



Medicare Part D Frequently Asked Questions: Benefit Design

This list of “Frequently Asked Questions” regarding the benefit design of the new Medicare Part D prescription drug benefit is designed to both inform advocates and be used as a tool to educate consumers. It is one document in a series that address four different categories: Eligibility & Enrollment, Benefit Design, Exceptions & Appeals, and Administrative Issues. This document will continue to evolve as new questions arise. If you have a question that is not addressed here, please contact NMHA’s Advocacy Resource Center at shcrinfo@nmha.org.

What are Medicare Part D plans required to cover? Do all the plans have to offer exactly the same coverage?

Plans offering Medicare drug coverage must provide access to at least two medications from each therapeutic category and class. Plans are also free to offer more comprehensive coverage, referred to as enhanced or supplemental coverage.

Medicare plans will have benefit design flexibility to construct tiered co-pays to manage costs. These tiered co-pays may vary but must average no more than 25% of medication costs up to the initial coverage limit and 5 % in the catastrophic coverage.

Below is a chart that summarizes cost-sharing requirements for Medicare Part D:

Summary Chart of Medicare Drug Benefits

	General Policy	Between 135% and 150% FPL¹	Under 135% FPL²	Dual-Eligible
Annual Premium	\$35 per month (\$420 annually)	Sliding Scale	None	None
Deductible (person pays in full)	\$250	\$50	None	None
Co-payment	25% for drug costs between \$250 and \$2,250 100% for drug costs between \$2,250 and \$5,100	15% for drug costs between \$50 and \$5,100	\$2 - \$5 co-pays for drug costs up to \$5,100	Under 100% FPL: \$1 - \$3 copays for drug costs up to \$5,100 Above 100% FPL: \$2 - \$5 co-pays for drug costs up to \$5,100 No copays for drug costs over \$5,100
Doughnut Hole	\$2,850 gap in Coverage	n/a	n/a	n/a
Catastrophic	5% or co-pays	Co-pays of	100% covered	100% covered

¹ And assets below \$10,000 for individuals and below \$20,000 for couples

² And assets below \$6,000 for individuals and below \$9,000 for couples

Coverage for drug costs over \$5,100	\$2-\$5	\$2-\$5		
---	---------	---------	--	--

What drugs are included or excluded from drug benefit plans?

By law, a Part D drug is any drug available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication. More specifically, a Part D drug includes prescription drugs, biological products, insulin, vaccines, and certain medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). The law excludes a few medications related to the treatment of mental health disorders, including: drugs when used for anorexia, weight loss, or weight gain; barbiturates; and benzodiazepines.

Plans are required to include at least two medications from each therapeutic category or class (unless there are only two drugs in a class in which case they can cover only one).

What is a formulary?

A formulary is a list of medications that are available to healthcare insurance program enrollees. Although Medicaid requires all medications that are not on formulary to be accessible through prior authorization, Medicare Part D permits programs to simply refuse to pay for any medications that are not on the list of approved medications.

Who decides what medications are on the formulary?

Plans establish their own formularies that are then reviewed by CMS. Plans will be required to include at least two drugs within each therapeutic category and class of covered Part D drugs within their formulary (unless there are only two drugs in a particular therapeutic class or category, in which case the inclusion of only one drug in that category would be required).

Plans will also be required to use a Pharmacy and Therapeutic (P&T) committee to develop and review their formularies. P&T Committee decisions about what medications are placed on the formulary will be considered binding by CMS. P&T committees will consist primarily of individuals who are practicing pharmacists and physicians, with a requirement of at least one pharmacist and one physician who are independent of the plan and are experts in the care of elderly or the disabled.

How often are formularies reviewed?

CMS regulations do not specify how often formularies need to be reviewed by P&T Committees. CMS will review plan formularies when they submit bids to take part in the Part D program, and it appears that CMS will conduct regular reviews after the first year. The final regulations state that CMS will consider the following issues when reviewing plans: (1) reviewing categories and classes in relation to the USP model; (2) assuring appropriate treatments are available for certain diseases; (3) comparing utilization management tools to make sure they support treatment guidelines; and (4) comparing formularies to identify outlier practices.

