Medicare Part D and Dual Eligibles: A Guide for California Advocates

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I. A Quick Glance at Medicare Part D

This section of the manual is intended for those seeking a brief overview of the program. Advocates who are unfamiliar with the program or with California healthcare programs may find this section useful. For a more in-depth discussion of the particulars of Medicare Part D, please proceed to the next section.

Basic Definitions You Will Need to Know

Is Medicare the same as Medi-Cal?

No. Medicare is a healthcare program financed by the federal government. In general, Medicare is available to people who are 65 or older or who have a permanent disability. Medicare is available regardless of a person's income or assets. A person usually must have a work history in order to qualify for Medicare. A person applies for Medicare through a local Social Security Administration office.

Medi-Cal = Medicaid ≠ Medicare

Medi-Cal is California's version of the Medicaid program. Medicaid is a healthcare program administered jointly by both the federal and state governments. The federal government pays for about half of all of Medi-Cal's costs. Medi-Cal beneficiaries are generally 65 or older or have a disability, like Medicare beneficiaries, but Medi-Cal beneficiaries also include children, families with children, and pregnant women. A person must have a low income and limited assets to be eligible for Medi-Cal. A person may apply for Medi-Cal through a county welfare office or by completing the joint Healthy Families/Medi-Cal application and sending it to the state's Single Point of Entry in Sacramento. SSI and CalWORKs recipients in California automatically receive Medi-Cal without the need to complete a separate application.

What are Medicare Parts A, B, and C?

Medicare Part A generally covers healthcare provided in a hospital, nursing facility or home health care following a hospitalization, some therapies, tests and lab work, hospice care, and kidney dialysis. Prescription drugs provided in a hospital setting generally are paid for by Part A. Most people do not have to pay a premium for Part A coverage. Part A does not cover 100% of the cost of hospitalization, and it covers a limited number of days in a hospital.

Medicare Part B generally covers out-patient services, doctor visits, durable medical equipment, prosthetic devices, some home health care, and some preventive care. When people enroll in Part A, they are generally enrolled in Part B as well, though a person may opt out of Part B. Part B requires payment of a monthly premium which may be deducted from a Social Security check. Low income people can apply at county welfare offices for programs that pay the Part B premiums. (See "What are Medicare Savings Programs?" below). Drugs such as injections administered in a doctor's office, including vaccinations, are covered under Part B.

Medicare Part C pertains to the provision of Medicare services by private managed care plans. Some private companies are paid by the Medicare program to provide care to Medicare beneficiaries through HMOs or PPOs. This program is currently called "Medicare Advantage." You may come across pre-2004 documents referring to the program as "Medicare + Choice."

What is Medigap Insurance?

Medigap insurance is private insurance regulated by the federal government to cover some of the healthcare expenses that Medicare does not pay for. Individuals may purchase Medigap insurance on their own.

What are Medicare Savings Programs?

Low-income individuals may be eligible to have their Medicare premiums and other costs not covered by Medicare paid for by the state. While the Medicare Savings Programs are administered by the Medi-Cal program, they do not give a person Medi-Cal coverage. However, a person may enroll in a Medicare Savings Program AND get full Medi-Cal coverage as well. A person applies for Medicare Savings Programs at the county welfare office.

The Qualified Medicare Beneficiary (QMB or "Quimby") program is available to people with income up to 100% of the current federal poverty level plus $20. The program also has resource limits. If a person qualifies for QMB, the state will pay the Part A premium (if any), Part B premium, and co-payments and deductibles.

The Specified Low Income Medicare Beneficiaries (SLMB or "Slimby") program is available to people with income below 120% of the federal poverty level. The program also has resource limits. If a person qualifies for SLMB, the state will pay the person's Part B premium only.

The Qualified Individual (QI) program is available to people with income between 120% and 135% of the federal poverty level. This program pays the person's Part B premium only.

What is a "dual eligible?"

A "dual eligible" is a person who has both Medi-Cal and Medicare coverage. These people are also sometimes called "Medi-Medi's."

Sometimes people who are enrolled in a Medicare Savings Program are also called dual eligibles or "partial dual eligibles." Similarly, a person who has full Medi-Cal coverage in addition to Medicare coverage is sometimes referred to as a "full dual eligible." In this manual, we will generally use the term "dual eligible" to refer to those who have full Medicaid or Medi-Cal coverage.

Medicare Part D: Prescription Drug Coverage

What does Medicare Part D cover?

Part D covers most types of outpatient prescription drugs, biologicals, and insulin. These drugs are the ones that you generally must get through a pharmacy with a doctor's prescription. Part D also covers medical supplies that are associated with the injection of insulin.

Do the Medicare Part D plans need to cover all of these prescription drugs?

No. With a few exceptions, they only need to cover two drugs in each category or class. For example, while there may be several prescription drugs available to lower cholesterol, a Part D plan need only cover two of those drugs.

Are there exceptions to this "two drugs" requirement?

Part D plans are required to cover "all or substantially all" of the following six categories of drugs: antiretrovirals (used to treat HIV/AIDS); antidepressants, antipsychotics, anticonvulsants, anticancer, immunosuppressants.

What types of drugs does Part D NOT cover?

Part D does not cover over-the-counter drugs that a person may purchase without a prescription. Part D also does not cover barbiturates, benzodiazepines, fertility drugs, weight loss or weight gain drugs, drugs for cosmetic or hair growth purposes. These are referred to as the Medicare Part D "excluded" drugs. However, some of the private drug plans cover some of these drugs anyway. Dual eligible beneficiaries can still get these medications through their Medi-Cal coverage. Part D also does not cover drugs already covered by either Medicare Part A or Part B.

Does this drug coverage cost anything?

It depends. If a person is low-income, she can enroll in the low-income subsidy program, and she will not need to pay most costs. However, if she is not low-income, she will need to pay a monthly premium, co-payments and/or coinsurance, and possibly a deductible.

What is the "doughnut hole?"

The basic prescription drug coverage provides coverage until the beneficiary has accumulated a certain amount of prescription drug costs. After she reaches this amount, her prescription drug plan will not pay any of the costs of her drugs until she reaches another certain amount of prescription drug costs. When she reaches this higher amount, then the drug coverage begins again. The amount of costs starts with zero on January 1 of each year, and the amounts at the beginning and end of the "doughnut hole" will change each year.

What if a beneficiary has trouble getting a drug covered?

If the drug is not on the drug plan's formulary, then the beneficiary can ask for an "exception" to the formulary. She will need the prescribing physician's help to get an exception. If the beneficiary is a dual eligible, but not enrolled in any prescription drug plan, the pharmacist may be able to bill the drug to the program's Point of Service (POS) plan, Wellpoint.

Enrolling in Medicare Part D

Who is eligible for this prescription drug coverage?

A person who is entitled to Medicare Part A or enrolled in Part B is eligible for Part D.

How does a beneficiary get coverage?

The beneficiary must enroll in a private Part D plan. She may enroll in a prescription drug plan (PDP) that only covers prescription drugs, or she may enroll in a Medicare Advantage drug plan (MA-PD) which is generally an HMO or PPO health plan that provides her general medical care as well as covers her prescription drugs.

Can a beneficiary enroll in the prescription drug coverage anytime she wants?

No. A beneficiary who has only Medicare may only enroll in Part D during her initial enrollment period, during the annual open enrollment period, or if she has a special enrollment period because she just became eligible for Medicare, she lost drug coverage under an employer-provided or retiree coverage, or for certain other reasons. However, if a beneficiary also has Medi-Cal, is enrolled in a Medicare savings program, or is enrolled in the Low-Income Subsidy (LIS or "Extra Help"), she always has a special enrollment period, and she can enroll in a plan or change plans at any time.

How does a person choose a prescription drug plan?

She should make a list of all of the medications, both prescription and over-the-counter, that she is currently taking. She should then consult her physician about the list, which medications are necessary, which could be replaced safely with other medications and the names of any substitute medications. She should also find out about possible generic substitutions. With this information, she should compare her drug needs to the formularies of Part D plans. She can input her medications into the Medicare Plan Finder online tool to find plans that best cover her medications. She will also need to note any restrictions on her medications and the costs involved with each plan she considers.

Do all beneficiaries need to take steps to enroll in a plan?

No. If a beneficiary is also on Medi-Cal, in a Medicare savings program, or in the low-income subsidy, she will be put into a low cost plan without her having to choose one. The drug plan

will not be chosen according to her particular drug needs; however, she can change plans at any time.

The Low-Income Subsidy (LIS or "Extra Help")

What is the low-income subsidy (LIS)?

The LIS is a program for covering much of the costs of the prescription drug program that a beneficiary would otherwise have to pay out-of-pocket. The subsidy is available to people with limited incomes and limited assets. The Social Security Administration refers to the LIS as "extra help."

How does a beneficiary get the LIS?

If a Medicare beneficiary is also a Medi-Cal beneficiary, receiving SSI, or is enrolled in a Medicare savings program, she gets the LIS automatically without the need to apply for it. Other Medicare beneficiaries can get an application at Social Security offices, welfare offices, or apply online through the Social Security Administration Web site.

What does a beneficiary get with the LIS?

If the beneficiary is in Medi-Cal, SSI, a Medicare savings program or under 135% of the federal poverty level and has limited resources, she will only need to pay low co-payments for her prescriptions. These beneficiaries can enroll in plans that have no premiums, they have no deductibles or coinsurance, and the beneficiaries do not experience the "doughnut hole." When their drug costs for the year reach the level of where the "doughnut hole" would have ended for them, they no longer even have to pay co-payments. If the LIS beneficiary's income is over 135% of the federal poverty level, but less than 150% of the federal poverty level and she has limited resources, she will receive a partial subsidy of the premiums and the deductible and pay lower coinsurance and co-payments.

II. Where's the Law on Medicare Part D?

Medicare is a federal program, so almost all of the laws that you need may be found in federal statutes, federal regulations, and documents issued by the Centers for Medicare and Medicaid Programs (CMS), the federal agency that oversees the Medicare and Medicaid programs. You will find much less in state law to help you.

Federal Medicare Part D statutes:

Most of the statutes regarding Medicare Part D can be found at **42 U.S.C. §§ 135w-101 through 135w-134**. These sections are sometimes also referred to as Sections 1860D-1 through 1860D-24. This program was added as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (frequently abbreviated as the "MMA"), Public Law No. 108-173, 117 Stat. 2066, enacted December 8, 2003. If you need to research the legislative history of the Act: For the House Conference Report and the President's Signing Statement on this legislation, see 2003 U.S. Code Cong. and Adm. News 1808-2201.

Federal regulations:

Most of the federal regulations covering Medicare Part D can be found at **42 C.F.R. §§ 423.1 through 423.910**.

CMS Documents:

Until recently, most of the important details of how the program operates were contained in subregulatory letters and guidances from CMS. Even the question and answer function on the CMS Web site holds some important policy pronouncements that an advocate should be aware of. CMS has been collecting the information contained in multiple, previous publications into a Medicare Part D manual. The most recent chapters of the Prescription Drug Benefit Manual can be found at:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage.

In particular, an advocate should bookmark the CMS Web site:
http://www.cms.hhs.gov/

Periodically, CMS sends out State Medicaid Directors Letters to give states guidance on how CMS interprets the Medicaid program. There are a number of these letters pertaining to Medicare Part D, particularly as it affects Medicaid beneficiaries. Look particularly at letters beginning in January 2004.
http://www.cms.hhs.gov/SMDL/SMD/list.asp

Advocates may find much useful information in "guidances" that CMS issues to the prescription drug plans. The guidances may be found at:

http://www.cms.hhs.gov/prescriptiondrugcovcontra/hpmsgh/list.asp?#TopOfPage

Some helpful information or direction to other CMS documents can often be found by clicking on the "Questions" function which appears on the toolbar of each page of the CMS Web site.

