

# Medicare Part D

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## Prescription Drug Program – Updated for 2019 Enrollment

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Special thanks to Andrew Koski at the Home Care Association, the Medicare Rights Center, National Council on Aging, Center for Medicare Advocacy, Families USA, the Kaiser Family Foundation, Paula Arboleda, and Amy Lowenstein. Also thanks to law interns Shane Hachey and Sun E. Kim (2005 version), & Avodah Corps fellows Sarah Steege (2006) and Aaron Rudnick (2015).

**For more information on Medicare Part D**, and other public health insurance topics, see <http://nyhealthaccess.org>, <http://medicareinteractive.org>, and <http://medicareadvocacy.org>.



Updated Sept. 30, 2018 - revised Oct. 5, 2018



# Table of Contents

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<b>Introduction .....</b>	<b>5</b>
What is Medicare Part D? .....	5
What does it cover? .....	6
How much does it cost? .....	6
Medicare Refresher.....	7
Two Types of Medicare Part D Plans - with Changes in Medicare Advantage in 2019 .....	9
<b>Coverage and Cost.....</b>	<b>969</b>
Basic Drug Benefit.....	969
What Drugs Are Covered? Utilization Management, New Opioid Restrictions, excluded Drugs.....	21
TrOOP – True Out of Pocket Costs .....	24
Pharmacies.....	25
<b>Extra Help = Low Income Subsidy .....</b>	<b>973</b>
What is Extra Help? .....	974
Eligibility for Extra Help.....	974
How Much Help Is Extra Help? .....	33
Keeping Extra Help.....	980
Quiz – Who Must Apply for Extra Help? .....	40
<b>Enrollment.....</b>	<b>956</b>
Initial Enrollment Period (IEP).....	956
Annual Coordinated Election Period (ACEP).....	956
Annual Medicare Advantage Open Enrollment Period (changed in 2019) .....	956
Special Enrollment Periods (SEPs) .....	44
Changing Plans .....	48
How do you enroll in a Part D plan?.....	49
Late Enrollment Penalty (LEP).....	50
Automatic Enrollment (Changes in 2019) .....	960
Reassignment.....	53
<b>Coordinating with Other Coverage.....</b>	<b>961</b>
Medicaid .....	961
New York Prescription Saver Card (NYPS).....	962
EPIC.....	59
Medigap.....	61
Patient Assistance Programs (PAPs).....	62
Veterans Health Care.....	63
<b>Appeals.....</b>	<b>964</b>
Exceptions/Coverage Determinations.....	964

Appeal Process..... 965  
**Endnotes..... 965**

**Table of Figures**

**Figure 1: Medicare’s Different Parts..... 8**  
**Figure 2: Sample NEW Medicare Card (Issued 2018-19)..... 9**  
**Figure 3: Combinations of Part D Coverage [“MA”= Medicare Advantage] ..... 11**  
**Figure 4: Maximum Out of Pocket Costs (MOOP) Chart 12**  
**Figure 5: Part D Chart – periods of coverage 20**  
**Figure 6: TrOOP Chart..... 25**  
**Figure 7 2018 Income and Asset Limits for Extra Help .... 31**  
**Figure 8: Summary of Extra Help Benefits .....31**  
**Figure 9: Many Roads to Extra Help .....32**  
**Figure 10: Copayments for Extra Help (2019)..... 35**  
**Figure 11: Changes in Situation for Redetermination..... 39**  
**Figure 12: Summary of Extra Help Coverage (2019)..... 955**

# Introduction

<b>Who gives it?</b>	Federal government – Centers for Medicare and Medicaid Services (CMS). Benefit delivered exclusively through private health insurance plans.
<b>Who gets it?</b>	People who already have Medicare Part A or Part B, and who have enrolled in a prescription drug plan.
<b>Eligibility</b>	<ul style="list-style-type: none"> <li>• Entitled to Medicare Part A OR enrolled in Medicare Part B; and</li> <li>• Resides in the service area of a prescription drug plan.</li> </ul>
<b>What do you get?</b>	Health insurance that covers prescription drugs taken on an outpatient basis, subject to restrictions including deductibles, premiums, co-payments, coverage gap, utilization management, and which drugs are covered.  Part D benefits can only be received through a private drug plan; the precise benefit structure varies from plan to plan.

**NOTE:**

Unless indicated otherwise, all dollar amounts provided in this reference are for the 2019 calendar year.

## What is Medicare Part D?

Medicare Part D is an optional prescription drug benefit available to anyone with Medicare Part A or B.<sup>1</sup> It first became available on January 1, 2006.

Prior to the introduction of Part D, Medicare did not cover prescription drugs except when administered in a hospital or doctor’s office. As a result, most Medicare beneficiaries had no drug coverage at all, forcing them to pay full retail price, import their drugs from cheaper Canadian pharmacies, or try to make do with free samples from doctors’ offices. In New York, seniors also had the option of using getting drug coverage through the **Elderly Pharmaceutical Insurance Coverage (EPIC)** program (see p. 59).

Under Original Medicare Parts A and B, the Federal government pays directly ( for each covered service you receive. Part D is different in that the benefit is provided through hundreds of private plans offered by health insurance companies. Drug coverage under Part D can also be provided through a **Medicare Advantage** plan (more about these later). Thus, in order to get prescription drug coverage, a Medicare beneficiary must join either a standalone **Prescription Drug Plan (PDP)**, or a **Medicare Advantage** plan with drug coverage (**MA-PD**).

For most Medicare beneficiaries, Part D is optional (although there may be a penalty for enrolling later than you were first eligible for Part D). However, for **Dual Eligibles** (those with both Medicare and Medicaid), Part D is

**PDP**

Prescription Drug Plan

**MA-PD**

Medicare Advantage w/Prescription Drug coverage

**Dual Eligible**

Someone with both Medicare and Medicaid

mandatory. Dual eligibles used to get their drugs covered under Medicaid before 2006. Since January 1, 2006, they must get their drug coverage under Part D. If they do not select a Part D plan, the government randomly assigns them to one. Part D is also mandatory for EPIC members.

## What does it cover?

Because Part D drug coverage is provided through numerous private plans, the precise nature of which drugs are covered and for what cost varies widely.

Part D only covers **outpatient prescription** drugs. This means that if the drugs are being administered in a hospital or doctor's office, Part D will not cover them (Part A or B would cover them instead). In addition, Part D only covers **prescription** drugs, so you can't use it for Over-The-Counter (OTC) medicines (i.e., Tylenol, Sudafed, etc.)

Each Part D plan has a **formulary**, meaning a list of drugs that it will cover. The government dictates that each plan must cover a certain number of drugs from each general class of drugs, but they still have a lot of flexibility to decide which drugs to include. In addition, there are certain types of drugs that are **excluded** altogether from the Part D benefit. Lastly, plans may make changes to their formularies at any time. As a result, **there is no guarantee that a given Part D plan will cover all of the drugs your client is currently taking, nor that it will continue to cover them in the future.**

## How much does it cost?

There are several different types of cost associated with Part D for the typical beneficiary. Every plan has a premium, deductible, co-payments, coverage gap, and catastrophic coverage.

There is a special "Low Income Subsidy" called **Extra Help** which makes Part D coverage much more affordable for beneficiaries with limited means. See below for more information on Extra Help.

See p. 21 for more on which drugs are covered by Part D

**Formulary** – list of drugs covered by any particular Part D plan

See p. 969 for more on the costs associated with Part D

## Medicare Refresher

Medicare has four parts, plus the supplemental **Medigap** plans provided by private health insurance companies:

### Part A

Medicare Part A covers inpatient hospital, skilled nursing facility, home health, and hospice care, with some deductibles and coinsurance. Most beneficiaries do not have to pay a premium for Part A, because they're "insured" for Social Security purposes. If a beneficiary is not insured, then they can purchase Part A coverage by paying a premium of up to \$441/mo.

A **Qualified Medicare Beneficiary (QMB)** who is not insured for Part A, whose income is under 100% FPL, could also apply for the **Part A Buy-In** program where the state pays their Part A premiums. See this Fact Sheet on this Buy-In <http://tinyurl.com/medicare-buy-in-MRC>. New York is a Buy-In state. In June 2018, the SSA made some improvements in the complex procedures for applying for the Part A Buy-in, which requires both "conditionally enrolling" in Medicare at a Social Security office and applying for QMB at the local Medicaid office. See SSA POMS HI 00801.140 *Premium-Part A Enrollments for Qualified Medicare Beneficiaries (QMBs) – Part A Buy-In States*, available at <http://policy.ssa.gov/poms.nsf/lnx/0600801140>.

Part A also covers prescription drugs administered during a Part A-covered inpatient hospital stay.

### Part B

Medicare Part B covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health, and some home health and ambulance services. Most beneficiaries pay a premium of \$134/mo.,<sup>2</sup> plus \$183 annual deductible and 20% coinsurance on most services (2019). In 2019, the Part B premium may increase for people enrolling in Part B for the first time or those who have Medicare but do not collect Social Security, so they pay the Part B premium separately. Some beneficiaries will pay a higher Part B premium, either because they delayed enrolling or because their income is over \$85,000/yr. (\$170,000/yr. for couples).

If a beneficiary is eligible for a **Medicare Savings Program**, then the state will pay their Part B premiums, and in some cases, their Part B deductibles and coinsurance. **WARNING:** If you lose MSP, whether because you are no longer eligible or simply because of a renewal error, your Part B premium may increase to \$134. See how the "hold harmless" provision may protect some

lower income people who are not in an MSP from increases in Part B premiums. See fn 2.

Part B also covers prescription drugs, but only those provided by and administered in a doctor’s office. See chart showing drugs covered by Parts B and D. [http://www.medicareinteractive.org/uploadedDocuments/mi\\_extra/B-vs-D-chart.pdf](http://www.medicareinteractive.org/uploadedDocuments/mi_extra/B-vs-D-chart.pdf)

### Part C (Medicare Advantage)

Optional mode for receiving Part A and B services through private managed care plans. Now known as **Medicare Advantage** plans, they include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee for Service plans (PFFSs), and Medical Savings Accounts (MSAs). You must have Medicare Parts A and B to join a Part C plan. Many of these plans now include Part D drug coverage (i.e., **MA-PD** plans).

### Medigap

Medigap is supplemental private insurance coverage for all or some of the deductibles and coinsurance for Medicare Parts A and B. Some of these include additional services not covered by Medicare. Not available to people enrolled in Part C. For more on Medigap, see p. 61.

### Part D

Part D is different than Parts A, B and C in some important ways:

**Figure 1: Medicare’s Different Parts**

	<b>Who provides the coverage?</b>	<b>How do beneficiaries use it?</b>	<b>Premium</b>
<b>Part A</b>	Federal government	Medicare card	Free for most
<b>Part B</b>	Federal government	Medicare card	\$134/mo. for most new enrollees, etc.
<b>Part C</b>	Private health plans (HMO, PPO, PFFS, MSA)	Medicare Advantage plan card	Usually free; additional premium for some plans
<b>Medigap</b>	Private insurance policies	Medigap plan card + Medicare card	Additional premium for all plans
<b>Part D</b>	Prescription drug plans (PDPs) and Medicare Advantage Drug Plans (MA-PDs)	PDP or MA-PD card	Additional premium for all plans, unless you receive the Extra Help subsidy

- HMO**  
Health Maintenance Organization
- PPO**  
Preferred Provider Organization
- PFFS**  
Private Fee For Service
- MSA**  
Medical Savings Account

**Figure 2: Sample NEW Medicare Card (Issued 2018-19)**

This card won't get your prescriptions filled! Medicare beneficiaries must enroll in a private plan and use their plan's card to access prescription drug coverage. The old Medicare card will still be accepted through 2019.

## Two Types of Medicare Part D Plans

### Prescription Drug Plans (PDPs)

Also called "Stand-Alone Plans" – These are private insurance plans offered by private companies. They provide ONLY prescription drug coverage through Part D, and do not affect beneficiaries' Parts A and B Medicare coverage. They are paid partially by the Federal government (through CMS) and partially by monthly premiums paid by members.

In 2019, there are 23 standalone PDPs for New York State, offered by 9 companies. Of the 23 plans,, eight (8) have a \$0 premium for people with Full Extra Help.<sup>3</sup>

See 2018 New York PDP List in the Appendix and posted at <http://www.wnylc.com/health/entry/221/>

### Medicare Advantage Plans (MA-PD)

Medicare Advantage (MA) or "Medicare Health Plans" are generally HMOs, PPOs, PFFS, or MSA plans offered by private companies that provide Medicare Part A and B services in a managed care model. Like PDPs, MA plans are paid partially by the Federal government, and partially by member premiums (although many MA plans have no premium). A Medicare Advantage plan that also offers Part D prescription drug coverage is called an MA-PD.

**Managed Care Plan**– an insurance company which is paid a flat fee per month to provide all covered services. To keep costs down, they can limit members to a network of participating providers, impose prior approval procedures, and adjust member cost-sharing.

In 2019, there are 61 different MA plans, offered by 16 companies, in NYC and Long Island, not all in each county or borough. Of these, 28 have \$0 premiums regardless of Extra Help status. <sup>4</sup>

See 2018 New York City-area MA List at <http://www.wnylc.com/health/entry/218/>

Most Medicare Advantage plans include Part D drug coverage (MA-PDs), but some do not (MA-only). If a beneficiary chooses to receive their Medicare benefits through an MA plan, then they must receive their Part D drug coverage through that plan. In other words, you can't have an MA plan and a standalone PDP. This is true whether or not the MA plan includes drug coverage (i.e., whether MA-only or MA-PD). If a beneficiary of an MA-only plan wants Part D, then they either have to switch to an MA-PD plan, or disenroll from the MA-only plan to switch to Original Medicare plus a standalone PDP. The exceptions to this are PFFS and MSA plans (see below).

Members of MA-only plans may still get drug coverage from other sources, such as retiree health benefits or Veterans Health Coverage.

### *Medicare Medical Savings Accounts (MSA)*

In 2011, there was a new kind of Medicare Advantage plan in NYS-- a Medicare Medical Savings Account (MSA).<sup>5</sup> These combine a special high-deductible Medicare Advantage plan with a bank account similar to a Health Savings Account (HSA). In these plans, Medicare deposits a certain amount of money into the MSA on behalf of the member, and the account earns interest tax-free. The member can use the funds in the account to pay for any medical care. If they don't use up all the funds, they roll over to the next year. If the member spends enough in a given year (whether from the account or from other funds) on Medicare-covered services to reach their plan's deductible, then their plan will pay for the rest of the year. Like other Medicare Advantage plans, each MSA plan has their own particular rules about networks, cost-sharing, and coverage restrictions.

MSA plans do NOT include Part D drug coverage, so members will have to enroll in a separate PDP.

Members are required to file a special form with their income taxes to prove that they only used the MSA for qualified medical expenses. If they spend any of this money on non-medical expenses, they will be subject to tax penalties. These plans require some financial discipline and do not provide any actual coverage until a high deductible has been met. MSAs are most appropriate for relatively affluent clients who want maximum freedom of provider choice and are willing to take a risk that they will have to spend some of their own savings before meeting the deductible.

There is only one MSA in NYS—MVP Smartfund – covering the whole state except NYC and Long Island.

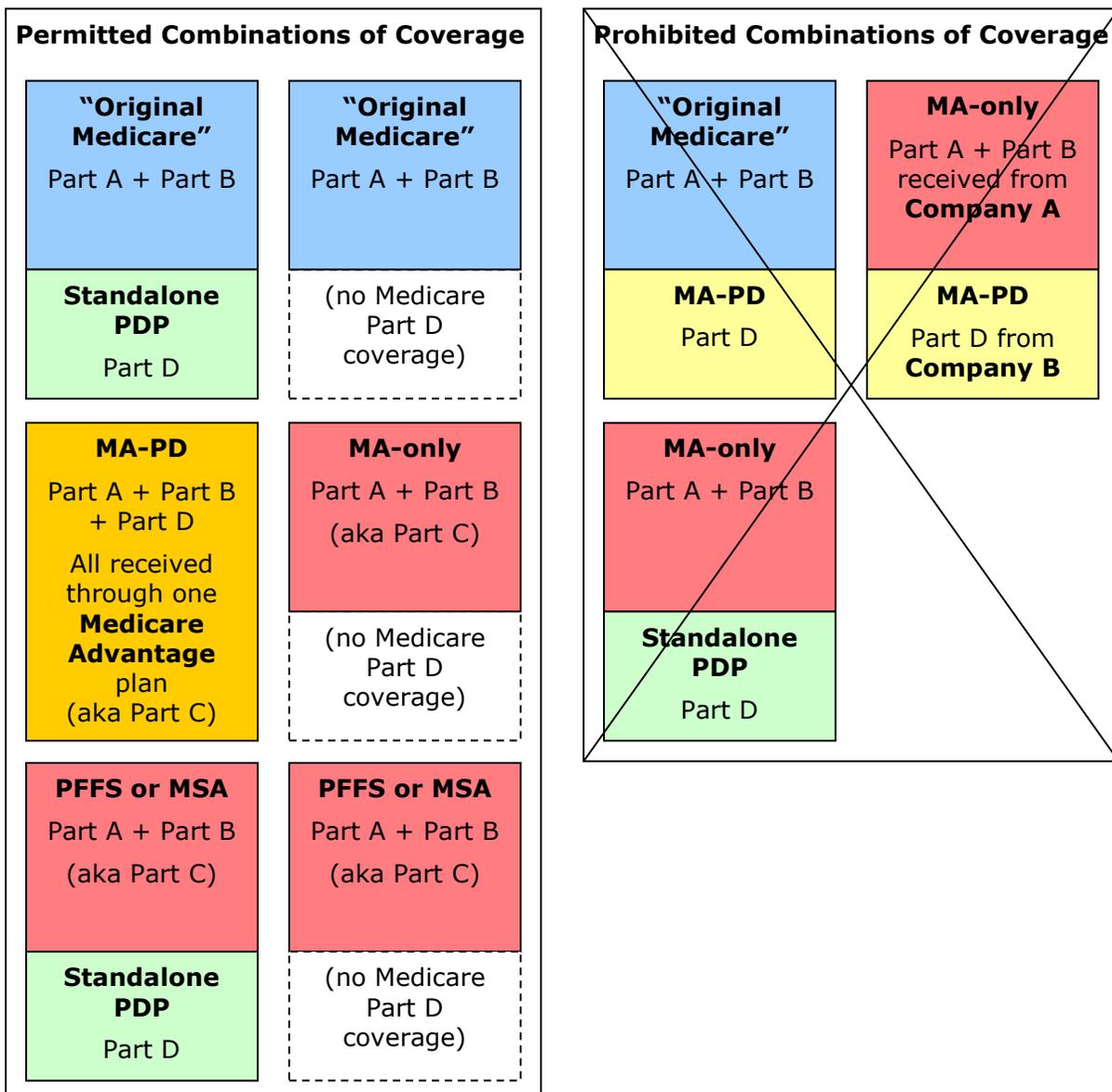
Unlike members of other Medicare Advantage plans, members of MSAs must enroll in a standalone PDP for drug coverage.

