Helping clients access their prescription drugs
Medicare Rights Center

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through

- Counseling and advocacy
- Educational programs
- Public policy initiatives
National Council on Aging

This toolkit for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) was made possible by grant funding from the National Council on Aging.

The National Council on Aging is a respected national leader and trusted partner to help people aged 60+ meet the challenges of aging. They partner with nonprofit organizations, government, and business to provide innovative community programs and services, online help, and advocacy.
Learning objectives

After this webinar, you should be able to:

❖ Understand the basics of Medicare Part D benefits
❖ Describe how Medicare Part B may cover prescription drugs
❖ Discuss drug management lock-in programs
❖ Understand Part D cost assistance programs, and be able to help clients apply for Extra Help
❖ Strategize other ways to help clients access prescription drugs
Medicare basics
Medicare

- Federal program that provides health insurance for those 65+, those under 65 receiving Social Security Disability Insurance (SSDI) for a certain amount of time, and those under 65 with kidney failure requiring dialysis or transplant
  § No income requirements
- Two ways to receive Medicare benefits

**Original Medicare**

Traditional program offered directly through federal government

**Medicare Advantage**

Private plans that contract with federal government to provide Medicare benefits
Parts of Medicare

- Medicare benefits administered in three parts
  - Part A – Hospital/inpatient benefits
  - Part B – Doctor/outpatient benefits
  - Part D – Prescription drug benefit

- Original Medicare includes Part A and Part B
  - Part D benefit offered through stand-alone prescription drug plan

- What happened to Part C? Medicare Advantage Plans (e.g., HMO, PPO)
  - Way to get Parts A, B, and D through one private plan
  - Administered by private insurance companies that contract with federal government
  - Not a separate benefit: everyone with Medicare Advantage still has Medicare

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Medicare Part D
Part D: Medicare drug coverage

- Covers most outpatient prescription drugs
- Each Part D plan has a **formulary**, the list of drugs covered by plan
- Beneficiary can get Part D coverage in two ways:
  - Stand-alone Part D plan that works with Original Medicare
  - Medicare Advantage Plan that includes prescription drug coverage
Excluded drugs

- Some drugs are excluded from Medicare coverage by law and cannot be covered by any Part D plan

- **Excluded drugs include**

<table>
<thead>
<tr>
<th>Drugs used to treat anorexia, weight loss, or weight gain; however, Part D may cover drugs used to treat physical wasting caused by AIDS, cancer, or other diseases.</th>
<th>Prescription vitamins and minerals, except prenatal vitamins and fluoride preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility drugs</td>
<td>Drugs used to treat erectile dysfunction</td>
</tr>
<tr>
<td>Drugs used for cosmetic purposes or hair growth</td>
<td>Drugs that have not been approved by Food and Drug Administration (FDA)</td>
</tr>
<tr>
<td>Drugs that are only used to treat cough or cold symptoms</td>
<td>Most over-the-counter drugs, like Tylenol® and Advil®</td>
</tr>
</tbody>
</table>

- If beneficiary needs to take one of these drugs, their Part D plan will likely not cover it; beneficiary will be responsible for full cost
Coverage restrictions

- Part D plans may have coverage restrictions on certain drugs

- Prior authorization
  - Plan requires beneficiary to get approval from plan before it will pay for drug
  - Beneficiary’s doctor can help get prior authorization

- Quantity limit
  - Plan restricts the amount of drug a beneficiary can get per prescription fill

- Step therapy
  - Plan requires beneficiary to try cheaper versions of drug before it will cover more expensive drug
Part D costs

- **Premium**: Amount beneficiary pays monthly to have coverage
  - § 2019 average Part D premium is $33.19/month

- **Annual deductible**: Amount beneficiary pays out of pocket before plan begins to cover drug costs
  - § 2019 maximum Part D deductible is $415/year

- **Coinsurance or copayment (copay)**: Cost-sharing amount beneficiary pays out of pocket for covered drugs
  - § Coinsurance charge is percentage of cost
  - § Copay is set amount
Drug tiers

• Many Part D plans use tiers to price drugs listed on their formulary
• Drugs in lower tiers are less expensive; drugs in higher tiers are more expensive
• Sample tiering structure
  § Tier 1: Generic drugs
  § Tier 2: Preferred brand-name drugs
  § Tier 3: More expensive brand-name drugs
  § Tier 4: Specialty drugs
Drug coverage under Medicare Part B
Part B versus Part D coverage

