CENTER FOR MEDICARE ADVOCACY, INC.

Medicare Part D 2013

* * *

Addressing Client Issues

Jocelyne Watrous
Medicare Advocate
Center for Medicare Advocacy

Late Enrollment Penalty (LEP)

- Must enroll during **Initial Enrollment Periods** if no other creditable drug coverage.
- Annual **Notice of Creditable Coverage** by September 30
- Save all Notices in case creditable coverage is lost and need to enroll in Part D in future.
- Absent or incorrect Notice is grounds for a SEP
  - Lapse in coverage of **63 days** or more since Initial Enrollment Period results in LEP
  - LEP is "lifetime"
    - if penalty is incurred before age 65, member gets another IEP and the penalty will be waived
    - LEP is waived if member qualifies for Part D Low Income Subsidy (LIS), a/k/a "Extra Help"

Attestations

- Member gets "**attestation form**" to declare type and dates of coverage, or exemption
  - Some plans may accept telephonic attestations
  - Proof not required; **signed attestation is sufficient**
  - Must be submitted within 30 days
- If no creditable coverage, or fails to submit attestation, plan initiates penalty
- Penalty notice indicates how many uncovered months and amount of the penalty
  - CMS, not the plan, calculates the amount of the penalty
  - Penalty is added to monthly premium, whether self-pay or SS withhold Plan may collect any back payments owed in a lump sum, then commence monthly billing

Reconsideration

- Request reconsideration within 60 days (Maximus). Decision 90 days.
  - penalty runs while the case is under reconsideration
  - follows member if plan changes
  - 1% of the national base beneficiary premium ($31.17) for every whole month not enrolled
  - Penalty can't go back further than June 2006. Rounded off to nearest .10

  E.g., member 65 in June 2006 but not enrolled until January 1, 2013. Penalty period is June 2006 – December 2012, or 79 months.
  - Calculation: 1% x 79 months x $31.17 = $24.60 added to premium each month.

  E.g., member turned 65 in March 2012. Enrolled January 1, 2013. IEP ended June 2012. Penalty period is July 2012 – December 2012, or 6 months.
  - Calculation: 1% x 6 x $31.17 = $1.87 added to premium each month.

Denied Drugs

"Non Formulary Drugs and UMR Denials"

- May be denied because:
  - not on formulary or subject to utilization management restrictions, (prior authorization, quantity limits or step therapy.)
  - 2012 Avalere: Prior Authorization and Quantity Limits on the rise
- As new generics introduced, many plans have taken brand names off formulary or moved them a higher cost sharing tier.
  - this impacts people who believe, correctly or incorrectly, that they cannot tolerate generic drugs.
- Large variations in number of covered drugs by plans
  - 2012 Avalere: Humana Enhanced covered 79% of all Part D drugs; Wellcare Classic covered only 49%
  - Benchmark plans have relatively skimpy formularies with many fewer brand names
  - The fewer drugs on a plan's formulary, the more likely drugs will be denied.

What to do in the Event of a Denial

- If beneficiary is on LIS, can switch to a more compatible plan.
- If switching plans is not an option:
  - Is there a therapeutically equivalent drug on formulary? Is physician is willing to submit statement of support if no other drug will suffice?
  - Ask for coverage determination to find reason for denial.
  - Contact physician to explain appeal process and gain cooperation in obtaining statement
  - If possible, draft statement for physician to sign, specifically explaining why the other drugs (or dosage, etc.) on formulary would be ineffective or have adverse effects. Statement may be brief but should tailored to beneficiary, including dates and effects of other drugs tried and failed.

Other Reasons for Denials
"Excluded Drugs"

- Usually not possible to appeal the denial of an excluded drug, but …
  - Cough and cold preparations excluded if only for symptomatic relief of cough and cold. Is a basis for appeal if drug is to treat an illness such as asthma.
  - Drugs for weight gain or loss are excluded unless the drug is prescribed for AIDs wasting or cachexia due to chronic disease
  - ED drugs not covered to treat sexual dysfunction, but ARE covered when prescribed for a medically accepted indication (e.g., pulmonary hypertension)
  - Drugs used to treat acne, rosacea, psoriasis, or vitiligo are not cosmetic
  - Vitamins generally not covered but Niacin products (Niaspan and Niacor) are covered, as are certain Vitamin D analogs (other than D2 or D3)
- Barbiturates and benzodiazepines no longer completely excluded

Other Reasons for Denials

"Off Label Drugs"

- Drugs not for a "medically accepted indications" excluded unless:
  - Support is found in one of three compendia named in statute:
    - American Hospital Formulary Service (AHFS- DI)
    - US Pharmacopeia National Formulary (USP- NF)
    - DRUGDEX Micromedex Health System
  - Burden is on member to produce support
  - DRUGDEX is the most useful but very expensive
  - Try to "cultivate" a medical source with access to this compendium
  - Explore FDA website and other on-line sources for information
- Note that for cancer drugs only, may use peer reviewed studies in lieu of compendia
- Medically acceptable limitation pertains only to diagnosis, NOT dosage of the drug
- Very low success rate with off label appeals. Always back up with a PAP if one exists.

Other Reasons for Denials

"Compound, DESI and LTE Drugs"

- Commercially available compounded drugs coverable if they include a Part D drug. Plan pays for Part D component and a mixing fee.
- Most extemporaneous compounds not covered because they consist of bulk powders, which are not drugs in themselves, therefore not covered by Part D.
- DESI and LTE (Less than Effective) drugs are not covered. Few or no grandfathered drugs remaining, according to FDA.

