

CHAPTER 4: MEDICARE

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§ 4.1 Medicare Overview

Medicare is a federally funded health insurance program available to the following individuals without regard to income or resources:

- age 65 and older; or
- receiving SSDI for 24 months; or
- with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant)

The Social Security Administration is the gate keeper of the Medicare program. Medicare questions should be addressed to the recipient’s local Social Security office. You can get information about Medicare at any Social Security Office, by calling **1-800-772-1213**, by calling **1-800-Medicare**, or at **www.medicare.gov**.

§ 4.2 Covered Services - Medicare “Parts”

Original Medicare coverage is broken into several parts, each covering a different type of care:

- **Part A (Hospital Insurance)** pays for *inpatient* hospital care, hospice care, skilled nursing home care, and some home health care.
- **Part B (Medical Insurance)** pays for outpatient services such as doctor visits (primary care physician and specialists), labs, X-rays, outpatient procedures, durable medical equipment, ambulances, physical therapy, screening tests and some home health care.
- **Part D (Prescription Drug)** provides prescription drug coverages through private health insurance companies regulated by Medicare. See § 4.11 for more information about Part D.

Instead of receiving services through Original Medicare, beneficiaries have the option of joining a managed care plan run by a private insurance company. These plans are known as Medicare Advantage plans or **Part C** plans. For more information on these plans, see § 4.9.

Each year, the Center for Medicare and Medicaid Services updates information about covered services in its annual publication, “*Medicare and You.*” Advocates can obtain a copy of this publication by calling Medicare or the Social Security Administration. This publication can also be accessed on Medicare’s website at **www.medicare.gov**.

§ 4.3 Accessing Medicare Services

Medicare recipients can choose to receive their Medicare covered services in two ways:

- **Original Medicare** (Parts A, B, D): For services covered by parts A and B, beneficiaries present their red, white and blue card; for prescription drug coverage, they use their Medicare Part D card (or other creditable coverage).
- **Medicare Advantage Plan** (Part C): Plans issue their own HMO or PPO cards. Medicare Advantage Plans cover hospital and medical insurance

(equivalent to Parts A and B) and almost always include prescription drug coverage (equivalent to Part D).

Medicare beneficiaries are generally not permitted to be in a Medicare Advantage Plan and stand-alone prescription drug plan at the same time. Enrolling in a stand-alone prescription drug Part D plan, while on a Medicare Advantage Plan will cancel the enrollment in the Medicare Advantage Plan and vice-versa.

§ 4.4 Original Medicare Costs

The costs for Original Medicare (Parts A and B) are described below. Beneficiaries who choose to receive Medicare through a Medicare Advantage plan are still responsible for the Part B premium (and the Part A premium if applicable), but other cost-sharing is set by the plan (such as deductibles, copays, and coinsurance). See § 4.11c for Part D (prescription drug coverage) costs. Pennsylvania provides assistance in paying these costs for low-incomes beneficiaries through Medical Assistance and/or the Buy-in Program. See § 4.7 for dual eligibles and § 4.8 for the buy-in program.

Part A (Hospital) Costs

Premium: Most people do not pay a premium for Part A. To qualify for premium-free Part A, a person needs to be eligible for Medicare due to disability or age, and have worked 40 quarters and contributed to Medicare taxes while working. People with fewer than 40 quarters of work may buy Part A coverage by paying premiums as follows in 2020:

- for people who have earned fewer than 30 quarters, the standard Part A premium is \$458
- for people who have earned 30-39 quarters, the standard Part A premium is \$252.

Deductible: Part A has a yearly deductible of \$1,408 in 2020.

Copays/coinsurance: Medicare Part A has copays for stays at hospitals and at skilled nursing facilities. For hospital stays, there are copays of \$0/day for the first 60 days, \$352/day for days 61-90, and \$704/day for days 91-150; for Skilled Nursing Facilities the copays are \$0/day for the first 20 days; \$170.50/day for days 21-100.

