Legal Basics: Medicare Part D

NATIONAL CENTER ON LAW & ELDER RIGHTS

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Key Lessons

1. In Medicare Part D, consumers face a choice of plans with many variables including premiums, formularies, and benefit design. State Health Insurance Assistance Programs (SHIPs) and the Medicare Plan Finder can help Medicare beneficiaries in reviewing plan choices and determining which is most appropriate and cost-effective.
2. The Low-Income Subsidy (LIS or "Extra Help") significantly lowers costs for people with modest income and offers more enrollment flexibility. Those with Medicaid and Supplemental Security Income (SSI) are automatically enrolled. Others apply through the Social Security Administration.
3. If a Part D plan denies coverage for a needed prescription drug, a system of standard and expedited appeals is available to seek an "exception" to the denial.

Section 1: What is Part D?

Part D is the prescription drug benefit for Medicare. Coverage is offered by private insurance companies that are contracted with the Medicare program and available either through a stand-alone prescription drug plan, known as a PDP, or as part of the benefit package of a Medicare Advantage plan (MA-PD) that combines both health and prescription drug benefits. Anyone enrolled in Medicare Part A or Medicare Part B can enroll in the Part D program. People who want their prescription drug coverage through a Medicare Advantage plan must be enrolled in both Part A and Part B. Of the 41 million people enrolled in Part D, about 60% receive the benefit through PDPs and 40% through MA-PDs.

An important part of the Part D program is the Low-Income Subsidy, also called "Extra Help" which significantly reduces the cost of the program for people with limited incomes. Extra Help will be discussed in more detail in Section 4.

Individuals with income at or above $85,000/year must pay an additional Income-Related Monthly Adjustment Amount (IRMAA). The IRMAA ranges from $13.30/mo. to $76.20/mo. depending on income.

Section 2: Enrolling in Part D

When can someone enroll or change plans?

Individuals should enroll in Part D at the same time that they first become eligible for Medicare. The Initial Enrollment Period is the seven months surrounding an individual's sixty-fifth birthday or, for those who qualify on the basis of a disability, the seven month period around the twenty-fifth month of Social Security Disability Insurance qualification.

Each year, everyone with Medicare can change Part D plans during the Open Enrollment Period, which extends from October 15 through December 7, with the new enrollment starting on January 1. People who enroll in a Medicare Advantage plan can also use the Medicare Advantage Disenrollment Period, from January 1 through February 14, to move out of a MA-PD and join a PDP. They may not, however, use the Disenrollment Period to move between PDPs or between MA-PDs.

Special Enrollment Periods (SEPs) also may apply in different circumstances. People with the Low-Income Subsidy have a continuous SEP, allowing them to change plans at any time with the new enrollment effective the next month. Other SEPs are available for people who move out of a plan's service area, for those entering or leaving a skilled nursing facility, for people who received erroneous information from a federal official, and in other circumstances.

What is the late enrollment penalty?

People who do not enroll when first eligible are subject to a late enrollment penalty unless they have "creditable coverage." Creditable coverage is coverage that is actuarially as good as the basic Part D benefit. Insurers provide an annual written notice affirming creditable status.

The late enrollment penalty is 1% of the national base premium amount multiplied by the total uncovered months. People with the Low-Income Subsidy are not charged a late enrollment penalty.

Section 3: How Do Part D Plans Work?

Consumers in all states have a wide range of choices, including MA-PDs and, on average, 22 PDPs. PDP premiums vary greatly, ranging from a low in 2017 of $14.50 to a high of $179.00. MA-PD choices also vary widely with some plans having a zero premium. Besides differing in price, plans differ in how they design their payment structure, the drugs they cover, and the pharmacies in their networks.

Plan payment structures are complex

Plans may impose a deductible charge of up to $400 but many do not. All plans divide drugs into payment tiers. Typically plans have five tiers, each with its own co-insurance amount. Preferred tiers offer lower co-insurance than non-preferred tiers. For each tier, plans can impose either a co-payment that is a set amount or co-insurance that is a percentage of the full drug price. Once drug costs reach a certain amount ($3700 for 2017), an individual enters the coverage gap (the "donut hole") where payments increase to 40% of the cost of brand name drugs and 51% of the cost of generics. After reaching another level of spending, they exit the donut hole and begin catastrophic coverage where payments are capped at 5% of a drug's cost.

Plan formularies vary

Plans must cover all or virtually all HIV/AIDS drugs, immunosuppressant medications, antidepressants, antipsychotics, anticonvulsants for seizure disorders, and anticancer drugs that are not covered by Part B. Plans are usually required to include at least two drugs in other drug classes, but have latitude to determine which drugs and what tier. They also may impose utilization management controls such as quantity limits, step therapy requirements or prior authorization requirements.

Medicare never covers certain drugs, including over-the-counter drugs, drugs prescribed for colds, erectile dysfunction drugs (unless prescribed for other purposes), and drugs for weight loss or anorexia. Drugs prescribed "off label" can only be covered if the off-label use is supported by a listing in one of three commercial compendia listed in the Part D statute.

SHIP counseling helps beneficiaries navigate Part D complexities

Choosing a cost-effective plan with the best drug coverage is daunting for most people with Medicare. They can get one-on-one assistance from State Health Insurance Programs (SHIPs) where trained volunteer counselors offer free and unbiased guidance. At the Medicare.gov website, consumers also can sort plan options based on the drugs they use, the pharmacies they prefer, and their zip code.