Social Security and the Low-income Subsidy (LIS)

The federal law on the LIS generally can be found at 42 U.S.C. §§ 1395w-114, 1395w-115 and 42 C.F.R. § 423.771-423.800.

Social Security has a good deal of information about the LIS on its Web site:
http://www.ssa.gov or
https://s044a90.ssa.gov/apps6z/i1020/main.html

California Law:

Since Medicare is a federal program, California law regarding Medicare Part D almost exclusively pertains to people who are dual eligibles.

AB 132 amended Welfare and Institutions Code § 14133.23 to remove most drug coverage for dual eligibles under the Medi-Cal program. The emergency drug coverage included in this bill has expired.

All-County Welfare Directors Letter 05-23 (August 4, 2005) gives guidance to the counties about Medicare Part D, the LIS, county duties, and additional information in regard to dual eligibles.

AB 1359 added Health and Safety Code § 1350 to provide for regulation of prescription drug plans by the Department of Managed Health Care or the Department of Insurance. Note, however, that CMS may exempt plans from much state regulation.

For information on how Part D works with the AIDS Drug Assistance Program (ADAP), the California Office of AIDS, part of the California Department of Public Health, has several fact sheets that are helpful: http://www.dhs.ca.gov/ps/ooa/Programs/CARE/adap.htm

III. Getting Help from Knowledgeable People

The National Health Law Program is a nonprofit law firm which addresses the health care issues of low-income people.
http://www.healthlaw.org

The Health Consumer Alliance assists low-income people with a variety of health care issues. We also have client-friendly materials about Medicare Part D for dual eligibles on the HCA Web site:
http://www.healthconsumer.org

Local Health Insurance Counseling and Advocacy Programs (HICAPs) work with Medicare beneficiaries to resolve many Medicare problems. To find the HICAP in your area, visit:
http://www.calmedicare.org/counseling/index.html

National Senior Citizens Law Center (NSCLC) provides support nationally on Medicare and other issues affecting seniors. The Oakland office in particular has been at the forefront of advocacy on Medicare Part D issues.
http://www.nsclc.org

California Health Advocates (CHA) provides legal and advocacy support to HICAP programs in California. CHA has been a leader on Part D issues in California.
http://www.cahealthadvocates.org

Project Inform provides information and assistance to people living with HIV/AIDS. The Project Inform Web site includes materials developed for people in Part D and ADAP.
http://www.projectinform.org

The Treatment Access Expansion Project (TAEP) has a toolkit and client materials on Part D and ADAP programs. The materials are geared to people living with HIV/AIDS but are also useful for other Part D advocacy.
http://www.taepusa.org/

IV. Medicare Part D Drug Coverage

Covered Drugs

Medicare Part D provides broad coverage of out-patient, prescription drugs to seniors and people with disabilities on Medicare. To begin, there are three things to note about the program:

- The client must be eligible for Medicare to take part in Medicare Part D. This will be discussed more in the next chapter.
- Medicare Part D covers out-patient drugs. If a beneficiary has Medicare Parts A, B, and D, Medicare-covered drugs provided as part of in-patient hospital care are still covered by Part A. Certain drugs or injections covered in an office visit under Part B are still covered under the beneficiary's Part B coverage. Out-patient drugs are those drugs that a beneficiary may take with or without assistance at home, in a nursing home, or in a setting not covered by either Part A or B.
- Medicare Part D drugs generally require a prescription. While some prescription drug plans or Medicare Advantage plans may provide some coverage for non-prescription drugs, they need not do so. Part D also covers biological products, insulin, some medical supplies associated with the injection of insulin, and vaccines.[1]

Medicare prescription drug plans must cover drugs within each therapeutic category and class, though they need not cover all drugs within the categories and classes.[2] Furthermore, each prescription drug plan must cover at least two drugs in each category and class, unless only one drug is available in a category or class.[3] Chapter 6 of the CMS Medicare Part D Manual describes which drugs Part D covers, provides guidance to plans as to how they should design their formularies, and sets forth the criteria CMS uses to review formularies.[4]

CMS currently requires prescription drug plans to cover "all or substantially all" of six categories of drugs: antiretrovirals (used to treat HIV/AIDS); antidepressants, antipsychotics, anticonvulsants, anticancer, immunosuppressants.[5] CMS is applying the "all or substantially all" requirement to these "classes of drugs of clinical concern" at least through 2008. Note, however, that there are a few drugs excepted from this rule, and plans need not cover all formulations such as extended-release or all dosages.[6] Plans may not require prior authorization or step therapy for

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[1] "Covered Part D drugs" is defined at 42 U.S.C. § 1395w-102(e)(1) (2005).
[2] 42 U.S.C.A. § 1395w-104(b)(3)(C)(i) (West Supp. 2005).
[3] 42 C.F.R. § 423.120(b)(2) (2006).
[4] CMS, *Medicare Part D Manual, Chapter 6—Part D Drugs and Formulary Requirements, at:* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf. Also note that formulary requirements can be found at 42 C.F.R. § 423.120(b).
[5] *Id*. See *"Why is CMS requiring 'all or substantially all' of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant, and HIV/AIDS categories?" at* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf. This policy has been incorporated into the *Medicare Part D Manual, Chapter 6—Part D Drugs and Formulary Requirements* at Section 30.2.5, at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf.
[6] *Id*.

these drugs.[7] Newly FDA-approved drugs in these classes that may be available for inclusion on a drug plan formulary are subject to an expedited review process. For beneficiaries taking HIV/AIDS drugs this includes drugs that suppress the HIV virus, but it does not include drugs commonly used to treat opportunistic infections to which people living with HIV/AIDS are more susceptible. Nor does this special rule apply to drugs prescribed to alleviate nausea or other side effects from cancer treatment.

Excluded Drugs

Certain categories of drugs are excluded from Part D coverage. If a drug is available to the beneficiary under Parts A or B, even if the beneficiary is not enrolled in that Part, it is excluded from Part D coverage.[8] Part D also does not cover:

- Barbiturates
- Benzodiazepines
- Fertility drugs
- Weight loss or weight gain drugs
- Drugs for cosmetic or hair growth purposes.[9]

If a beneficiary is denied one of these excluded drugs and believes that the drug was incorrectly treated as an excluded drug, this denial is still a coverage determination subject to reconsideration and appeal.[10] CMS has clarified that though a drug may serve one of these purposes, if it is prescribed for a "medically accepted indication," generally in relation to another condition, it should not be treated as an excluded drug, but must be covered.[11] An example of this would be a drug prescribed to help a person with HIV/AIDS or in cancer therapy to maintain a healthy weight. Under these circumstances, a Part D plan should cover an otherwise excluded weight gain drug.

Advocates should distinguish between this list of "excluded drugs" that Part D does not cover and those drugs that a particular plan does not cover because it has chosen to cover other drugs in the same category and class. If a plan does not cover a drug that it has determined is excludable, the determination that it should be treated as an excludable drug is appealable, but unless the advocate can show that it is prescribed for a medically accepted indication that takes it out of the excluded categories, the drug remains excludable. On the other hand, a drug that otherwise would be coverable by Part D, but is not on the plan's formulary may be addressed in a couple of ways. The beneficiary may ask for an exception to the formulary. Alternatively, the beneficiary may be able to switch to another plan that includes the drug on the formulary.

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[7] *Id.*
[8] 42 U.S.C.A. § 1395w-102(e)(2)(B) (West Supp. 2005).
[9] 42 U.S.C.A. §§ 1395w-102(e)(2)(A), 1396r-8(d)(2), 1396r-8(d)(3) (West Supp. 2005).
[10] 42 U.S.C.A. § 1395w-102(e) (West Supp. 2005).
[11] A CMS chart shows a number of drugs and conditions for which drugs that might otherwise be excluded from Part D should be covered. Part D Drugs/Part D Excluded Drugs, in Appendix B of the *Medicare Part D Manual, Chapter 6—Part D Drugs and Formulary Requirements, at:* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf.

Medi-Cal Coverage and Dual Eligibles

Dual eligibles should expect to get most of their prescriptions through their Part D plans. However, dual eligibles may also get Medi-Cal coverage for the "excluded drugs" noted above. Medi-Cal continues to cover many of these drugs for Medi-Cal beneficiaries.[12] Dual eligibles remain able to get coverage for these drugs to the same extent as other Medi-Cal beneficiaries who are not in Part D. Medi-Cal, however, will not pay for a dual eligible's drug that is a Part D drug but which is not included on the drug plan's formulary.

> Advocate's Tip: If a pharmacy tells a dual eligible that a drug is not covered, check first to see whether the drug may be one of the excluded drugs. Many pharmacists do not yet understand that a dual eligible can still get coverage for these drugs under Medi-Cal. If it is an excluded drug, you may also argue that it is prescribed for a medically indicated condition for which CMS has stated that Part D plans still should cover the drug.

What the Beneficiary Pays for Part D Coverage

Medicare Part D beneficiaries may encounter four types of cost sharing: premiums, co-payments, coinsurance, and deductibles. If you do not understand the difference between these terms, please check the glossary in Appendix A.

The Medicare law describes the basic benefit and coverage under Part D.[13] Under the basic benefit, a beneficiary must pay monthly premiums, which may be billed to the beneficiary or deducted from a Social Security check. The plan year runs January 1-December 31 each year, so a beneficiary's cost sharing obligations begin anew each calendar year. It is also important to note that each cost sharing dollar amount and threshold will increase annually by an amount determined by the Secretary of Health and Human Services.[14] The basic benefit has a deductible of $275. During the initial coverage period, the beneficiary is responsible for paying a 25% coinsurance on her prescription drugs. Once the cost of the beneficiary's drugs has reached the initial coverage limit of $2,510, the prescription drug plan pays nothing and the beneficiary pays 100% of the costs of medication until the plan payments plus the beneficiary's out-of-pocket costs ($4,050) reach the annual threshold of $5,726. This gap in coverage is what is popularly termed the "doughnut hole." Once the beneficiary reaches the out-of-pocket threshold, she is only responsible for the greater of $2.25 (generics) to $5.60 (brand names) per prescription or 5% coinsurance.

A plan which does not look exactly like the basic coverage, but monetarily works out to the same coverage and cost sharing amounts is considered "actuarially equivalent." If the plan covers

[12] CMS maintains a list of categories of excluded drugs covered under many states' Medicaid programs, organized by state, *at* http://www.cms.hhs.gov/States/EDC/list.asp#TopOfPage. California previously posted a list of specific Part D excluded medications that the state Medi-Cal program covers, but that list no longer seems to be available.
[13] 42 U.S.C.A. § 1395w-102(b) (West Supp. 2005).
[14] 42 U.S.C.A. § 1395w-102(b)(6) (West Supp. 2005).

only the basic coverage or its actuarial equivalent, it is termed a "benchmark plan." For 2008, California residents can choose from nine benchmark plans.

For the Medicare-only beneficiary who is not in Medi-Cal or otherwise eligible for the low-income subsidy, Part D coverage may look like the basic coverage above, its actuarial equivalent, or something more comprehensive. Prices for each of these types of coverage range from $14.60 to $68.50 for a basic plan. Enhanced plans with greater coverage cost up to $102.70.

Advocate's Tip: Under California law, Medicare beneficiaries can get prescription drugs at Medi-Cal prices. If a Medicare beneficiary must pay for a prescription drug out-of-pocket, she should get the prescription from a Medi-Cal participating pharmacy. For more on this program, see the information on the Medi-Cal Web site: http://www.dhcs.ca.gov/individuals/Pages/PresDrgDisPrgmMedRcpts.aspx.