For more detailed information, see the Medicare's official yearly handbook *Medicare and You*.

Part B (Medical)

Premium: All Medicare recipients have a monthly premium for Part B. For people with low incomes and few resources, the state pays this premium through the buy-in program (see § 4.8). If the state is not covering the premium, the premium is deducted monthly directly from Social Security, Civil Service retirement, or Railroad Retirement benefits. For people without any of

those cash benefits, premiums are billed directly to the Medicare beneficiary on a quarterly basis.

The Medicare Part B premium for new enrollees and almost all current enrollees in 2020 is **\$144.60** per month. A small number of current enrollees will continue to pay the 2019 amount of \$135.50.

Medicare recipients with higher incomes are required to pay higher part B premiums. This additional premium amount is called the income-related adjustment amount (IRMAA). The IRMAA determination is based on a beneficiary's Modified Adjusted Gross Income (MAGI) as reported to the IRS two (2) years prior. For 2020 premiums, if an individual's MAGI in 2018 was more than \$87,000 (single) or \$174,000 (couple), their 2020 premiums will be higher than the standard Medicare premium. Recipients who have had a life-changing event can ask for a reduction from the higher premium by completing this form: <https://www.ssa.gov/forms/ssa-44-ext.pdf>.

Deductible: Part B has a yearly deductible of \$198 in 2020.

Copays/coinsurance: In general, beneficiaries are responsible for a 20% coinsurance on covered outpatient services. For example, if a doctor charges \$200, the patient is responsible for \$40.

For more information on Medicare costs for 2020 see: <https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance>

§ 4.5 Medicare Eligibility

Generally, the following people are eligible for Medicare:

- People who have received disability benefits from Social Security Disability Insurance (SSDI), Railroad Retirement or Civil Service Retirement systems **for two years;**
- People age 65 or older;
- People suffering from end stage renal disease;

For beneficiaries on SSDI and Railroad Retirement Board Disability benefits, Medicare has a two-year waiting period starting from the first month of payment. Counting the five-month waiting period for SSDI and Railroad Retirement Board Disability, Medicare begins 29 months from the disability onset date. If a person loses Medicare benefits due to an improvement in their health but later becomes disabled, they may be able to skip the 24-month waiting period.

There is no waiting period for Medicare recipients who are age 65 or older, or are suffering from end-stage renal disease.

ACTION NEEDED: Individuals NOT receiving Social Security Disability or Retirement income at 65 need to apply for Medicare coverage when they turn 65, including people with End Stage Renal Disease (ESRD). Case managers should actively help clients apply for Medicare if they are not on Social Security benefits or if they have ESRD. Medicare

applications can be found here: <https://www.ssa.gov/benefits/medicare/>

Applying for Medicare: Clients may apply for Medicare by going to www.SocialSecurity.gov, by calling Social Security at 1-800-772-1213, or by walking into their local Social Security office.

§ 4.6 Transitioning from Other Health Insurance Coverage to Medicare

Transitioning from Medical Assistance Coverage to Medicare MA recipients who received their MA services through an MA Managed Care Organization (MCO; see § 5.10) are disenrolled from their MCO plans when they become eligible for Medicare and are automatically enrolled into a Medicare Part D plan. Clients who are eligible for Medicare and MA have to enroll in a Community HealthChoices MCO plan to receive their MA services (see § 4.7).

Transitioning from Market Place Coverage to Medicare: Individuals who are on Market Place insurance prior to turning 65 will lose their coverage when they turn 65. Individuals are required to enroll in Medicare. Once they receive the Medicare card they will need to determine if they want to receive their Medicare service through Original Medicare or a Medicare Advantage Plan. If they decide to use Original Medicare they will have to enroll in a Part D prescription drug plan. In addition, individuals choosing to receive their Medicare through Original Medicare also need to determine if they want to choose a Medigap plan if they are financially ineligible for MA. See § 4.10.

