice in an urban area— specifically Philadelphia County. The Waiver Pilot will begin in Philadelphia on January 30th. An Implementation Group has been meeting with the state agencies to plan on how the Pilot will work in that county and to begin to identify and address local issues. If the Pilot continues to go well, the State hopes to expand Community Choice to the rest of the state later in 2004.

We will continue to update you on the Community Choice pilot in upcoming editions of Senior Health News.

PACE Expansion Began January 1

In December, the PACE program was expanded so that beginning January 1, many more older Pennsylvanians became be eligible for the PACE or PACENET programs.

	PACE	PACENET
Age	65 or Older	65 or Older
Residency	A Resident of PA for at least 90 days prior to date of application for PACE	A Resident of PA for at least 90 days prior to date of application for PACENET
Insurance Status	Cannot have prescription coverage under Medical Assistance	Cannot have prescription coverage under Medical Assistance
Income	Total income in 2003: $14,500 or less —Single person $17,700 or less— Married couple	Total income in 2003: $14,500—23,5000—Single Person $17,700—$31,500—Married Couple
Benefit	Enrollee must pay $6 copayment for each generic medication and $9 copayment for each brand-name medication	Enrollee must pay $40 monthly deductible (or $480/enrollment year) then $8 copayment for each generic medication and $15 copayment for each brand-name medication

Pennsylvania Health Law Project
924 Cherry Street, Suite 300
Philadelphia, PA 19107