Getting Help with Part D Drug Costs

- Estimated that one in five Americans has gone without medications, split pills or skipped dosages to save money.
  - Drugs still unaffordable for many despite Donut Hole discount
  - Many not aware of help available despite extensive outreach since 2005
  - Middle income elders and disabled (slightly above LIS and MSP limits) often the most needy
- Under 2013 Standard Benefit, maximum out-of-pocket costs prior to catastrophic coverage = $4,750, excluding premiums. Averaged out over the year, budget $396 /mo. for basic Rx
- Cost sharing could be much more if the member has higher-than-average (catastrophic) drug costs

Part D Low Income Subsidy

- Premium assistance:
  - 100% with full LIS subsidy if in benchmark plan
  - 25% - 75% with partial LIS subsidy
- Reduced deductible ($0 if full subsidy; $66 if partial subsidy)
- No Donut Hole
- Co-Pay assistance for brand and generic drugs
  - $0 to $6.60 max with full subsidy before catastrophic coverage
  - 15% max. with partial subsidy before catastrophic coverage
- Full benefit duals and beneficiaries with MSP are deemed eligible for full LIS subsidy. Others must apply. BUT, many low income seniors are still not aware despite heavy outreach since 2005
- Income limit (partial subsidy) = 150% of FPL ($16,755 single) ($22,695 couple)
- 2013 resource limit (partial subsidy) = $13,330 (single) $26,580 (couple)
- LIS also confers automatic year-round SEP and exempts from LEP!

Medicare Savings Programs
QMB, SLMB and QI (ALMB)

- The most valuable source of help. All three programs pay Part B premium
- QMB also acts like a Medigap
- Eligibility for MSP = automatic eligibility for full subsidy LIS
  - No deductible or Donut Hole
  - Max. co-pays $2.65 generics and $6.60 for brand name
  - $0 premium if in "benchmark" plan
  - May be in "enhanced" plan if pay difference in premium
- Each state sets its own eligibility criteria
  - Some states have eliminated asset test for these programs
  - Therefore MSP = "back door" to eligibility for LIS. If denied LIS because of LIS asset test, may still qualify for LIS by virtue of MSP

"SPAPs"
(State Pharmaceutical Assistance Programs)

- SPAPS are state funded programs that provide low income elders with prescription drug assistance. Some SPAPs also provide help to disabled.
- Currently, about 20 states have SPAP programs that "wrap-around" (add value to) the Part D benefit.
- SPAPS may provide assistance with premiums, coo-pays, deductibles and Donut Hole costs. May also cover excluded drugs.
- Assistance from "qualified" SPAPS counts toward Part D out-of-pocket costs and help speed the beneficiary through the Donut Hole.

Partial Listing of Other Resources

- People barely above LIS, MSP and SPAP limits may have an especially difficult time paying for drugs. Some other sources of Help:
- Pharmaceutical Company Patient Assistance Programs (PAPs) – offer free and reduced cost drugs, mostly to low income uninsured but often help Part D members who are in the Donut Hole and cannot afford their drugs even at discount.
  - See www.needymeds.org for listing of PAPs by drug manufacturer; coupons; discount cards
  - See www.PPARX.org helps get free or low cost medications
  - See www.patientassistance.com free or low cost medications
  - See www.Rxhope.org – free or low cost medications
- National Organization for Rare Disorders (NORD) – help with drugs not yet on the market. See www.raredisearses.org
- AIDS Drug Assistance Programs (ADAPS) – cover HIV/AIDs meds for low income as payer of last resort
- Retailer Discount Cards – offered through chain pharmacies. Discounts cannot be applied to Part D co-pays, nor can drugs purchased with discount cards count toward Part D out-of-pocket costs.

Involuntary Disenrollment for Non-Payment of Premium

- Involuntary Disenrollment may occur for non-payment of premium, IRMAA, or both.
- Plan must provide pre-termination notices and final warning before disenrollment (2 months)
- May not disenroll if in SS withhold status or enrolled in qualified SPAP
- May be reinstated if:
  - Request reinstatement within 60 days
  - Meets “good cause” criteria
  - Pays all amounts owing in full
- “Good cause” = non payment due to circumstances outside the member’s control and could not be expected to foresee

Good Cause

YES

- Federal government error
- Prolonged illness, hospitalization or institutionalization
- Serious illness of spouse or other family member
- Loss of home due to fire, flood, etc, or declaration of federal disaster area

NO

- Authorized representative did not pay bills on time
- Alleges did not receive pre-termination warnings
- Did not understand pre-termination notices
- Could not afford premiums or IRMAA

Best Routes to Solve (or Cope)

- Request reinstatement from CMS (1-800-Medicare or RO) if member appears to meet conditions
  - Obtain CTM complaint confirmation number
- If member does not meet conditions (or reinstatement is denied), may not re-enroll until next AEP unless qualifies for a SEP
  - Always screen for LIS eligibility (directly or thru MSP), which would confer a SEP
- Member will have a Late Enrollment Penalty (LEP) for the number of months he/she is uncovered
- Pursue other resources for necessary drugs during uncovered months (PAPs, discount cards, local and national drug assistance programs such as NORDs, ADAP, etc.)