§ 4.7 Dual Eligibles – Medicare and Medical Assistance

Medicare beneficiaries can also be eligible for Medical Assistance (MA). Beneficiaries must apply for MA through DHS (see §5.6 for the MA Application Process). Medicare is the primary payer and MA is the secondary payer. People with both Medicare and MA are said to be “dual eligible.”

Dual eligible benefits include:

- No out-of-pocket costs for Hospital or Medical care, as MA will pay for services that Medicare does not pay.
- Dual eligibles are automatically enrolled into Social Security’s Full Premium - Low Income Subsidy (“Extra Help” to pay toward drug costs) for the entire year. Any individuals who have MA at any time between January and June, will have Extra Help through the end of that calendar year, even if they lose MA. Any individuals who have MA between July – December will have Extra Help through the end of the following calendar year.

- Ability to change prescription Part D drug plan or Medicare Advantage Plan once per calendar quarter.
- Services Medicare does not cover such as basic dental, vision, incontinence supplies, and over-the counter medicine.
- Payment of Medicare Part B premiums if eligible. See § 4.8. Not everyone who receives MA qualifies to have their Part B premiums covered.

A client becomes a Dual Eligible in two situations:

(i) **Client with MA becomes eligible for Medicare.** For example, a person with MA will become eligible for Medicare after receiving SSDI for 24 months. The person will then receive a Medicare card. Their coverage under their MCO will end and Medicare will become their primary coverage. If they still qualify for MA, they will be assigned to a *Community HealthChoices* MCO plan for secondary coverage. They will also need to sign up for a Part D prescription drug plan.

TIP: Medicare offers a greater choice of health care providers, because many more providers accept it than MA. Case managers must proactively assess clients for MA eligibility, even if they have Medicare coverage so that MA will cover costs not covered by Medicare.

(ii) **Clients with Medicare coverage becomes eligible for MA.** Clients using Original Medicare (the red, white, and blue card) who become eligible for MA will be assigned to a *Community HealthChoices* plan to access their MA coverage. For clients in a Medicare Advantage plan, they will be switched to a Medicare Advantage plan with a special needs program (SNP) and also assigned to a *Community HealthChoices* plan.

Community HealthChoices: In 2018, Pennsylvania implemented Community HealthChoices (CHC) as a new way to deliver MA services for some beneficiaries, including dual eligible. For more information on CHC see § 5.10.

For Medicare beneficiaries, the implementation of CHC does not affect the way they receive their Medicare services. Medicare will continue to be their primary insurance and they can continue to see their primary doctor and/or specialist. Clients' medical providers do not need to be in the CHC plans' network to bill for covered Medicare services. Unfortunately, some doctors have chosen not to accept all CHC plans, patients based on which CHC plan a patient has.

Dual eligibles use their *Medicare card* for primary coverage. In addition, they will use their *CHC MCO card* to access their MA coverage, which will serve

as their secondary insurance and pay for services that Medicare does not cover (for example, the 20% coinsurance for out-patient services). They will use their *Medicare prescription drug card* at the pharmacy.

§ 4.8 Medicare Buy-In Program

‘Buy-In’ is a program in which the Department of Human Services (DHS) pays the Medicare B premium for eligible low-income people. Depending on the beneficiaries’ income, they may also get help with deductibles, copays and coinsurances for Medicare Parts A and B, as well as Part A premiums if any.

Buy-In also is known as the Medicare Savings Program (MSP). Buy-In is a *state* benefit and is administrated by DHS. All questions regarding eligibility and/or discontinuance of this benefit should be addressed to client’s local County Assistance Office.

All Buy-in participants are deemed eligible for SSA’s 100% Low Income Subsidy (a.k.a. Extra Help; see § 4.11e).

Most individuals over 65 receive premium-free Part A based on their own or their spouse's work history. Individuals without a sufficient work history are not entitled to premium-free Medicare Part A. Instead, they must pay the Part A premium, in addition to the Part B premium.

DHS will pay the Part A premium for the following persons.