Section 4: The Part D Low-Income Subsidy ("Extra Help")

The Medicare Low-Income Subsidy (LIS), also called Extra Help, offers significant Part D savings. LIS beneficiaries also experience a simplified program design and have the right to change plans at any time.

Enrollment in the LIS is automatic for Medicare beneficiaries who receive Supplemental Security Income (SSI) payments or Medicaid benefits, including those who are only in Medicare Saving Programs (QMB, SLMB and QI). People with Medicaid with a share of cost need only meet their share of cost once and they have LIS for the rest of the year. If they meet their share of cost in July or later, they qualify for the LIS for the rest of the year and all of the following year.

Others can apply to the Social Security Administration based on their income and resources. The LIS is available for individuals with incomes up to 150% of the Federal Poverty Level and up to $12,320 ($24,600 for a couple) in assets. Asset and income counting rules are simpler than those usually applied by state Medicaid agencies.

LIS benefits are substantial

With the full LIS benefit, "benchmark" plans (those with a premium below a threshold set by CMS each year) are available to LIS enrollees without premiums. LIS co-pays range from $0 to $8.25 with no deductibles, no donut hole, and no catastrophic coverage co-pays. Instead of five tiers, full LIS beneficiaries only face two co-payment tiers. Those with partial LIS (between 135% and 150% FPL) pay partial premiums, can be charged a limited deductible, and have higher, though still modest, co-pays. All LIS beneficiaries can change plans at any time.

Auto-enrollment into plans

To ensure that people with LIS get the Part D benefit, CMS auto-enrolls them into a "benchmark" PDP if they do not choose a plan themselves. Auto-enrollment is random and does not take into account a beneficiary's prescription drug needs.

CMS attempts to auto-enroll LIS beneficiaries on their first day of eligibility. If this does not happen, a point of sale enrollment process can be used at the pharmacy. The individual is enrolled for two months in LI-NET, a plan with an open formulary and no utilization management or pharmacy restrictions. In many cases, LI-NET enrollment can be completed right at the pharmacy so the beneficiary can leave with the needed prescription. LI-NET enrollment lasts for two months after which the individual is auto-enrolled in a benchmark plan.

In other cases, individuals are already in a Part D plan and then become eligible for the LIS. If the plan records do not correctly show LIS status, another point of sale procedure, called Best Available Evidence (BAE) can be used. With evidence of LIS status, such as a Medicaid card, the pharmacy should be able to contact the plan and get an on-the-spot reduction in the co-payment amount. If the plan member has difficulty producing BAE, plans have an affirmative obligation to take steps to help confirm LIS status.

Section 5: Filing an Appeal

Plan members have the right to appeal any decision related to their access to a prescription drug or payment

for a drug.

In the most frequent scenario, a plan rejects a prescription when it is presented at the pharmacy. The pharmacist must give the individual a generic notice titled "Medicare Prescription Drug Coverage and Your Rights," which states that a beneficiary can file an appeal and advises calling the plan.

Denial at the pharmacy does not trigger an appeal. When there is a denial, either the beneficiary or the prescriber should contact the plan to learn clearly why the prescription was denied. There may be an easy solution like switching to a different brand that is on the plan's formulary or fulfilling a utilization management requirement. But, if the beneficiary wants to appeal, she must start by asking for a "coverage determination."

If the requested coverage determination is about drug coverage, it is called an "exception." An exception should be supported by a physician's statement. The standard timeframe for deciding an exception is 72 hours from receipt of the physician's statement, but an expedited determination (24 hours) is available if the physician confirms the need for a faster decision.

Pursuing additional levels of appeal

If an exception request is denied, there are additional levels of appeal:

- Reconsideration: a paper review within the plan of its original decision;
- Redetermination by the Independent Review Entity (IRE), also a paper review;
- Review by a Medicare Administrative Law Judge by video conference or telephone;
- Review by the Medicare Appeals Council; and
- Federal District Court.

In thinking about appeal strategies, advocates should keep in mind that physician support is the critical factor for success. Also getting to an independent review—either at the IRE or ALJ level—often is the critical factor in success.

Conclusion

Advocates can play an important role in helping Medicare beneficiaries navigate the Medicare Part D program. The Part D Low-Income Subsidy is particularly vital in making Part D benefits available and accessible to those with low incomes.

Additional Resources

- Georgia Burke, gburke@justiceinaging.org
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- Statutes
    - » 42 U.S.C. 1395w-111 through 1395w-134 (Title 18 of the Social Security Act Sections 1850D-11 through Sec 1860D-16), available at ssa.gov/OP_Home/ssact/title18/1800.htm
- Regulations
    - » 42 C.F.R. Part 423, available at law.cornell.edu/cfr/text/42/part-423
- Sub-regulatory Guidance
    - » Prescription Drug Benefit Manual, available at cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

- Government websites
  - » Medicare Plan Finder, available at medicare.gov/find-a-plan/questions/home.aspx
  - » Social Security Administration "Extra Help" page, available at ssa.gov/medicare/prescriptionhelp
- Other websites
  - » SHIP referral page, available at shiptacenter.org
  - » Medicare Rights Center medicarerights.org
  - » Center for Medicare Advocacy medicareadvocacy.org
  - » National Council on Aging ncoa.org/economic-security/benefits/prescriptions/part-d

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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