

Medicare Part D: What to look for in 2008

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A CMS perspective...

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2008 will mark the third year that prescription drug coverage is available through the Medicare program. While the Part D program has been challenging for some providers, it's been a success for both beneficiaries and taxpayers. In 2007, more than 90 percent of people with Medicare signed up for Part D or had creditable coverage, and a recent survey found that 85 percent of beneficiaries were happy with the program. The program is good news for taxpayers as well: the 10-year cost of Part D has turned out to be \$200 billion less than original estimates, due primarily to competition among Medicare drug plans and the increased use of generics. The average national monthly premium in 2008 is expected to be \$25 (40 percent lower than the initial estimate), and people with Medicare prescription drug coverage are saving an average of \$1,200 per year.

One reason that Part D costs are lower is that Medicare drug plans are competing for beneficiaries in a very price-sensitive environment. Consumers can visit Medicare's www.medicare.gov website and use the user-friendly "plan compare" web tools to figure out exactly which of the competing Medicare drug plans can supply them with their medications at the lowest price. Because the market is so price-sensitive, plans have had to aggressively control their costs. They've demanded lower prices from drug manufacturers, and created formularies that encourage consumers to use brands that are less expensive to obtain. As a practicing physician, I know just how much of a hassle these formularies have been, but using the free Epocrates software on my PDA has allowed me to adapt my prescribing patterns to fit various plan formularies without too much trouble, thereby avoiding the need to file appeals.

Open enrollment for Medicare Part D occurs every year from November 15 -December 31. All Part D beneficiaries are eligible to join, switch or drop their Medicare drug coverage during this period. Once this open enrollment period ends, most Medicare patients are locked into their current plan until the end of the year. New Medicare beneficiaries who "age in" to the Medicare program will of course be able to join a Part D plan when they become eligible, and people with limited income (those receiving Medicaid or SSI, or who applied and qualified for the Low-Income Subsidy) can change plans any time during the year.

Some of your patients who have limited incomes may still qualify for the Low-Income Subsidy, which can help them pay for Medicare Part D. Patients with annual income of less than \$15,355 (individual) or \$20,535 (family) should call Social Security at 800-772-1213 or visit their website to see if they qualify for this extra help, which covers a significant amount of the cost of the benefit.

This is what you can expect for 2008.

Vaccine Coverage

Until 2006, Medicare Part B was only permitted to pay for four vaccines: pneumococcal vaccine, flu, Hepatitis B for patients at increased risk, and Tetanus when given as a part of the treatment of a traumatic wound. Part D came along in

2005, and most vaccines became Medicare-covered. However, there was no legal basis to pay for the administration of these "Part D" vaccines. On December 20, 2006 the President signed the Tax Relief and Health Care Act, and among its provisions was legal authority for Medicare to pay for the administration of the Part D vaccines. This new benefit will be implemented in stages. This year, physicians have been able to bill their Part B carrier for the administration fee, but next year they'll no longer be able to do so. Beginning in 2008, the cost of administering vaccines covered by Part D will be the responsibility of the Medicare drug plans. Most physicians will probably elect to bill their patients for the vaccine and the administration, and the patient will have to submit a claim to their Part D plan for reimbursement. Network pharmacies operating in states that allow pharmacists to administer vaccines will be able to bill the Part D plan directly if they administer a vaccine to a covered beneficiary. Both the vaccine and the administration fee for the Part B vaccines mentioned above will continue to be covered under Part B and billed to Medicare. More information on vaccine administration and Part D can be found [here](#)

For patients who change plans

This table lists the steps we have taken to ensure that patients who change plans continue to get their medications during the transition period. New plans must provide patients with at least a 30-day supply of any medication covered by their previous plan. The new plan must also initiate notification processes to give patients time to either get a new prescription for a comparable drug covered by the new plan, or to file an exception request. You can find a copy of the standardized exception form [here](#)

CMS transition process requirements and expectations in 2008

Enrollees: transition process

CMS requirements, expectations

Non long-term care enrollees who are:

- New enrollees into prescription drug plans on January 1, 2008, following the 2007 annual coordinated election period

- Newly eligible Medicare beneficiaries from other coverage in 2007 into a Part D plan

- Individuals who switch from one Part D plan to another after January 1, 2008

(also applies to re-assignees and an individual moving to a new plan)