- (1) Qualified Medicare Beneficiaries (QMBs):** These are persons whose countable income is less than 100 % of the FPIG (**\$1,063** in 2020) using SSI counting rules (see § 2.5a). QMBs may include persons in the Healthy Horizons category and SSI/SSDI concurrent recipients.
- (2) Qualified Disabled Working Individual (QDWI):** To be a QDWI, a person must (i) be under age 65, (ii) be disabled according to the SSA disability requirements, (iii) have family income less than 200 % of the FPIG, (iv) not have resources more than \$4,000 (individual) and \$6,000 (couple), and (v) have exhausted nine months of the Social Security trial work period and the 36-month extended period of eligibility.

DHS will pay the Part B premium for the following:

- (1) Qualified Medicare Beneficiary (QMB)**
- (2) Specified Low Income Medicare Beneficiary (SLMB)**
- (3) Qualified Individual-1 (QI-1)**

Qualified Medicare Beneficiary (QMB): The QMB program has the same income limit (100% of the federal poverty level) as the Healthy Horizons category (see § 5.3c.1) and also uses SSI counting rules. The resource limit for the QMB program is higher than Healthy Horizons category: \$7,730 (individual), and \$11,600 (couples). Clients eligible for the Healthy Horizons category should be encouraged to apply for MA under that category instead of QMB only. Under Healthy Horizons category, DHS pays Part A and B premiums, deductibles, and coinsurance, and client are eligible for full MA coverage, which include dental, vision, and other MA benefits.

Specified Low Income Medicare Beneficiary (SLMB): The SLMB program's income limit is between 100-120 % of the federal poverty level and uses SSI counting rules. DHS pays Medicare Part B monthly premiums for SLMB recipients, but they pay their own Medicare copays and deductibles. SLMB recipients do not get assigned to a CHC MCO unless they are also enrolled in one of DHS's special MA programs, such as MAWD or Waiver. Resource limits are \$7,730 (individual), and \$11,600 (couples).

Qualified Individual 1 (QI-1). The QI-1 program's income limit is between 120- 135 % of the federal poverty level and uses SSI counting rules. In the QI-1 program, DHS pays the Medicare Part B monthly premiums on a first-come, first-served basis. Clients must re-apply each year. Recipients of QI-1 benefit do not get assigned to a CHC MCO. Resource limits are \$7,730 (individual), and \$11,600 (couples).

IMPORTANT: QI-1 participants (unlike SLMB recipients), cannot receive MA coverage from DHS's special programs like MAWD or Waiver. QI-1 eligible clients will need to choose between either having their Part B premium paid for (via the Buy-In program) or having their deductible and copays/coinsurance covered (via MAWD or Waiver). Clients whose income limits are within 120-135% should be assisted with choosing between MA special categories and the QI-1 program. This decision needs to be made on a case-by-case basis depending on the client's situation. For example, if a client rarely sees a doctor, it may be more cost effective to choose QI-1 coverage that pays the monthly part B principle.

DHS does not offer any Medicare Part B premium payment assistance for clients with income greater than 135 % of the federal poverty levels. These clients have to pay the Medicare Part B premiums either from their cash benefits or out-of-pocket. Clients whose income is more than 135% of the FPIG should be encouraged to apply for the MAWD or one of the Waiver programs, if eligible, to pay for deductibles and copays/coinsurance that Medicare does not pay.

VERY IMPORTANT: Clients who try to save money by disenrolling from Part B face serious financial penalties, if they need to re-enroll in Medicare Part B at a later stage. **Clients should strongly be advised against disenrolling from Part B coverage, and instead be referred to an attorney for legal advice.**

Medicare Part B eligible clients who have yet to enroll, but are approved for the Buy-In program, will be enrolled in Medicare Part B beginning the month the Buy-In was approved, without regard to the Part B enrollment period. They will not be subject to a penalty, if any, for late enrollment in Part B. They will be enrolled into Medicare Part B any time of the year and will not have to wait for the annual open enrollment period that runs January – March. The application for the Buy-In can be completed on COMPASS. Buy-in specific paper applications can be found here: <http://services.dpw.state.pa.us/oimpolicymanuals/ma/PA-600-M-AS-08-18.pdf>.

