Medicare Part D Basics

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Introduction

Welcome to the **Medicare Part D Basics** course.

The overall goal of this course is to help you learn and understand the basic structure of the Medicare Part D benefits offered for enrollment.

A course is considered completed with a passing score of 90% or higher on the product certification test for this module. Once you have successfully completed this module, you will see a completion checkmark on your online training list.

This module may also be used for agent re-education, if necessary, in the event of a sales inquiry. **Note:** You may return to this module at any time, for a refresher on Medicare Part D benefits training.

Learning Objectives

- Describe the Medicare Part D plan structure and benefit phases
- Identify how Part D plans may differ from the Medicare standard
- Define Part D concepts – Formulary, Exceptions, Creditable Coverage
- Describe member costs including premium, copays, other expenses
- Explain how Part D prescription drugs are covered at Preferred, In-Network and Out-of Network pharmacies
- Overview of Extra Help/Low Income Subsidy (LIS)

Medicare Part D Overview

Medicare Part D is Outpatient Prescription Drug insurance coverage.

The Medicare Prescription Drug Program (Part D), consists of plans administered by private insurance companies contracted with the federal government. Private health plans contract with the Centers for Medicare & Medicaid Services (CMS) to administer Prescription Drug benefits.

All plan contracts are subject to regular review. All plan contracts must be renewed on an annual basis.

Medicare Part D Overview

Medicare beneficiaries have several plan options available in order to receive Part D drug benefits.

The most common types of Part D plans are:

- Stand-alone Prescription Drug Plans (PDPs) that work with Original Medicare

- Medicare Advantage-Prescription Drug (MA-PD) Plan, which is an MA health plan that also covers Part D prescription drugs

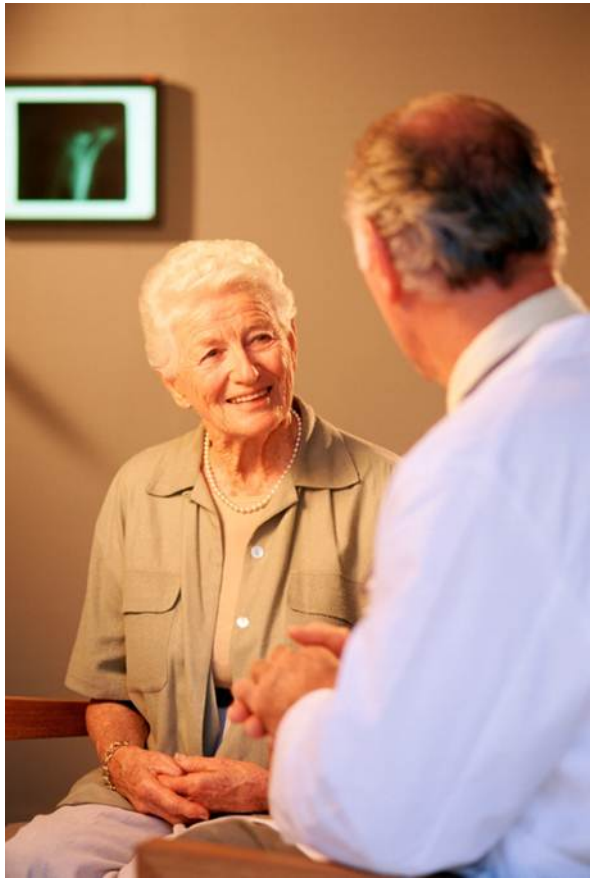
There are other drug benefit fulfillment methods less commonly utilized. These include (but are not limited to) Employer Group benefits, Veterans Administration (VA) benefits, and Union Group benefits.

Eligibility Criteria

To be eligible for a Stand-alone Part D plan, the enrollee must:

- Be entitled to Part A or enrolled in Part B
- Reside in the drug plan's service area

For those beneficiaries who choose the option to get prescription drug coverage through a Medicare Advantage Prescription Drug (MA-PD) plan, eligibility requirements follow the standard Medicare Advantage plan regulations as described by CMS.