### Private Fee-For-Service plans (PFFS)

Only one plan is offered in NYS – and not in NYC and many other counties (WellCare Today's Options Premier). The touted benefit of these plans is that there is no restrictive provider network. However, before you receive any services, you must check with the provider to ensure they agree to accept the PFFS plan's terms and conditions (in particular, the reimbursement rate).<sup>6</sup> If the provider agrees to see you on those terms, then the PFFS plan will cover that service. If the provider does not agree to accept the plan's terms, you will be responsible for the full cost of the services and the plan will pay nothing.<sup>7</sup> Because of this risk, PFFS plans are not a good match for most Medicare beneficiaries.

As with MSAs, members of PFFS plans may enroll in a standalone PDP for drug coverage.

**Figure 3: Combinations of Part D Coverage ["MA"= Medicare Advantage]**



## *What's the Advantage of Medicare Advantage?*

### **Potentially Low Costs**

Of the 33 MA-PD plans offered in Manhattan in 2019 in the NYC area (excluding SNPs for Dual Eligibles), 20 (60%) have a \$0 premium, whether or not the beneficiary has Extra Help. Four other plans have premiums under \$20. By contrast, none of the 23 standalone PDPs have \$0 premiums, and only 8 of them have \$0 premiums for people with Full Extra Help. Without Extra Help, the cheapest premium for a PDP is \$15.50/mo.

In addition, about one-third of MA-PD plans have no deductible. As a result, joining an MA-PD is the only way of getting premium-free and deductible-free Part D coverage for people who are not eligible for Extra Help or EPIC.

In addition, Medicare Advantage plans generally have fixed co-payments for the most common medical services, which are more predictable and may be more affordable than the 20% coinsurance and \$183 annual deductible of Part B. However, most MA plans have comparable high out of pocket costs as Original Medicare for the inpatient hospital deductible or Skilled Nursing Facility daily rate after Day 21. Consumer must weigh the risk of needing these costly services and paying the out-of-pocket costs against the cost of a Medigap policy.

### ***MOOP – Maximum Out of Pocket Costs***

Medicare Advantage plans must cap the member's out of pocket costs for all Part A and B Covered Services – but not Part D drug coverage or any added benefits.<sup>8</sup> The “MOOP” cap does not include any premium. Services are covered by plan at 100% after MOOP is met. Regulations amended in 2018 effective 2019 will change how MOOP is calculated, potentially requiring more out of pocket costs. 42 CFR § 422.100(d), 422.101.

**Figure 4 Maximum Out of Pocket Costs -MOOP**

	<b>Mandatory MOOP</b>	<b>Voluntary MOOP</b>
HMO	\$6,700	
PPO	\$6,700 in-network \$10,000 In and Out of network combined	\$3,400 in-network \$5,100 In and Out of network combined
Inpatient	6 days \$1,860	6 days \$2,325
Skilled nursing facility	(First 20 Days) \$0/day	(First 20 Days) \$0/day
Emergency care	\$90	\$120
Primary care physician/Specialist	\$35/\$50	\$35/\$50

## Frills and new “Supplemental Benefits” Beginning 2019

One of the biggest marketing points for Medicare Advantage plans is that they cover certain services that Original Medicare does not cover. These typically include things like vision, hearing, dental, podiatry, chiropractic, and even gym memberships. However, all of these extra benefits are very limited. For example, the dental coverage is typically limited to one check-up per year with x-ray and cleaning, and no coverage of more extensive work, such as fillings or root canals. In addition, you have to find a dentist who is in the Medicare Advantage plan’s provider network. In light of these limitations, these extra frills should never be the only reason to join a Medicare Advantage plan.

In 2019, MA plans are allowed to offer more benefits. They may reduce cost sharing for certain covered benefits, offer specific extra benefits, and charge different deductibles for some enrollees who meet specific medical criteria.

### 2019 changes!

Also in 2019, MA plans will also have the ability to offer supplemental benefits that are not directly considered “medical treatment,” and that address the social determinants of health instead. Possible service expansions include nutrition services, non-skilled in-home aide services, adult day care, and home modifications. Advocates are concerned that marketing materials may promise more services than are actually available. One large plan, Anthem Blue Cross Blue Shield, which is in many states but not New York, announced a supplemental benefit package for 2019 called “Everyday Essentials” or “Everyday Extras.” A member may choose ONE of SIX benefits:

1. Food delivery – max 64 deliveries per calendar year,
2. Transportation -- max 60 one-way trips per year to health-related or other necessary appointments.
3. Alternative medicine benefit - 24 acupuncture or therapeutic massage visits each year.
4. Home care – max 124 hours annually of licensed health aide for respite care, home-based chores and ADLs
5. Adult day care – one visit/week
6. Safety devices, such as shower stools, reaching devices and temporary wheelchair ramps – max \$500

See *Anthem Adds Home Care Benefits Under Relaxed Medicare Advantage Rule* (Home Health Care News, 10/1/18)

<https://homehealthcarenews.com/2018/10/anthem-adds-home-care-benefits-under-relaxed-medicare-advantage-rule/>.

### *Medicare **Dis-Advantage?***

#### **Network Limits and Lock-In**

Members must generally use in-network providers, especially in plans with no premium. Beginning on March 31<sup>st</sup> of each year, Medicare Advantage enrollees are LOCKED IN to their plan for the rest of the year, with limited rights to disenroll. Only those with Extra Help have the right to change their plan assignment once per quarter through September 30<sup>th</sup> (change in 2019). Other Special Enrollment Periods (SEPs) may be available. See below.

#### **Limited Choices and Confusion**

Many more medical providers accept “Original Medicare” (Parts A & B) than accept any particular Medicare Advantage plan. As a result, many people find that after switching to a Medicare Advantage plan, they can’t go to their preferred doctor anymore. Those who are considering Medicare Advantage should make sure that their preferred doctors, hospitals, and other providers are in the plan’s network before enrolling.

Insurance agents selling Medicare Advantage products may persuade elderly people to join these plans on the basis of misinformation, such as statements that it is just for drug coverage, that they won’t “lose their Medicare,” or that their doctors are covered (when in fact they aren’t). This is particularly true for so-called Special Needs Plans (SNP), which cater to dual eligibles, nursing home residents, and people with chronic conditions, but in fact are typically no different than regular MA-PD plans.

Choices may be more confusing because of 2018 changes that take effect in 2019. Federal regulations adopted in 2018 eliminate the requirement that if an Insurance Company offers more than one plan in the area, there had to be a **meaningful difference** in the coverage, meaning **an** economic/actuarial difference between plans offered by same company. Also eliminated was the requirement that there had to be **uniformity** in premium, benefits and level of cost sharing for beneficiaries residing in plan service area. The increased “flexibility” afforded to plans in designing their benefit packages and launching new plans means that variance of MA plans may increase greatly. It may be more difficult to compare plans and make decisions – much info won’t be in the Planfinder, and will have to be found out by digging into the plan websites and Evidence of Coverage.

#### **SNPs, Medicaid Advantage, and FIDA**

There are three types of managed care “Special Needs Plans” in New York that are only available to dual eligibles (i.e., those with both Medicare and

Medicaid). They are a combination between a Medicare Advantage Special Needs Plan and a Medicaid managed care plan. Members must use the plan for all of their medical care, whether covered by Medicare or Medicaid. The three hybrid plans are **Medicaid Advantage, Medicaid Advantage Plus and FIDA (Fully Integrated Dual Advantage)**.

FIDA and Medicaid Advantage Plus (MAP) plans are only available to those dual eligible who need Medicaid-covered long-term care services, such as home care, adult day care, and nursing home.

Medicaid Advantage plans without the “PLUS” do NOT offer home care and their members may not join a Managed Long Term Care plan. To get Medicaid home care, they must disenroll and switch to a Medicare Advantage Plan or Original Medicare, and then also join an MLTC plan.

Any Medicaid Advantage or MAP plan will consist of a Medicare Advantage Special Needs Plan (SNP), plus Medicaid managed care benefits. Thus, in order for a dual eligible to enroll in one of these plans, they must change their Medicare enrollment into one of these SNPs.

### **Utilization Management**

Under Original Medicare, a patient and her doctor are generally the only ones who decide whether to pursue a given course of treatment. In Medicare Advantage, the plan itself may restrict access to certain services, usually by requiring prior authorization, in order to keep costs down. This creates an additional burden on the patient to advocate with the plan.

In spite of the above disadvantages, Medicare Advantage may be right for some clients, since costs can be lower. Some clients who were previously in Medicaid Managed Care plans before they became enrolled in Medicare are accustomed to the managed care concept, so are comfortable with Medicare Advantage. However, many clients are best served by having Original Medicare plus a standalone PDP, with or without a Medigap plan to supplement.



# Coverage and Cost

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## Basic Drug Benefit

The drugs covered and costs associated with Part D vary from plan to plan. However, there are some general similarities between the plans, most required by Federal law. The following explanation is for a fictional “basic plan,” which will give you a sense of what to expect. All companies offering Part D plans must provide at least one that is actuarially equivalent to the basic benefit structure discussed below.<sup>9</sup> However, they may also offer **enhanced plans**, which may cover a larger list of drugs, or reduced out-of-pocket costs; these generally have higher premiums.<sup>10</sup> This section is limited to a discussion of standalone PDPs; see p. 9 for information on Medicare Advantage plans.

There are **23 PDPs** in 2019 in NYS. Lists of PDPs and Medicare Advantage plans with Part D posted here: <http://www.wnylc.com/health/entry/221/>

## Premium

All 23 PDPs in NYS in 2019 have a monthly premium. The 2019 premiums in New York range from \$15.50/mo. (WellCare Value Script) to \$92.90/mo. (Express Scripts Medicare - Choice). The median premium is \$37.90/mo. The average premium for a PDP with basic coverage is \$37.42/mo. There are eight (8) PDPs in 2019 that have \$0 premiums for people with Full Extra Help (other people must pay a premium). See list with comparison with 2018 “benchmark” plans here <http://www.wnylc.com/health/entry/221/>

Since 2011, people with higher income must pay a surcharge added to the Part D premium similar to Part B. Medicare beneficiaries with annual income over \$85,000 (or for couples, \$170,000) pay a surcharge directly to the Federal government, in addition to the Part D premium they pay to their plan. They pay the means-tested surcharge by whatever means their Part B premium is paid (usually by deduction from the Social Security check). The Social Security Administration uses the same method of determining income as for the Part B means-tested premium (i.e., Modified Adjusted Gross Income, or MAGI). The amount of the surcharge is determined by a sliding scale.

To see the current means-tested premium at various income levels above \$85,000/year, see <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>. In 2019, for

To see how the costs are different for someone with Extra Help see section on Extra Help.

singles, the add-on to the regular Part D premium ranges from \$12.40/mo at income of \$85,001 to \$77.40/mo for income above \$500,000.

## Deductible

Some PDPs have an annual deductible, where the beneficiary must pay the full cost of their drugs until their drug costs (including what the plan pays) reach a certain threshold. The maximum deductible a PDP may have in 2019 is \$415. Of 24 PDPs in 2019, 11 have the maximum \$415 deductible, five range from \$100 to \$360, and 8 have no deductible. See <http://www.wnylc.com/health/entry/221/> (see Landscape of stand-alone PDP plans).

## Co-payments

After meeting the deductible, beneficiaries enter the **Initial Coverage Period**, when they are responsible for co-payments or coinsurance. This means that they will have to pay a certain amount towards the cost of their drugs, and the plan pays the rest (this balance should come out to about 25% beneficiary, 75% plan). Most plans have **tiered co-payments**, meaning that they have divided up their drug list into different tiers based on cost. For example, cheap generic drugs might be in the lowest tier, followed by brand-name drugs in the second tier, more expensive brand-name drugs in the third tier, and very expensive, specialty drugs in a fourth tier. The higher the tier, the higher the co-payment. Some plans use coinsurance instead of a fixed co-payment for certain tiers.

## Coverage Gap (“Donut Hole”)

All plans have something called a **coverage gap** (aka “donut hole”), which is like a second deductible that must be met once your drug costs reach a certain threshold. In 2019, after the beneficiary has met the deductible, they pay 25% of costs or the tiered copayments during the Initial Coverage Period. Once their own payments plus the cost paid by the plan reaches \$3,820 (“Initial Coverage Limit”), they are in the Coverage Gap.

### *Closing the Coverage Gap*

Before 2011, once a beneficiary reached the coverage gap, he or she was responsible for 100% of the cost of their drugs. Some plans provided very limited coverage during the gap, but most beneficiaries complained of major problems affording the cost of their drugs during the gap.

One of the changes brought by the Affordable Care Act<sup>11</sup> is a gradual phasing out of the donut hole, started in 2011 and phasing out by 2020.<sup>12</sup> In 2019, beneficiaries will save approximately 75% on all brand-name drugs, and approximately 63% on all generic drugs.

### **Co-payments**

A fixed dollar amount the beneficiary must pay for a drug

### **Coinsurance**

A percentage of the drug cost that a beneficiary must pay

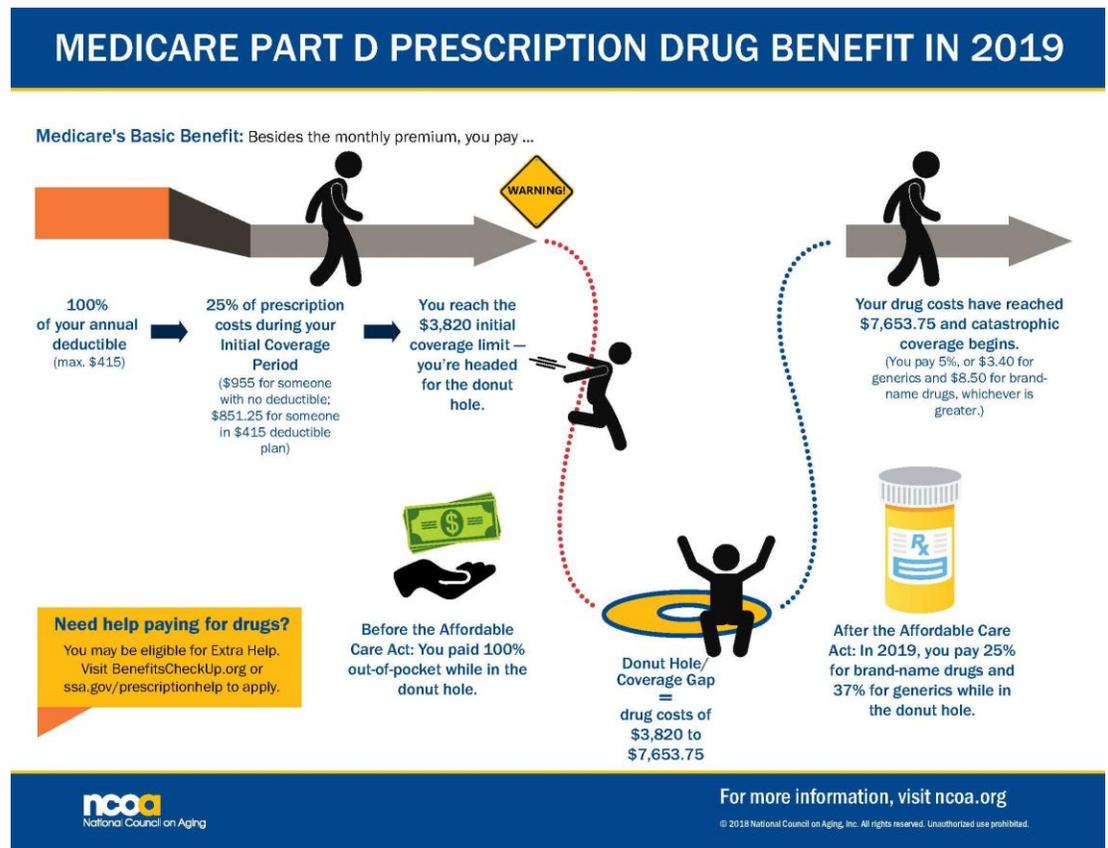
In 2019, the beneficiaries' costs during the Coverage Gap are:

- BRAND NAME DRUGS (Plan-covered drugs only = on formulary or approved with an exception to formulary) –
  - 25% - % beneficiary pays (drug and pharmacy dispensing fee)
  - 70% - % discount provided by drug manufacturer – this DOES count towards TrOOP
  - 5%- % plan pays – but this payment does NOT count towards TrOOP (i.e., towards getting the member out of the donut hole and into catastrophic coverage).
  
