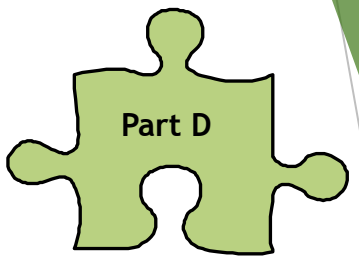
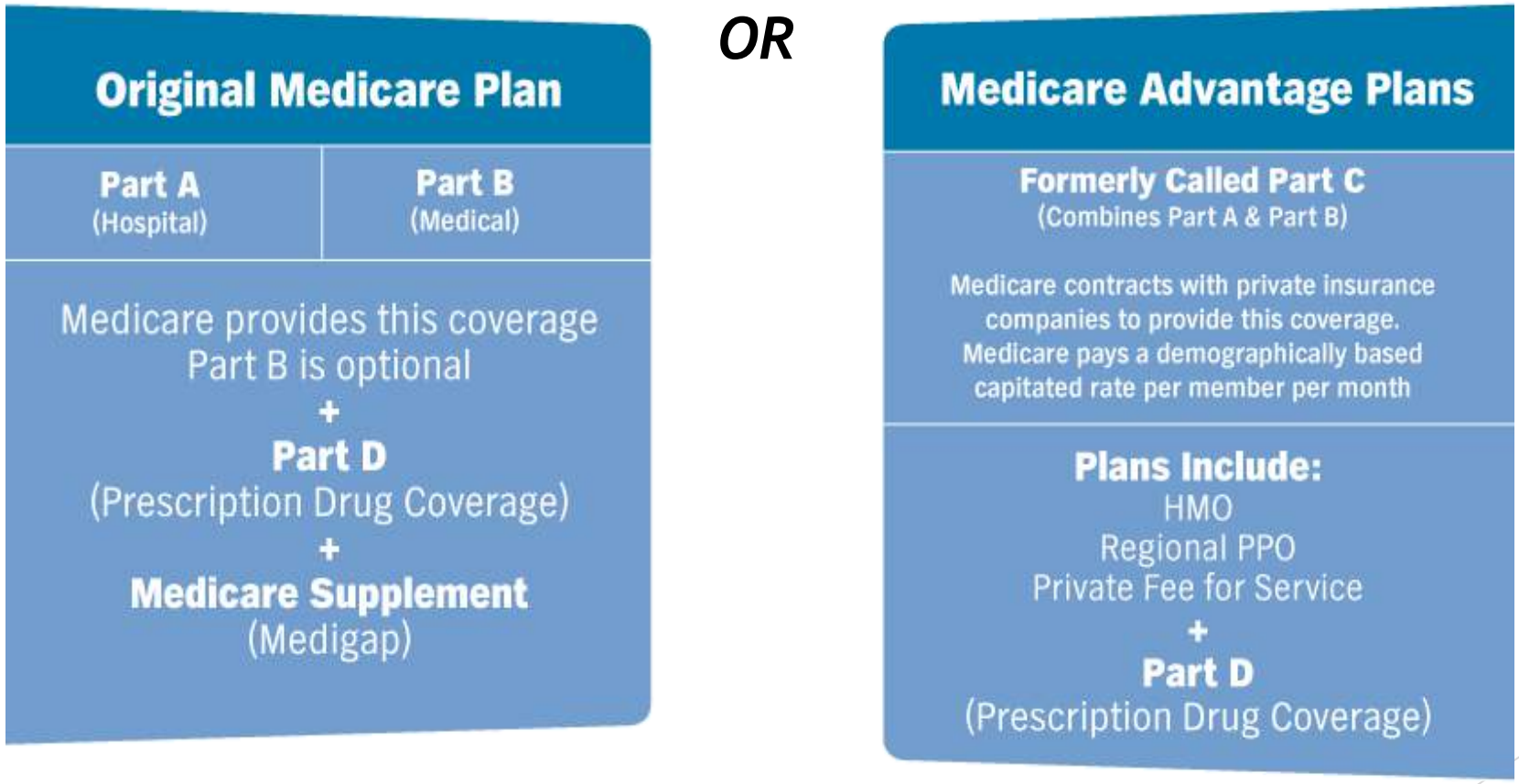
Part D
Prescription Drugs



- The Medicare Modernization Act (MMA) was signed in to law December 2003, establishing the Part D Program.
- First effective date for coverage was January 1, 2006.
- Plans are administered by private companies and like Part C, these companies take financial risk.
- Financial assistance for premiums and cost-sharing amounts is available for low-income and institutionalized individuals.
- Full Benefit Dual Eligibles (individuals eligible for both Medicare and Medicaid) will receive drug benefits under Medicare, NOT state administered Medicaid programs; auto-assigned by CMS to a private plan who offers a Part D premium at or the below the regional benchmark.