Delayed Enrollment for Part D

Enrollment in Part D is voluntary. However, a Late Enrollment Penalty (LEP) may be assessed if an eligible member does not enroll:

During the initial enrollment period; or

When there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled and was not covered under any creditable prescription drug coverage

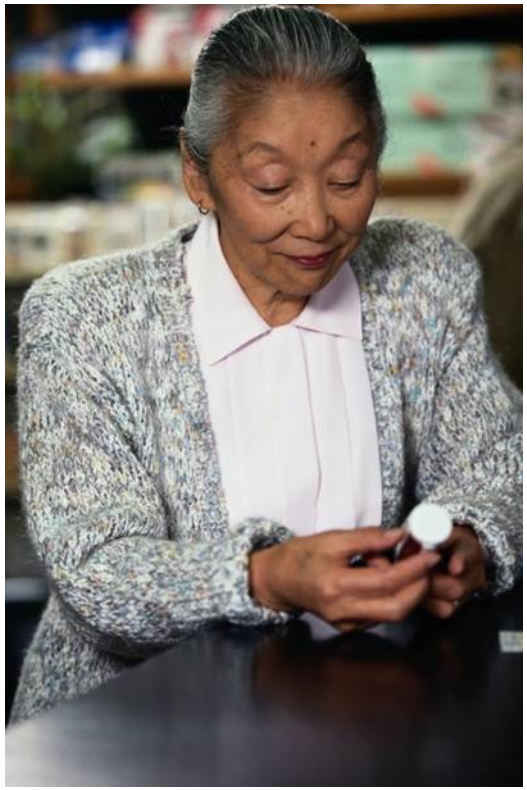
This penalty does not apply to Low-Income Subsidy (LIS) members or members with creditable coverage.

The agent or broker must inform the beneficiary of this penalty.

Creditable Prescription Drug Coverage

Creditable coverage is drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.

Beneficiaries who maintain a source of creditable coverage may stay in that plan, are not required to enroll in Medicare Part D and may avoid late enrollment penalty.



Part D Plan Structure – General

There are generally four benefit phases associated with a Medicare Part D plan. In order of “appearance” they are:

- Deductible
- Initial Coverage
- Coverage Gap
- Catastrophic Coverage

Because CMS give carriers some flexibility in how they administer the plans, some plans may waive the deductible or coverage gap phases.

Part D Plan Structure – Deductible Phase

Deductible

The amount a member must pay for their covered services before the Part D plan begins to pay.

Some plans may have a lower deductible or none at all.

Some plans may choose to limit the deductible to Brand Name drugs only.

Part D Plan Structure – Initial Coverage Phase

Initial Coverage

During the Initial Coverage phase, the beneficiary is responsible for paying a copay or coinsurance for their covered drugs, until the Initial Coverage Limit (ICL) is reached.

Initial Coverage is calculated by adding the amount paid by the member (including any deductible) and the amount paid by the plan for covered prescription drugs.

Part D Plan Structure – Coverage Gap Phase

Coverage Gap

The Coverage Gap phase begins when the member has reached a pre-determined amount in **total** drug costs – or the total of what the member and plan pays for the cost of the drugs.

During this timeframe, members are usually responsible for paying a greater portion of the drug cost than they did in the Initial Coverage Phase.

Part D Plan Structure – Coverage Gap Phase (cont.)

Coverage Gap Discount Program

Under this program, drug manufacturers who sign an agreement with CMS, will provide a discount on brand drugs during the Coverage Gap phase. Drugs covered by this discount are called “applicable drugs.”

Brand discounts are only available for drugs provided by manufacturers who have signed an agreement with CMS.

Part D Plan Structure – TrOOP

True Out-Of-Pocket Costs (TrOOP)

The portion of cost-sharing incurred by the members of a drug plan is also referred to as TrOOP. TrOOP is calculated to determine when a member qualifies for Catastrophic Coverage.

- TrOOP expenditures include:
  - Annual deductible, coinsurance and copayments
  - Cost for prescription drugs incurred in the coverage gap portion of the standard benefit, including drug manufacturers discounts for Brand drugs in the coverage gap

Part D Plan Structure – Catastrophic Coverage

Catastrophic Coverage

Catastrophic Coverage begins once the member reaches the TrOOP threshold.

The member is responsible for a minimum drug copayment, or a co-insurance percentage, whichever is greater for the rest of the year.

There is no limit on the amount the plan will pay for covered drugs in a calendar year.

In-Network and Out-of-Network Pharmacies

Most carriers will form a network of pharmacies for Part D plans. Members should use a network pharmacy in order to maximize the plan benefits.

Part D plans may not pay for prescriptions if an out-of-network pharmacy is used, except in certain cases.

Some network pharmacies are contracted as **preferred pharmacies**. Members have reduced cost-share amounts on certain formulary tiers when utilizing preferred pharmacies.