After the initial year of the program, CMS will also review the history of plan formulary appeals to identify issues with the plan's formulary, and will conduct additional research on evaluating formularies and drug benefit designs.

Are plans required to notify enrollees of formulary or benefit changes?

Plans must provide at least 60-days notice to CMS, SPAPs, entities providing other prescription drug coverage, authorized prescribers, network pharmacies, and pharmacists prior to removing a drug from its formulary, or changing cost-sharing rules.

Plans must also provide direct written notice to affected enrollees at least 60 days prior to a formulary change becoming effective, or at the time an affected enrollee requests a refill, provide the enrollee with a 60-day supply of the medication and notice of the formulary change.

Plans may not change the formulary or co-payments of medications during the annual coordinated election period or for 60 days after the beginning of the contract year.

Medications determined unsafe by the FDA or removed from the market may be removed from the formulary immediately and without the 60-day notice.

I understand that there have to be two drugs in every therapeutic category and class. Who sets the categories and classes?

The prescription drug plans and Medicare Advantage prescription drug plans (MA-PD) plans have two options for their classification system. They may present their own for CMS review, or per the statute, they may use the model guidelines recently published by U.S. Pharmacopeia (USP), available at <http://www.usp.org/pdf/drugInformation/mmg/finalModelGuidelines2004-12-31.pdf>. CMS contends that it will nonetheless evaluate submitted formulary designs to ensure they contain adequate access to medically necessary drugs and do not discriminate against any groups of enrollees regardless of which classification system is used.

Currently, the U.S. Pharmacopoeia guidelines differentiate between older antipsychotics and atypical antipsychotics. However, the guidelines put older antidepressants, SSRIs, and SSNRs in the same therapeutic class. There are also no requirements to include newer medications in the formulary classes.

What utilization management techniques are plans permitted to use for their benefit?

In contrast to Medicaid law, Medicare Part D specifically allows plans to establish closed formularies (which means that plans will not pay for medications not on the formulary). The final regulations allow the use of prior authorization, fail first, and step therapy. Further, there are no continuity of care, or “grandfathering” requirements in the regulations, which means that consumers will not be guaranteed access to their current medications, even if those medications are working, if they are not listed in the formulary.

CMS has indicated that some cost containment strategies used under Medicaid will not be used for the new benefit, including: limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage, limiting the frequency of dispensing a drug, pharmacy lock-in programs, or refill limits.

How can I get supplemental coverage for the drug benefit?

Enrollees with limited means are eligible for low-income subsidies to cover the gap (e.g., doughnut hole) in coverage, and almost 11 million are expected to sign up for this in 2006. For enrollees with incomes above 150% of the poverty level, there are a number of ways in which enrollees may have access to more comprehensive benefits, including:

- employers and unions,
- state pharmaceutical assistance programs,
- charitable assistance, and
- supplemental coverage within Part D.

For more information about what patient assistance programs you might be eligible for, access <http://www.helpingpatients.org>.

Will the premium increase each year? How much?

Yes. The amount of the premium is expected to grow each year, much as other health care premiums grow. The exact amount of the increase will depend on how plans bid in subsequent years. Factors affecting drug costs and therefore premiums include how many new drugs enter the market, how many drugs go off patent, competitive pressures on drug prices, and changes in utilization patterns.

Enrollees with incomes below 150% of the federal poverty level will either pay a reduced premium or no premium at all. Dual eligibles will pay no premiums.

What are True Out-of-Pocket costs (TrOOP)?

The new Medicare law creates a distinction between all enrollee out-of-pocket expenditures and those that will be counted toward the annual Part D out-of-pocket threshold—the latter are known as “true” out-of-pocket (TrOOP) expenditures. These are costs actually paid by the beneficiary, another person on behalf of the enrollee, or a qualified State Pharmaceutical Assistance Program (SPAP) and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer) that will count toward the TrOOP threshold that determines the start of the catastrophic coverage. Most third-party assistance, such as that from employers and unions, does not count toward the TrOOP threshold. Any payments for a drug that Part D does not cover, (like benzodiazepines), and for drugs not on a plan's formulary which the enrollees pay for themselves, also do not count towards the TrOOP.

How does Medicare Part D apply to individuals in institutions?