Clients can apply for the Buy-In program at any time, even many years after becoming eligible for Medicare. There is no annual open enrollment period to apply for the Buy-In program. If approved, client’s Part B premium will be paid for by the DHS for the month of application and three (3) retroactive months, if income and resource eligible. If there is any delay in DHS approving or paying for Part B premiums, the client should get a refund from SSA for the months that client was eligible for the Buy-in benefits. DHS will not pay for Medicare premiums which predate the MA application for QMBs. However, DHS will authorize retroactive Buy-In coverage up to three months for SLMBs and QI-1s.

Chart 4-1 contains the income limit for Buy-In programs:

CHART 4-1: Comparison of QMB, SLMB, QI-1 (2020)			
Program	Monthly income – 1 person	Monthly income – 2 persons	Coverage
QMB (<100 % of FPIG)	\$1,063	\$1,436	<ul style="list-style-type: none"> - Medicare Part B premiums paid - Medicare Part A premium paid, if any - Community HealthChoices MCO card for Medicare deductible, coinsurances, copays - Automatic enrollment in SSA’s 100% Low Income Subsidy program (“Extra Help”) -May be eligible for full MA via Healthy Horizons, MAWD, or Waiver (which would add dental and vision coverage via

			CHC MCO)
SLMB (<120 % of FPIG)	\$1,276	\$1,724	<ul style="list-style-type: none"> - Medicare Part B premium paid - Automatic enrollment in SSA's 100% Low Income Subsidy program ("Extra Help") - Can have full MA through Waiver or MAWD (to cover Part A and B cost-sharing)
QI-1 (<135 % of FPIG)	\$1,436	\$1,940	<ul style="list-style-type: none"> - Medicare Part B premiums, on a first-come, first-served basis - Automatic enrollment in SSA's 100% Low Income Subsidy program ("Extra Help") - Must recertify each year - <u>Cannot</u> be on Waiver or MAWD or have full MA

Buy-In Resource Limits: The resource limit for the QMB, SLMB, and QI-1 categories are different than other MA categories. The resource limit for a Buy-In eligible client is **\$7,860** (2020) for an individual and **\$11,800** for a couple.

§ 4.9 Medicare Advantage Plan (Medicare Part C)

Instead of accessing Medicare Part A and B services through the red, white, and blue card, Medicare recipients may choose to join an HMO or PPO plan, known as a Medicare Advantage Plan (formerly called Medicare Part C). Recipients enrolled in a Medicare Advantage Plan access their Medicare coverage using their HMO or PPO card instead of the red, white and blue card. Coverage through the HMO/PPO cards will include inpatient/outpatient services and usually also include prescription drug coverage. Some Medicare Advantage plans have an additional monthly premium above the regular Part B premium. If recipients decide to enroll in a Medicare Advantage Plan with a premium, they can opt to have the Social Security Administration deduct the premium directly from their Social Security check. A person must have Medicare Parts A and B to be enrolled in a Medicare Advantage Plan.

Medicare Advantage plans can alter the cost-sharing rules of Original Medicare. For example, instead of being charged a 20% coinsurance to see a doctor (as under Part B) a Medicare Advantage plan can charge a copay, like \$20. They can also adjust the annual deductible. Medicare Advantage plans can also require referrals.

Clients considering joining a Medicare HMO/PPO should check to see if their preferred health care providers are part of the plan's network. Clients in a

Medicare Advantage plan are limited to the plan's in-network providers, with very few exceptions. Once a client enrolls in a Medicare Advantage plan, the Original Medicare card can no longer be used to pay for services. Clients should save the Medicare card, however, for possible future use.