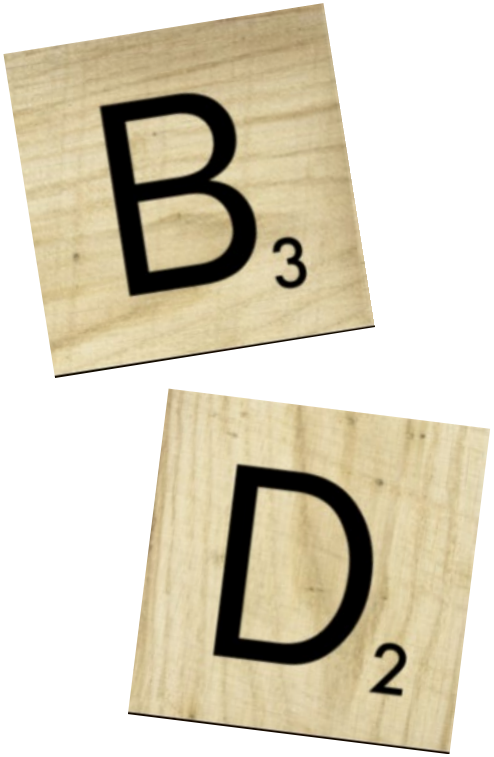
Members can continue to go to our other network pharmacies that are not contracted as preferred but will have a higher cost share than when utilizing preferred pharmacies.

Part D Prescription Drug Benefits

There may be times when members get their prescriptions covered if they go to an out-of-network pharmacy. Medicare requires carriers of Part D plans to cover an out-of-network pharmacy if one of the following applies:

- If the prescriptions are related to care for a medical emergency or urgently needed care.
- The member is unable to get a covered drug in a timely manner within the service area because there are no network pharmacies within a reasonable driving distance providing 24-hour service.
- The member is trying to fill a covered prescription that is not regularly stocked in an in-network retail or mail-order pharmacy.

Prescription Drug Coverage



Outpatient Prescriptions can be covered under Part B or Part D depending on the drug and where services are administered.

- Part B drugs are typically covered subject to a coinsurance.
- Part D drugs are typically covered subject to a copayment or coinsurance depending on the drug tier.

A drug can either fall under Part B or Part D. It cannot be covered under both.

Medicare Part B Prescription Drug Benefits

Some prescription drugs may be covered under Part B benefits. Examples of outpatient prescription drugs under Medicare Part B include:

- Some Antigens
- Some Osteoporosis Drugs
- Erythropoietin (for ESRD)
- Hemophilia Clotting Factors
- Injectable drugs
- Some oral cancer drugs
- Part B-covered chemotherapy drugs
- Oral anti-nausea drugs

For more Part B drug information, please see the Summary of Benefits.

Medicare Part D Prescription Drug Benefits

Part D plans may cover any drug as long as it is:

- Available only by prescription
- Approved by the Food and Drug Administration (FDA)
- Used and sold in the United States
- Used for a medically acceptable reason (but not prescribed for Off-label use)

Formulary Tiers

Covered drugs fall into a particular category, known as **formulary tiers**, to determine the member cost-share of prescriptions.

Plans may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much the member pays for a drug.

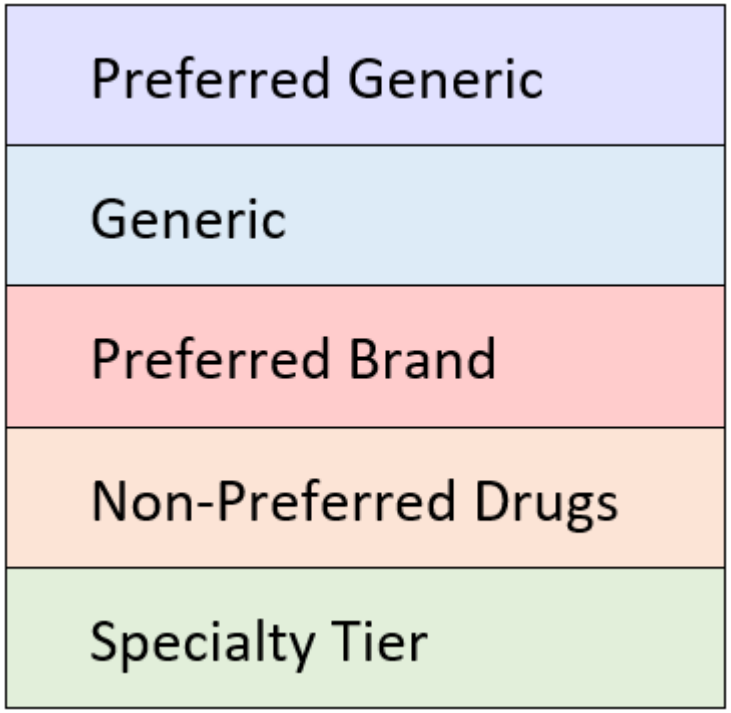
Impacted members will be notified before a change is made.