- GENERIC DRUGS –
  - 37% - % beneficiary pays (drug and pharmacy dispensing fee)
  - 63% - % plan pays – but this payment does NOT count towards TrOOP (i.e., towards getting the member out of the donut hole and into catastrophic coverage).

### **Catastrophic Coverage**

Once the beneficiary and the plan has spent a combined total of \$7,653.75 in "true out-of pocket costs" (TrOOP – see below) in formulary drugs, then they enter catastrophic coverage. From this point onward (until the next January), the beneficiary is responsible for only the greater of 5% coinsurance or \$8.50 copay for brand drugs and \$3.40 copay for generic drugs, and the plan pays the rest (2019).

**Figure 5 Part D Chart - Periods of Coverage**



NCOA Donut Hole Chart -- <https://www.ncoa.org/wp-content/uploads/Donut-Hole-2019.pdf>

Read the chart from left to right, starting with the **Deductible**. Unless someone joins Part D mid-year, the left edge of the chart will begin on January 1. As the beneficiary gets their prescriptions refilled throughout the year, their drug costs move them into the **Initial Coverage Period**, then the **Coverage Gap**, and finally **Catastrophic Coverage**. (NOTE that during coverage gap, manufacturer pays 70% brand name drugs, plan pays 5% and member pays 25%).

Some beneficiaries have relatively low drug costs, and thus will remain in the Initial Coverage Period all year long. Other beneficiaries may spend half of the year in the Initial Coverage Period, and half in the Coverage Gap, and never reach Catastrophic Coverage. Still other beneficiaries might have extremely high drug costs, and reach Catastrophic Coverage early in the year, and remain there until next January.

The amount a beneficiary will have to pay towards their drug coverage will probably vary from month to month throughout the year. As a result,

whether Part D provides effective coverage will largely depend on what percentage of the year one is in the coverage gap. Part D coverage might be a great deal for people with low drug costs, who spend most of the year in the Initial Coverage Period; and for people with high drug costs, who spend much of the year in Catastrophic Coverage. But for folks who spend much of the year in the Coverage Gap, Part D can be a very costly enterprise – though less costly in 2019.

Even when beneficiaries are exposed to some portion of the full cost of the drug (such as the deductible and coverage gap), plans are required to pass on to members any negotiated discounts that they obtain from drug companies. Thus, members should continue to use their plan cards during the coverage gap to obtain these discounts.<sup>13</sup> This is especially true now that all drugs are discounted during the coverage gap.

## What Drugs Are Covered?

### Formulary

Each PDP has a formulary. This is a list of covered drugs. In other words, each plan has some drugs that it chooses not to cover.

The Center for Medicare & Medicaid Services (CMS) requires each plan's formulary to include at least two drugs in each **Therapeutic Category** (e.g., Antidepressants, Cardiovascular Agents), and in each **Pharmacologic Class** (e.g., MAO Inhibitors, Reuptake Inhibitors).<sup>14</sup>

Formularies must include “all or substantially all” drugs in **six classes of clinical concern**:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Antineoplastic (cancer)
- Immunosuppressant (for organ and tissue transplant patients), and
- Antiretroviral (for treatment of HIV/AIDS).<sup>15</sup>

These must include generic drugs and older brand-name drugs. Plans may impose utilization management for these six classes of drugs, but are discouraged from doing so for HIV/AIDS drugs.<sup>16</sup> In addition, plans may not employ PA or ST requirements on these drugs for members who are currently taking them. If the plan cannot determine at the point of sale whether a member is already taking the drug, the plan must treat them as if they are.<sup>17</sup>

### Formulary

List of drugs covered by a Part D plan.

## Utilization Management

Plans may have **Utilization Management (UM)** for drugs on their formulary,<sup>18</sup> including:

- **Prior Authorization (PA)** – If a plan imposes a PA requirement on a drug, it means that the prescribing physician must first request permission from the plan before it will cover the drug. To get a PA request approved, physicians must typically show that the patient has a certain diagnosis or test results.
- **Step Therapy (ST)** – For ST, the plan will not cover the prescribed drug unless the beneficiary shows that they have first tried a specific list of alternative drugs, and that these were either ineffective or produced negative side effects.
- **Quantity Limits (QL)** – If a drug has QL, then it means that the plan will only cover a certain quantity of pills per month – or eyedrops, etc.

Each plan decides its own criteria for which drugs to impose UM, and what the beneficiary must prove to satisfy the UM. The Medicare website indicates which drugs have UM for each plan, but not what these criteria are (i.e., how many pills-per-month is too much, how prior authorization requests are decided, and which drug must be tried first in step therapy). Plans are now required to post the detailed UM criteria for all three varieties of UM on their websites.<sup>19</sup> In addition, Quantity Limits are now available directly through the Medicare.gov PlanFinder website (<http://www.medicare.gov/find-a-plan>).

## New Opioid Restrictions

The Comprehensive Addiction and Recovery Act (CARA) creates new Medicare rules to limit opioid use. Part D plans are permitted to establish drug management programs. 42 CFR § 423.153(f). CARA allows them to identify beneficiaries who appear to have dangerous patterns of opioid use and attempt to prevent potential misuse. The plan first sends notice to beneficiaries to declare them “potentially at-risk” (PARB). The Plan then determines whether beneficiary receives “at-risk” designation, which requires a second notice, which also gives them an option to select provider and pharmacy preferences, and to appeal for redetermination. 42 CFR § 423.153(f).

Additionally, new Prescriber and pharmacy lock-in rules require beneficiaries to obtain flagged medications through one provider or provider group and pharmacy or pharmacy chain. Beneficiary-specific point-of-sale claim edits can be used to further limit access.

“At-risk” beneficiaries may not use the Special Enrollment Period (SEP) for the Low Income Subsidy, which allows those with LIS to change plans once per quarter. These beneficiaries have access to all other SEPs and enrollment periods. 42 CFR § 423.100, § 423.38, § 423.153(f)

## Formulary Changes and Transition Fill

Plans may change their formularies at any time. Plans may remove drugs from their formulary, move drugs to a less preferred tier status, or add utilization management requirements, but only if enrollees currently taking the affected drug are exempt from the formulary change for the remainder of the plan year.<sup>20</sup> In addition, plans must provide 60 days’ advance notice to all members when they remove a drug from their formulary or change the cost-sharing. If they do not provide such notice, they must cover a 60-day refill of the affected drug at the next refill.<sup>21</sup>

**Transition fill.** If the formulary changes for the next year, so that a drug taken by a member is no longer covered, or will have new restrictions, the plan must provide a one-time 30-day supply of the drug in the following year.

## Excluded Drugs

Certain drugs are **excluded** from and not covered by the Medicare drug benefit.<sup>22</sup> This is different than those drugs that are simply not on a given plan’s formulary. If a drug is excluded, it means that **no basic Part D plan can cover it**, although some enhanced plans may.<sup>23</sup> In addition, the amount spent on an excluded drug does not count towards TrOOP (more about this on p. 24).

The following is a non-exhaustive list of excluded drugs:<sup>24</sup>

- Drugs for anorexia, weight loss, or weight gain
- Fertility drugs
- Cosmetic or hair growth drugs
- Cold medicine
- Prescription vitamins and minerals, and other over-the-counter drugs
- Drugs for treatment of erectile dysfunction
- Drugs covered under Medicare Part A or Part B<sup>25</sup>
- Drugs prescribed “off-label” (i.e., for treatment of an indication other than the one indicated on the drug’s FDA-approved labeling, and for an indication not approved in one of three pharmaceutical compendia).<sup>26</sup>

Medicaid will still cover these drugs for dual eligibles, to the extent they were covered before. Since 2013, EPIC will cover Part D excluded drugs as long as

they are on the EPIC formulary and the Part D deductible (if any) has been met.

Since 2013, benzodiazepines (e.g., Valium, Ativan, Xanax, Klonopin, Alprazolam, Lorazepam, Restoril) and barbiturates (e.g., Amytal) were no longer excluded from the Part D benefit.<sup>27</sup> Both types of drugs may be subject to prior authorization restrictions to limit them to the FDA-approved indication. This means that those taking these drugs “off-label” will still not be able to access them via Part D.

## TrOOP – True Out of Pocket Costs

Which drug costs count towards the running tally that pushes a beneficiary from deductible to initial coverage period, into the coverage gap, and into catastrophic coverage? The answer is: **TrOOP** (which stands for **True Out-Of-Pocket**, which is enough of a misnomer that I won’t even bother to explain it.)

TrOOP is an annual, running, cumulative total of certain types of expenditures made for Part D covered drugs, both **by the beneficiary** and in some cases **on behalf of** the beneficiary. The cost paid by the plan during the Initial Coverage Period counts, but not the 5% the plan pays during the Coverage Gap/ Donut Hole. Thus, a beneficiary might have low *actual* out-of-pocket costs in the form of co-payments, but because the **total cost** of their drugs (paid by the plan in the Initial Coverage Period) is high, they will reach the coverage gap (and get out of it) more quickly than someone taking cheaper drugs. The 70% discount on brand name drugs provided by the drug manufacturer during the coverage gap/ donut hole **DOES** count toward TrOOP, but not the 5% paid by the plan.

But not all drug costs count towards TrOOP. For example, **excluded drugs** do not count towards TrOOP (see p. 23). Nor do drugs that are covered by Part D, but not on the plan’s **formulary**). Nor do payments made by the Part D plan during the coverage gap (plan pays 5% on brand name drugs). Nor do drugs you buy in Canada or at an out-of-network pharmacy. The following chart shows which costs are TrOOP-eligible and which are not.

**Figure 6: TrOOP Chart<sup>28</sup>**

TrOOP-eligible	Not TrOOP-eligible
<ul style="list-style-type: none"> <li>• Amounts paid (by member <i>and</i> plan) for drugs on plan's formulary (or that were approved in exception process) during the deductible &amp; initial coverage period</li> <li>• Amounts paid by member – but not the 5% paid by plan -- in coverage gap/donut hole</li> <li>• The <b>entire payment made by EPIC</b> or ADAP (AIDS Drug Assistance Program) counts towards TrOOP costs, not just the portion paid by the client. But this is only for drugs on the PDP formulary.<sup>29</sup></li> <li>• Contributions from family, friends, and charities (as long as not employer- or union-affiliated)</li> <li>• Payments on member's behalf by Health Savings Account, Flexible Spending Account, or Medical Savings Account</li> <li>• CASH assistance (not actual drugs) provided by drug manufacturer patient assistance programs (PAP). See p. 62.</li> <li>• Drugs not on the plan formulary, if plan granted an exception initially or on appeal</li> <li>• Co-pays waived or reduced by pharmacy (if member has Extra Help; or if not, as long as waiver isn't advertised or routine, and pharmacist determines that member is financially needy and cannot pay co-pay)</li> <li>• 70% manufacturer discount on brand-name drugs during coverage gap (in addition to the 45% paid by member;) but the discounted portion of the dispensing fee does not count towards TrOOP</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly premiums</li> <li>• <b>Drugs not on plan formulary</b>, if no exception was granted or appeal won</li> <li>• Drugs <b>excluded</b> from the Medicare drug program (ie cosmetic, weight loss) . See p. 23.</li> <li>• Payments for <b>over-the-counter</b> drugs, vitamins</li> <li>• Drugs purchased at a pharmacy that is not in the plan's network</li> <li>• Drug costs that are paid or reimbursed by insurance, group health plan, Federally-funded program, or other third-party payment arrangement</li> <li>• Payments by insurance that is not "creditable" - workers comp, auto insurance</li> <li>• Payments by government programs such as VA, TRICARE, or Black Lung, even though they are creditable.</li> <li>• Drugs provided by a drug manufacturer <b>patient assistance program (PAP)</b>. See p. 62</li> <li>• Drugs purchased from Canadian mail-order pharmacies</li> <li>• 63% plan discount on generic drugs and 5% plan discount on brand name drugs during coverage gap in 2019 (i.e., only the actual amount paid by member PLUS manufacturer's discount on brand name drugs in coverage gap counts)<sup>30</sup></li> </ul>

## Pharmacies

Once a beneficiary has enrolled in a Part D plan (either a PDP or MA-PD), they can only use their drug coverage at pharmacies that are in the plan's network. If a beneficiary goes to a pharmacy that is not in their plan's network, then the plan **will not pay** any portion of the cost, nor will the amount they spend count towards TrOOP. Thus, it is important, when selecting a plan, to ensure that one's favorite pharmacy is in-network.

The government sets rules about how many pharmacies any given Part D plan must have in their network in a given geographic area.

- **Urban** - must contract with enough pharmacies that 90% of Medicare beneficiaries, on average, live within 2 miles of a network pharmacy.<sup>31</sup>

- **Suburban** - 90% must live within 5 miles of a network pharmacy.
- **Rural** -70% must live within 15 miles of network pharmacy.

In the New York City area, the majority of pharmacies accept all Part D plans. However, some independent, non-chain pharmacies do not, so it's still important to check before recommending a particular plan.

### **Mail-Order Pharmacies**

Plans may use **mail-order pharmacies**, but may not require members to use mail-order.<sup>32</sup> However, they may provide incentives, like cheaper co-pays. As a result, it is often most cost-effective for beneficiaries to use their plan's mail-order system. If a beneficiary uses their plan's mail-order pharmacy, they will have to order 90-day supplies of all their prescriptions.

### **Residents of nursing homes**

Drug plans are required to contract with any qualified pharmacy willing to participate in the plan's Long Term Care network. Plans must have a network of pharmacies that provide convenient access for nursing home residents enrolled in the plan.<sup>33</sup>

### **Preferred vs. Non-Preferred Pharmacies**

In-network pharmacies are divided between preferred and non-preferred. Although the plan will cover a beneficiary's drugs in a non-preferred pharmacy, their out-of-pocket cost will be higher.<sup>34</sup> Clients should select Part D plans for which their favorite pharmacy is preferred. This distinction is particularly important for Part D plans affiliated with particular pharmacy chains -- a member of the Humana/Walmart PDP may use any in-network pharmacy, but will only get the cheapest preferred pricing at a Walmart pharmacy.

# Extra Help = Low Income Subsidy

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<b>Who gives it?</b>	Federal government – Centers for Medicare and Medicaid Services (CMS) Those who are not deemed eligible must apply through the Social Security Administration (SSA) pursuant to separate eligibility rules administered by SSA
<b>Who gets it?</b>	Medicare beneficiaries who are eligible for Part D and who have limited income and/or resources
<b>Eligibility (2019)</b>	<ul style="list-style-type: none"><li>• <b>Deemed Eligible</b> by receiving Medicaid, MSP, or SSI; <b>OR</b></li><li>• Application approved by SSA under one of the following:<ul style="list-style-type: none"><li>– <b>Full Extra Help (135% FPL)</b> Income below \$1,386/mo. (single), \$1872/mo. (couple) Resources below \$9,060 (single), \$14,340 (couple)</li><li>– <b>Partial Extra Help (150% FPL)</b> Income below \$1,538/mo. (single), \$2,078/mo. (couple) Resources below \$14,100 (single), \$28,150 (couple)</li></ul></li></ul> <p><b>*income includes \$20 disregard and assets include \$1500 burial fund</b></p>
<b>What do you get?</b>	Subsidy that reduces or eliminates many of the costs associated with Medicare Part D drug coverage

## What is Extra Help?

**Extra Help**, also known as the **Low- or Limited-Income Subsidy (LIS)**, is a Federal subsidy administered by CMS that helps Medicare beneficiaries with limited income and/or resources to pay for some or most of the costs of Medicare prescription drug coverage. Some of the costs covered in full or in part by Extra Help include the monthly premiums, annual deductible, co-payments, and the coverage gap.

There are two types of Extra Help, **Full** and **Partial**, that differ in terms of eligibility and how much of a subsidy they provide.

## Eligibility for Extra Help

There are two different ways of becoming eligible for Extra Help: being deemed eligible by receiving Medicaid or a Medicare Savings Program, or by applying to the Social Security Administration (SSA).

## Deemed Eligible

Some people are “deemed” eligible for Extra Help and will be automatically enrolled in Extra Help.<sup>35</sup> They do not need to file an Extra Help application.<sup>36</sup>

Individuals are **deemed eligible**<sup>37</sup> who:

- Are entitled to benefits under Medicare Part A (hospital insurance) or enrolled in Medicare Part B (supplementary medical insurance) or both;<sup>i</sup>  
**AND**
- Are enrolled in one of the following:
  - **Supplemental Security Income (SSI)** benefits (including 1619(b)),<sup>38</sup> or
  - **Medicaid**,<sup>39</sup> or
  - **Medicare Savings Program (MSP)** such as Qualified Medicare Beneficiaries (QMB)<sup>40</sup>, Specified Low-Income Medicare Beneficiaries (SLMB)<sup>41</sup>, or Qualifying Individuals (QI-1)<sup>42</sup>.

### Dual Eligibles

Those who receive Medicaid and Medicare are called **dual eligibles**. They are deemed eligible for Full Extra Help. Before January 1, 2006, dual eligibles had drug coverage through Medicaid. On that date, CMS switched them *en masse* onto Medicare drug coverage through Part D.

All dual eligibles are deemed eligible for Full Extra Help. When CMS identifies a dual eligible without Part D coverage, they will automatically enroll them in a standalone PDP chosen at random from among the available “benchmark” plans that are free for people with Full Extra Help.

This includes Medicaid recipients with a spend-down. Anyone who meets the spend-down in any month from July to December of the current year should be automatically enrolled in Extra Help for all of the next year. This is true even if they were cut off Medicaid later in the current year or will be cut off next year. See p. 980.

## Medicare Savings Programs

In these programs, the Medicare Part B premium (full 2018 rate of \$134.00)<sup>43</sup> is paid for by the State of New York. One of the MSPs, QMB, also pays for the deductibles, coinsurance, and co-payments charged under Medicare Part A and B (as long as the patient sees a provider who accepts Medicaid).