Although the option of getting all Medicare covered services (including prescription drug coverage) in one card seems attractive, clients should verify that all their health insurance needs are covered before they enroll in a Medicare HMO/PPO and determine if this option is cost effective given clients' health status.

The Special Pharmaceutical Benefits Program (SPBP) has yearly partnerships with Medicare Advantage plans where SPBP will pay the plan's monthly premium (but not the Part B premium) and any prescription drug costs. Picking a Medicare Advantage plan that partners with SPBP could save clients a significant amount of money.

There are special Medicare Advantage Plans called Special Needs Plans (SNP). Some of these plans are for dual eligibles and are called D-SNP (Dual-Special Needs Plan). There are also other Special Needs Plans such as C-SNP (chronic condition) and I-SNP. These plans were created to provide tailored plans for these special populations.

More information on Medicare Advantage plans can be found here: <https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans>

Enrollment Period for Medicare Advantage Plans

Initial Coverage Election Period (ICEP): When an individual is first eligible to enroll in Medicare, they have an initial coverage election period (ICEP). The ICEP is the 7-month period that starts 3 months before an individual is eligible to enroll in Part A and Part B. For most people the month they turn 65 is the month they are eligible for Medicare. For example, if a person turns 65 in June, their ICEP goes from March to September. While a person can elect a plan up to 3 months prior to becoming eligible for Medicare, the plan cannot start until eligibility in Medicare begins. As long as a plan has not reached its member limit, it must accept a person during this period regardless of health conditions.

Annual Election Period (AEP): October 15 – December 7

There is an annual election period when beneficiaries can choose a plan for the following year, with coverage beginning on January 1. During the AEP recipients can choose to (i) stay with the plan that they had for that year, (ii) enroll in another Medicare Advantage Plan, or (iii) disenroll from Medicare Advantage Plan all together. and return back to Original Medicare, using their red white and blue card (in this situation recipients should choose a stand-alone prescription drug plan).

Medicare Advantage Open Enrollment Period (MA-OEP): January 1 – March 31

During this period, people enrolled in a Medicare Advantage Plan can switch to another Medicare Advantage Plan or can drop the Medicare Advantage Plan and return to Original Medicare and use their Medicare card to receive care (in the latter scenario, recipients must choose a stand-alone prescription drug plan). Only people enrolled in a Medicare Advantage plan can make changes during this period. People on Original Medicare cannot enroll in a Medicare Advantage Plan during this period (they must enroll during the annual election period).

After this period, most people on Medicare Advantage plans cannot make changes until the annual election period unless they qualify for a special enrollment period due to changes in their life. A major exception to this rule is that any client who receives some benefit paid by the state (whether full Medical Assistance or just payment of Part B premiums) can switch Medicare Advantage Plans or return to Original Medicare once every calendar quarter. Clients disenrolling from Medicare Advantage plan need to choose a stand-alone prescription plan to access their prescription benefit for the rest of the year.

NOTE on the APPRISE Program: Clients who need assistance enrolling in a Medicare Advantage Plan may be referred to the State Health Insurance Program (SHIP) to seek free counseling on choosing the appropriate plan. In Pennsylvania, SHIP is known as “APPRISE” and services are offered through the county Area Agency on Aging via volunteer counselors. Medicare recipients who need APPRISE counselling and plan comparison should call **1-800-783-7067** to be referred to a counselor in their county. More information on the APPRISE program can be found at <https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx>

ACTION: Clients can also enroll in a Medicare Advantage Plan and/or a Medicare prescription drug plan by visiting **Medicare.gov/find-a-plan**.

§ 4.10 Medicare Supplementary Plans (Medigap)

Medicare Supplementary Plans, also known as Medigap insurance, cover costs Medicare does not. Medigap policies are offered by Medicare-regulated private insurance companies and cover costs such as Medicare Part A and B deductibles and Medicare Part B coinsurance of 20% for outpatient services. Medigap policies do not cover prescription drugs or over the counter medications. Medigap insurance requires monthly premium payments.