Plans must provide a temporary 30-day fill (unless enrollee presents with a prescription written for <30 days when presenting at a pharmacy to request a refill of a non-formulary drug that patient was taking

before enrollment (including Part D drugs that are on a plan's formulary but that require pre-authorization or step therapy under a plan's utilization management rules) within the first 90 days of coverage, under the new plan

New enrollees who are residents of long-term care facilities

Plans must provide a temporary 31-day fill (unless the prescription is written for <31 days) of non-formulary Part D drugs—including Part D drugs that are on a plan's formulary but require pre-authorization or step therapy under a plan's utilization management rules. Also, plans must honor multiple fills of non-formulary Part D drugs (including Part D drugs that are on a plan's formulary but require pre-authorization or step therapy under a plan's utilization management rules) during the first 90 days of their coverage, under the new plan

Enrollees who remain in same plan as in 2007 but experience negative formulary changes in 2008 (eg, taking a drug that was on formulary in 2007 but is not on formulary in 2008, or had an exception granted in 2007 that will not be honored in 2008).

After enrollees receive their Annual Notice of Change on October 31st of a given year, CMS expects plan sponsors to select 1 of the following 2 options for effectuating an appropriate, meaningful transition for enrollees who experience negative formulary changes:

1. Provide a transition process for current enrollees consistent with the transition process required for new enrollees beginning on January 1, 2008.

To prevent coverage gaps, plans choosing this option are expected to provide a temporary supply of the requested prescription drug (where not medically contraindicated), consistent with the 2008 Formulary Transition Guidance, and provide enrollees with notice that they must either switch to a therapeutically appropriate drug on the plan's formulary or get an exception to continue taking the requested drug

2. Effectuate a transition for current enrollees prior to January 1, 2008.

In effectuating this transition, plans must aggressively work to (1) prospectively transition current enrollees to a therapeutically appropriate formulary alternative; and (2) requests for formulary and tiering exceptions to the new formulary had to be completed before January 1, 2008

Enrollees who request an exception, but the plan fails to issue a timely decision on the request by the end of the transition period

CMS expects plans to make arrangements to continue providing requested drugs via a case-by-case extension of the transition period to the extent that the individual's exception request or appeal has not been processed by the end of the minimum transition period

Enrollee who remains in same plan as in 2007 and is using a drug as a result of an exception that was granted in 2007
Plans have the option of "honoring" exceptions granted in 2007 beyond the end of the plan year (ie, a plan may choose to honor an exception for as long as the beneficiary remains in the plan)

If a plan is not going to honor an exception beyond the end of the plan year, it must have notified the enrollee in writing at least 60 days before the end of the 2007 plan year and either (1) offer to process a prospective exception request for the 2008 plan year, or (2) provide the enrollee with a temporary supply of the requested prescription drug (if not medically contraindicated) at the beginning of 2008, and notify the enrollee that he/she must either switch to a therapeutically appropriate drug on the plan's formulary or get an exception to continue taking the requested drug

Enrollee who remains in same

plan as in 2007 and is using a drug with a prior authorization requirement that is expiring

Before the beginning of the new plan year, enrollees may attempt to satisfy the pre-authorization requirement by requesting a coverage determination or by requesting a formulary exception if he/she cannot satisfy the pre-authorization requirement

Current enrollees experiencing a level-of-care change

Enrollees who are outside their transition period may experience circumstances that involve level-of-care changes in which a beneficiary is changing from one treatment setting to another. CMS encourages, but does not require, plans to incorporate processes in their transition plans that allow for transition supplies to be provided to current enrollees with level-of-care changes. Thus, beneficiaries and providers must avail themselves of plan exceptions and appeals processes

Current enrollees entering long-term care settings from other care settings

These enrollees will be provided emergency supplies of nonformulary drugs (including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules). This transition supply is not limited only to initial enrollment

Current enrollees in a long-term care setting requiring an emergency supply of a nonformulary drug

To the extent that an enrollee in a long-term care setting is outside his/her 90-day transition period, the plan must still provide an emergency supply of nonformulary Part D drugs (including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules) while an exception is being processed. These emergency supplies must be for at least 31 days of medication, unless the prescription is written by a prescriber for <31 days