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In addition to these benefits, all beneficiaries approved for any MSP are deemed eligible for Full Extra Help. As a result, the best way of helping a client to get Extra Help is by applying for an MSP.

For MSP eligibility, see the chart on p. 976.<sup>44</sup>

### *No Asset Test*

Since April, 2008, there is no longer any asset limit for *any* of the MSPs. As a result, it is the perfect solution for clients whose income is low but whose savings put them over the limit on the Extra Help or Medicaid application.

### *Applying for MSP*

It's easy to apply for an MSP! There is a one-page application form<sup>45</sup> for all three programs, which can now be submitted to the local District of Social Services (DSS) in person or by mail. For NYC, the DSS is HRA; other counties usually just call it the DSS. The Medicare Rights Center (MRC) gives training sessions to help you become a **Deputized Agent** to take MSP applications in NYC. Contact MRC to find out more about this program: 800-333-4114.

## **Application for Extra Help**

Those individuals who are not automatically deemed eligible for Extra Help may still be eligible based on their income and resources, but these people must submit an application to Social Security.

Unlike the rest of the Part D program, which is administered by CMS, applications for Extra Help are administered by the Social Security Administration (SSA).<sup>46</sup> New York State Departments of Social Services (i.e., HRA in NYC) may also begin accepting applications for Extra Help.

To be eligible for Extra Help via application, the individual must:<sup>47</sup>

- Be entitled to benefits under Medicare Part A (hospital insurance) or enrolled in Medicare Part B (supplementary medical insurance) or both;
- Be entitled to Medicare Part A and/or enrolled in Medicare Part B at the time the application is filed. If it is not filed in an enrollment period, SSA will deny the application and send him/her a notice that he/she is not eligible for the subsidy because he/she is not entitled to Medicare Part A and/or enrolled in Medicare Part B.

If a claimant meets all the requirements for the subsidy (except for enrollment in a Part D or MA-PD plan) and is in an enrollment period at the time he/she files the application or before the SSA makes a final decision, the claimant will be sent a notice about his/her eligibility for the subsidy and will be advised of the need to enroll in a Prescription Drug Plan or a Medicare Advantage Prescription Drug Plan. If the individual

**To Apply for Extra Help:**

<http://www.ssa.gov/i1020/>

is in an enrollment period but does not enroll in a plan, CMS will select and enroll him or her in a plan at the end of his or her enrollment period.

If the individual is not entitled to Medicare Part A and/or enrolled in Medicare Part B but is in an enrollment period at the time the application for the subsidy is processed, the record will be held in a conditional status until the individual files for Medicare. A notice will be sent to the individual which states that SSA will not make a determination until he/she becomes entitled to Part A and/or enrolled in Part B. Once the individual files for Medicare, the system will issue the award or pre-decisional notice. If the claimant does not become entitled to Medicare Part A and/or enroll in Medicare Part B before the first redetermination is scheduled, the record will be denied and he/she must file a new application for extra help and become entitled to Medicare Part A and/or enroll in Medicare Part B during a subsequent enrollment period.<sup>48</sup>;

- Reside in one of the 50 states or the District of Columbia;
- Have countable income and resources within specified limits<sup>49</sup> (see chart below); and
- File an application with SSA online<sup>50</sup>, at Social Security office, or by mail<sup>51</sup>

Not everything your client owns or earns is counted in determining Extra Help eligibility. Common disregards include the client's home, a burial fund, Holocaust reparations, and funds received or conserved to pay for medical and/or social services.

Thanks to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),<sup>52</sup> in-kind support and maintenance (e.g., someone else pays your rent for you or buys you groceries) will no longer count as income. In addition, the cash surrender value of life insurance policies will no longer be counted as a resource.

## **Backdoor to Full Extra Help**

You will notice from the chart on the next page that the income limit for QI-1 and for obtaining Full Extra Help by application to SSA is identical: 135% FPL (which comes out to \$1,386/mo. for a single applicant in 2018). However, QI-1 (like SLMB and QMB) has **no asset test**. As a result, QI-1 provides a way for clients with low income but more than \$9,060 of savings to obtain Full Extra Help. This is why we sometimes call the MSPs a "backdoor" to Extra Help eligibility.

Finally, a pooled trust can be used to shelter income in excess of 135% FPL, to qualify an individual for an MSP and therefore for Full Extra Help.

**Figure 7: 2018 Income and Asset Limits for Extra Help**

	% of premium subsidy	One		Two	
		Income <sup>ii</sup>	Assets <sup>iii</sup>	Income <sup>ii</sup>	Assets <sup>iii</sup>
<b>Full Extra Help</b>	<b>100%</b>				
<b>Deemed Eligible</b>	<b>100%</b>				
QI-1 135% FPL	100%	\$1,386	NO LIMIT	\$1,872	NO LIMIT
SLIMB 120% FPL	100%	\$1,234	NO LIMIT	\$1,666	NO LIMIT
QMB 100% FPL	100%	\$1,032	NO LIMIT	\$1,392	NO LIMIT
Medicaid < 90% FPL	100%	\$862	\$16,650	\$1,253	\$25,200
<b>By Application to SSA</b>					
<b>Full Extra Help</b>			<\$9,060 <sup>54</sup>		\$14,340 <sup>56</sup>
135% FPL	<b>100%</b>	\$1,386 <sup>53</sup>	Lower Level	\$1,872 <sup>55</sup>	Lower Level*
<b>Hybrid Extra Help</b>	100% but \$83 deductible, 15% copays		\$9,061 - \$14,100		\$28,150
135% FPL <sup>57</sup>		\$1,386	Higher Level	\$1,872	Higher Level
<b>Partial Extra Help</b>	\$83 deductible, 15% copays				
<b>140% FPL</b>	<b>75%</b>	\$1,373	\$14,100	\$1,858	\$28,150
<b>145% FPL</b>	<b>50%</b>	\$1,422	\$14,100	\$1,925	\$28,150
<b>150% FPL</b>	<b>25%</b>	\$1,538 <sup>58</sup>	\$14,100 <sup>59</sup>	\$2,078 <sup>60</sup>	\$28,150 <sup>61</sup>
<b>Over 150%</b>	<b>0%</b>	Ineligible for Partial Extra Help			

\* ALL asset levels in chart include \$1500 burial fund, for comparison.

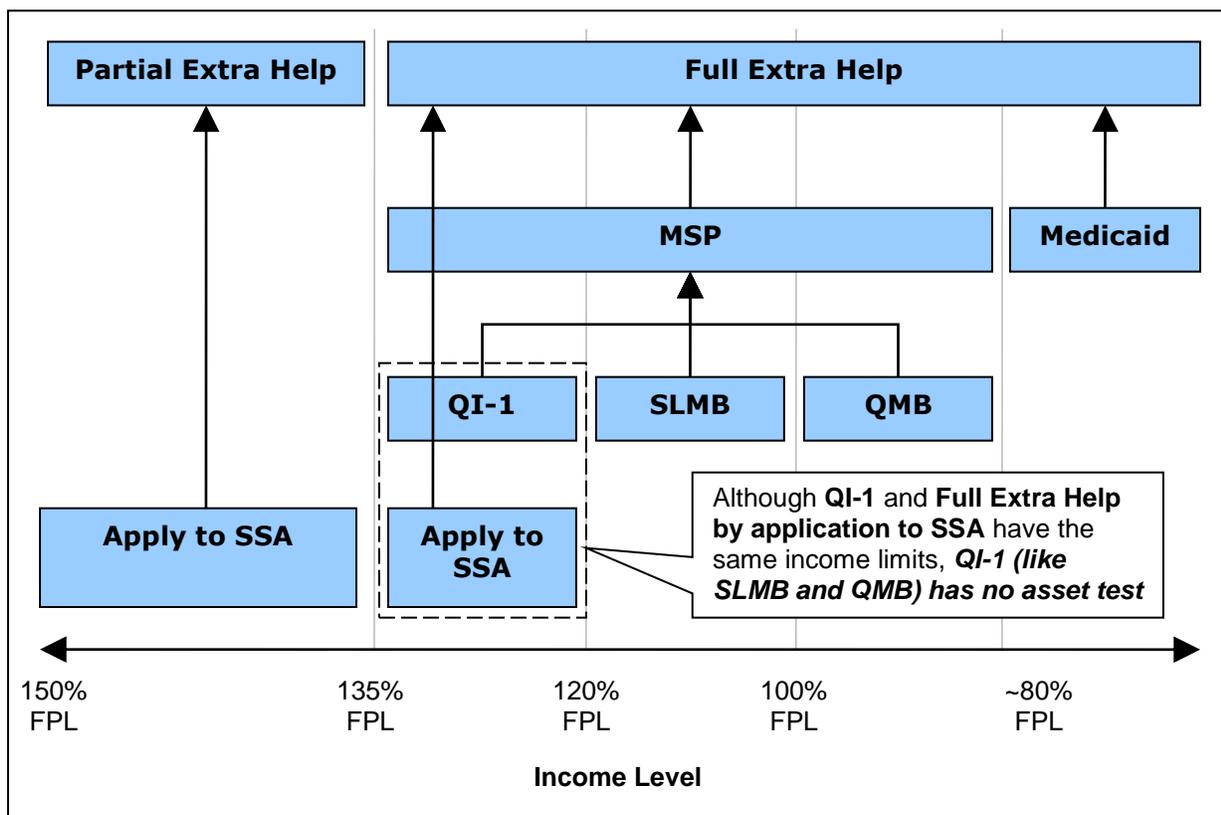
**Figure 8: Summary of Extra Help Benefits**

	% Premium subsidy	Deductible	Copay in Initial Coverage Period	Donut Hole/ Coverage Gap	Catastrophic Coverage
<b>No Subsidy</b>	0	\$415	25%	25% brand, 63% generic	Greater of 5% or \$3.40 generics \$8.50 brand
<b>Full Extra Help</b>	100%	Fully subsidized	See Figure 10	See Figure 10	No copays
<b>Hybrid Extra Help</b>	100%	\$83	15%	15%	\$3.40 generics \$8.50 brand
<b>Partial Extra Help</b>	25 - 75%	\$83	15%	15%	\$3.40 generics \$8.50 brand

<sup>ii</sup> Income figures are monthly, take into account the \$20/mo. disregard from unearned income per household.

<sup>iii</sup> Includes an extra \$1,500 for singles and \$3,000 for couples for burial expenses.

**Figure 9: Many Roads to Extra Help**



**Applications for Extra Help will be deemed applications for MSP**



One of the changes wrought by MIPPA is that beginning January 1, 2010, every time someone applies for Extra Help with SSA, it will be automatically deemed an application for the Medicare Savings Program.<sup>62</sup> Unless the applicant opts not to have their Extra Help application treated as an MSP application,<sup>63</sup> SSA will transmit their data to their state of residence so that the state may determine their eligibility for MSP.

In New York, the State Department of Health (DOH) will match the Extra Help application data from SSA against their rolls of Medicaid and MSP recipients. If an applicant is found to have at least Medicare Part A, and is income-eligible, then DOH will automatically open an MSP case for 12 months. These individuals will receive a notice from DOH stating that they have been approved for MSP, and requesting additional information about health insurance premiums to see whether they can be upgraded to a more beneficial level of MSP (e.g., from QI-1 to SLMB).

Those who have at least Part A but are over the income limit for MSP will be sent a denial notice, but they will also be urged to re-apply with an enclosed MSP application. Because SSA uses slightly different eligibility rules than New York's MSP program, DOH will not always be able to tell based on the data transmitted by SSA whether an applicant is eligible for MSP.

DOH will not determine MSP eligibility for those Extra Help applicants who don't yet have Part A, those with an open Medicaid case, or those for whom SSA has not transmitted adequate data. These folks' applications will be forwarded to the appropriate local district (in NYC, the Human Resources Administration) for processing.

All recertifications for individuals who are approved for MSP through the above process will be handled by the local districts.

## How Much Help Is Extra Help?

The amount of help provided by Extra Help depends upon a number of factors. See the table on page 955 for a summary of the factors that determine how much a person must pay towards drug coverage.

The following pages compare each cost component of a drug plan – premium, deductible, co-pays, coverage gap, and catastrophic coverage – between a basic plan with no extra help, with Full Extra Help, and with Partial Extra Help.

### Premiums

#### *Basic Plan*

Those without Extra Help must pay a monthly premium. The average premium for basic New York standalone PDPs will be \$47.12/month in 2019.

#### *Full Extra Help*

Monthly PREMIUM IS FREE for those with the Full Extra Help. It is paid for by a subsidy.<sup>64</sup> However, the premium is free only if one enrolls in one of the eight "benchmark" plans offered in New York State in 2019.<sup>65</sup> For a plan to be considered "benchmark," its premium for basic coverage must be less than the benchmark amount for New York State in 2019, which is \$39.33.

If an extra help beneficiary opts for one of the non-benchmark basic plans, he or she must pay the difference between the full premium and the premium subsidy amount.<sup>66</sup> If she opts of an enriched plan, she must pay the part of the premium allocated to the "enriched" benefit, plus the amount of the basic premium that exceeds the premium subsidy amount.

### *Partial Extra Help*

The Partial Extra Help premium is on an income-based sliding scale ranging from 25% – 75% of the basic plan premium.<sup>67</sup> The table below calculates the cost of the premium assuming a plan premium of \$39.33 (the average premium for a benchmark plan in 2019); the actual premium owed with Partial Extra Help varies from plan to plan.

## **Deductible**

### *Basic plan*

In 2019, \$415 is the maximum deductible for a basic plan (although some have a lower, or no, deductible).

### *Full Extra Help*

Full Extra Help has NO deductible. <sup>68</sup>

### *Partial Extra Help*

In 2019, Partial Extra Help has a \$85 deductible (or lower, if the plan has a lower deductible for those without a subsidy).<sup>69</sup>

## **Co-Payments**

### *Basic Plan*

After meeting the \$415 deductible, basic plan members must pay approximately 25% of drug costs in co-payments until they have reached \$3,820 in TrOOP. The Part D plan pays the other 75%.

### *Full Extra Help*

The co-pays owed by Full Extra Help recipients depend upon whether they are on Medicaid, and where their income falls relative to the Federal Poverty Line. The co-pays range from \$0 up to \$8.50 per drug.<sup>70</sup> See the table at p. 955.

Medicaid recipients pay NO co-pay in a nursing home, or if they are enrolled in the FIDA program (Fully Integrated Dual Advantage) (solely available in New York City, Nassau, Westchester and Suffolk Counties) or a Home and Community-Based Services Waiver Program (e.g., Nursing Home Transition and Diversion [NHTD] waiver, Traumatic Brain Injury [TBI] waiver, or the waiver for people with developmental disabilities [OPWDD]).<sup>71</sup>

**NOTE** – In Medicaid, if a beneficiary tells the pharmacist that she cannot afford the co-payment, the pharmacist must give the drug anyway (i.e., “waive the co-payment”). THAT IS NOT TRUE in Part D! Pharmacists *may* waive the co-payment, but are not required to. See p. 980.

### Partial Extra Help

After meeting their \$85 deductible, beneficiaries on Partial Extra Help must pay 15% of their drug costs as co-pays.<sup>72</sup>

**Figure 10: Copayments for Extra Help (2019)**

	Generic Drugs	Brand-Name Drugs
<b>Full Extra Help</b> – < 135% FPL – Copayments charged until total drug costs reach \$7,653 (including costs paid by drug plan), then reach Catastrophic Coverage -- NO COPAY for the rest of the year		
Medicaid recipients with income < 100% FPL	\$1.25	\$3.80
Medicaid recipients with income between 100% – 135% FPL	\$3.40	\$8.50
Non-Medicaid recipients with income under 135% FPL <sup>73</sup>	\$3.40	\$8.50
Medicaid recipient in a waiver program (TBI, NHTDW)	\$0.00	\$0.00
Medicaid recipient in a nursing home, even a brief stay	\$0.00	\$0.00
<b>Partial Extra Help</b> – 135% – 150 % FPL	15%	15%
	Reduced to \$3.40 in catastrophic coverage	Reduced to \$8.50 in catastrophic coverage

## Coverage Gap (Donut Hole)

### Basic Plan

In the basic plan, once members have incurred \$3,820 in drug costs (2019)(i.e., TrOOP), they are in the “coverage gap.” Thanks to the ACA, this gap has been gradually closing. In 2019 you will pay 25 percent for your *brand name* drugs and the manufacturer plus the plan together will pay 75 percent. For *generic drugs* you will pay 37 percent of the cost of the drug and the manufacturer will pay 63 percent. The coverage gap will be completely phased out in 2020 when you will typically pay no more than 25 percent of the cost of your drugs at any point during the year after you've met your deductible. Note that a bill pending in Congress would repeal some of this coverage during the Coverage Gap, which was enacted as part of the ACA.

### Extra Help

In both types of Extra Help, there is **no coverage gap**. After their TrOOP reaches \$3,820, beneficiaries continue paying the same co-pays shown in Figure above until they reach catastrophic coverage.

## Catastrophic Coverage

### *Basic Plan*

Once basic plan members make it across the coverage gap by incurring \$3,833.75 in drug costs during the coverage gap (including the discounts during the donut hole), their co-pays are reduced to the greater of 5% of drug cost or \$3.40 generics / \$8.50 brand-name for the rest of the year.

### *Full Extra Help*

NO co-payments once TrOOP reaches \$7,653.75 in drug costs.<sup>74</sup>

#### **About waiving co-pays**

Because Full Extra Help recipients only pay co-pays until incurring \$7,653.75 in covered drug costs, those with high monthly drug costs may only have to pay co-pays for a few months out of the year. For this reason, they may be able to convince pharmacists to waive the co-pays until they reach that limit, secure in the knowledge that their plans will pay the full cost for the rest of the year.