Common Medicare Coverage



Medicare Modernization Act

The biggest change to the Medicare program since its inception in 1965:

- Eligible individuals must be entitled to Part A and/or enrolled in Part B
- Part D Enrollment must be within CMS defined time frames:
  - Initial Enrollment Period for Part D is the same as Part B – individuals who are becoming eligible for Medicare have a 7 month period to enroll (3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D)

Like Part B enrollment delays, a penalty will also apply to delays in Part D enrollment (1% of average Part D premium).

Medicare Modernization Act

Enrollment into Part D is **voluntary**.

As long as an individual has “creditable” coverage or signs up for a Part D Plan (PDP) within 63 days of losing creditable coverage, penalties do not apply.*

Creditable coverage is defined as prescription drug coverage that is actuarially equivalent or better than the basic Part D plan.

*States can lengthen the number of days.

Medicare Modernization Act

- **Marketing & Enrollment Time frames**
  - Beginning in 2011, individuals will only be able to enroll and/or disenroll during Initial Coverage Election Period, Annual Election Period, Medicare Advantage Disenrollment Period or any applicable Special Election Period
  - MA plans can begin marketing new plan benefits in October of each year for the following year; enrollment applications cannot be accepted until October 15

Enrollment Period	Timing
Annual Enrollment Period (AEP)	▪ October 15 to December 7 ▪ MA/MAPD plan changes can be made for 1/1 effective date ▪ Drug coverage decision must be made by 12/7
Medicare Advantage Disenrollment Period (MADP)	▪ January 1 to February 14 ▪ Change from MA/MAPD plan back to Original Medicare ▪ Change from MAPD allows change to a standalone Prescription Drug Plan and Original Medicare

Medicare Modernization Act

Plans who wanted to participate in the Part D program were required to offer the "Standard Benefit."

In 2018

Deductible: $405 for the calendar year

Initial Coverage Tier: Once the deductible has been met, plan will pay 75% of drug costs up to $3,750 in total expenditures and individual pays 25%

Coverage Gap: Between $3,750 (Deductible + Initial Coverage Tier) and $5,000 in out of pocket costs (Troop), the individual is responsible for most of the drug costs

Catastrophic Coverage Tier: Once the individual has reached $7,508.75 in total drug costs, plan will pay approximately 95% of drug costs for the rest of that year

Changes in Standard Medicare Benefits

Medicare Part D drug parameters change each year

Medicare Parameter	2018	2017	2016	2015	2006
Deductible	$405	$400	$360	$320	$250
Initial Coverage Limit	$3,750	$3,700	$3,310	$2,960	$2,250
OOP Threshold	$5,000	$4,950	$4,850	$4,700	$3,600
Catastrophic Co-pays	$3.35/8.35	$3.30/$8.25	$2.95/$7.40	$2.65/$6.60	$2.00 / $5.00

Medicare Modernization Act

- True Out of Pocket costs – TrOOP
  - Protection against very high drug costs; in 2018 the threshold is $5,000 in "true" out-of-pocket costs (TrOOP)
  - TrOOP expenses include:
- Annual deductible
- Coinsurance and copayments
- Cost for prescription drugs incurred in the donut hole portion of the standard benefit
- Any payments by CMS on behalf of beneficiaries who qualify for Low Income Assistance (LIA)
  - Only those costs actually paid by the member, family member, other individuals, charities, or State Prescription Assistance Programs count towards TrOOP
- Does not include reimbursements by a third-party (such as a supplemental insurance plan sponsored by a former employer)

Medicare Modernization Act

- Formulary Requirements:
  - Drugs must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication
  - Each formulary is required to meet CMS minimum standards; for example, plans must offer at least two drugs in each therapeutic class
  - CMS requirements aim to prevent discrimination against certain groups of people
  - Excluded drugs: prescribed for anorexia, weight loss, fertility, cosmetic purposes, vitamins, symptom relief from colds, drugs covered under Part B, all non-prescription drugs