Dual eligible beneficiaries have far less cost sharing than Medicare-only beneficiaries. Dual eligible beneficiaries, like people who are in Medicare savings programs, are automatically enrolled in the low-income subsidy (LIS) (see Chapter VI.) If a beneficiary enrolled in the LIS enrolls in a benchmark plan, she pays reduced or no premiums, coinsurance, or a deductible. She also has coverage through the "doughnut hole." Chart A indicates the co-payments for various categories of people in the low-income subsidy. Note that for many of these beneficiaries, all cost sharing ceases once they reach the level at which they would have otherwise passed out of the doughnut hole. As with other Medicare beneficiaries, co-payments and other costs will increase annually.

Advocate's Tip: A co-payment is charged per scrip, that is, each time a prescription is filled. Therefore, if a client can get a prescription for a three-month supply of a medication, she only pays one co-payment. This can cost her much less than getting the same medication for three one-month periods and paying three co-payments.

Chart A: Cost sharing for beneficiaries in the low-income subsidy

	Premiums (if enrolled in a benchmark plan)	Deductible	Coinsurance or Co-payments before and through the "doughnut hole"	Costsharing after the "doughnut hole"
Dual eligibles or people with income at or below 100% of FPL	None	None	$1.05 generic $3.10 brand name	None
Dual eligibles in the 250% Working Disabled Program, people in Medicare Savings Programs, others up to 135% of FPL	None	None	$2.25 generic $5.60 brand name	None
People with incomes over 135% and below 150% of FPL	Sliding scale based on income	$56	15%	$2.25 generic $5.60 brand name

Tracking TrOOP

To get to the "doughnut hole" and through it, there needs to be a running total of the amount spent on a beneficiary's prescription drugs since January 1 of each year. Information about purchases by a beneficiary with the source of payment (e.g. paid by the plan, paid by the beneficiary, etc.) is forwarded to Part D plans for determining how much of a person's TrOOP she has met at any point in the year.

Most, but not all, expenses on a beneficiary's prescription drugs count toward this running total. The expenses that count are called "True Out-of-Pocket" expenses or "TrOOP." In general, what a beneficiary pays for her prescription drugs count towards her TrOOP. If family members or a bona fide charity purchases drugs for her, they may apply those expenses toward TrOOP as well.

Payment of drug expenses from several sources do not count toward a beneficiary's TrOOP. Any expenses paid for by a federal government program cannot count toward TrOOP.[15] CMS has interpreted this prohibition to include payments from an ADAP program. Note that some advocates are reporting that ADAP payments are being incorrectly counted toward TrOOP. Beneficiaries whose ADAP is counted toward their TrOOPs should contact the California ADAP office.

Some states have a state pharmacy assistance program (SPAP) funded only with state money, and payments from these programs count toward TrOOP.[16] Drugs paid for by a drug company's

[15] 42 C.F.R. § 423.464(e)(iv) (2006).
[16] To date, California has only one federally qualified SPAP, the Genetically Handicapped Program.

pharmacy assistance program (PAP), a group health plan, or other third parties generally do not count toward TrOOP.[17]

Utilization Controls

Prescription drug plans are encouraged to put utilization controls in place.[18] To date, all prescription drug plans have formularies that include some type of utilization controls. Advocates should familiarize themselves with the various types of utilization controls. Knowing which controls apply to your clients' medications is important because they can pose barriers to getting medically necessary drugs.

> Advocate's Tip: If you are assisting a client with finding prescription drug plans that meet her needs, be sure to check the fine print on the drug plan formularies. Utilization controls are not well designated or advertised.

The most frequently used utilization controls are:

Prior authorization: This is one of the most common barriers to getting prescription drugs. The pharmacist and/or the prescribing physician must get an approval from the PDP before the prescription will be paid for.

Formulary tiers: A formulary may be divided into multiple levels or tiers with more expensive drugs on a lower tier separate from less expensive drugs on a higher or "preferred" tier. The formulary may have a tier dedicated to generic drugs at the top or a "specialty" tier at the bottom. Tiers are important for two reasons: If a drug is on a higher or preferred tier, a beneficiary will often pay less for that drug than for one on a lower tier. Also, drugs on a higher tier tend to have fewer utilization controls, because they are less expensive, and therefore, the beneficiary would encounter fewer barriers to getting the medications.

Quantity limits: Some PDPs may limit the number of pills that a person can obtain at one time for reasons other than medical necessity. Many prescription drugs, e.g. antibiotics, are usually prescribed for a limited period of time. However, problems may arise when a physician prescribes a medication to be taken for a longer period of time than the PDP allows based on a standard of care that may or may not be appropriate for the particular patient.

Dosage limitations: Although a physician may prescribe a particular dosage, the PDP may not cover that dosage. Patients may be forced to take twice as many pills or split pills. Either of these options can lead to greater chances of incorrect dosages or other medication errors.

Fail-first limitations: For many conditions, older, less expensive drugs are available along with newer, more expensive drugs. The PDP may require the patient and the doctor to show that the

[17] 42 C.F.R. § 423.464(f)(2) (2006).
[18] 42 U.S.C.A. § 1395w-104(c)(1) (West Supp. 2005).

patient has first tried the less expensive drug and either found it not as effective or the patient had problems such as side effects from the drug.

Higher cost sharing: PDPs may require a member to pay a higher share of the cost for more expensive drugs, both as a reflection of the drug's expense and to encourage the member to seek out a less costly alternative medication. This cost utilization measure should not be an issue for dual eligibles since PDPs are limited in the co-payments that they can require of these beneficiaries.

V. Enrolling in Medicare Part D

Although, Medicare Part D is ostensibly a voluntary program,[19] a beneficiary may have little real choice about whether to enroll or not. Some beneficiaries are enrolled automatically, while others may need to enroll or else face higher costs at a later date. Dual eligibles must enroll if they want to have prescription drug coverage. If they do not, they cannot turn to Medi-Cal to cover drugs that Part D could cover.

When May or Must a Beneficiary Enroll?

When a beneficiary first becomes eligible for either Part A or Part B, she has a seven month period, the "Initial Enrollment Period," to enroll in Part D.[20] The seven month period includes the month that the beneficiary first becomes eligible for either Part A or B, plus the three prior and the three subsequent calendar months. Enrollment begins at the beginning of the month that the beneficiary is first eligible or the month following the month of enrollment, whichever is later.[21]

> Advocate's Tip: A beneficiary who is approaching eligibility may enroll in a plan in advance of actual eligibility. If an advocate can assist a client to choose a plan that meets her needs, she can benefit by enrolling in the plan of her choice before her coverage would actually take effect.

If the beneficiary does not enroll when she first becomes eligible, she generally must wait until the annual coordinated election period (AEP) which is from November 15 to December 31 each year.[22] Generally, Medicare-only beneficiaries may only change plans during this time period. Enrollment during the AEP becomes effective January 1 of the following year.[23]

Certain circumstances or changes in a beneficiary's drug coverage can trigger a special enrollment period (SEP) that will allow the beneficiary to enroll in a plan or change plans at a time other than during the AEP. Dual eligibles have an on-going SEP which enables them to change plans as often as they need to.[24] Circumstances that trigger an SEP include changing a residence outside the Part D plan service area,[25] when a PDP is terminated or its contract expires,[26] involuntary loss of creditable drug coverage,[27] moving into or out of institutional

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[19] The title of the program is "Part D—Voluntary Prescription Drug Benefit Program." See heading preceding 42 U.S.C.A. § 1395w-101 (West Supp. 2005).
[20] Centers for Medicare and Medicaid Services, PDP Guidance, Eligibility, Enrollment and Disenrollment [hereinafter *PDP Enrollment Guidance*], incorporated in the *Medicare Prescription Drug Benefit Manual* as Chapter 3, § 20.1, *at* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CurrentPDPEnrollmentGuidance.pdf.
[21] PDP Enrollment Guidance, *supra* § 20.4.
[22] PDP Enrollment Guidance, *supra* § 20.2.
[23] PDP Enrollment Guidance, *supra* § 20.4.
[24] PDP Enrollment Guidance, *supra* § 20.3.2. This SEP includes people who do not have Medi-Cal, but are enrolled in a Medicare savings program. In addition, all people enrolled in LIS or losing LIS have a SEP. PDP Enrollment Guidance, *supra* § 20.3.8 #7.
[25] PDP Enrollment Guidance, *supra* § 20.3.1.
[26] PDP Enrollment Guidance, *supra* § 20.3.4.
[27] PDP Enrollment Guidance, *supra* § 20.3.5.

care,[28] and other circumstances. If an advocate encounters a situation in which a beneficiary has a need to enroll in a PDP or change plans outside the IEP or AEP, the advocate should check Section 20 of the CMS PDP Eligibility, Enrollment and Disenrollment Guidance for an applicable SEP.

As a general rule, enrollment in a Part D plan is not retroactive. Coverage usually begins in the month following enrollment in the plan. Only a few SEPs and retroactive dual eligibility allow for retroactive Part D coverage.

The beneficiary may choose to pay premiums, if any, by having premiums deducted from Social Security checks or to be billed.

> Advocate's Tip: While automatic deductions from the Social Security check are convenient, a number of advocates have found that poor coordination between plans and the contractors for federal agencies have lead to incorrect Social Security deductions. Until these problems are better resolved, it may be advisable to have clients ask to be billed. Billing also enables the client and advocate to see if the bills are correct. However, billing would not be advisable for clients who have limitations that would possibly result in unpaid bills.

Late Enrollment Penalties

Most Medicare beneficiaries should enroll in Part D when they first become eligible to enroll. Although a beneficiary may not be taking any prescription drugs at the moment, she likely will need that coverage at a later date. If she does not enroll in Part D when she is first eligible but later enrolls, she will pay a penalty for late enrollment.[29] The penalty applies if she has a break of 63 days or more from when she first becomes eligible for Part D and when she enrolls in Part D or has creditable coverage.[30] The penalty consists of paying a higher monthly premium. The amount of the penalty is based on 1% of a national base beneficiary premium multiplied by the number of months that she did not have coverage.[31] Because the base premium likely will rise annually and the penalty is a permanent add-on to the beneficiary's monthly premium, delaying enrollment in Part D when first eligible can be costly in the long run.[32]

Creditable Coverage in Lieu of Part D

There is one major exception to the rule as to when a beneficiary must enroll in order to avoid penalties. If a beneficiary has prescription drug coverage that is as good as or better than she would have under the basic Part D benefit, she does not need to enroll in Part D. This coverage

[28] PDP Enrollment Guidance, *supra* § 20.3.8 #5.
[29] 42. C.F.R. § 423.46 (2006).
[30] *Id.*
[31] 42 C.F.R. §423.286 (2006).
[32] Note that CMS has a policy eliminating the late enrollment penalties for people who enroll late in Part D up through the end of 2008. A copy of the memorandum announcing the policy may be seen at: http://hiicap.state.ny.us/documents/2008LEPdemoextensionmemo9-24-2007v1_3_000.pdf.

is called "creditable coverage." A beneficiary can find out whether her current prescription drug coverage is "creditable" by contacting the administrator of the prescription drug coverage.

> **Advocate's Tip:** Get a statement of creditable coverage in writing from the plan administrator. This is an important document that the beneficiary should retain in her files. Should she later enroll in a Part D plan, proof of creditable coverage would be vital to avoid the need to pay the premium penalties. An advocate should always check this document and confirm that the coverage is creditable before advising a client to decline Part D coverage. Advocates should also find out from the plan administrator what would happen if the beneficiary were to enroll in a Part D plan. (See the second paragraph below.)

Insurance plans that include prescription drug coverage must disclose to Part D eligible individuals whether the prescription drug coverage is creditable.[33] If the coverage is not creditable, the disclosure must also tell the beneficiary that there are limitations as to time periods when one may enroll in a Part D plan and the beneficiary could be subject to late enrollment penalties.[34] The disclosure notification must be sent before an individual's initial enrollment period, prior to each annual open enrollment period, when there is a change affecting whether the coverage is creditable, and at an individual's request.[35] If an individual is not adequately informed that the drug coverage is not creditable, she may be able to have the coverage treated as creditable for purposes of avoiding late penalties.[36] If an individual is misinformed that the coverage was not creditable, she gets a special enrollment period to disenroll from her Part D plan and re-enroll in her previous creditable plan.[37] However, an advocate should help the client make sure that the prior, creditable plan will allow her to re-enroll before disenrolling from Part D.