Pharmacists are allowed to waive Part D co-pays, as long as they do not advertise that they do it, or do it routinely. If the customer does not have Extra Help, then the pharmacist may waive co-pays only after “determining that the beneficiary is financially needy or after failing to collect the cost-sharing amount despite reasonable efforts.”<sup>75</sup>

### *Partial Extra Help*

Co-pays are reduced to \$3.40 (for generic drugs) and \$8.50 (for brand-name drugs) when they reach catastrophic coverage.<sup>76</sup>

For both Full and Partial Extra Help, the \$7,653.75 catastrophic threshold includes amounts paid by the beneficiary, by the plan, and by the Extra Help subsidy.

## Keeping Extra Help

As with all other public benefits, being approved initially does not mean that the applicant will receive the benefit forever. Beneficiaries must recertify their eligibility in order to keep Extra Help. But because there are different ways of obtaining Extra Help, there are also different ways of recertifying (with different names, naturally).

## Redeeming

Those who are **deemed eligible** for Extra Help (because they have Medicaid, SSI, or an MSP) are subject to **redeeming** to keep their Extra Help from year to

year. This generally means that they must have been on Medicaid, SSI, or an MSP for at least one month before a certain cut-off date in the current year to continue having Extra Help in the coming year.

For someone who was deemed eligible in 2018 to keep their deemed status in 2019, they must have been eligible for Medicaid or MSP for at least one month in July 2018 or after.

For example, if an individual lost QI-1 in May 2018 and did not become eligible for any other MSP or Medicaid by July, then they will *not* be redeemed for 2019. Their Extra Help will continue for the remainder of 2018, but will terminate effective January 1, 2019. In September 2018, CMS sent letters (printed on gray paper) to beneficiaries who will not be redeemed in 2019, including an application for Extra Help.<sup>77</sup>

There is a Special Enrollment Period for those who lose Extra Help. For example, if a client's financial situation has changed in a way that causes them to lose the subsidy effective January 1, they can still switch to a more appropriate Part D plan through March 31. See p. 44 for more on SEPs.

See table in the Appendix for a list of mailings beneficiaries might receive.

## Redetermination

Whereas those who have Extra Help by being **deemed** eligible undergo **redeeming**, those who **applied** for Extra Help undergo **redetermination**. Redetermination is the process by which SSA decides whether those who received Extra Help in the past will continue to have it, and at what level.

Remember, redetermination applies only to those who *applied to SSA* for Extra Help, which will not include any clients with Medicaid or an MSP.

In addition, SSA does not send redetermination forms to *everyone* who applied and was approved for Extra Help. Those who do not receive forms will be passively redetermined eligible for Extra Help in 2019.

If a beneficiary receives a redetermination form from SSA, then **they must return the enclosed form within 30 days** (or request an extension), or else their Extra Help will be terminated effective January 1, 2019, and they will have to reapply. This is true even if they had no change in their financial situation.

There are two types of redetermination that can occur:<sup>78</sup>

### *Initial Redetermination*

In August of each year, SSA will send redetermination forms to a sub-set of those who were approved for Extra Help between May of the prior year and April of the current year.

Only those who meet one of the following criteria will be selected for this initial redetermination:

- Beneficiaries for whom SSA data indicates a potential change in subsidy;
- Beneficiaries who are members of a couple with different filing dates or different subsidy amounts;
- Beneficiaries who reported an event that could impact Extra Help eligibility or amount (such as a change in income or assets);
- Beneficiaries who did not respond to a request by SSA's Office of Quality Performance for review of eligibility;
- Beneficiaries for whom the Office of Quality Performance found errors in their record.

### *Cyclical Redetermination*

For its cyclical redetermination, SSA selects from all Extra Help recipients, including those who were approved for Extra Help in previous years. This sub-set is based on those who fit a profile for individuals who are more likely to have a change in household size or finances that would affect eligibility for Extra Help. The cyclical redetermination will also include:

- Beneficiaries who are members of a couple with different filing dates or different subsidy amounts;
- Beneficiaries who reported an event that could impact Extra Help eligibility or amount (such as a change in income or assets);
- Surviving spouses
- Beneficiaries who did not respond to a request by SSA's Office of Quality Performance for review of eligibility;
- Beneficiaries for whom the Office of Quality Performance found errors in their record.

The following table shows what kinds of events could impact Extra Help eligibility or amount, how long the recipient has to respond, when the change will be effective, and what will happen if the form isn't returned.

**Figure 10: Changes in Situation for Redetermination**

Changed Situation	Must Return Redetermination Form Within: <sup>79</sup>	Effective Date of Change in Subsidy <sup>80</sup>	If Redetermination Form is Not Returned, Subsidy Will Be Terminated: <sup>81</sup>
<b>“Subsidy-Changing Events” (SCEs):</b> You marry You and your spouse, who lives with you, divorce Your spouse, who lives with you, dies You and your spouse separate, unless the separation is a temporary absence You and your spouse resume living together after having been separated You and your spouse, who lives with you, have your marriage annulled	90 Days	The month following the month of your report	The month following the expiration of the 90-day return period. Within 90-day period, you may request an extension up to 30 days <sup>82</sup>
<b>“Other Events”:</b> <ul style="list-style-type: none"> <li>You (or your spouse, who lives with you, if applicable) expect your estimated annual income to increase or decrease in the next calendar year</li> <li>You (or your spouse, who lives with you, if applicable) expect your resources to increase or decrease in the next calendar year</li> <li>Your family size has changed or will change</li> <li>Any other change other than an SCE</li> </ul>	30 Days <b>However</b> , SSA will postpone redetermination based on reports of “other events” until the annual redetermination at the end of the year (between August and December) <sup>83</sup>	January of the next year	January of the next year

**Note on terminology:** “Other Events” can also result in a change in subsidy.

### *Aid Continuing and Appeal*

If SSA decides to change a recipient’s Extra Help, it must send a notice of proposed action, stating the effective date and appeal rights.<sup>84</sup>

The individual has the right to continue receiving Extra Help at the previously established level until there is a decision on their appeal *if the appeal is filed within 10 days after receipt of the notice*.<sup>85</sup>

Thus it is very important to file an appeal immediately if you lose Extra Help on a redetermination.

Those who lose Full or Partial Extra Help for 2019 will be eligible for a Special Enrollment Period, from January through March 2019, to switch to a different plan. See p. 44 for more on SEPs.

## Quiz – Who Must Apply for Extra Help?

Which of these people are automatically enrolled in Extra Help and which must apply to SSA? And if so, will their application be approved? The answers are in the endnote.<sup>86</sup>

- Kate is a 68 year old widow and has Medicare and Medicaid with a spend-down of \$300. She gets 20 hours/week of Medicaid home attendant services.
- Henry is a 53 year old man on Social Security Disability who has Medicare, but the Part B premium is not being deducted from his SSDI check each month. (answer to this might be wrong?)
- Natalie and Jack are both 69 years old. Neither has Medicaid nor is enrolled in an MSP program. Their income is \$33,750 a year.
- Ralph's annual income from Social Security is \$15,000. He has Medicare, but not Medicaid or an MSP. He has \$12,000 in the bank between his checking and savings accounts.

**Figure 12: Summary of Extra Help Coverage (2019)**

	Full Extra Help						Partial Extra Help		
	Standard Benefit	Dual in Nursing Home or Waiver	Dual < 100% FPL	Dual 100% – 135% FPL or MSP <sup>(6)</sup>	LIS Applicant < 135% FPL with “low” assets	LIS Applicant < 135% but “high” assets <sup>(11)</sup>	135% – 140% FPL	140% – 145% FPL	145% – 150% FPL
<b>Method of Enrollment</b>	N/A	Deemed	Deemed	Deemed	Application	Application	Application	Application	Application
<b>Premium</b>	\$39.33/mo. <sup>(1)</sup>			None <sup>(2)</sup>			25% <sup>(3)</sup>	50% <sup>(3)</sup>	75% <sup>(3)</sup>
<b>Deductible</b>	\$415			None <sup>(4)</sup>		\$85		\$85 <sup>(5)</sup>	
<b>Co-Pays</b>	25%	\$0	\$1.25 generic, \$3.80 brand	\$3.40 generic, \$8.50 brand	\$3.40 generic, \$8.50 brand	15%		15% <sup>(7)</sup>	
<b>Coverage Gap</b>	25% brand \$3,820 – \$7,653.75	63% generic <sup>(8)</sup>	There is <b>no coverage gap</b> for Full or Partial Extra Help recipients. They pay the same co-pays they were paying before reaching \$3,820 until they reach the \$7,653 catastrophic threshold.						
<b>Catastrophic Co-Pays</b>	Greater of: \$3.40 generic \$8.50 brand - or - 5%		\$0 – The catastrophic threshold is reached when the total out of pocket costs are \$7,653.75, regardless of what the plan pays. No copays are charged after that point.					\$3.40 generic, \$8.50 brand <sup>(10)</sup>	

- (1) Average premium for basic plan in New York.
- (2) 42 CFR § 423.780(a), 423.780(e)(1)
- (3) This is the percentage of the benchmark premium that the beneficiary is responsible for paying.
- (4) 42 CFR § 423.782(a)(1)
- (5) 42 CFR § 423.782(b)(1)
- (6) The regs governing Extra Help do not indicate what co-pay subsidy is provided to MSP participants. 42 C.F.R. § 423.782(a)(2)(i). However, the POMS indicates that MSP and SSI-only beneficiaries have the Full Extra Help co-pays. SSA POMS § HI 03001.001E, at <http://policy.ssa.gov/poms.nsf/lnx/0603001001> (November 16, 2007).
- (7) 42 CFR § 423.782(b)(2)
- (8) Without Extra Help, members of basic plans formerly had *no coverage* during the doughnut hole. However, under the Affordable Care Act, pharmaceutical company and Part D plans pay. In 2020, there will be no coverage gap.
- (9) 42 CFR § 423.782(a)(3); 42 U.S.C. §§ 1396w-102(b)(4)(C)(ii), 1396w-102(b)(4)(B)(i)(I), CMS Issue Paper #3, Additional Help to Those Who Need It Most: Those With High Drug Costs and Those With Low Incomes (January 21, 2005), at <http://www.cms.hhs.gov/States/Downloads/MedicarePrescriptionDrugProgram&LimitedIncomeAssistance.pdf>.
- (10) 42 CFR § 423.782(b)(3)
- (11) POMS HI 03001.005 Medicare Part D Extra Help, <http://policy.ssa.gov/poms.nsf/lnx/0603001005> (12/15/17)



# Enrollment

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Remember that there are two types of enrollment involved in Part D: enrollment in a drug plan, and enrollment in Extra Help. This section is just about enrolling in a drug plan.

## Initial Enrollment Period (IEP)

When someone first becomes eligible for Medicare, because they have either turned 65 or received Social Security Disability Insurance (SSDI) for 2 years, they have an **Initial Enrollment Period** for Part D identical to the Initial Enrollment Period for Part B. They have a 7-month period to enroll in a drug plan. The period begins 3 months before and ends 3 months after the month of either (a) their 65th birthday, or (b) the month they begin to receive Medicare based on disability (the second anniversary of receiving SSDI).<sup>87</sup>

## Annual Coordinated Election Period (ACEP)

Anyone can enroll or change plans during Annual Coordinated Election Period (ACEP). Since 2011, the ACEP is from October 15 to December 7, with the enrollment taking effect January 1 of the following year.<sup>88</sup>

Those who didn't enroll during their IEP, but who waited until the ACEP, may have to pay a Late Enrollment Penalty when they do enroll, unless an exception applies. See p. 50.

## Annual Medicare Advantage Open Enrollment Period (changed in 2019)

2019 Changes!!

Beginning in 2019, there is a change for Medicare Advantage (MA) enrollment changes. From **January 1 – March 31<sup>st</sup>** beginning in 2019, there will be a continuous MA open enrollment and disenrollment period. During this time, enrollees in Medicare Advantage Plans may **change their MA plan or elect traditional Medicare and enroll in a standalone Part D plan.**

This is a big change from the rules from 2011 - 2018, when there was an Annual Disenrollment Period from **January 1 to February 14.** During this period you could disenroll from a Medicare Advantage plan and return to Original Medicare and enroll in a standalone PDP. You could not switch

from one Medicare Advantage plan to another, nor from Original Medicare to a Medicare Advantage plan.

## Special Enrollment Periods (SEPs)

Special Enrollment Periods<sup>89</sup> are opportunities for certain Medicare beneficiaries to make certain enrollment decisions outside of the IEP and ACEP. There are at least 35 different SEPs. Each SEP corresponds to a different circumstance. Due to the large number of SEPs, the following list is not exhaustive, but includes the most common SEPs. The SEP's with the 2019 changes are listed in the

### *Involuntary Loss of Creditable Coverage*

If an individual loses prescription drug coverage that is creditable (see p. 50), through no fault of their own, then they will have a SEP ending two months after the loss, or after they receive notice of the loss, whichever is later.<sup>90</sup> The loss of creditable coverage through an Employer Group Health Plan, including retiree and COBRA, triggers a SEP that ends two months after the end of the EGHP coverage. The entitlement to the EGHP must end, the SEP isn't triggered by simply not paying the EGHP premium.

### *Extra Help- Four SEP'S*

There is a big change in 2019 for all Extra Help recipients – dual eligibles, MSP participants, and people with Full or Partial Extra Help through Social Security. Before, through 2018, they may change plans in any month. Beginning 2019, they may change plans only **once per quarter for the first 3 quarters of the year**. The date of the change is considered the date of the election, not the effective date of the change, for purposes of counting the changes made in one quarter. They may not change in the fourth quarter of the year.<sup>91</sup> This SEP is NOT available for those identified as “At risk” or “potentially at risk” for misuse of frequently abused drugs. “At risk” designation is determined by plan, with written notice that beneficiary can appeal.

Second, a separate SEP occurs **when LIS is approved, discontinued, or changed from Partial to Full LIS or vice versa**. The individual may change within 3 months of the change/approval, effective 1st of the next month (Or from notification of such a change, whichever is later).

EX: Jane lost Medicaid in May 2018 so has deemed Extra Help the rest of 2018. But she is not re-deemed for 2019. She has a SEP to change Part D plans from Jan – Mar of 2019 – the 3 months after Extra Help ended.

See MRCs SEP table at [www.medicareinteractive.org/uploadedDocuments/mi\\_extra/SEP-Chart.pdf](http://www.medicareinteractive.org/uploadedDocuments/mi_extra/SEP-Chart.pdf)

**Extra Help SEP's**  
Changes in 2019!!!!!!

Third – NEW 2019 --**individuals who are auto-enrolled into a plan by CMS or the State have a SEP to enroll into a different plan.**<sup>92</sup> They may make one-time election before the enrollment is effective or within 3 months of the effective date or notification of the assignment, whichever is later. This includes people assigned to a plan when first approved for Medicaid or Extra Help, or EPIC, or people assigned to a plan after their plan closes or loses “benchmark” status.

Fourth, anyone may enroll in or disenroll from **FIDA or FIDA-IDD** in any month, and switch to any other FIDA or MAP plan or to Original Medicare with an MLTC plan and stand-alone PDP.

### *Plan Moves or Terminates*

Those whose PDP or MA plan ceases operating in their area or whose contract is terminated by the plan or CMS mid-year have a three-month SEP.<sup>93</sup> If a plan ceases to operate effective January 1<sup>st</sup> of the next year, the SEP is from December 7<sup>th</sup> of the year in which it is closing through the end of February the next year.

### *SEP65- Enrolled in Medicare Advantage at 65 – may switch to PDP*

Beneficiary enrolls in Medicare Advantage plan (with Part D) during Initial Coverage Election Period when turns 65. Must have enrolled “surrounding their 65th birthday” –within 3 months before or after 65th birthday. She has 12 months from effective date of the initial enrollment to switch to a stand-alone Part D plan (PDP) and Original Medicare.

### *Medicare Advantage “TRIAL” SEP*

If enroll in a Medicare Advantage plan when first eligible at age 65, within 12 months may disenroll from their first Medicare Advantage plan to go to Original Medicare + PDP + Medigap.

If dropped a Medigap policy to enroll in an MA-PD plan for the first time, you have 12 months to return to Original Medicare & enroll in PDP & reinstate Medigap. The SEP to enroll in the PDP begins the month of Medicare Advantage disenrollment and continues for the next two months.

### *Disenrolled from Medicare Advantage because Lose Medicare Part B*

To stay in Medicare Advantage, one needs both Part A and Part B. If you lose Part B, you will automatically be disenrolled from the Medicare Advantage Plan. You only need Part A to enroll in Part D. You have a SEP to enroll in a stand alone PDP.

### *Beneficiary Moves within USA or Moves from Outside USA or Prison*

People who move outside the coverage area of their PDP can change plans once during a SEP that runs from one month before the month of their move to two months after the month of their move.<sup>94</sup> Timing can be more complicated depending on whether and when they notified the old plan that they were moving.

Someone who was in prison, or lived outside of US when they were first eligible for Part D were not eligible to enroll in Part D. If they now move to the USA or get out of prison, this SEP applies.

### *Material Contract Violation*

People whose PDP substantially violated a material provision of its contract, such as by failing to provide benefits on a timely basis or in accordance with applicable quality standards, or by materially misrepresenting the plan's provisions in marketing the plan to the person.<sup>95</sup>

### *5-Star Plans*

You can switch to a Medicare Advantage Plan (or MA-PD) or Medicare PDP that has a 5-star rating at any time between December 8 of the year before the 5-star rating until November 30 of the year of the 5-star rating. You can use this SEP to change plans once per year. Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can get a rating between one to five stars. A 5-star rating is considered excellent.

- The overall plan star ratings are available on the Plan Finder at <http://www.medicare.gov/find-a-plan>. WARNING: There are sub-ratings for a variety of domains (e.g., customer service) which may appear in plan communications. Only the OVERALL plan rating of 5 stars entitles members to a SEP. Only use the star ratings on Plan Finder!
- You can only join a 5-star Medicare Advantage Plan if one is available in your area.
- You can only use this special enrollment period to switch to a 5-star plan one time each year.