• Part D covers most outpatient prescription drugs (meaning those received at pharmacy)

• Part B covers most drugs administered by providers
  § Covers medications at dialysis facility if provider or facility buys and supplies drugs
  § Covers some outpatient prescription drugs, mainly certain oral cancer drugs

• Some drugs are covered by either Part B or Part D, depending on the circumstances
Step therapy for Part B-covered drugs

- Medicare Advantage Plans may use step therapy for Part B drugs
  - Plan may require enrollees to use plan-preferred Part B drug before using different Part B drug
  - Plan may also require beneficiary to use Part D drug before Part B drug, or vice versa

- Plans should inform beneficiaries of Part B step therapy requirements in Annual Notice of Coverage (ANOC) and Evidence of Coverage (EOC)

- Beneficiaries may request an exception to their plan’s step therapy requirement
Drug management lock-in programs
Drug management lock-in programs

- Part D plans can implement drug management programs to limit opioid access for at-risk beneficiaries
- Plans use clinical guidelines to identify beneficiaries at risk of misuse or abuse of frequently abused drugs, such as opioids
- At-risk beneficiaries:
  § May be required to use one provider and one pharmacy to get flagged medications (known as pharmacy or provider lock-in)
  § Cannot use the Extra Help Special Enrollment Period (SEP) to make coverage changes
Lock-in notice rights

- Plans must send notices regarding at-risk designation
- **First notice**: Informs beneficiary that they are potentially at risk
  - Includes plan’s proposed coverage limitations (such as pharmacy lock-in) for drug and timeframe for plan’s decision
  - Provides information about Extra Help SEP, if applicable
  - Informs beneficiary that they and/or provider can submit information to plan if they do not agree with at-risk designation
  - In case of proposed lock-in, beneficiary can submit provider and pharmacy preferences
Lock-in notice rights (continued)

- **Second notice**: Informs beneficiary that plan has found them to be at risk
  - § Provides opportunity for beneficiary to submit provider and pharmacy preferences
  - § Includes appeal instructions for requesting redetermination if beneficiary does not agree with at-risk designation
Exemptions

• Certain beneficiaries will not be labelled at-risk
  § Individuals who elect hospice or receive palliative end-of-life care
  § Individuals who reside in long-term care facilities
  § Individuals being treated for active cancer-related pain
Part D cost assistance programs
Programs that help pay Medicare drug costs

- Extra Help (sometimes called the Low-Income Subsidy or LIS)
- State Pharmaceutical Assistance Programs (SPAPs)
- Patient Assistance Programs (PAPs)
Extra Help

- Federal program that helps pay some or most Part D drug costs
  § Works with Part D coverage
  § No or low premium and deductible for drugs
  § Low copays
- Provides Special Enrollment Period (SEP) for beneficiary to change drug coverage once per calendar quarter
- Eliminates Part D late enrollment penalty beneficiary will have if they delayed Part D enrollment and did not have creditable coverage
- Beneficiary must meet federal income and asset limits to qualify
- Two types of Extra Help
  § Partial Extra Help
  § Full Extra Help
# Partial Extra Help eligibility in 2019

Partial Extra Help 2019 income limits

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<thead>
<tr>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $1,581/month</td>
<td>Up to $2,134/month</td>
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</table>

Partial Extra Help 2019 asset limits

<table>
<thead>
<tr>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $14,390</td>
<td>Up to $28,720</td>
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</table>
## Full Extra Help eligibility in 2019

### Full Extra Help 2019 income limits

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<tr>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $1,425/month</td>
<td>Up to $1,922/month</td>
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</table>

### Full Extra Help 2019 asset limits

<table>
<thead>
<tr>
<th>Single</th>
<th>Couple</th>
</tr>
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<tbody>
<tr>
<td>Up to $9,230</td>
<td>Up to $14,600</td>
</tr>
</tbody>
</table>

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Extra Help costs in 2019

• Full Extra Help
  § Beneficiary pays no monthly premium for plans with premium below state’s benchmark amount
    » Benchmark amount varies by state
  § $3.40 copay for generic drugs
  § $8.50 copay for brand-name drugs

• Partial Extra Help
  § Beneficiary’s monthly premium depends on income
  § $85 deductible or plan’s deductible, whichever is cheaper
  § 15% coinsurance or plan copay, whichever is cheaper
Extra Help SEP