Formulary Tiers (cont.)

Formulary Tiering (Example)

Covered drugs fall into a particular category to determine the member cost-share of prescriptions.

Agents must confirm drug coverage with the beneficiary if they have specific medication concerns. Formularies, our list of covered drugs, are different by MA-PD and PDP plan.



Formulary Tiers (cont.)

These medications are assigned to Formulary tiers depending upon their cost and form, in accordance with Medicare guidelines.

Generic drugs are defined as a drug product that meets the approval of the Food and Drug Administration (FDA) and is equivalent to a brand-name product in terms of quality and performance, but may differ in other characteristics (shape, flavor, etc.).

Formulary Tiers (cont.)

Preferred Generic – Generic prescription drugs that are covered in order to offer a choice of low-cost medications.

Generic – Certain generic prescription drugs that are covered in order to offer a larger choice of generic medications. The member's share of the cost is higher for generic drugs than **preferred** generics.

Formulary Tiers (cont.)

Preferred Brand – A prescription drug that is invented by a manufacturer and is sold under the manufacturer's chosen name. Some generics may also appear on this tier because the cost is closer to a brand medication.

Non-Preferred Drugs – Certain brand name or generic prescription drugs that are covered in order to offer a larger choice of medications. The member's share of the cost is higher for these non-preferred drugs.

Specialty drugs – Medications frequently given by injection or infusion and often require special packaging, mailing and storage. This tier also includes oral medications.

Formulary Transition Requirements

CMS requires Part D plans to provide a single 30-day fill of their non-formulary drugs during the first 90 days of coverage to new members or current members impacted by a formulary change.

Enrollees who reside in a long-term care facility (LTC) will be allowed to refill their prescription until we have provided them with a transition supply – consistent with the dispensing increment.

During the transition period, the Part D plan does not apply prior authorization or step therapy rules.

Drug Exceptions

The exception process usually occurs when a member submits a request to the plan to make a decision on whether to cover a drug or to allow a lower member cost-share for a formulary drug.

There is no guarantee that the member will be able to obtain:

- Drugs that are not on the formulary
- Drugs on a formulary at a lower cost sharing tier

The member must be informed that plan decisions may be appealed.

Drug Exceptions (cont.)

Drug exceptions occur in three forms:

- A **formulary exception** allows a member to obtain a Medicare-covered prescription drug that is not on a plan's formulary.
- A **tiering exception** is when a member requests to obtain a Medicare covered prescription drug at a more favorable cost-sharing level.
- A **utilization restriction** exception is when a member requests to obtain a Medicare covered prescription drug with prior authorization or quantity limits waived or set at a higher level.

Low-Income Assistance

Low-Income Assistance or Extra Help is offered by the Social Security Administration. It provides beneficiaries, with limited income and resources, financial assistance towards the cost of paying plan premiums and may assist with deductibles and copayments.

Some beneficiaries automatically qualify and do not need to apply. Those who do not automatically qualify will need to contact the Social Security Administration.

Low-Income Assistance (cont.)

To qualify for Extra Help, annual income may not exceed 150% of the Federal Poverty Level (FPL). The FPL varies geographically and is higher for both Hawaii and Alaska as compared to the other states.

The Social Security Administration offers 4 levels of low-income assistance based on Federal Poverty Level data.

Once a beneficiary qualifies for low-income assistance, they will receive a "low-income subsidy" until such time as they fail to meet the qualifications.

Qualifications for low-income assistance are reviewed on an annual basis.

Applying for Extra Help

Encourage beneficiaries with limited income and resources to apply to their State Medicaid and/or Social Security Administration Office.

- Beneficiaries may apply at any time.
- If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office may also check eligibility for other low-income assistance programs.
- Beneficiaries may call the SSA at 1-800-772-1213 or apply online at: www.socialsecurity.gov/prescriptionhelp

Part D Assessment

An assessment will be given to test your knowledge on the information presented. A score of 90% or above on the assessment is required to successfully pass this module. If a score of 90% is not obtained, the assessment can be attempted again immediately.

Please click the link to access the assessment.

After completing the assessment for this course, refer to your online training summary for your certification progress.

CLICK HERE FOR ASSESSMENT