**Note:** You may lose your prescription drug coverage if you move from a Medicare Advantage Plan that has drug coverage to a Medicare Advantage Plan that doesn't. You will have to wait until the next open enrollment period to get drug coverage, and you may have to pay a late enrollment penalty.

As of the date of these materials, we do not know the overall star ratings of the PDPs in New York State in 2019.

### *Low-Performing Plans*

You have a SEP if you have been in a consistently low-performing Medicare Advantage or Part D plan, with an overall Medicare star rating of less than three stars for three consecutive years. You may enroll into a plan rated 3 stars or more anytime during the year. You should receive a notice from CMS in late October, explaining your right to change from a low-quality plan. To use this SEP, call 1-800-MEDICARE directly.

### *Your Plan Stops Contracting with Many Providers*

If CMS determines that your Medicare Advantage plan has stopped contracting with a substantial number of providers in its network, your plan will notify you of a one-time SEP to change plans or switch to Original Medicare. You have until two months after the month you receive the notice to change plans. If you switch to Original Medicare, you can buy a Medigap plan any time, since NYS has open enrollment year-round for Medigap.

### *Exceptional Circumstances*

People who “meet other exceptional circumstances as CMS may provide.”<sup>96</sup>  
A few common examples:

- **SEP EGHP** - A SEP exists for “individuals enrolling in employer/union group-sponsored Part D plans, for individuals to disenroll from a Part D plan to take employer/union-sponsored coverage of any kind, and for individuals disenrolling from employer/union-sponsored coverage (including COBRA coverage) to enroll in a Part D plan. The SEP EGHP may be used when the EGHP allows the individual to make changes to their plan choices, such as during the employer’s or union’s “open season....” This SEP is available to individuals who have (or are enrolling in) an employer or union plan and ends 2 months after the month the employer or union coverage ends.”<sup>97</sup> Thus, those who leave their job but cannot afford to pay the high COBRA premiums will be able to enroll in Part D upon losing their COBRA coverage.
- **NURSING HOME** - Anyone who moves into, resides in, or moves out of a variety of institutional settings, including Skilled Nursing Facilities and Nursing Facilities. The SEP upon moving out is for 2 months.<sup>98</sup>
- **EPIC** -- Individuals enrolled in a State Pharmaceutical Assistance Program (SPAP), such as EPIC, have a SEP to make one enrollment choice by the end of the calendar year.<sup>99</sup> See p. 59 for more on EPIC.
- **PACE or Medicare Advantage SNP**– May disenroll from a PDP and enroll in a PACE or MA-SNP plan any time. If disenroll from PACE, have a SEP for up to 2 months after the effective date of PACE disenrollment to enroll in a PDP. If no longer have a “special need”

#### **EPIC Members Have a SEP**

EPIC members can make one additional enrollment choice each year.

qualifying for a SNP, have a SEP to enroll in a PDP within 3 months after disenrollment from the SNP.

- **MISLEADING STATEMENT** -- Individuals who enrolled in Medicare Advantage plans “based on misleading or incorrect information provided by plan employees, agents or brokers.” To use this SEP, it is best to select the new plan first, then call 1-800-MEDICARE and explain the facts. The customer service representatives have authority to decide whether this SEP applies on a case-by-case basis.<sup>100</sup> It has been relatively easy for people to disenroll prospectively, but it may require more advocacy for your client to be disenrolled retroactively.
- **CORRECT MISTAKES** – CMS can approve SEPS to correct mistakes, whether by a federal employee in not completing an enrollment, or by the beneficiary who client thought she was buying a Medigap policy or enrolling in a Medicaid managed care plan with a similar name, not a PDP. CMS must approve the SEP, and can make it retroactive.
- **Disenrollment from Part D to Maintain Retiree or Other Creditable Coverage, Including VA and Tricare** -- Part D SEP to disenroll from Part D or MA-PD plan (NOT to enroll in or switch plans) in order to maintain retiree coverage. Some retiree health insurance is federally subsidized. The law does not allow you to be in two subsidized plans – it’s double dipping. By staying in Part D plan, you risk losing retiree coverage, which may be better than PDP or MA-PD, or may cover spouse. The SEP allows disenrollment from Part D. The effective date of disenrollment is the first day of the month following the month a disenrollment request is received by the Part D plan.

## Changing Plans

Generally, people can only change Part D plans during the ACEP, which since 2012 is from October 15 to December 7 of each year, with an effective date of January 1 of the next year.

**EXAMPLE:** Lourdes became eligible for Medicare in March 2018. She can use her Initial Enrollment Period to enroll in a Part D plan as late as June 30, 2018. HOWEVER, if she waits until then to enroll, she won’t be able to change plans until the ACEP from 10/15/2018 to 12/7/2018.

Beneficiaries get to make one enrollment choice during a given enrollment period. **This means that if someone wants to switch plans, they should not disenroll from the old plan.** They should just use their enrollment period to enroll in a new plan, and they will be automatically disenrolled from the old one.

In general, a beneficiary may make ANY enrollment choice during an enrollment period (either enroll for the first time, disenroll, or switch plans). However, there are some SEPs where only certain changes can be made.

## Lock-In

If a Medicare beneficiary enrolls in a PDP or MA plan during their IEP or ACEP, they generally are **locked in** to that plan until the next ACEP. Only if they are covered by a SEP, or if they want to make one of the changes available during the OEP for Medicare Advantage, can they switch plans between ACEPs.

## How do you switch plans?

To change plans (assuming you have an enrollment period that allows you to do so), you just enroll in a new plan. By enrolling in a new PDP or MA-PD, you will automatically be disenrolled from the old plan. **You do not need to contact the current plan to disenroll!** In fact, doing so could cause problems. You don't even need to tell the current plan you're leaving. The Medicare computer system automatically informs them that you have disenrolled once your enrollment in the new plan is processed. There will be no gap in coverage.

## How do you enroll in a Part D plan?

There are several different ways to enroll in a Part D plan (assuming you have an enrollment period that allows you to enroll). The fastest way is probably to call the customer service number of the plan in which you want to enroll. However, you might need to call 1-800-MEDICARE to invoke your rights under a SEP.

- Call the plan
- Call 1-800-MEDICARE
- Use the Plan Finder website at <http://www.medicare.gov/find-a-plan>

## When is the enrollment effective?

All enrollments or plan changes made during the Annual Coordinated Election Period (ACEP) – between October 15 and December 7, 2018 – will be have an effective date of January 1, 2019. In the past, enrollments late in the ACEP were not guaranteed to actually work at the pharmacy on January 1, due to the lag time for processing the enrollment. This is one reason why the ACEP was moved up to conclude on December 7. Now, any enrollment or change during the ACEP should be fully effective on January 1.

Enrollments during the IEP, ADP, or a SEP will have different effective dates, depending upon the enrollment period used.

### **Automatic deduction of the premium**

A plan may offer to deduct automatically a member's premium from his Social Security check each month. This is similar to the way in which many people have their Part B premiums deducted.

This seems convenient for people who don't want another monthly bill; however, due to the many problems with this feature in 2006 and 2007, CMS has recommended that people not activate the deduction from their Social Security checks.

**Best option:** Your client can set up an auto-debit from his checking account or an automatic monthly charge to his credit card.

Alternately, the client can opt to receive a book of premium coupons, which the client must send in each month along with a check for the premium.

## **Late Enrollment Penalty (LEP)**

### **What is the Late Enrollment Penalty?**

Although the Part D prescription drug benefit is "voluntary," there is a penalty for not enrolling in it as soon as you're eligible. A Part D-eligible person is subject to the penalty when she waits more than 63 days after losing creditable coverage to enroll in Part D. (This includes those who were eligible for Part D by May 2006 and didn't sign up, even though they didn't have any creditable coverage to lose.) The penalty is added to the person's Part D monthly premium for as long as the person stays on Part D.<sup>101</sup> There are some exceptions.

### **Creditable Coverage**

There is NO penalty for delay (up to 63 days) as long as the beneficiary has drug coverage that is "creditable."<sup>102</sup> This is drug coverage that is as good as or better than the standard basic Part D benefit. The only way to know whether drug coverage is creditable is to get a written notice from the insurer; it's not up to the beneficiary to decide whether their coverage is as good as Medicare's.

**NOTICE** – Employers, unions, Medigap and other health insurers are required to send notices to their members (employees, retirees, etc.) each Fall as to whether or not their coverage is considered "creditable" by Medicare.<sup>103</sup>

Beneficiaries should be urged to request these notices if they don't have them, and to keep them in a safe place.

Once you lose "creditable coverage," you have 63 days to sign up for Part D.<sup>104</sup> If you do this, there will be no penalty when you do join.

### *Examples of creditable coverage*

- VA coverage and Tricare (military) coverage **is** creditable.
- EPIC used to be creditable coverage, but is not any longer as of January 1, 2012.<sup>105</sup> Anyone who has delayed enrollment in Part D due to EPIC must now select a Part D plan or be subject to a LEP. See more about EPIC at p. 59. However, the LEP will not be charged if they were enrolled in EPIC from 2006-2011, only beginning 2012.

### *Examples of non-creditable coverage*

- ADAP, unfortunately, does not count as "creditable" coverage.
- Medigap policies H, I, and J, which cover some prescription drug costs, are not creditable. Some old Medigap policies bought before 1992 may be creditable. Those with Medigap plans that cover drugs may keep these plans – they will not expire. The LEP only applies if they choose to leave the Medigap plan and join Part D, which they may reasonably decide never to do. See more on Medigap at p. 61.
- Employer, retiree, union, and other health insurance **may or may not be creditable**. It has to be pretty bad to NOT be as good as Part D!
  - WARNING ABOUT RETIREE BENEFITS: Retirees who receive notice that their retiree coverage is creditable do not have to join a Part D plan to avoid a penalty. But what if they join one anyway – perhaps they are confused, or fall prey to aggressive marketing? They risk losing their entire retirement health package, not just their drug coverage.<sup>106</sup>
  - People should NOT sign up for Part D if they or their spouse has "creditable" retiree coverage without verifying that the retiree plan will not cut off their or their dependent's health coverage.

## **How much is the penalty?**

The beneficiary's monthly premium is increased by 1% of the current year's "base beneficiary premium" per month of delay.<sup>107</sup> The base beneficiary premium for 2019 will be \$39.33.<sup>108</sup> The beneficiary will have to pay this penalty for as long as he's enrolled in Part D. The amount of the premium changes each year based upon changes in the base beneficiary premium.

## Extra Help wipes out the penalty

If a beneficiary has Full or Partial Extra Help, there is NO LEP. If someone with a LEP gets Extra Help, their LEP will be wiped out permanently, even if they subsequently lose Extra Help.<sup>109</sup>

## Automatic Enrollment – Changes in 2019

There are three instances that allow for automatic enrollment. One is for Medicare beneficiaries newly approved for Extra Help. One is for Medicare recipients who were just approved for Medicare. The third is for enrollees in a Dual Special Needs Plan that closes.

In all three situations, these individuals have access to the new passive enrollment Special Enrollment Period (SEP), which allows three months to change plans or move to Original Medicare after passive enrollment. They also may use the Extra Help SEP – changed in 2019 to allow someone with Extra Help to change plans once per quarter in the first three calendar quarters.

### *1. Medicare beneficiaries newly approved for Extra Help are automatically enrolled into a Part D plan.*

**Medicaid** – Once somebody becomes a dual eligible, she will be required to join a Part D plan as a condition of Medicaid eligibility. If she does not select a plan by a certain date, then CMS will automatically assign her to a basic Part D plan.

**MSP, Full or Partial Extra Help** – Those with Extra Help but who are not on Medicaid will also be automatically enrolled in a Part D plan if they have not selected one on their own.

This automatic assignment is RANDOM to a “benchmark” plan, of which there are eight plans in 2019 (list on <http://www.wnylc.com/health/entry/221/>). The assignment takes no account of the individual’s actual needs - whether the plan covers their medications or includes their local pharmacies.

The only Extra Help beneficiaries *not* assigned randomly are those already enrolled in Medicare Advantage (MA). They will be assigned to the Medicare Advantage plan’s drug plan (MA-PD).

### *2. Medicaid recipients newly enrolled in Medicare – new 2019*

For new Medicare beneficiaries who were previously on Medicaid and enrolled in Medicare managed care plans -- when they become eligible for Medicare, they are disenrolled from their Medicaid managed care plan. Until

now, they were informed of the option of joining a Medicare Advantage or Medicaid Advantage plan, but if they did not opt to do so, they were enrolled in Original Medicare. Under 2018 regulatory changes, CMS now allows the State to auto-enroll them into the Medicare Advantage Dual-Special Needs Plan (Dual-SNP) affiliated with their old Medicaid managed care plan. The member would receive 60-day notice before enrollment, explaining the cost differences when compared to their old Medicaid managed care plan, and explaining the right to opt out and join different plan or Original Medicare.

The Medicare Advantage SNP must be a 3-star plan or too new for star ratings. 42 CFR § 422.66(c)(2)(amended July 2018). They can use the Extra Help SEP to change plans once a quarter.

### 3. Dual-SNP Plan Closes – Auto-Enrolled into another Plan

When an integrated Dual SNP plan closes, new regulations in 2018 allow the members to be auto-assigned into another integrated D-SNP. The beneficiary should receive notice with the right to opt out and switch to a different plan or to Original Medicare. 42 CFR 422.60 (g)(1). Members may only be auto-assigned to a plan with a substantially similar provider and facility network and with similar Medicare and Medicaid covered benefits.

## Reassignment

Every year, there are some plans that leave the Part D program, and others that increase their monthly premiums. So what happens if your client's plan is going out of business in 2019? And if they are currently paying no premium for Part D because they have Full Extra Help, will they have to start paying a premium in 2019 if the plan's premium increases?

To address this situation, CMS will reassign **two categories of people** into new plans for the next year.<sup>110</sup>

**Whom will CMS reassign?**

*In New York, no one will be reassigned for 2019 for the reasons below – none of the “benchmark” plans are changing.*

### Plan Moves Above Benchmark

CMS will send a blue notice in late October 2018 to individuals:

- Who **had Full Extra Help in 2018;**
- Who **continue to be eligible for Full Extra Help** in 2019;
- Who **were auto-enrolled into their 2018 plan by CMS;**
- Who **did not affirmatively choose or switch** their plan; **AND**
- Whose 2018 plan will either:

- Go above benchmark in 2019;<sup>111</sup> or
- Change from a standard to an enhanced plan in 2019.

The blue notice informs the individuals of the 2018 below-benchmark plan to which they have been reassigned. If they do nothing, recipients of this letter will automatically be reassigned to the plan selected by CMS. They may also choose to stay in their 2018 plan and pay any portion of the premium not covered by the low-income subsidy. They may also choose any other plan, and the notice includes a list of below-benchmark plans.

### *De Minimis*

There are some plans whose 2019 premium is no more than \$2.00/mo. above the benchmark amount.<sup>112</sup> Ordinarily, those plans would be required to relinquish their Extra Help members through the reassignment process. However, in order to reduce the number of beneficiaries who are reassigned each year, CMS has allowed plans to voluntarily waive the increased premium amount for members with Extra Help. Thus, members of *de minimis* plans will not be reassigned. In addition, anyone with Full Extra Help can choose to enroll in a *de minimis* plan and will have the extra premium amount waived. However, CMS will not auto-assign new Extra Help beneficiaries into *de minimis* plans.<sup>113</sup>

### **Plan Terminates**

CMS will send a different blue notice in November 2018 to individuals:

- Who **had Full or Partial Extra Help in 2018**;
- Who **continue to be eligible for Full or Partial Extra Help** in 2019;
- Whose 2018 **PDP or MA-PD plan is terminating coverage** in their area in 2019.

These individuals will be reassigned whether CMS auto-enrolled them or they chose the plan themselves. They will have a choice of either allowing CMS to reassign them to the plan identified in the notice, or enrolling in a different plan. The notice includes a list of below-benchmark plans.

Those who were in MA-PD plans that terminate in 2019 will be reassigned to Original Medicare plus a PDP.<sup>114</sup>

Those who satisfy either of the above criteria will be reassigned as follows:

- If the same company that offered their 2018 plan has a Basic plan in 2019 that is below benchmark (or *de minimis*), the company will reassign them to that plan. If the company has more than one such plan in 2019, it will randomly choose one.
- If the company that offered their 2018 plan does **not** have a Basic plan in 2019 with a premium below benchmark, then CMS will randomly assign

*de minimis*, *adj.* [Latin “of the least”] 1. Trifling; minimal. As in, “*de minimis non curat lex*” – “the law does not concern itself with trifles.”

**How will CMS reassign them?**

them to such a plan available in their region offered by a different company.

By way of example, note that **CMS will not reassign the following people:**

- Someone whose plan terminates in 2019, but who does not have Extra Help;
- Someone whose plan increases its premium in 2019, but who has Partial Extra Help, or who loses Full Extra Help, or who never had Extra Help;
- Someone with Full Extra Help whose plan increases its premium in 2019, but who selected their own plan instead of being auto-assigned;
- Someone whose Medicare Advantage plan increases its premium in 2019;
- Someone who was auto-enrolled in their 2018 plan **by EPIC.**

**Whom will not be reassigned by CMS?**

Beneficiaries who are subject to CMS reassignment will also receive a second blue notice in December listing which of their drugs will not be covered by the 2019 plan to which they will be reassigned.<sup>115</sup>

No New Yorkers with Extra Help will be reassigned by CMS in 2019. This means that we have to check whether their plans will work for them in 2019. Although beneficiaries should have received an Annual Notice of Change from their plans this fall, most folks won't read them. As a result, their first notice that their plan's premium has increased will be when they get a bill in January, when it will be too late to change. For a summary of changes in benchmark plans from 2018 to 2019, see our list at <http://www.wnyc.com/health/entry/221/>



# Coordinating with Other Coverage

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## Medicaid

### What happened to Medicaid on January 1, 2006?

“Dual eligibles” are people who receive both Medicare and Medicaid benefits. There are about 600,000 dual eligibles in New York State. Before January 1, 2006, their drugs were provided by Medicaid, just like for other Medicaid recipients.