Institutionalized dual eligible individuals pay no cost-sharing for drugs covered under their Part D plan. In other words, full-benefit dual eligible individuals in nursing homes will have no cost sharing at all and can retain their limited personal needs allowances for their personal expenses as long as the plans available to them cover the medications they need.

Other low-income institutionalized individuals will receive cost sharing subsidies based upon their level of income and resources. Part D institutionalized individuals who do not qualify for the low-income subsidy who were paying for drugs using private sources will now benefit from the Part D prescription drug benefits, including catastrophic coverage for drug expenditures in excess of \$5,100.

How do I determine whether my pharmacy is included in the plan network?

After you enroll in your plan (or CMS auto-enrolls you into a plan if you are a dual eligible), your plan should send you materials including information on which pharmacies are in the plan's network. It is important to remember that your current pharmacy may not be the pharmacy that you must use after January 1, 2006, when Medicare Part D begins.

What do I do if I lose my Part D card?

If you lose your Part D card, you should call your plan and request a new card. If you lose your card after January 1, 2006, and you have already been to the pharmacy and used your benefits under Part D, the pharmacy should have your plan information in their computer. You should still call your plan and request a new card. Even if you don't have your card the first time you go to the pharmacy, the pharmacist should be able to determine which plan you are enrolled in and what medications are covered.

Who has access to my enrollment information?

You are the only person, besides your prescription drug plan, who will have complete records of your enrollment information. Your new network pharmacy may have access to your plan information, and so, if you lose your Part D card, you may be able to still get your prescriptions from this pharmacy. Your

treating physician may be able to call the pharmacy and verify your enrollment with your permission. They will need your name and social security number in order to do so.

Is the plan required to continue my existing prescription during the initial implementation in January 2006?

Even if your plan does not cover a medication that you currently take, your plan *may* continue your existing prescription for 30 days, as long as it isn't excluded from Part D by the Medicare law (for example, benzodiazepines). However, the plan is not *required* to fill this 30 day supply. During this time you may file an exception with the plan, asking them to cover this medication for you. If your exception is approved, the prescription is good for one year. (See the section on grievances and appeals to learn more.)

Will I be required to switch my medication?

Plans are not required to cover all medications. Your medication may not be covered by the plan you choose, or are auto-enrolled into. If your plan does not cover your prescription, you may request an exception. If your plan denies your exception, you can appeal, but if you do not get a favorable decision at any stage, you may not have access to the drug. If you do not wish to switch medications, there are other programs that may allow you to get access to your medications but not have to pay the complete cost out of pocket (see question on other resources for obtaining your medications). If you are a dual eligible you may switch to a different plan (as frequently as once a month).

What if I can't pay my co-pay at the pharmacy? Can I still get my medication?

Under Medicaid law, pharmacies must give Medicaid consumers their prescription drugs even if they cannot pay the co-pay. Medicare Part D does not operate under this rule. The pharmacist has discretion under Medicare law to dispense prescriptions if the consumer cannot afford the co-pay, but they are not required to do so. If you are denied your prescription, you should try to get your prescription filled at another network pharmacy and see whether they will dispense the medication without a copay. Also, you should see if your state provides assistance with covering Part D co-payments.

What other resources exist for me to get access to my medications?

There are other resources that you can turn to if your prescription is not covered under your Medicare drug plan. The following Internet links can provide you with information about each type of resource in your state.

Programs providing medications or cost-sharing assistance directly to consumers:

- State Pharmacy Assistance Programs (SPAPs) <http://www.ncsl.org/programs/health/drugaid.htm>
- Prescription Assistance Programs <http://www.helpingpatients.org>
- Partnership for Patient Assistance <https://www.pparx.org/Intro.php>

Agencies providing information to consumers:

- Medicaid offices <http://www.nasmd.org/links.htm>
- State ombudsman offices http://www.ltombudsman.org/static_pages/ombudsmen.cfm
- Protection & Advocacy organizations <http://www.napas.org>
- MHAs <http://www.nmha.org/affiliates/directory/index.cfm>
- Medicare ombudsman (no information available yet)
- State Health Insurance Assistance Programs (SHIPs)
<http://www.medicare.gov/contacts/static/allStateContacts.asp>