If a beneficiary has creditable coverage, in many cases, she should not, in fact, enroll in Part D. If her creditable coverage is part of an employer-provided health plan or retirement plan, enrolling in Part D could cause her to lose her entire health coverage. Once lost, the employer or administrator is not required to allow her to re-enroll.

> **Advocate's Tip:** Creditable coverage does not always pose a conflict with Part D enrollment. Coverage through the Veterans Administration, TRICARE, and CHAMPVA are all forms of creditable coverage, yet a beneficiary of one of these programs may also join a Part D plan without problems. See the Medicare Fact Sheet at: http://www.cms.hhs.gov/partnerships/downloads/tricare.pdf.

Several types of prescription drug coverage are deemed to be creditable coverage, and an advocate should be able to ascertain immediately: group coverage under the Federal Employees

[33] 42 C.F.R. § 423.56(c) (2006).
[34] 42 C.F.R. § 423.56(d)(2), (d)(3) (2006).
[35] 42 C.F.R. § 423.56(f) (2006).
[36] 42 C.F.R. § 423.56(g) (2006).
[37] PDP Enrollment Guidance, *supra* § 20.3.6.

Health Benefits Program,[38] military coverage,[39] Indian Health Service or tribal organization,[40] enrollment in a PACE plan,[41] or coverage through the Managed Risk Medical Insurance Program (MRMIP).[42]

If a beneficiary loses her creditable coverage, she has a two month special enrollment period following the loss of creditable coverage to enroll in Part D without penalty.[43]

Medicare Beneficiaries Who Become Medi-Cal Beneficiaries

A person who is first a Medicare beneficiary will presumably have prescription drug coverage under either Part D or other creditable coverage before becoming a Medi-Cal beneficiary. If she is not enrolled in a Part D plan when she becomes a Medi-Cal beneficiary, she will be auto-enrolled into a Part D plan.[44] If she is auto-enrolled, her eligibility becomes effective the first of the month in which she becomes Medi-Cal eligible.[45] Problems may arise if the Medi-Cal beneficiary has a share of cost (SOC). With a SOC, she does not appear on the monthly data exchange between the California DHCS and CMS until she meets her SOC.[46] Only once she meets the SOC will she appear on the data exchange and thus be automatically enrolled—and deemed eligible for the low-income subsidy. However, once she is in a Part D plan as a dual eligible, she will receive most of her drugs from the Part D plan, excluded drugs from Medi-Cal, and be deemed into the low-income subsidy.

Medi-Cal Beneficiaries Who Become Eligible for Medicare

Ideally, the transition from Medi-Cal drug coverage to Medicare Part D coverage should be seamless to the beneficiary. Unfortunately, that is not always the case. Once the Medi-Cal beneficiary becomes eligible for Medicare Part D, the state cannot claim federal matching money from the federal government for her Part D covered drugs.[47] State law prohibits payment of drugs for dual eligibles where the federal matching payments are not available.[48] The California Department of Health Care Services (DHCS) provides notice to dual eligibles that their drug coverage under Medi-Cal will be taken over by Medicare. However, CMS has told states that the notice need not be sent in advance of the change, so many beneficiaries may first learn of the change in coverage when they go to the pharmacy.

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[38] 42 C.F.R. § 423.56(b)(3) (2006).
[39] 42 C.F.R. § 423.56(b)(7) (2006). This would include CHAMPUS and TRICARE.
[40] 42 C.F.R. § 423.56(b)(9) (2006).
[41] 42 C.F.R. § 423.56(b)(10) (2006). PACE plans include Scan Health Plan (Southern California) and OnLok Senior Health Services (San Francisco Bay Area).
[42] 42 C.F.R. § 423.56(b)(12) (2006). This would only apply where a person is eligible for Part A alone. If a person is eligible for both Parts A and B, then s/he is ineligible for MRMIP. See MRMIP Handbook *at* http://www.mrmib.ca.gov/MRMIB/MRMIP.html.
[43] PDP Enrollment Guidance, *supra* § 20.3.5.
[44] PDP Enrollment Guidance, *supra* § 30.1.4.
[45] PDP Enrollment Guidance, *supra* § 30.1.4 B.
[46] Conference call with DHS, August 25, 2006.
[47] 42 U.S.C.A. § 1396u-5(d)(1) (West Supp. 2005).
[48] AB 132, 2006 Cal. Stat. 2, (Jan. 20, 2006), amending Welf. & Inst. Code § 14133.23.

At present, some beneficiaries may experience a gap in coverage. CMS has asked states to identify Medicaid beneficiaries who are approaching age 65 or the end of the 24-month disability waiting period. However, many beneficiaries may be missed. CMS is planning fixes to eliminate or minimize this gap. Nevertheless, the Part D auto-enrollment effective date is the latter of the beginning of the month in which the individual became Medicare eligible, or the month in which she receives notification of retroactive entitlement to Medicare Part A or B.[49]

Advocate's Tip: Advocates can help Medi-Cal beneficiaries who are approaching Medicare eligibility. A beneficiary may choose a prescription drug plan in advance of actual eligibility, and coverage will begin when the beneficiary becomes eligible for Medicare. This advance preparation can help the beneficiary avoid a coverage gap.

When a Medi-Cal beneficiary is transitioning to Medicare drug coverage, she may need particular help choosing a plan and understanding how her coverage will work. Be sure to read the section on choosing a plan later in this chapter.

Dual Eligibles and Auto-Enrollment

If a dual eligible beneficiary has not chosen a plan, CMS will automatically enroll her into a benchmark prescription drug plan. This plan may or may not meet her drug needs. If the plan does not meet her needs, as a dual eligible, she may change to another plan at any time with the change to be effective the following calendar month.

However, what might have been a benchmark plan which was fully subsidized in one year, may not be a fully subsidized plan the next calendar year. Some sponsors discontinue benchmark plans. Other sponsors may raise the premiums of the benchmark plans above the regional limit of the low-income subsidy. If the dual eligible (or any other Part D beneficiary entitled to the full LIS) remains in a plan to which she was assigned, and that the premiums for that plan will not be fully subsidized in the next calendar year, CMS re-assigns the beneficiary to another benchmark plan for the next calendar year.[50] There are two important notes about reassignment: 1) A beneficiary is only reassigned if she remains in a plan to which she was assigned. If she has chosen to change plans during the year and her current plan's premiums increase, she is not reassigned. Thus, she may be faced with a need to take action to change plans for the subsequent calendar year in order to avoid premiums or she may choose to remain in her current plan and pay a portion of the premium.[51] 2) If her current plan's premium in the coming year is more than the regional limit of the low income subsidy ($19.80 in 2008), but that premium does not exceed the limit by more than a "de minimis" amount ($1.00 in 2008 for a total premium of $20.80), then she will not be re-assigned, and she will not be charged the amount of the premium which exceeds the LIS limit. Note, however, that this "de minimis" addition to the LIS limit is

[49] PDP Enrollment Guidance, *supra* § 30.1.4 B.
[50] These beneficiaries receive a letter from CMS on blue paper indicating that they are being re-assigned and the name of the plan to which they will be reassigned unless they choose another plan before reassignment at the beginning of the calendar year.
[51] These beneficiaries receive a letter from CMS on tan-colored paper indicating that their current plan's premium will not be fully subsidized in the next calendar year. CMS terms these beneficiaries as "choosers" and the choice of whether to remain in the same plan with a monthly premium cost or to change plans is left to the beneficiary.

only available to beneficiaries who are already in a benchmark plan—if another beneficiary wished to change to the same plan, she would need to pay the small difference between the LIS limit and the actual premium.

Dual Eligibles Who Lose Medi-Cal Eligibility

If a dual eligible individual loses her Medi-Cal eligibility, she has a three-month special enrollment period in which she can change plans.[52] Note that though she may lose her Medi-Cal eligibility, she does not automatically lose her enrollment in—or eligibility for—the low-income subsidy. She retains her enrollment in the subsidy for at least the balance of the calendar year. If she was a Medi-Cal beneficiary in July or later in the year, she will also retain the subsidy for the next calendar year.

How Does a Beneficiary Enroll in a Part D plan?

Enrollment requires only that a beneficiary sign up with either a prescription drug plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD). Enrollment may be completed by phone, by mail, by fax, by auto-enrollment, by facilitated enrollment, or over the Internet.[53] The drug plan checks the beneficiary's eligibility for Part A or B. The beneficiary does not need to fill out an application with Medicare.

Dual eligibles may voluntarily choose a plan and enroll, but if they do not and they do not affirmatively decline Part D coverage, they will be automatically enrolled into a Part D plan. As CMS becomes aware of new dual eligibles through monthly data exchanges with the states, the individual's coverage is checked to see whether the person has already chosen a plan. If she has not, then she is automatically enrolled into a "benchmark plan," i.e. one of the plans covering the service area where she lives and that provides the basic Part D coverage for a premium price that is fully covered by the low-income subsidy. If she is already in a Medicare Advantage plan, then she is automatically enrolled into the MA-PD associated with that Medicare Advantage plan.

If a beneficiary is automatically enrolled, she will receive a notice from Medicare telling her that she is being automatically enrolled and the name of the plan into which she will be enrolled. For many beneficiaries, auto-enrollment may work fine. However, CMS also auto-enrolls beneficiaries who are enrolled in employer-sponsored or retirement plans.[54] People who have these types of coverage may need to act quickly to opt out of auto-enrollment as it could potentially cause them to lose all coverage under those plans. Once auto-enrollment has occurred, an advocate should check first with the beneficiary's prior plan to make sure that the beneficiary can remain in or re-enroll in the plan before dropping any redundant Part D coverage.

Beneficiaries in Medicare Savings Programs (QMB, SLMB, or QI) but not in Medi-Cal and other people who are enrolled in the low-income subsidy receive a process similar to automatic enrollment when they enroll in a Medicare Savings Program. These beneficiaries get "facilitated

[52] PDP Enrollment Guidance, *supra* § 20.3.2.
[53] PDP Enrollment Guidance, *supra* § 30.
[54] PDP Enrollment Guidance, *supra* § 30.1.4. A

enrollment." Like auto-enrollment, they receive notice that they will be assigned to a benchmark plan unless they choose their own. However, facilitated enrollment is always prospective and allows the beneficiary the opportunity to choose a different plan or opt out before the facilitated enrollment takes effect.[55]

Changing Plans and Disenrollment

A beneficiary may change plans at the same times as when she may enroll in a plan, since, of course, changing plans necessitates enrolling in another plan. As described above, dual eligibles may change plans at any time with the new enrollment taking effect the first of the next month.

> Advocate's Tip: Technically, a change in plans takes effect the first of the following month. If a beneficiary wishes to change plans, it is advisable to enroll in the new plan early in a month. Many advocates have seen difficulties with changes made late in the month.

A beneficiary should be able to disenroll from a plan by simply calling or writing to a plan or by calling 1-800-MEDICARE. However, experience has shown that some plans resist disenrollments, and disenrollment can be unnecessarily difficult. Unless a beneficiary is intending to opt out of Part D altogether, she should never disenroll from a plan without being sure that she is in an enrollment period or SEP that will permit her to enroll in a new plan.

> Advocate's Tip: Many advocate have found that beneficiaries who affirmatively disenroll from one plan and enroll in another plan often experience gaps in coverage. When changing plans, affirmatively disenrolling is not necessary. Simply enroll in the new plan. Since a person can only be in one plan at a time, the new enrollment automatically effects a disenrollment from the previous plan.