TIP: Clients eligible for Medical Assistance do not need Medigap insurance, because Medical Assistance will cover most things Medicare does not cover. It is illegal for an insurance company to sell a Medigap policy to someone with full Medical Assistance benefits.

Clients ineligible for Medical Assistance should consider a Medigap policy, after comparing it to coverage available from Medicare Advantage plans.

A Medigap policy may be obtained at any time after a client's Medicare coverage has begun and is not subject to annual open enrollment periods. However, it is important to note that a **client buying a Medigap policy within six (6) months of Medicare coverage (known as the *guaranteed issue period*) are not subject to health status inquiry and will have greater choices of Medigap policies at lower costs.** Clients ineligible for Medical Assistance coverage should, therefore, be strongly encouraged to enroll in a Medigap plan within six (6) months of the commencement of Medicare coverage.

IMPORTANT: It is imperative that the clients who have pre-existing conditions enroll in a Medigap plan during the *guaranteed issue period* to avoid being asked health questions and getting denied the additional health insurance coverage due to pre-existing conditions.

Younger clients on SSD benefits who did not enroll in a Medigap plan during the guaranteed issue period when their Medicare coverage first began will receive another guaranteed issued period when they turn 65. During this second guaranteed issued period they can enroll in a Medigap plan without being asked health questions and can purchase plans at competitive rates.

For clients who need assistance enrolling in a Medigap plan, please see the Note on the APPRISE Program in § 4.9.

ACTION: clients can also enroll in a Medigap plan by visiting **Medicare.gov/find-a-plan**

§ 4.11 Medicare Prescription Drug Coverage (Medicare Part D)

Medicare prescription drug benefit (known as Medicare Part D) is an optional prescription drug benefit offered to all Medicare recipients who have Medicare Part A and/or Part B. Under this program, Medicare-approved private insurance companies offer prescription drug coverage to persons who enroll in either (i) Medicare-approved stand-alone prescription drug plans, or (ii) Medicare Advantage Plan with prescription drug coverage. Medicare requires that all plans offering Medicare prescription drug benefit cover HIV medication.

Part D Late Enrollment Penalty: Clients should be advised to enroll in a prescription drug plan (PDP) as soon as they become eligible to avoid the late enrollment penalty. Failure to enroll in a prescription drug plan (PDP) when beneficiaries first became eligible for the benefit will result in recipients paying a 1% penalty of their monthly premium amount for each month that the recipient was not enrolled in a PDP for as long as they have Medicare prescription drug coverage. However, the penalty does not apply if the Medicare recipients have other *creditable* prescription drug coverage. Recipients who are (i) dual eligible or (ii) receive Low Income Subsidy (“Extra Help”; see § 4.10e) or (iii) have Buy-In benefits (see § 4.8) do not pay a penalty even if they enrolled in a Part D plan late. Case managers should assist clients with enrolling in a suitable PDP or refer them to the APPRISE program for counseling and enrollment.

NOTE: “Creditable Coverage” is other prescription drug coverage that is as good as, or better than, the Medicare prescription drug coverage (see examples below). Recipients can request the source of coverage to issue a certificate of creditable coverage to avoid the penalty.

Creditable Coverage can include the following:

- Any coverage under Medicare Part D prescription drug plan or drug coverage offered under a Medicare Advantage Plan.
- Deemed eligibility or Medicaid coverage;
- Group Health Plan (GHP) coverage, such as employer or union plans;
- State Pharmaceutical Assistance Program participation;
- Veteran Administration (VA) coverage;
- Medigap with prescription drug coverage;
- PACE or PACENET coverage;
- Military service-related coverage including TRICARE

Medical Assistance (MA) recipients who become eligible for Medicare coverage are required to actively enroll in a PDP as soon as they become eligible for Medicare.