- Increases flexibility to join and change Part D plans
  - Allows enrollment in Part D once per calendar quarter in the first three quarters of each year
    - January through March, April through June, July through September
    - Changes effective first of the following month
    - Beneficiaries use Fall Open Enrollment during the fourth quarter, with changes effective January 1
Getting Extra Help

• **Automatic enrollment**
  § Beneficiary should get Extra Help automatically if they have Medicaid, a Medicare Savings Program (MSP), or Supplemental Security Income (SSI)

• **Active enrollment** through Social Security Administration (SSA). Apply:
  § By filling out online application (www.ssa.gov)
  § By phone (800-772-1213)
  § By going in person to local SSA office
  § For all of the above, individual declares income and assets but does not need to provide proof

• If beneficiary is denied, they can appeal by following instructions on denial notice
State Pharmaceutical Assistance Programs (SPAPs)

- State-based programs that may help pay drug costs
  - § Not all states have SPAP
- Program may have specific
  - § Eligibility requirements
  - § Application instructions
  - § Rules and conditions that beneficiary must follow in order to get benefit
- To learn if your client’s state has an SPAP, contact State Department of Health or visit
  https://www.medicare.gov/pharmaceutical-assistance-programs/state-programs.aspx
Patient Assistance Programs (PAPs)

- Pharmaceutical assistance programs that provide discounts on certain drugs, through the drug manufacturer.
- Each PAP generally offers discounts on specific type of brand-name or generic medication.
- Some programs may not work if beneficiary has Medicare prescription drug coverage.
- Program may have specific
  § Eligibility requirements
  § Application instructions
  § Rules and conditions that beneficiary must follow in order to get benefit
Finding PAPs

**RxAssist**

[Logo]

Directory of PAPs for qualifying individuals

[www.rxassist.org](http://www.rxassist.org)

**NeedyMeds**

[Logo]

Directory of PAPs, charities, and other resources for low-cost or free prescription drugs for qualifying individuals

[www.needymeds.org](http://www.needymeds.org)
Other strategies for accessing drugs
Evaluate options

In addition to drug cost assistance programs, there may be other options to help a client afford their drug costs:

1. Appeal to drug plan to lower drug costs
2. Explore lower-cost options
3. Change plans, if possible
4. Ask doctor for samples
Appeals

Determine whether you can help beneficiary appeal. Two types of appeals can help lower cost of beneficiary's drug, depending on circumstance:

- Tiering exception request
- Formulary exception request
Tiering exception request

- If beneficiary takes a drug on a high tier, they can ask plan to put drug on lower tier with a lower copay
  - However, beneficiary cannot request tiering exception for a drug on a specialty tier

- **To request tiering exception**
  - Doctor contacts plan by phone or in writing for paperwork (usually Coverage Determination Request Form)
  - Doctor writes letter that explains that drugs/treatments on lower tiers are ineffective or harmful to beneficiary
Tiering exception request

- **Standard timeline:** Plan must give decision within 72 hours of receiving request
- ** Expedited timeline:** Plan must give decision within 24 hours of receiving request
  - Doctor can request expedited timeline if beneficiary’s health would be harmed by waiting standard timeline
- If plan denies tiering exception request, beneficiary and their doctor can appeal within 60 days by following instructions on denial notice
- Approved tiering exception request usually lasts until end of current calendar year
If beneficiary’s drug is not on formulary, they can request formulary exception
  § Drugs on formulary are generally cheaper than full cost of drugs not on formulary

To request formulary exception
  § Doctor contacts plan by phone or in writing to request formulary exception
  § Doctor includes letter of support explaining that drugs on formulary would be harmful to beneficiary’s health
  § Doctor should demonstrate that beneficiary has tried drugs on formulary and had negative reactions to them
Formulary exception request

• **Standard timeline:** Plan must respond within 72 hours of receiving request

• **Expedited timeline:** Plan must respond within 24 hours of receiving request
  
  § Doctor can request expedited timeline if beneficiary’s health would be harmed by waiting standard timeline

• If plan denies formulary exception request, beneficiary and their doctor can appeal within 60 days by following instructions on denial notice

• Approved formulary exception request usually lasts until end of current calendar year
Consider lower-cost options