Helping a Client Choose and Enroll in a Medicare Part D Plan

A well-trained advocate can be extremely helpful to a confused beneficiary who may not know where to begin with choosing and enrolling in a Part D plan. Below is a checklist of questions and issues that can help the advocate best assist her client.

√ **Does the client have prescription drug coverage now?** Be sure to ask about all possible types of health and other coverage she may have. If she is not sure, check with health plan administrators and check her benefits booklet.

If she does not, then she should probably enroll in a prescription drug plan.

If she has some kind of employer-provided or retirement coverage:

√ **Is it creditable coverage?**

If it is creditable, she does not need to enroll in a Part D plan. If she wishes to enroll, find out from the plan administrator whether she can do so without causing problems with her coverage.

[55] PDP Enrollment Guidance, *supra* § 30.1.5.

If it is not creditable, be sure that the client has this in writing. She probably should enroll in a Part D plan.

If she has Medi-Cal, then she will have no real choice but to enroll in Part D. Even if she does not have prescription drug needs, she can still do so at no cost to her by choosing a plan that is fully subsidized under the low-income subsidy.

√ **Get a list of ALL medications that the client is currently taking.** Have her bring in the bottles of everything she is taking, including over-the-counter medications, so that you can note the dosages and other details. Be sure to write down the chemical name of the drug, how often it is taken, whether it is time release, etc. If she is able to make the list herself, let her do so. There are several helpful charts available on the Internet to help collect this information.[56]

√ **The client should take her list to her prescribing physician(s).** Physicians often do not know all of the medications that a patient is taking. This may be an opportunity for the physician to adjust a regimen or delete some medications.

√ Questions for the client to ask the prescribing physician(s):

1. Should I stop taking any of the drugs that I am currently taking?
2. Am I taking any drugs that have no alternative, including a generic version?
3. Can any of my medications be changed to generic versions? If so, please write down the name of the generic version.
4. Are there drugs that can be substituted for any drugs that I am taking now? If so, please write down the names of those drugs, including their generic names.

√ **Is the client limited in her choice of pharmacies? Is the choice of pharmacy important to her?** If she lives in a rural area or can only get to the pharmacy near her home, the advocate will want to make sure that the pharmacy contracts with the prescription drug plan that she chooses. Also see whether the client may benefit by getting her prescriptions by mail.

√ **Use the Medicare Prescription Drug Plan Finder (http://www.medicare.gov/MPDPF/) to find the drug plan(s) which cover(s) the client's drugs.**

[56] Disability Benefits 101 has helpful Medicare Part D Planning Tools in English and Spanish *at* http://www.disabilitybenefits101.org/ca/news/news_1642.htm. The advocate or the client may use this form to list all current medications.

√ Perform a "General Plan Search." Enter the information that your client has Medicaid and the full low-income subsidy, or as is appropriate for your client. When prompted, enter each of her current drugs. If a plan says that it covers her drugs, be sure to check any footnotes to see if there are utilization controls associated with the drugs. If you cannot find a plan that covers all of her drugs, check for the substitute drugs that her doctor recommended or generic versions of her drugs.

√ If none of the plans with premiums completely covered by the low-income subsidy cover all of her drugs, check the plans which have premiums that are not completely subsidized. Check with the client to see whether she can pay the partial premium each month.

Advocate's Tip: If your client has Medi-Cal with a share of cost and she must pay part of the premium for her Part D plan, the portion of the premium that she pays can be deducted from her income when determining the amount of her share of cost. "Health care premiums" are deducted from income in order to determine a client's share of cost. If her income after she pays the partial premium is low enough, she may qualify for the Medi-Cal Aged & Disabled Federal Poverty Level program and be eligible to receive Medi-Cal with no share of cost.

VI. The Low-Income Subsidy (LIS) or "Extra Help"

What is the Subsidy?

Many Medicare Part D beneficiaries may be eligible for the low-income subsidy which will greatly reduce their costs under the prescription drug program. The federal government often refers to this program as "extra help" because some Medicare beneficiaries may be reluctant to apply for it if they thought that they were applying for a federal subsidy.

To be eligible, a beneficiary must have income under 150% of the Federal Poverty Level (FPL) and limited assets. People may get the full subsidy or only a partial subsidy. For the full subsidy, the person or couple must have income at or below 135% FPL.[57] Beneficiaries who also have Medi-Cal, receive SSI, or are enrolled in a Medicare Savings Program automatically receive the full subsidy and are treated like others who apply for and receive the full subsidy.[58] Other Medicare beneficiaries with income above 135% FPL to 150% FPL and who meet the assets limits may apply for and receive a partial subsidy.[59]

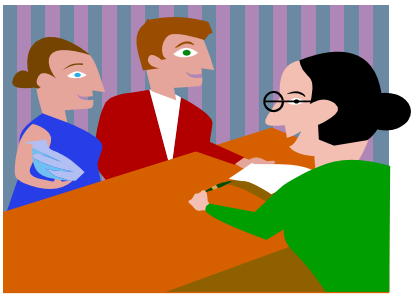
Income and assets are counted according to SSI rules, although the asset limits for the LIS are higher than for SSI eligibility. In 2008, assets for an individual can be no more than $6,290, and for a couple, $9,440 for the full subsidy and $10,490 for an individual and $20,970 for a couple for a partial subsidy.[60] Beneficiaries in the LIS have cost sharing as follows:

[57] 42 C.F.R. § 423.780(d)(1) (2006).
[58] 42 C.F.R. § 423.773(c)(1) (2006).
[59] 42 C.F.R. § 423.780(d) (2006). For individuals with income above 135% up through 140% FPL, 75% of the premium is subsidized. If an individual's income is higher that 140%, but no higher than 145% FPL, she receives a 50% subsidy. If her income is higher than 145%, but less than 150% FPL, then 25% of the premium is subsidized.
[60] Resources are counted using SSI rules, except allowing higher asset limits than SSI allows. The resource limits do not include excludable resources (e.g. the beneficiary's home). If a beneficiary or beneficiary couple put aside $1,500 each for burial plots, these amounts increase to $7,790 and $12,440 respectively for the full subsidy, and $11,990 and $23,970 respectively, for the partial subsidy. These are the amounts that Social Security usual advertises as the resource limits. The resource limits will increase annually based on the annual percentage increase in the consumer price index from the previous September. 42 U.S.C.A. §§ 1395w-114(a)(3)(D)(ii), 1395w-114(a)(3)(E)(II) (West Supp. 2005).

Chart B: Cost sharing for beneficiaries in the low-income subsidy

	Premiums (if enrolled in a benchmark plan)	Deductible	Coinsurance or Co-payments before and through the "doughnut hole"	Costsharing after the "doughnut hole"
Dual eligibles or people with income at or below 100% of FPL	None	None	$1.05 generic $3.10 brand name	None
Dual eligibles in the 250% Working Disabled Program, people in Medicare Savings Programs, others up to 135% of FPL	None	None	$2.25 generic $5.60 brand name	None
People with incomes over 135% and below 150% of FPL (partial subsidy)	Sliding scale based on income	$56	15%	$2.25 generic $5.60 brand name

Applying for the Low-Income Subsidy



Medi-Cal and Medicare Savings Program beneficiaries are deemed eligible for the subsidy, so they do not need to separately apply for it. Since SSI beneficiaries automatically get Medi-Cal, they are also deemed eligible for the LIS.

Other Medicare beneficiaries who are not deemed eligible may apply for the subsidy in several ways. A beneficiary may apply online at the Social Security Web site.[61] A beneficiary may also obtain paper applications at Social Security Administration offices or at local welfare offices. Paper applications are only available in English and Spanish. The Social Security Web site has mock applications ("instructions") in fifteen languages. These are translations of the questions on the English application, but they are not meant to be submitted as applications. Beneficiaries who need help completing the application may apply over the telephone by calling Social Security at 1-800-772-1213. Beneficiaries may also submit applications to local welfare offices.[62]

[61] http://www.ssa.gov.

[62] While beneficiaries may submit applications to local welfare offices, those offices may be forwarding the applications to Social Security for processing. Nevertheless, individuals should be screened for Medicare savings programs.

Advocate's Tip: While most people who are eligible for Medicare Savings Programs are also eligible for Medi-Cal, some individuals may be eligible for a Medicare Savings Program, but either not be eligible for Medi-Cal or not wish to apply for Medi-Cal. These individuals should be encouraged to apply for Medicare Savings Programs. If they are found eligible, it will not only save them money, but they will be deemed eligible for the LIS without the need to complete an application. If they apply for the LIS at the local welfare office, they should be screened for the Medicare Savings Programs. If they apply at Social Security, they will not be screened for these programs.

LIS Coverage of Premiums

The subsidy covers the portion of a Part D plan's premium that covers the basic "benchmark" coverage up to $19.80 in 2008.[63] As long as the client is in a basic, benchmark plan that costs less than this maximum, she should have no premium cost. However, if she enrolls in a Part D plan which costs more than this maximum, she will pay any premium amount over this maximum. The subsidy only covers the basic coverage. Therefore, if she enrolls in an "enhanced" plan, one that covers more than is required for basic Part D coverage, the plan is only subsidized for the basic portion of the coverage. The value of the "enhanced" coverage must be paid by the beneficiary. Unfortunately, the value that each sponsor places on the basic coverage varies from one plan to another, so when a beneficiary has the LIS and wishes to enroll in an enhanced plan, she will need to find out from the plan the value of the enhanced portion, and thus her share of the premium.[64]

LIS and Medi-Cal Beneficiaries with a Share of Cost

A problem arises for clients on Medi-Cal with a share of cost (SOC). Because Medi-Cal coverage for beneficiaries with a SOC does not begin until they meet their SOC, they do not appear on the Medi-Cal rolls in the months when they do not meet the SOC. If a client never meets her SOC, she will not appear on the Medi-Cal rolls, and when the state and CMS exchange data, she does not get counted, and therefore she does not get deemed into the low-income subsidy. One option is for her to complete an application for the low-income subsidy. If her income is too high for Medi-Cal with no share of cost, it may also be too high for the subsidy, or she may only be found eligible for the partial subsidy. However, if she meets her SOC in one month, she appears on the Medi-Cal rolls, and when the information is exchanged with CMS, she will be deemed into the full low-income subsidy for that month and for the balance of the calendar year. If she meets her SOC in the month of July or later, she will be deemed into the

[63] The CMS "de minimis" policy is an exception to this rule. If a beneficiary is in a benchmark PDP to which she was assigned and at the beginning of the year the premium increases more than the maximum subsidy amount ($19.80 in 2008) but no more than a "de minimis" amount ($1 more or $20.80 in 2008), the beneficiary may stay in that plan and need pay no premium. A beneficiary who wishes to change to the very same plan, however, would need to pay any amount over the maximum subsidy amount and could not take advantage of the "de minimis" option.

[64] Each private company or "sponsor" assigns a different dollar value to the basic coverage. CMS does not publicize information which would enable a beneficiary to know how much this is for a particular plan and thus find out in advance how much she will need to pay in premiums for an "enhanced" plan.

full subsidy not only for the balance of the current calendar year, but also for the subsequent calendar year.

Advocate's Tip: Some Medi-Cal beneficiaries with a SOC would not be eligible for the low-income subsidy if they were to apply for it. If the client meets her SOC each year in July or a later month, she should receive the full subsidy for the balance of the year as well as the next year. Remember that people with a SOC can use unpaid bills from earlier months to satisfy a SOC. Therefore, an advocate can help a client with high drug needs, but few other health care needs to plan the use of her medical bills toward a month which will keep her deemed into the low-income subsidy.