Since January 1, 2006, dual eligibles no longer have drug coverage under Medicaid. Instead, they were auto-enrolled into Prescription Drug Plans under Medicare Part D, which now provide their drug coverage (with some minor exceptions). Medicare has always been the primary payor of hospital and outpatient services for dual eligibles. Now that Medicare has a drug benefit, it becomes primary for drugs, too.

People who have MEDICAID ONLY, with no Medicare, are NOT affected. Medicaid will continue paying for their drugs – mostly through their managed care plans.

Those Medicare beneficiaries who become newly eligible for Medicaid or MSP, or who successfully apply for Extra Help with Social Security, will be automatically randomly assigned to a plan within a few months of their eligibility for those programs.

Everyone else (those without Extra Help) must enroll in a plan directly.

Only those with Medicare - “dual eligibles” are affected. Medicaid will continue to pay for ALL drugs for recipients who do not have Medicare. This includes:

- People under age 65 who are in the first 2 years of receiving Social Security disability, and
- People who have only SSI, not Social Security, if the state has not enrolled them in Medicare – this includes many immigrants

### When does someone become a dual eligible?

A Medicare beneficiary who applies for Medicaid is not officially a “dual eligible” for this purpose until:

- she has been determined eligible for Medicaid AND

Only **dual eligibles** are required to join Part D.

Medicaid beneficiaries *without Medicare* keep their Medicaid drug coverage.

- CMS has coded the person as a “dual” based on data transmitted by the State Dept. of Health AND
- CMS has enrolled the person into a “benchmark” Part D plan and that enrollment is effective.

Until that time, which is around 2 months after the person was accepted as eligible by Medicaid, Medicaid will continue to pay for her prescription drugs.

## Medicaid “wrap around”

### *Excluded Drugs*

Medicaid will continue to pay for drugs “excluded” from the Medicare basic drug benefit (see p. 23) AND for all other medical services as before.

### *Non-Formulary and Utilization Management*

Due to the emergency caused by the initial glitches in Part D implementation, New York State initially allowed pharmacists to bill Medicaid for drugs that *should* have been covered by Part D, but were not. **This wrap is over.**

From January 1, 2007 until October 1, 2011, New York Medicaid continued to pay for **four classes of drugs**, if the plan refused to pay:

- Atypical antipsychotics
- Antidepressants
- Antiretrovirals used in the treatment of HIV/AIDS
- Anti-rejection drugs used in the treatment of tissue and organ transplants

You will notice that these four classes overlap almost completely with the **six classes of clinical concern**, of which all Part D plans must cover “all or substantially all” drugs. See p. 21. As a result, it is very unlikely a dual eligible’s Part D plan will ever deny coverage for one of these four classes, thereby invoking Medicaid’s limited wrap-around.

As of October 1, 2011, Medicaid no longer covers these drugs – it only covers the excluded classes of drugs not covered by Part D at all. See above.

## New York Prescription Saver Card (NYPS)

The **New York Prescription Saver Card (NYPS)** was a free prescription discount card for people who were between ages 50 - 65 so were too young for EPIC. This program ended on June 1, 2015, based on available help through the Affordable Care Act.

### Remember:

Medicaid will generally **not** cover a drug that is not covered by Part D because it is not on the plan’s formulary, or because it is subject to utilization management!

## EPIC

EPIC is a NYS-funded prescription drug program for seniors age 65+. Effective April 1, 2014, income limits increased dramatically - for singles the income limit increased from \$35,000 to \$75,000 a year and for couples from \$50,000 to \$100,000/year, subject to deductibles.<sup>116</sup> There is NO asset test.

### *Eligibility Rules:*

- Must be age 65 or older and a NYS resident.
- Income eligibility threshold: \$75,000/year for singles; \$100,000/year for married couples.
- No asset test.
- Must be enrolled in Medicare Part D –or EPIC will assign you to a plan.

### *Benefits:*

- Wrap-around of Part D covered drugs by further reducing co-payments (after meeting Part D deductible and, if applicable, EPIC deductible)
- Wrap-around of drugs excluded from Part D (if covered by EPIC)
- Wrap-around during the donut hole
- Premium subsidy (in addition to Extra Help) for EPIC members with income below \$23,000 (\$26,000 for couples)
- Additionally, EPIC will help members enroll into the Part D Low Income Subsidy ("Extra Help") and Medicare Savings Programs.

### *Two different programs within EPIC*

The overall income threshold remains the same, but EPIC will have two tiers of coverage (as it used to prior to 2012).

- "Fee" program.
  - Income eligibility threshold: \$20,000 yearly/singles, \$26,000/couples.
  - Members are charged an annual fee on a sliding scale basis. Fee ranges from \$8 to 300 and is waived for full "Extra Help" recipients.
  - [https://www.health.ny.gov/health\\_care/epic/fee\\_schedule.htm](https://www.health.ny.gov/health_care/epic/fee_schedule.htm)
- "Deductible" program:
  - Income eligibility threshold: \$20,001-\$75,000 yearly (single); \$26,001-\$100,000 yearly (couples).
  - No fee charged, but EPIC coverage doesn't kick in until/unless member's out of pocket Part D drug costs meet a specified limit (their "EPIC deductible amount"). The amount of the deductible ranges from \$530 to \$1,715, based on the household income.

- [https://www.health.ny.gov/health\\_care/epic/deductible\\_schedule.htm](https://www.health.ny.gov/health_care/epic/deductible_schedule.htm)

Here are the EPIC member co-pay amounts for both fee and deductible members (before, during and after the coverage gap):

If Member co-pay without EPIC is...	EPIC member pays this amount
Up to \$15	\$3
\$15.01 to \$35	\$7
\$35.01 to \$55	\$15
Over \$55	\$20

Some EPIC members have plans which charge an annual Part D deductible. EPIC cannot cover the cost of the Part D deductible.

EPIC will cover Part D excluded drugs.

And EPIC will continue to help members enroll in Part D Extra Help and the Medicare Savings Program.

EPIC will also continue to provide its premium subsidy for members with annual income at/below \$23,000 year (single)/\$29,000 (couple). The subsidy for 2019 will be up to the benchmark amount, which is \$39.33/mo.

### **Mandatory Part D – No Exceptions (since 2012)**

As of July 1, 2007, all EPIC enrollees – with some exceptions – were required to join Part D. As of January 1, 2012, there are no longer exceptions – to receive EPIC, client must be enrolled in a Part D plan. This will disqualify some immigrants who do not qualify for Medicare, as well as some Medicare beneficiaries who are not enrolled in a Part D plan or an MA-PD plan. Some of them have retiree coverage that they or their dependents would be at risk of losing if they enrolled in Part D. This is no longer an exception to mandatory enrollment. They will be assigned to a plan if not in one.

EPIC is a “**State Pharmaceutical Assistance Program**” or SPAP.<sup>117</sup> This means that costs paid by EPIC, not just the client’s own copayments, will count toward TrOOP. See p. 25. This will help them reach the “catastrophic coverage” limit sooner.

### **EPIC and Extra Help**

For members with **Full Extra Help**, there is no Part D monthly premium. However, there are still some benefits for them from joining EPIC:

1. EPIC will pay for drugs *excluded* from Part D during the doughnut hole/coverage gap;

2. They have the option to enroll in a more expensive enhanced Part D plan, since they can combine the premium subsidy from Extra Help with the premium subsidy from EPIC.
3. For drugs covered by the Medicare drug plan, the copayments with Extra Help are \$3.40 for generics and \$8.50 for brand name. EPIC subsidizes that co-payment, according to the chart on the previous page. With its co-payment wrap, EPIC will reduce the \$8.50 copayments to \$3.00.

For members with Partial Extra Help, EPIC will still pay for their Part D premium in 2019, since they are below \$23,000 single/\$29,000 couple.

EPIC has identifies members who would be eligible for Full and Partial Extra Help on the basis of their income, and asks them to submit information to EPIC about their assets. If they are found to be eligible for Extra Help, EPIC will apply for it on their behalf.

Members are required to provide their asset information, if asked, as a condition of EPIC eligibility. Thus, it is very important that EPIC members send this information, or else they could lose their EPIC.

## EPIC and Medicaid

Generally, a client cannot have both EPIC and Medicaid. However, it is permissible for those with a Medicaid spend-down to join EPIC. This creates a situation where a person might have three different types of drug coverage: Part D, EPIC, and Medicaid.

Here's what the pharmacy should do for these folks:

- First bill the **Part D** plan. If the plan pays, it means that the client is not in the doughnut hole/coverage gap. The Medicaid recipient would be charged the "Extra Help" copayments and EPIC will not pay anything. Since Medicaid recipients have no doughnut hole/coverage gap, this should continue year-round.
- Pharmacy would bill **Medicaid** only for drugs **excluded** from Part D and over-the counter drugs.

## Medigap

Medigap plans are private insurance policies designed to pay some of the coinsurance and deductibles in Medicare Part A and Part B, when provided through "Original Medicare." Medigap plans are not available to those enrolled in a Medicare Advantage plan. See p. 8.

Of the 10 standard plans available before 2006, the 3 most expensive offered limited prescription coverage (Plans H, I, and J). None of these are creditable, because the annual cost limit is \$1500 - \$3000.<sup>118</sup> These 3 plans will no longer be sold, though people who already have them may keep them.

Some Medigap plans offered before 1992 may offer creditable prescription drug coverage. Plans must have informed their members of this before November 15, 2005. If coverage is creditable, they may keep the plan, and not risk being charged a late enrollment penalty later if they join Part D.

The choices for people with the post-1992 plans and pre-1992 non-creditable plans are the same:

- They may keep these plans, but then may *not* also join a PDP. They will face a late enrollment penalty if they enroll in Part D later because the Medigap is not generally “creditable coverage.”
- If they do join a PDP, they will LOSE the drug coverage under the Medigap plan. The Medigap premium will then be reduced to reflect this change.
- They may drop their Medigap plan altogether (or switch to a different one), and join a PDP or enroll in an MA-PD.

For more info on Medigap see <http://www.wnylc.com/health/entry/35/> including links to NYS Medigap premium tables.

## Patient Assistance Programs (PAPs)

Patient Assistance Programs (PAPs) are programs run by private pharmaceutical companies and health care providers that provide low cost or free prescription drugs to needy persons. Some provide drugs furnished by pharmacies, clinics, or hospitals. Some are run by pharmaceutical manufacturers or charities. Some provide prescription drugs to needy persons through a provider, others offer cash assistance directly to consumers.

CMS has-stated that the new law does not prohibit PAPs from providing drug assistance, even to people enrolled in Part D.<sup>119</sup> If a PAP provides free or discounted drugs during the deductible period, or in the coverage gap, the part of the cost of the drugs provided by the PAP may not be counted towards TrOOP. Only if the PAP provides cash assistance for the purchase of the drug, can this count toward TrOOP. See p. 25.

PAPs may be a good solution for helping beneficiaries bridge the coverage gap. To search for which PAPs cover your client's drugs (and whether your client is eligible), visit the following websites:

- **Partnership for Prescription Assistance** – a collaboration of various organizations, including the American Academy of Family Physicians, the American Autoimmune Related Diseases Association, the Lupus Foundation of America, the NAACP, the National Alliance for Hispanic Health and the National Medical Association.  
<https://www.pparx.org>
- **NeedyMeds.com** – a non-profit organization that has a listing of PAPs, as well as other forms of medical assistance.  
<http://needymeds.com>

## Veterans Health Care

For most veterans, the drugs they get through the VA cost less than what they would pay in Part D. The highest VA copay is \$8 per 30-day supply, with no deductible, premium or coverage gap. Some veterans are able to get prescriptions for free, if their income is low enough.

The VA prescription coverage is almost always accessed via mail-order pharmacy. However, the VA generally only covers drugs that are prescribed by VA doctors, and VA doctors can only be seen at VA Medical Centers. As a result, some homebound veterans may have difficulty accessing their VA drug coverage. If you have clients with VA coverage, they may want to consider enrolling in Part D if they want to have prescriptions from non-VA doctors covered.

VA is creditable coverage, so if a veteran wants to delay enrolling in Part D, they will not be subject to a **Late Enrollment Penalty**. See p. 51. However, that does not mean that they can enroll whenever they want! Although there is a Special Enrollment Period for *losing* creditable coverage such as VA (see p. 44), there is no SEP for people who continue to have VA coverage. Therefore, most VA members will only be able to enroll in Part D during the ACEP from Oct. 7th – December 7.



# Appeals

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## Exceptions/Coverage Determinations

If a Part D enrollee disagrees with a decision by their plan (generally, a decision not to cover a prescribed drug), then they may request an exception to that decision. Note that the plan member should receive a notice at the pharmacy counter explaining their right to appeal, but this is usually not provided. Advocates are working on improving notice to the member at the pharmacy counter so that they can exercise their appeal rights.<sup>120</sup>

An **exception** is actually a specific type of **coverage determination**, but you are unlikely to encounter the other types of coverage determination.

An exception may need to be requested when:

- a non-formulary drug is prescribed and medically necessary,<sup>121</sup>
- an enrollee is using a drug that has been removed from their plan's formulary mid-year,<sup>122</sup>
- plan uses various cost utilization tools, such as Prior Authorization, Step Therapy, Quantity Limits, or Generic Substitution (see p. 22)
- enrollee wants to reduce cost-sharing for a formulary drug.
  - But no exceptions allowed from generic co-pay rate if plan has separate copay tier for generics
  - If plan has separate tier for high-cost or unique drugs, those drugs are not eligible for tiering exception.<sup>123</sup>

What must be shown to get an exception:

- To reduce cost-sharing:
  - Physician must assert that lower-tiered drug is less effective or would have adverse effects.
- To get drug not on the formulary or that is being dropped from the formulary:
  - Physician must determine that ALL formulary drugs on ANY tier would not be as effective as non-formulary drug, would have adverse effects, or both.
  - Plans can establish their own standard of proof for what medical or scientific evidence is needed to show that the drug is not safe, including published results of clinical trials!

### **Who can request an exception?**

Enrollee, appointed representative, or prescribing physician<sup>124</sup>

### **How long does plan have to decide?**

For a Coverage determination, the plan must decide in 72 hours or 24 hours if the request is expedited and justification exists.

For a Redetermination by plan – the deadline is 7 days/ 72 hours expedited.

## **Appeal Process**

If drug plan denies request for exception, there are five additional levels of appeal.

For more extensive information on the Medicare Part D Exceptions and Appeals process, see Medicare Rights Center's Medicare Interactive section on Part D appeals, available at

<https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/part-d-appeals/introduction-to-part-d-appeals>.

See this article about Medicare Advantage appeals.

<https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/medicare-advantage-appeals>

# Endnotes

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<sup>1</sup> 42 C.F.R. § 423.30(a)(1)(i) and (ii)

<sup>2</sup> The Medicare Part B premium has fluctuated for some lower income beneficiaries since 2009. The “hold harmless” provision of the Social Security Act ensures that your Social Security check will not be reduced in the new year. If the increase in the Medicare Part B premium is greater than your cost of living (COLA) increase, your Part B premium will be less than the regular amount of \$134. See 42 U.S.C. §1395r(f). If the Part B premium is increased in 2019, you will be “held harmless” from the full increase if:

1. You are entitled to Social Security benefits for November and December of the current year (2018);
2. The Part B premium will be or was deducted from your Social Security benefits in November 2018 through January 2019;
3. You are not high income - you don’t pay higher Part B premiums because of Income-Related Monthly Adjustment Amount (IRMAA) eligibility;
4. And, you do not receive a COLA large enough to cover the increased premium. The COLA in 2018 was 2% of your Social Security benefit.

See examples of how this works at <https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/original-medicare-costs/increases-in-part-b-premiums-and-the-hold-harmless-provision>. People in the MSP program don’t have to pay the Part B premium anyway, so they are not held harmless.

<sup>3</sup> See NYS lists at <http://www.wnyc.com/health/entry/221/>, which are excerpted from national list available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/>.

<sup>4</sup> Id.

<sup>5</sup> CMS, <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans> (10-1-18)

<sup>6</sup> CMS, Medicare Private Fee-For-Service Plans, <https://www.cms.gov/Medicare/Health-Plans/PrivateFeeForServicePlans/index.html> (last modified 2016)

<sup>7</sup> See more at <https://www.medicareinteractive.org/get-answers/types-of-medicare-advantage-coverage/medicare-private-fee-for-service-pffs-plans/pffs-basics>.

<sup>8</sup> 42 CFR §422.100(f)(4) and (5) and §422.101(d)(2) and (3). The annual limits are set in the annual Call Letter. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>. Plans using a Voluntary MOOP limit have greater flexibility for individual service category cost sharing.

<sup>9</sup> 42 C.F.R. § 423.104(f)(2).