**Consider a generic drug**

- Generic drugs are often less expensive than brand-name drugs
- Beneficiary could save money by switching to generic version of a brand-name drug, if possible
- Beneficiary should check with doctor to see if a generic drug is an option for them
Consider lower-cost options

Consider a different brand-name drug
- Contact plan to learn if there are similar but less expensive drugs on formulary
- Beneficiary should check with doctor to see if other brand-name drugs are an option for them
Consider lower-cost options

Use mail-order pharmacy

§ Some plans offer option to get drugs through mail-order pharmacy
§ This option may be less expensive than getting drugs through retail pharmacy
Change plans

Beneficiary may need to consider changing plans. Reasons may include:

§ Drug copay/coinsurance charge is too expensive under current plan
§ Plan’s deductible and/or premium are too expensive
§ Drug is not on plan’s formulary

• There may be other plans that have lower costs and/or cover needed drug(s)

• Beneficiary can only change coverage during certain times of the year
  § Fall Open Enrollment Period
  § Special Enrollment Period

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Fall Open Enrollment Period

- October 15 – December 7 each year; any changes made take effect January 1 of following year
- Beneficiary can make changes to Medicare coverage
- If beneficiary is unhappy with their drug coverage, they can explore other stand-alone Part D or Medicare Advantage Plans for following year
- Resources to find new plan
  § Use Medicare Plan Finder by visiting www.medicare.gov/find-a-plan
  § Call 1-800-MEDICARE
  § Contact State Health Insurance Assistance Program (SHIP) by visiting www.shiptacenter.org or calling 877-839-2675
Special Enrollment Periods

- In certain situations, beneficiary can make changes to their health and/or drug coverage
- See if there is SEP beneficiary can use to switch to different stand-alone Part D or Medicare Advantage Plan
- Length of SEP and effective date of new coverage depend on reason for SEP
SEP examples

- **Extra Help SEP**
  § A beneficiary enrolled in Extra Help can change their drug coverage once per calendar quarter for the first three quarters of the year

- **SPAP SEP**
  § A beneficiary enrolled in SPAP can choose new Medicare Advantage or Part D plan once per year (unless their SPAP automatically enrolled them in Part D plan)

- **Five-star SEP**
  § If there is five-star stand-alone Part D plan or Medicare Advantage Plan in beneficiary’s service area, they can enroll in that plan
Ask doctor for samples

Finally, beneficiary may be able to get samples from their doctor.

- Temporary solution because doctor may not be able to provide samples for very long
- Beneficiary can take samples while exploring other options for lowering drug costs
Review

- **Part D: Medicare prescription drug coverage**
  - Available through stand-alone Part D plans and Medicare Advantage Plans
  - Covers most outpatient drugs

- **Drug assistance programs**
  - Extra Help
  - State Pharmaceutical Assistance Programs (SPAPs)
  - Patient Assistance Programs (PAPs)

- **Strategies for lowering drug costs**
  - Appeal by filing tiering exception or formulary exception request
  - Take generic or different brand-name drug
  - Use mail-order pharmacy
  - Change plan, if possible, during Fall Open Enrollment Period or Special Enrollment Period
  - Ask doctor for samples
Resources for information and help

State Health Insurance Assistance Program (SHIP)
- www.shiptacenter.org
- www.eldercare.gov

Social Security Administration
- 800-772-1213
- www.ssa.gov

Medicare
- 1-800-MEDICARE (633-4227)
- www.medicare.gov

Medicare Rights Center
- 800-333-4114
- www.medicareinteractive.org

National Council on Aging
- www.ncoa.org
- www.centerforbenefits.org
- www.mymedicarematters.org
- www.benefitscheckup.org

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Medicare Interactive

- www.medicareinteractive.org

- Web-based compendium developed by Medicare Rights for use as a look-up guide and counseling tool to help people with Medicare
  - Easy to navigate
  - Clear, simple language
  - Answers to Medicare questions and questions about related topics
  - 3+ million annual visits

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Medicare Interactive Pro (MI Pro)

- Web-based curriculum that empowers professionals to better help clients, patients, employees, retirees, and others navigate Medicare
  - Four levels with four to five courses each
  - Quizzes and downloadable course materials
- Builds on 30 years of Medicare Rights Center counseling experience
- For details, visit www.medicareinteractive.org/learning-center/courses or contact Jay Johnson at 212-204-6234 or jjohnson@medicarerights.org