Maintaining Enrollment in the LIS

As long as a dual eligible beneficiary remains in Medi-Cal with no share of cost or is enrolled in a Medicare Savings Program, she will continue to be deemed into the LIS. As noted above, Medi-Cal beneficiaries with a share of cost may need to meet their shares of cost at least in one month in order to remain deemed into the program. Dual eligibles who remain eligible for LIS should receive a notice indicating that they automatically remain eligible. Some beneficiaries may receive conflicting and confusing notices if they do not appear as dual eligibles on the July rolls which trigger these notices, but they later appear on the Medi-Cal rolls (e.g. they meet a share of cost), and they receive notice that they are deemed eligible for LIS.

For Medicare-only beneficiaries, the Social Security Administration sends out a redetermination form annually. A beneficiary need only complete the form saying that she remains eligible for the LIS. The form does not request documentation to prove continued eligibility. Additionally, the Social Security Administration has not received sufficient funding to monitor the accuracy of the information that beneficiaries submit.

VII. Troubleshooting Your Client's Part D Problems

This section will deal with some common problems with Medicare Part D and suggested ways to resolve those problems. Each problem is followed with steps in the resolution process. The problem may be resolved after a couple of steps which may obviate the need to continue with the subsequent steps.

Problem #1: The prescription drug plan does not cover the client's drug.

Step 1: If the PDP is saying that it does not cover your client's drug, first ascertain the exact name of the drug, including whether it is a special formulation such as a sustained release version and what dosage was prescribed. Ideally, get the name and prescription information directly from the pill bottle, rather than relying on what the client tells you. If the client is taking multiple medications, she may be confused as to the purpose of this particular prescription. You also need to know which drug plan the client is in. It is very important to get the exact name because the same company may offer 2-3 plans with similar names. If the client has her PDP membership card, take a photocopy of it.

> Advocate's Tip: You should also do some quick research to find the scientific name for the drug and any brand or generic names. Also note what class of drug it is (e.g. a barbiturate) as this information can be useful. You can do a quick search on the drug at Web sites such as MedlinePlus, http://medlineplus.gov/ or WebMD, http://www.webmd.com/. You should do this research before you tackle a drug plan's formulary so you will know the multiple names and formulations to look for.

Step 2: Find out exactly what happened at the pharmacy. What did the pharmacist say? A client may simply hear, "it's not covered," but the pharmacist may have been saying that the drug required prior authorization or something else. At this point, you will need to assess whether you should contact the pharmacy to find out the exact reason(s) why the client was unable to get her drug. Do your homework in the next couple of steps before calling the pharmacy.

Step 3: Check the drug plan's formulary. Contact information for each plan sponsor is available on the Medicare Plan Finder. Under "Learn More About Plans in Your Area," type in "California." The Web sites of some of the common drug plans can usually be found by inserting the name of the plan into an Internet search engine such as Google or Ask.com.[65] You can also use the Medicare Formulary Finder at: http://www.medicare.gov/MPDPF/Shared/Include/Formulary/FormularyFinder.asp?language=english. Look through the formulary for the drug under its various names. Each time you find the

[65] Web sites and contact information for the benchmark plans are available from NSCLC at: http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.6262442724/article.2006-10-13.8987178857/at_download/attachment.

drug on the formulary, note the name, dosage, and any restrictions (e.g. prior authorization requirements or quantity limitations) in footnotes.

Step 4: If the drug is not on the formulary, is it an excluded drug? If you are not sure what an excluded drug is, read the section, **What types of drugs does Part D NOT cover?** in "A Quick Glance at Medicare Part D." If the drug is this type of drug, then Medi-Cal may pay for it. You may need to assist the pharmacist to understand that dual eligibles still have "excluded" drugs covered under Medi-Cal. (Many pharmacists mistakenly think that dual eligibles may only get drugs under Medicare and no longer have Medi-Cal drug coverage as well.) You may also want to check the Medi-Cal list of contract drugs, i.e. the Medi-Cal formulary, in the Pharmacy Provider Manual at: http://files.medi-cal.ca.gov/pubsdoco/p_manual.asp. If the drug is not on the formulary under any name, skip to Step 6.

Step 5: If the drug appears under one name or another on the drug plan formulary, check it against the dosage and any restrictions. Here you might have several avenues:

- The drug appears under the name prescribed, in the dosage prescribed, and there are no restrictions. It is time to call the pharmacy and find out why the transaction did not go through.
- The drug appears under the name prescribed, but not in the dosage prescribed, and there are no restrictions. You should either contact the prescribing physician or send the client back to the prescribing physician with this information. The prescribing physician should prescribe a different dosage or consider a different drug on the formulary.
- The drug appears under the name prescribed, perhaps in the dosage prescribed, but with restrictions. What are the restrictions? If the drug requires prior authorization or has a quantity limitation, you should contact the prescribing physician and inform the physician of this limitation. If this drug is truly necessary for the client, you will need to gauge the physician's willingness to assist with obtaining a formulary exception. If the physician is not going to cooperate with obtaining an exception, you should see whether the physician can write a prescription for an alternative drug. The most expedient solution for the client may be a new prescription for a formulary drug without the restrictions.
- The drug appears under a different name than that prescribed. Check also for dosages and restrictions. If the drug appears as a generic, the pharmacy may be able to substitute the generic version for the brand name version. Most people can take a generic version of a drug as well as the brand name version. However, for reasons that are not entirely clear, some people have physical reactions to generic versions of some drugs. If the pharmacy cannot make this substitution, contact the prescribing physician to see if a new prescription for the formulary version can be written in a way to avoid dosage and restriction problems.

Step 6: The drug does not appear on the formulary or appears on the formulary, but the prescribing physician insists that the client needs the drug as prescribed. If the drug requires prior authorization, the pharmacist and the prescribing physician's help will be needed to get this authorization. The physician will need to document the need for this particular drug, perhaps with medical records and laboratory test results.

Advocate's Tip: At this point you will also need to assess your case. If you have a physician who is willing to assist with an exception to the formulary, then filing for an exception can be useful. Without the physician's cooperation, you will not be able to successfully pursue an exception. If the client is a dual eligible or otherwise enrolled in the full low-income subsidy, she can change plans at any time, so changing plans may be the best option. However, keep in mind that changing PDPs will only take effect the first of the next month at best.

Step 7: File for an exception to the formulary. Each prescription drug plan has its own form for doing this and some allow exceptions to be filed over the phone. If needed the exceptions and appeals contact information for all plans is available on this Webpage: http://www.cms.hhs.gov/prescriptiondrugcovgenin/04_formulary.asp. However, all plans must accept the standard exceptions request forms, also called a coverage determination, found at: http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf and http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/ModelCoverageDeterminationRequestForm.pdf. Prescription drug plans are required to accept these model forms.[66]

On the form, you can indicate what kind of exception is requested, whether it should be expedited, and other vital information. To understand the exceptions and appeals process, you may find the Medicare Part D exceptions and appeals process flowchart to be helpful: http://www.healthlaw.org/library.cfm?fa=detail&id=86823&appView=folder.

Problem #2: The client is not in any prescription drug plan.

Step 1: Confirm that the client is in Medicare Part A and/or Part B. Without one or both of these, the client is not eligible for Part D.

Step 2: Did the client have trouble getting drugs paid for because she was not appearing as enrolled in a prescription drug plan? If the pharmacy queried the computer system and the client was not in a drug plan, the pharmacy can enroll the client in the Wellpoint (Anthem) national prescription drug plan at the pharmacy. The Wellpoint plan is available to dual eligibles who not enrolled in a plan.[67] The dual eligible should have been automatically enrolled in a benchmark plan if she did not affirmatively enroll in a plan. The Wellpoint plan is not available for situations in which a person is in a plan already, but is having trouble getting her drugs covered. She can also choose a plan, and that choice should take effect the first of the next month.

[66] See CMS, *Medicare Prescription Drug Benefit Manual*, Chapter 18, Section 40.1. *at* http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDManualChapter18.pdf.

[67] If the pharmacist is not familiar with the Wellpoint POS option, then you may want to provide her with this information from CMS: http://www.cms.hhs.gov/Pharmacy/downloads/POSFEPharmacyTipSheet12707.pdf.

Step 3: Did the client sign up for a Part D plan? If so, then does the client have proof or information about when and which plan she enrolled in? If she does, contact the plan to find out what happened with the enrollment.

Problem #3: The client is enrolled in the wrong plan or in more than one plan.

Step 1: Confirm with the client which plan she wishes to be enrolled in and that this plan covers her prescription drugs.

Step 2: Contact the plan in which she wishes to be enrolled. Confirm her enrollment in that plan or figure out why her enrollment was not completed in that plan. The client may need assistance completing enrollment in the plan of her choice.

Step 3: Enrollment in a plan is supposed to automatically disenroll her from any other plan in which she is enrolled.[68] If she was in the wrong plan, enrolling her in another plan should automatically cause her to be disenrolled from the existing plan. If she is enrolled in two plans, you may need to assist her with disenrolling from the undesired plan. She may disenroll in writing, via the Internet, or by calling 1-800-MEDICARE.[69]

Problem #4: The client has problems with a prescription drug plan, other than coverage of a prescription drug.

Step 1: File a grievance with the prescription drug plan. Each plan must have a system for accepting grievances. A plan may accept oral grievances, but written documentation of a grievance may be preferable if you want to document a systemic problem. If the beneficiary has a plan handbook, check the handbook for a description of the grievance procedure or a member services phone number. Grievances are appropriate for problems such as:

- Poor customer service or waiting too long on hold when contacting the PDP
- Incorrect premium amounts are deducted from the beneficiary's Social Security check
- The beneficiary does not get materials or interpretation in her primary language
- A network pharmacy provides poor service or dispenses drugs of a poor quality

The more you are able to document the grievance with times, dates, and other details, the more likely the PDP will need to pay attention to the grievance.

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[68] See § 20.5 of the PDP Enrollment Guidance, *supra* p. 28, *at* http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdate.pdf .
[69] See § 40.1 of the PDP Enrollment Guidance, *supra* pp. 58-59 *at* http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/Downloads/PDPEnrollmentGuidanceUpdate.pdf.

Step 2: Review the response. Did the plan respond? If the plan has not responded within 30 days, this is an unacceptable delay in processing a grievance. If the plan does not respond, proceed to the next step. Is the response adequate? If the response is not adequate proceed to the next step.

Step 3: Appeal the grievance. The plan may or may not have a formal process for appealing grievances. The written response to the grievance may tell you whether an appeal exists and how to appeal. If no clear appeal exists, you may consider taking one or both of these actions:

- Write to the home office of the prescription drug plan sponsor.
- Write to the Centers for Medicare and Medicaid Services (CMS)

With either of these steps, enclose a copy of the original grievance as well as a copy of the plan's response.

Problem #5: Prescription drug plan marketing fraud or abuse

Step 1: Look at the CMS guidance on prescription drug plan marketing.[70] CMS actually allows the prescription drug plans to market plans and sign up new members in ways that advocates would discourage. Some sample rules from the CMS marketing guidance:

- A PDP may make a "cold call" to a beneficiary to market a plan. If the plan commences the call (an "outbound call"), it may not gather enrollment information from the beneficiary.
- Plans may try to sell additional services or products to a caller.
- Plans must comply with the national "Do Not Call" Registry.
- Plans are prohibited from soliciting door-to-door or sending unsolicited emails.
- Providers may not steer beneficiaries to certain plans or groups of plans that further the financial or other interests of the provider.

Before making a complaint, you will want to make sure that the plan is engaging in conduct which is prohibited under the marketing guidance.

Step 2: Call 1-800-MEDICARE and lodge a complaint. Provide the customer service representative with as many details of the violation as possible.