- <sup>10</sup> 42 C.F.R. § 423.104(f)(1).
- <sup>11</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148.
- <sup>12</sup> CMS, Medicare Coverage Gap Discount Program beginning in 2011, available at [http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount\\_043010v2.pdf](http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010v2.pdf) (April 30, 2010).
- <sup>13</sup> CMS, Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections, 20.5, available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html> (click on Ch. 5) (Sept. 20, 2018)
- <sup>14</sup> 42 C.F.R. § 423.120 (b)(2)(i); United States Pharmacopeial Convention, Inc., Medicare Model Guidelines Version 6.0, at <http://www.usp.org/health-quality-safety/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40> (accessed 10/1/18).
- <sup>15</sup> CMS, Prescription Drug Benefit Manual, Chapter 6: Part D Drugs and Formulary Requirements, 30.2.5, available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100\\_18.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf) (rev. Jan. 15, 2016).
- <sup>16</sup> Plans may exclude drugs from these six classes of clinical concern under the following circumstances:
- “multi-source brands of the identical molecular structure;
  - extended release products when the immediate-release product is included;
  - products that have the same active ingredient or moiety; and
  - dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals)”
- See note 17.
- <sup>17</sup> See note 17.
- <sup>18</sup> 42 C.F.R. § 423.153(b)
- <sup>19</sup> CMS, Prescription Drug Benefit Manual, Chapter 7: Medication Therapy Management and Quality Improvement Program, 60.4 & 60.5, at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100\\_18.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf) (Feb. 19, 2010).
- <sup>20</sup> CMS, Prescription Drug Benefit Manual, Chapter 6: Formulary, 30.3.3.3. See note 17.
- <sup>21</sup> 42 C.F.R. § 423.120(b)(5); CMS, Prescription Drug Benefit Manual, Chapter 6: Formulary, 30.3.4.1, see n 17.
- <sup>22</sup> See definition of “Part D Drug” at 42 C.F.R. § 423.100
- <sup>23</sup> 42 C.F.R. § 423.104(f)(1)(ii)(A)
- <sup>24</sup> Id. at 20.1. See note 15. See also 42 C.F.R. § 423.100; MMA 1860-2(e)(2) and 1927(d)(2); 42 U.S.C. § 1395w-102(e)(2)(A).

For a list of excluded drugs with additional comments, see CMS, CMS Prescription Drug Benefit Manual, Chapter 6: Formulary, 20.1 – 20.4. See note 17.

- <sup>25</sup> Id. at 20.2. See note 17. For more information on Part B versus Part D coverage issues, see <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf> (See Appendix C - Part B Drugs and Part Coverage Chart) <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/bvsvsdcoverageissues.pdf> (last accessed 10/1/18)
- <sup>26</sup> Id. at 10.6. See note 17. Note that beginning in 2009, Congress amended Medicare regulations through the 2008 Medicare Improvements for Patients and Providers Act, expanding Part D coverage to off-label uses of anti-cancer drugs,, if supported by compendia other than the three usually accepted by Medicare, and/or peer-reviewed medical literature. In addition, the decision in the Layzer v. Leavitt, 770 F. Supp. 2d 579 (S.D.N.Y. 201), addressing an off-label use for a symptom of muscular dystrophy, not cancer, removes the off-label restriction for Medicare beneficiaries living in the Southern District of New York (Manhattan, Bronx, Westchester, Putnam, Rockland, Orange, Dutchess, and Sullivan counties). Also see Tangney v. Burwell, 2016 WL 2732157 (D. Mass., May 10, 2016) (federal district court reversing Medicare Appeals Council denial of off-label use for Dronabinol to control nausea for beneficiary receiving palliative care, rejects narrow interpretation of Compendia), available at <https://docs.justia.com/cases/federal/district-courts/massachusetts/madce/1:2014cv14149/165455/23> ; see analysis in <http://www.medicareadvocacy.org/federal-court-issues-favorable-off-label-part-d-drug-coverage-decision/>
- <sup>27</sup> Pub.L.111-148, the *Patient Protection and Affordable Care Act of 2010* (PPACA) Section 2502.
- <sup>28</sup> CMS, Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections, 30. See note 3.
- <sup>29</sup> 42 U.S.C. § 1395w-102(b)(4)(C). (This is a change – ADAP payments originally did not count toward Troop.
- <sup>30</sup> Id.
- <sup>31</sup> 42 C.F.R. § 423.120
- <sup>32</sup> 42 C.F.R. § 423.120(a)(10)
- <sup>33</sup> 42 C.F.R. § 423.120(a)(5); CMS, Long-Term Care (LTC) Convenient Access Standard Statement, at <http://www.hcca-info.org/Portals/0/PDFs/Resources/library/Long%20Term%20Care%20Convenient%20Access%20Standard%20Statement.pdf> (November 8, 2005); CMS, Long Term Care Guidance, at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/LTCGuidance.pdf> (March 16, 2005).
- <sup>34</sup> 42 C.F.R. § 423.120(a)(9)

- <sup>35</sup> 42 C.F.R. § 423.773(c); 20 C.F.R. § 418.3105
- <sup>36</sup> 42 C.F.R. § 423.773(c)(2)
- <sup>37</sup> 42 C.F.R. § 423.773(c)(1)
- <sup>38</sup> 42 C.F.R. § 423.773(c)(1)(ii). In New York, all those who qualify for SSI will also qualify for Medicaid, and thus qualify for “full extra help.” This provision is just for those states with more restrictive eligibility criteria for Medicaid.
- <sup>39</sup> 42 C.F.R. § 423.772(d); 42 C.F.R. § 423.773(c)(1)(i)
- <sup>40</sup> 42 C.F.R. § 423.773(c)(i)(iii); SSA POMS SI § 01715.005A.5, at <http://policy.ssa.gov/poms.nsf/lnx/0501715005> (rev. 11/23/2011, last accessed 10/1/18). See New York State Dep’t of Health website at <http://tinyurl.com/W393P>. (as of 10/1/18 not updated; for current limits – see <http://www.wnylc.com/health/entry/99/>)
- <sup>41</sup> 42 C.F.R. § 423.773(c)(i)(iii); SSA POMS SI § 01715.005A.6, see n 45.
- <sup>42</sup> 42 C.F.R. § 423.773(c)(i)(iii); see n 45.
- <sup>43</sup> See note 2.
- <sup>44</sup> See note 42.
- <sup>45</sup> NYS Dep’t of Health, Form DOH-4238, available at <http://www.health.ny.gov/forms/doh-4328.pdf> (Aug. 2017).
- <sup>46</sup> SSA POMS § HI 030 –Table of Contents for Extra Help eligibility and procedures, <https://secure.ssa.gov/apps10/poms.nsf/subchapterlist.openview&restrictcategory=06030> (10/1/18)
- <sup>47</sup> POMS § HI 03001.010 (rev. Feb. 3, 2016), <http://policy.ssa.gov/poms.nsf/lnx/0603010010>
- <sup>48</sup> POMS § HI 03001.010D (rev. Feb. 3, 2016), <http://policy.ssa.gov/poms.nsf/lnx/0603010010>
- <sup>49</sup> SSA POMS § HI 03020.055 (January 25, 2008)
- <sup>50</sup> <http://www.ssa.gov/i1020/>
- <sup>51</sup> You must contact SSA at 1-800-772-1213 to request a paper Extra Help application. You must mail this application to: Social Security Administration / Wilkes-Barre Data Operations Center / P.O. Box 1020 / Wilkes-Barre, PA 18767-9910.
- <sup>52</sup> Pub. Law 110-275.
- <sup>53</sup> 42 C.F.R. § 423.773(b)(1); SSA POMS § HI 03001.020, at <http://policy.ssa.gov/poms.nsf/links/0603001020> (2/7/2018).
- <sup>54</sup> 42 C.F.R. § 423.773(b)(2); SSA POMS § HI 03030.025 (Resource Limits), at <http://policy.ssa.gov/poms.nsf/links/0603030025> (12/20/2017).
- <sup>55</sup> See note 53.
- <sup>56</sup> See note 54.

- 57 POMS HI 03001.005 Medicare Part D Extra Help, <http://policy.ssa.gov/poms.nsf/lnx/0603001005> (12/15/17)
- 58 42 C.F.R. § 423.773(d); SSA POMS § HI 03001.020, at <http://policy.ssa.gov/poms.nsf/links/0603001020> (rev 2/7/18).
- 59 42 C.F.R. § 423.773(d)(2); SSA POMS § HI 03030.025, at <http://policy.ssa.gov/poms.nsf/links/0603030025> (rev/ Dec. 20, 2017)).
- 60 See note 53.
- 61 See note 54.
- 62 Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 113. See also Center for Medicare Advocacy, Important New Medicare Law Provisions: a Beneficiary's Perspective (Part 2), available at [http://www.medicareadvocacy.org/Reform\\_08\\_08.14.MIPPAKeyProvisions2.htm](http://www.medicareadvocacy.org/Reform_08_08.14.MIPPAKeyProvisions2.htm) (September 29, 2009).
- 63 Applicants can opt out by checking the box at question 15 on page 5 of the Extra Help application. See copy with instructions at <https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf>.
- 64 42 C.F.R. § 423.780(a)
- 65 See note 3.
- 66 42 C.F.R. § 423.780(b); Federal Register, Vol. 70, No. 18, pgs. 4384-4385
- 67 42 C.F.R. § 423.780(d)
- 68 42 C.F.R. § 423.782(a)(1)
- 69 42 C.F.R. § 423.782(b)(1); CMS, Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, available at <https://www.cms.gov/medicare/health-plans/medicareadvtspecratestats/downloads/announcement2016.pdf> (April 6, 2015).
- 70 42 C.F.R. § 423.782(a)(2)
- 71 42 C.F.R. § 423.782(a)(2)(ii)
- 72 42 C.F.R. §§ 423.782(a)(2)(iii)(A)-(B), 423.782(b)(2)
- 73 42 C.F.R. § 423.782(a)(2)(iii)(B)
- 74 42 C.F.R. § 423.782(a)(3)
- 75 CMS, Prescription Drug Benefit Manual, Chapter 5: Benefits and Beneficiary Protections, 30.4. See note 133.
- 76 42 C.F.R. § 423.782(b)(3)
- 77 CMS, Loss of Deemed (Extra Help) Status Letter, Publication No. 11198, at <http://www.cms.hhs.gov/LimitedIncomeandResources/downloads/11198.pdf> (August 2009).

- <sup>78</sup> 20 CFR § 418.3125(b); SSA POMS § HI 03050.011, at <http://policy.ssa.gov/poms.nsf/lnx/0603050011> (September 9, 2008).
- <sup>79</sup> 20 CFR § 418.3120(b)
- <sup>80</sup> 20 CFR § 418.3123(a), (b)
- <sup>81</sup> 20 CFR § 418.3123(c), (d)
- <sup>82</sup> SSA POMS § HI 03050.005B.1 (February 27, 2006)
- <sup>83</sup> 20 CFR § 418.3120(b)(2); SSA POMS § HI 03050.005B.2 (February 27, 2006)
- <sup>84</sup> 20 CFR § 418.3510
- <sup>85</sup> 20 CFR § 418.3515
- <sup>86</sup> (1) Kate is a dual eligible. She is auto-enrolled in the “full” extra help. It does not matter how much her spend down is, since she meets it with home care.
- (2) Henry is in the Medicare Savings Program so is deemed eligible for the “full” extra help and does not have to apply.
- (3) Natalie and Jack -- Since their income is well over 150% FPL for a couple, they will not qualify for extra help.
- (4) Ralph’s monthly income (\$1,250/mo.) is between 135% and 140% FPL, which makes him income-eligible for Partial Extra Help. His assets are below the asset limit of \$12,510. Thus, he is eligible for Partial Extra Help (with a 75% premium subsidy), and must apply to SSA.
- <sup>87</sup> 42 C.F.R. §§ 423.38(a)(3), 407.14; CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 20.1, at [https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY\\_2019\\_PDP\\_Enrollment\\_and\\_Disenrollment\\_Guidance.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY_2019_PDP_Enrollment_and_Disenrollment_Guidance.pdf) (rev. 7/31/2018); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.2, at [https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY\\_2019\\_MA\\_Enrollment\\_and\\_Disenrollment\\_Guidance.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf) (rev. July 31, 2018).
- <sup>88</sup> 42 C.F.R. § 423.38(b)(2); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 20.1 (see note 8888); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.1 (see note 88).
- <sup>89</sup> For Medicare Advantage plans, it is called a “Special Election Period,” and the same criteria apply. 42 C.F.R. § 422.62(b); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4 (see note 88).
- <sup>90</sup> 42 C.F.R. § 423.38(c)(1); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 20.3.5 (see note 88); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4(9) (see note 88).

- <sup>91</sup> 42 C.F.R. §§ 423.38(c)(4), (c)(8)(ii); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.2, 30.3.8(7) (see note 88); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4(5), 30.4.4(12) (see note 88).
- <sup>92</sup> CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8(15) (see note 87).
- <sup>93</sup> 42 C.F.R. § 423.38(c)(6); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.4 (see note 88); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.3 (see note 88).
- <sup>94</sup> 42 C.F.R. § 423.38(c)(7); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.1 (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.1 (see note 87).
- <sup>95</sup> 42 C.F.R. § 423.38(c)(8)(i); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.3 (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.2 (see note 87).
- <sup>96</sup> 42 C.F.R. § 423.38(c)(8)(ii); CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8 (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4 (see note 87).
- <sup>97</sup> CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8(1) (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4(1) (see note 87).
- <sup>98</sup> CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8(5) (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4(5) (see note 87).
- <sup>99</sup> CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8(9) (see note 87); CMS, Medicare Managed Care Manual, Chapter 2: Medicare Advantage Enrollment and Disenrollment, 30.4.4(11) (see note 87).
- <sup>100</sup> CMS, Prescription Drug Benefit Manual, Chapter 3: Eligibility, Enrollment and Disenrollment, 30.3.8(9), 60.3 (retroactive disenrollment)(see note 87);
- <sup>101</sup> 42 C.F.R. § 423.46
- <sup>102</sup> 42 C.F.R. §§ 423.46(a), 423.56(a)
- <sup>103</sup> 42 CFR 423.56(c), (d), and (f)(3). CMS, Prescription Drug Benefit Manual, Chapter 4: Creditable Coverage Period Determinations/Late Enrollment Penalty, [https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY\\_2018\\_CreditableCovera](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY_2018_CreditableCovera)

[geandLEPGuidance\\_01\\_05\\_18.pdf](#) (effective 4/5/18); see also <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/CreditableCoverageLateEnrollmentPenalty.html>).

<sup>104</sup> 42 CFR 423.46

<sup>105</sup> EPIC, Sample letter to members informing them that EPIC is no longer creditable coverage, available at [http://nyhealth.gov/health\\_care/epic/docs/non\\_creditable\\_coverage\\_20120101.pdf](http://nyhealth.gov/health_care/epic/docs/non_creditable_coverage_20120101.pdf).

<sup>106</sup> CMS, [Qualifying Covered Retirees](#), at [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/20080530-Retiree-Issues-Guidance\\_final.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/20080530-Retiree-Issues-Guidance_final.pdf) (May 30, 2008).

<sup>107</sup> The penalty amount is calculated as “1 percent of the base beneficiary premium (computed under paragraph (c) of this section),” which provides that “[t]he base beneficiary premium for a Part D plan for a month is equal to [a complicated formula].” 42 C.F.R. §§ 423.286(d)(3)(i)(B), 423.286(c)  
 “The premium that would otherwise apply is increased by at least 1% of the base beneficiary premium (which is set by CMS and published each year) for each month without creditable coverage. This penalty may apply for as long as the individual remains enrolled in Part D. The individual’s higher premium charge will be recalculated each year, because the base beneficiary premium changes annually.” CMS, [Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance](#), 4, [http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated\\_Guidance\\_02\\_15\\_07.pdf](http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated_Guidance_02_15_07.pdf), (February 15, 2007).

<sup>108</sup> CMS, Annual Release of Part D National Average Bid Amount and other Part C & D Bid Information, at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2017.pdf> (2017)(2018 info on file with NYLAG EFLRP)

<sup>109</sup> Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. Law 110-275, § 114; Center for Medicare Advocacy, [Important New Medicare Law Provisions: A Beneficiary’s Perspective \(Part 1\)](#), at [http://medicareadvocacy.org/Reform\\_08\\_08.07.MIPPAKeyProvisions.htm](http://medicareadvocacy.org/Reform_08_08.07.MIPPAKeyProvisions.htm) (August 7, 2008).

<sup>110</sup> CMS, <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Reassignment>. CMS, Tip Sheet: Reassignment, Pub. No. 11221-P, available at <http://www.cms.gov/partnerships/downloads/11221-P.pdf> (updated 2015).

<sup>111</sup> See note 69

<sup>112</sup> See note 112.

<sup>113</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3303; CMS, [Announcement of Calendar Year \(CY\) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call](#)

- Letter, available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf> (April 2, 2018)
- <sup>114</sup> CMS, Reassignment <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Reassignment.html> (Feb. 4, 2015).
- <sup>115</sup> CMS, Guide to LIS Beneficiary Mailings from CMS, Social Security and Plans, available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf> (2018-19).
- <sup>116</sup> New York State Dep't of Health, Elderly Pharmaceutical Insurance Coverage (EPIC) Program, at <http://www.health.state.ny.us/nysdoh/epic/faq.htm> (August 2015).
- <sup>117</sup> A State Pharmaceutical Assistance Program (SPAP) is a state program that does not receive any federal funding that provides or supplements prescription drug coverage or benefits on behalf of financially or medically needy individuals. Costs paid by a certified SPAP count toward the beneficiary's TrOOP costs, helping them meet the catastrophic coverage threshold. An SPAP may not contract with or steer members to any particular plan. 42 USCA § 1395w-133(b); <http://tinyurl.com/3DBR8B>. EPIC is the only SPAP in New York State.
- <sup>118</sup> See sample notice of non-creditable coverage at <http://tinyurl.com/34UNQI>.
- <sup>119</sup> See <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PAPData.html> (accessed 10/1/18)
- <sup>120</sup> See, e.g., testimony of Medicare Rights Center, April 2015, available at <http://www.medicarerights.org/newsroom/press-releases/4815-2>,
- <sup>121</sup> 42 CFR 423.578(b)
- <sup>122</sup> 42 CFR 423.578(b)(1)(i)
- <sup>123</sup> This rule is not in the statute, it is only in the final regulation
- <sup>124</sup> 42 CFR 423.578(b)(4)