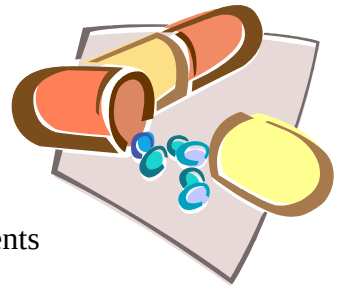
Problem #6: The client's drug coverage does not coordinate with ADAP

Step 1: If you're not sure how ADAP and a Medicare Part D plan work together—or don't—be sure to look at the materials from the California Office of AIDS regarding ADAP and Part D: http://www.dhs.ca.gov/ps/ooa/Programs/CARE/adap2.htm

[70] The Medicare Marketing Guidelines Handbook for PDPs and MA-PDs comprise Chapter 2 of the *Medicare Prescription Drug Benefit Manual, at* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf.

ADAP clients who also have Medicare must enroll in a Medicare Part D plan.[71] ADAP clients with both Medicare and Medi-Cal are automatically enrolled into a Part D plan, just like other dual eligibles. Prescription drugs are paid for in this order: Medicare, Medi-Cal, ADAP. Therefore, as long as a person has Part D coverage, that coverage pays before ADAP. However, ADAP pays a beneficiary's cost sharing on ADAP drugs, but it does not pay cost sharing for drugs that are not on the ADAP formulary.[72] In 2008, ADAP can also pay premiums for Part D coverage, but these beneficiaries must pay their own Part B premiums (if the Medi-Cal program is not paying them.)[73]

Many dual eligible (Medicare and Medi-Cal) beneficiaries who have Medi-Cal with a share of cost are facing new medical costs that they did not face prior to January 1, 2006. Previously, these beneficiaries did not need to concern themselves with their share of cost because ADAP paid the share of cost. Since Medicare, not Medi-Cal, is paying for most of their HIV medications now, ADAP will not pay the share of cost for these individuals.[74] These individuals must now find other medical expenses to meet their shares of cost.[75]



Beneficiaries with Medicare and ADAP, but not Medi-Cal, must be advised regarding their drug coverage and the "doughnut hole" gap in Part D coverage. When they reach the gap, their Part D plans will stop paying for their prescription drugs. At this point, ADAP takes over the coverage of their drugs that are on the ADAP formulary. However, clients must be aware of two things:

- ADAP does not count toward TrOOP expenses, so ADAP expenditures will not count toward getting them out of the "doughnut hole."[76]
- While in the "doughnut hole," ADAP will pick up only those drugs on the ADAP formulary. Thus, if a client is taking drugs that are not on that formulary, neither ADAP nor the Part D plan will pay for them. For most clients, this means that they will pay for the drugs out-of-pocket. If they have few or no non-ADAP drug

[71] HRSA, *Medicare Part D & Ryan White HIV/AIDS Program*, p. 10, as of October 2007, *at* ftp://ftp.hrsa.gov/hab/partdmed.pdf.
[72] The California ADAP formulary is quite extensive, but it still only covers drugs that are related to HIV/AIDS. The formulary can be found at: http://www.dhs.ca.gov/ps/ooa/Programs/CARE/pdf/ADAP/adapformulary022208.pdf.
[73] See the California Office of AIDS materials noted in the text. If a beneficiary has Medicare, Medi-Cal, and ADAP and is enrolled in a benchmark plan, s/he should not have premiums to pay, similar to any other dual eligible. For 2008, see the Office of AIDS letter regarding payment of premiums, particularly p. 2 for non-dual eligibles at http://www.dhs.ca.gov/ps/ooa/Programs/CARE/pdf/ADAP/2008MedicarePartDLetter111507.pdf.
[74] See the California Office of AIDS materials noted in the text. Note that ADAP still pays the share of cost for beneficiaries who have only Medi-Cal with a share of cost and ADAP, but not Medicare Part D.
[75] If you have a client who is unfamiliar with how to meet her share of cost, see the Health Consumer Alliance brochure on "Meeting Your Share of Cost for Medi-Cal" and "Medicare Part D with a Medi-Cal Share of Cost #2," at: http://healthconsumer.org/publications.htm.
[76] A number of advocates have found that ADAP expenditures are in fact—and incorrectly—sometimes being counted toward clients' TrOOP. If an advocate discovers this problem, it should be resolved quickly in order that the client does not end up with a sizeable bill from a PDP in the future.

expenses, they, essentially, will remain in the "doughnut hole" for the rest of the calendar year.

Step 2: Find out what pharmacy the client is using. The client should be using a pharmacy that contracts with both her Part D plan and ADAP.[77] ADAP only contracts with limited pharmacies. If the pharmacy is a provider under the Part D plan, but not ADAP, ADAP will not be able to pick up the client's cost sharing.

If among the pharmacies that contract with the Part D plan there are convenient pharmacies that also contract with ADAP, encourage the client to use those pharmacies for her prescription drug needs. If you cannot find a pharmacy that contracts with her Part D plan and ADAP, the client will need to switch to another Part D plan if she wants to get full coverage.

Problem #7: There is confusion over whether a drug should be covered by the client's Medicare Part A, Part B, or Part D.

Step 1: If you are not sure what Parts A and B cover, read the short explanation in the section, "A Quick Glance at Medicare Part D." In general, Part A will cover all of a beneficiary's drugs during a hospitalization; Part B will cover drugs, including injections, that are "incident to an office visit," i.e. when the beneficiary is in the doctor's office for an outpatient visit. Part D covers outpatient medications that generally are bought at a pharmacy for home use.

In some situations, Part B and Part D coverage may not be easy to distinguish. CMS has put together a couple of documents that explain what each of these cover in common situations.[78] For example, a diabetic beneficiary's insulin and syringes are covered by her Part D plan. However, Part B pays for her blood glucose strips and lancets.

Step 2: Figure out which part of Medicare pays for the medication. Check the medication against the CMS documents in the previous footnote or against the definitions of covered drugs for Parts A, B, and D.[79] Many pharmacists still are not familiar with the parameters of Part B and Part D coverage, so you may need to share what you learn with the client's pharmacist.

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[77] California contracts with a pharmacy benefits administrator for ADAP. To sign a client up for ADAP or to find out which pharmacies are ADAP pharmacies, contact Ramsell Public Health Rx at (888) 311-7632 or on the Web at: http://www.publichealthrx.com/ca_adap.html.

[78] The "Medicare Parts B/D Coverage Issues" table *at* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverageIssues.pdf and the much longer, "Medicare Part B versus Part D Coverage Issues" memorandum *at* http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf are very helpful for resolving these types of problems.

[79] Part A covered drugs are described in general terms at 42 U.S.C.A. §§ 1395x(b)(2), (m)(5) (West Supp. 2005); Part B covered drugs are described in general terms at 42 U.S.C.A. § 1395x(s)(2) (West Supp. 2005); Part D covered drugs are defined at 42 U.S.C.A. § 1395w-102(e) (West Supp. 2005)

Problem #8: The client has drug coverage from an employer or as a retiree. What does this mean for the client and Part D?

Step 1: Review your client's employer or retiree drug coverage. Is the drug coverage "creditable?" See if your client has a recent letter from the plan administrator indicating whether the drug coverage is creditable or not. Plan administrators must advise employees and retirees on Medicare annually as to whether the coverage is creditable. Do not rely on a letter from a previous year in case the drug coverage has changed. If you are not sure, contact the plan administrator. The contact information should be in the client's evidence of coverage booklet.

Step 2: Is the client currently enrolled in a Part D plan? If the client cannot tell you whether she is enrolled, find out by calling 1-800-MEDICARE or going to www.medicare.gov.

Step 3: Follow one of the following scenarios depending on what you found out:

A. The client has creditable employer or retiree coverage and she is not enrolled in a Part D plan. The client does not need to enroll in Part D. If she loses the drug coverage or it is no longer creditable at a later date, she will have a special enrollment period to enroll in Part D. If she also has Medi-Cal coverage, she will be automatically enrolled in a Part D plan unless she affirmatively declines Part D enrollment. Find out from the plan administrator what will happen if she is enrolled in a Part D plan. For some employer or retiree plans, it would pose no problem to have both types of coverage. However, if the employer or retiree plan's drug coverage is subsidized by CMS and she enrolls—or is automatically enrolled—in a Part D plan, she could lose all coverage, including her health care coverage, under the employer or retiree plan. If this could happen, be sure that she affirmatively declines Part D coverage.

B. The client has creditable employer or retiree coverage and she is enrolled in a Part D plan. Immediately check with the plan administrator to find out what this means for the client. Enrollment in a Part D plan could cause her to lose all of her coverage under the employer or retiree coverage. However, if this has already occurred, before disenrolling her from the Part D plan, make sure that she can re-enroll in the employer/retiree coverage. The plan administrator is not required by law to allow her to re-enroll. You should also check her evidence of coverage to see what her rights are in regard to re-enrolling.

C. The client does not have creditable coverage, and she is enrolled in a Part D plan. She should not have problems obtaining her medications from the Part D plan. If she did not enroll at the first opportunity that she was eligible for Part D and without creditable coverage, she may need to pay a penalty in the form of higher monthly premiums for her drug coverage. If she is also a Medi-Cal beneficiary, or is otherwise enrolled in the LIS during 2008, she will not pay a penalty for enrolling late if she enrolls anytime during 2008.[80]

[80] See the Social Security publication *at* http://www.ssa.gov/pubs/10126.pdf.

D. The client does not have creditable coverage and she is not enrolled in a Part D plan. If she is in her Initial Enrollment Period, she should consider enrolling in a Part D plan. If she does not enroll when she is first able, she will later pay a penalty in the form of a higher monthly premium for her drug coverage. Even if she currently has few or no prescription drug needs, it may be worthwhile in the long run to enroll in the least expensive Part D plan that she can in order to avoid penalties later. If she is a dual eligible or becomes a Medi-Cal beneficiary, she will be automatically enrolled in a benchmark Part D plan unless she first chooses her own plan. If she has recently lost creditable coverage, she has a Special Enrollment Period to enroll in a Part D plan. For the reasons just given, it is probably advisable for her to enroll in a plan.

Problem #9: The client is a dual eligible, but the pharmacy says that the plan is telling it to charge more than the low co-payments.

Step 1: Confirm that your client is a dual eligible and should be entitled to the LIS.

Step 2: Confirm with the prescribing physician or the pharmacy that the medication is on the drug plan's formulary and that the pharmacy is attempting to charge the correct prescription drug plan.

Step 3: Present the pharmacist with proof that the client is a dual eligible: A Medi-Cal BIC, Medicare card, and, if necessary, an I.D. are sufficient, but other proof is also acceptable. Take along (or send along with the client) a copy of the CMS "Best Available Evidence" Guidance.[81] The guidance indicates that a beneficiary may present herself at the pharmacy with documentation showing that she should be enrolled in the LIS. The prescription drug plan must make computer edits in order to enable her to obtain her medications at the low co-payment levels that correspond to the proof she submits.

Unfortunately, many advocates have found that most prescription drug plan customer service representatives are woefully unaware of this policy. The advocate or the pharmacist may need to seek the help of supervisors at the drug plan in order to get the corrections made.

[81] The full guidance is available at: http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420/article.2007-07-17.9306407013/at_download/attachment.

Appendix A: Glossary of Basic Medicare Part D Terms

ADAP (AIDS Drug Assistance Program) = A program to provide HIV/AIDS-related drugs to people living with HIV/AIDS. Each state receives funds from the federal government for an ADAP program through the Ryan White CARE Act. California's ADAP is also funded with state funds and is available to people with income up to $50,000 annually. More information about the California ADAP is available at: http://www.dhs.ca.gov/ps/ooa/Programs/CARE/adap.htm.

AEP (Annual Coordinated Election Period) = The annual period of time running from November 15 through December 31 when Part D beneficiaries may choose or change Part D plans.

Benchmark plan = A Part D plan which provides the basic coverage described in the federal Medicare law or coverage that would be financially equivalent coverage.

CFR = Code of Federal Regulations = The CFR has the regulations that federal agencies issue to fill in some of the areas not clearly spelled out in laws passed by Congress. The regulations for the Medicaid and Medicare programs are in Title 42 of the CFR.

CMS = Centers for Medicare and Medicaid Services = CMS is the federal agency that oversees both the Medicare and Medicaid programs. CMS is part of the Department of Health and Human Services. CMS used to be called HCFA.

Coinsurance = The part of the cost of health care that a patient must pay, usually expressed as a percentage of the total cost of the care. For example, if the insurance pays 80% of the cost, the patient has coinsurance costs of 20%.

Co-payment = A payment, usually expressed in a dollar amount, that a beneficiary must pay when she receives a service. For example, a dual eligible beneficiary must pay a co-payment of $1 to $3 when she purchases a Part D covered drug.

Cost sharing = the part of the cost of care that a person has to pay herself. Cost sharing includes co-payments, coinsurance, premiums, and deductibles.

Coverage Determination = A decision by a Part D plan not to provide or pay for a drug, or on an exception request, or on the amount of costsharing for a drug. A failure to make a timely coverage determination when a delay would adversely affect a beneficiary's health is also a coverage determination. [See 42 C.F.R. § 423.566(b)]

Creditable coverage = Prescription drug coverage that a person has from an employer or retirement plan which is as good as or better than she could get under the basic Part D coverage.

Deductible = The amount that an insured person must pay out-of-pocket before the insurance begins to pay. The deductible must be "met" annually.

Doughnut Hole = The coverage gap in basic Medicare Part D coverage which follows the initial coverage and ends when the beneficiary has accumulated drug costs sufficient to reach the catastrophic coverage level. The dollar amounts for the beginning and end of the coverage gap will change annually.

Dual eligibles = People who have both Medicaid (in California, Medi-Cal) and Medicare coverage. Sometimes also called "Medi-Medis."

Entitlement = A person has a property right under an entitlement program. This is important because this property right cannot be taken away without due process of law. Also, under an entitlement program, a state may not have waiting lists or refuse to cover a person who is otherwise eligible.

Exception = When a Part D beneficiary requests her Part D plan to cover a drug that she needs, but is not on the plan's formulary or she requests that the plan allow her to purchase the drug at lower cost to her.

Excluded Drugs = Drugs that are not included in the Medicare Part D benefit package.

Expedited appeal = When a beneficiary or her physician requests that a decision by her plan as to whether to cover a drug should be made more quickly because her health would be in danger if she were denied the drug.

Extra Help = The Social Security Administration uses this term to describe the Low-Income Subsidy (LIS). A Medicare Part D beneficiary may apply for this subsidy to reduce her prescription drug costs under Part D.

Fair hearing = The informal process in front of a judge where a person can challenge an action that the state Medicaid program took. A fair hearing is like a "mini-trial," but much simpler and more informal than a trial.

FFP = Federal Financial Participation = The Medicaid program is funded in part by the federal government and partly by each state. The federal government pays at least 50% of the costs of the program in each state, but it pays more in poorer states. In California, the federal government pays 50% of most costs of the Medi-Cal program.

Formulary = A list of drugs that an insurer will pay for. The formulary should also provide information on any restrictions or limitations to a person obtaining the drug.

FPL = Federal Poverty Level = Each year, the federal government sets a new amount of income as the official poverty level. The amount is based on the size of a family. A family living at the poverty level is said to have income at 100% of the FPL. If the family's income is twice that much, the family is said to have income at 200% of the FPL.

Generic drug = A drug for which the original patent has expired making it possible to be sold more cheaply by many manufacturers. Most, but not all, people are able to take a generic form of a drug as easily as and more inexpensively than the brand name version.

Grievance = A complaint that a person can file with her Part D plan. The Part D plan may accept the complaint orally or in writing, but it is expected to respond to a member's complaint.

HHS = U.S. Department of Health and Human Services = HHS is the federal cabinet-level agency that oversees the Medicare and Medicaid programs as well as many other federal programs. (Also: DHHS)

HMO = Health Maintenance Organization = HMOs are one form of managed care. In HMOs, a person usually has a doctor or nurse practitioner who is the person's primary care provider (PCP). A person must get all of her health care services through the HMO and only when the PCP has agreed that she needs the services.

IEP (Initial Enrollment Period) = The period of time during which a person may first enroll in a Part D plan. The IEP runs for seven months.

IRE (Independent Review Entity) = An outside, CMS-contracted agency which reviews Part D plan denials of members' requests for a coverage determination after a first denial and a redetermination.

Low-Income Subsidy (LIS) = A federal subsidy that low-income Medicare Part D beneficiaries can get to eliminate or lower most of the costs to a beneficiary of the prescription drug coverage. Social Security and Medicare refer to the LIS as "extra help."

LTC = Long-Term Care = Facilities, like nursing homes or "rest homes," or other services that an elderly person or a person with a disability may need to take care of their daily needs, perhaps for a brief period of time or maybe the rest of a person's life.

Managed care = A way of organizing the way a person gets health care which limits a person's access to health care services and specialists in order to cut down on unnecessary care. Managed care is supposed to make health care cost less because people only get what they really need.

MA-PD (Medicare Advantage Prescription Drug Plan) = A private managed care plan that provides healthcare services, including prescription drug coverage, to Medicare beneficiaries who have Medicare Parts A, B, and D.

Medicaid (In California: Medi-Cal) = A program funded by the federal and state governments to provide health care to low-income children, elderly, pregnant women, and people with disabilities. To be eligible, a person must have low-income and few resources.

Medical necessity = A requirement that for insurance to cover the cost of medical treatment, the person must medically need it. Most insurance does not pay for treatment that a person just wants, but does not need.

Medicare = A federal program to provide health care coverage for people who are elderly or have a disability. Medicare eligibility does not require a person to be low-income, but it generally requires a history of working.

Medicare Advantage = The Medicare program that provides healthcare services to Medicare beneficiaries through private managed care HMOs or PPOs. Medicare Advantage is Medicare Part C and used to be called Medicare + Choice.

Medicare Savings Programs (MSP) = Programs that allow the Medi-Cal program to pay Medicare premiums and/or cost sharing for low-income Medicare beneficiaries. A beneficiary in an MSP does not have Medi-Cal coverage, but she may apply separately for Medi-Cal and have both an MSP and Medi-Cal. The Medicare Savings Programs are QMB ("Quimbies"), SLMB ("Slimbies"), and QI.

Medigap = Private insurance that a person may purchase to cover many costs that Medicare does not cover.

MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003) = The federal act of Congress which created the Medicare prescription drug program and made a number of other changes to Medicare.

Non-preferred [provider] = A pharmacy which a beneficiary may use to get her drugs because it has a contract with her Part D plan, but which may cost her more to use than some other pharmacies. See Preferred Provider.

Notice of Action = A letter that a beneficiary receives which describes an action that the state or the Medi-Cal program will take regarding the beneficiary's Medi-Cal eligibility or coverage for services. A beneficiary should get a notice of action whenever she is denied a service (the whole thing or only part of it) or denied eligibility for the program.

PDP (Prescription Drug Plan) = A private insurance plan that provides only outpatient prescription drug coverage to a Medicare Part D beneficiary.

Plan year = The plan year for Medicare Part D runs January 1 through December 31 of each year. All expenses for a beneficiary, such as a deductible, are based on the plan year.

POS (Point of Sale) = The computer system a pharmacy accesses for matching prescription drug purchases to payers, such as the beneficiary's Part D plan.

Preferred [provider] = A pharmacy which contracts with the beneficiary's Part D plan and which the plan prefers plan members to use. Plan members are often encouraged to use preferred providers through lower costs to the member at these pharmacies.

Premium = A monthly amount that a Part D beneficiary pays for a Part D plan to provide drug coverage. A beneficiary may choose to be billed for premiums, have them deducted from a Social Security check, or have them charged to a credit card.

Prior authorization = For some services or prescription medications, a health care provider or pharmacist must first get permission from the Part D plan before providing the service or medication. If the health care provider or pharmacist does not get the permission first, the Part D plan will not pay for the drug.

Quantity limit = A limit on the amount of medication (e.g. number of pills) that a Part D plan may cover for a beneficiary on a single prescription fill.

Reassignment = The CMS process in which a full LIS beneficiary who is in a benchmark plan to which she was assigned is reassigned to another benchmark plan for the following calendar year because the first plan will no longer be offered or no longer offers a premium that will be fully subsidized.

Reconsideration = This is the step in the appeals process after a Part D plan has denied a plan member's exception request and the member's request for a redetermination also resulted in a denial. The reconsideration is handled by an Independent Review Entity.

Redetermination = This is the first step a beneficiary may take after receiving a negative response to an exception request or coverage determination by the Part D plan.

Resources = The things that a person owns that are not income. Resources can include real property (land and houses), bank accounts, household furnishings, automobiles, stocks and bonds, and burial plots. If a resource is "exempt," that means that it is not counted when the state is trying to figure out a person's eligibility for a public program.

SEP (Special Enrollment Period) = A special period of time during which a Part D beneficiary may enroll in a Part D plan or change Part D plans. An SEP may be triggered by circumstances that cause a beneficiary to lose existing coverage. Dual eligibles have an ongoing SEP which enables them to change plans at any time.

Share of cost (SOC) = A monetary amount in healthcare costs that a Medi-Cal beneficiary must incur in a month in order for Medi-Cal coverage to begin for that month. A beneficiary need only incur this amount, not necessarily pay it out-of-pocket. A beneficiary may use bills from other months or other family members to meet a share of cost in a month in which the beneficiary needs additional healthcare coverage from Medi-Cal. In the Medicaid program, this is referred to as "spend down."

SNF = Skilled Nursing Facility = Nursing home or other facility which provides a high level of nursing care to the residents.

Specialty tier = If a health plan's formulary is divided into various levels of coverage, this level contains the most costly drugs or biologicals.

Sponsor = The private company or partnership of companies that sell Part D plans. A sponsor may sell more than one plan.

SSA = Social Security Administration = The federal agency that oversees Social Security Retirement and Disability benefits and SSI benefits. A person can also apply for Medicare Parts A and B or the Part D low-income subsidy at the SSA office.

SSI = Supplemental Security Income = Also called Title XVI. SSI is a federal program which provides cash assistance to low-income elderly and people with disabilities. Unlike Social Security (or Title II) benefits, SSI does not require a work history, and it requires a person to be low-income and have few resources.

Step therapy = A requirement that a Part D beneficiary must try certain, usually less expensive, medications before the Part D plan will pay for a particular drug. Usually, the beneficiary's doctor must demonstrate that the beneficiary has tried these other drugs and the drugs have failed or the beneficiary was unable to tolerate the drugs.

Therapeutic substitution = The practice of a pharmacy filling a prescription with another drug from the same class of the drug that the physician has prescribed, rather than the drug that was actually prescribed. Some Part D plans encourage this practice in order to reduce drug costs.

Tier(s) = Creating different levels of coverage or cost sharing within a Part D plan's formulary. A plan may encourage beneficiaries to choose drugs from higher, lower cost tiers and discourage prescriptions of drugs in lower, higher cost tiers.

TrOOP (True Out of Pocket costs) = Prescription drug costs that a Part D beneficiary pays out-of-pocket during the plan year and which count when determining what stage of the basic Part D coverage the beneficiary is at. Payments by a beneficiary's family members or a charity on behalf of a beneficiary also count toward TrOOP.

Utilization controls = These are various devices that a Part D plan may use to reduce the cost of covering a beneficiary's drugs and encouraging the use of the least expensive medications. The term includes: prior authorization, step therapy, therapeutic substitution, and quantity limits.

"Yellow Notice" = The letter that a dual eligible beneficiary receives from Medicare telling her the name of the Part D plan that she will be enrolled into if she does not choose a plan herself. This letter is usually on yellow paper, hence the name.

§ = Section = This symbol refers to a section of a law or a regulation.

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Medicare Part D and Dual Eligibles: A Guide for California Advocates Manual Evaluation (Revised April 2008)

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