It is to the recipients’ advantage to enroll in a PDP as early as possible in a calendar month so that the enrollment process can be complete before the end of the month. If the process is completed before the end of the month, medications may be refilled by the first of the following month. However, if the coverage is not effective at

the beginning of the month, but becomes effective later in the month, the client should ask the pharmacy to bill the PDP plan and refund any out-of-pocket expenses.

§ 4.11a Medicare Part D Enrollment Periods

Initial Enrollment Period (IEP): All new Medicare beneficiaries receive an initial enrollment period during which they can enroll in a prescription drug plan (PDP). The IEP runs for **seven months**, consisting of three months prior to and three months after the month of first-time eligibility for Medicare. For example, if an individual’s first month of eligibility is June, then the IEP runs from March to September. The month of first-time eligibility will be the month a recipient turns 65 or 24 months after the recipient receives their first Social Security Disability check.

Annual Election Period (AEP): The AEP to change a PDP runs from **October 15 - December 7** each year, for coverage beginning January 1 of the following year. During this period, beneficiaries can decide to switch their PDP, or decide to stay with their current plan.

General Enrollment Period (GEP): If Medicare recipients have Part A coverage, but get Medicare Part B for the first time during the GEP that runs January 1 - March 31, they can also enroll in a PDP during those months continuing through April 1 – June 30 for coverage that would begin July 1 of that same year.

Special Enrollment Period (SEP): Missing an IEP or AEP period will result in a client having to wait until the next AEP to enroll or change their PDP unless the beneficiary is eligible for a Special Enrollment Period (SEP). Beneficiaries eligible for an SEP can change their plan during the year, multiple times if they need to, for coverage to become effective first of the following month. The categories of beneficiaries who are eligible for SEP include:

- Dual eligibles (clients who are eligible for both Medicare and Medical Assistance; see § 4.7). If these clients do not select a Medicare Part D plan, Medicare will automatically enroll them into a prescription plan with an ongoing special enrollment period.
- Recipients of SSA’s Full or Partial Low Income Subsidies (LIS or “Extra Help”; see § 4.11e)
- Beneficiaries who are eligible for the Medicare Buy-In program (see § 4.8)
- Beneficiaries who lose Medical Assistance coverage
- Beneficiaries who have involuntarily lost creditable drug coverage (e.g., loss of coverage due to unemployment)
- Beneficiaries who move out of the geographical area covered by the Part D plan

- Beneficiaries who move into or out of an institution (e.g., nursing home, incarceration)
- Beneficiaries who lose coverage because the Part D plan terminated the service in the beneficiary's state (e.g., Medicare terminating the contract with the Part D due to violation of contract with Medicare)
- Beneficiaries who enroll in a Medicare Advantage plan based on incorrect or misleading information

For a comprehensive list of circumstances that may lead to SEP enrollment, refer to: <https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods>

§ 4.11b Enrollment in a Part D Plan

Medicare recipients or their authorized representative can enroll clients in a prescription drug plan. PDP enrollment can be done online at **www.medicare.gov**, or by calling Medicare at **1-800-Medicare** (1-800- 633-4227 or 1-877-486-2048 for TTY). If the client has decided which plan to enroll in, the client may call the plan directly to enroll.

Case managers assisting clients to enroll in a PDP should have the following information ready to enroll the client:

- Full name of the client as it reads on the Medicare card and the Medicare unique identification number (found on the red, white and blue card);
- Effective date of Medicare Part A and Part B (found on the red, white and blue card);
- Names of all the medications, strength, and quantity needed each month;
- Name and address of the client's pharmacy;
- Particulars of other prescription coverage.

Before enrolling a client in a plan, case managers should diligently verify if the PDP has any restrictions - such as (i) quantity limits on drugs, and/or (ii) prior authorization requirement, and/or (iii) step therapy requirement (see below for definitions of these terms). These verifications can be done while enrolling a client online or by calling the individual plan. Client and case managers should endeavor to enroll the client in a plan that is least restrictive. In addition, when making the decision as to the suitability of the plan, the client should consider the PDP's annual costs, formulary, and pharmacy network.

“Prior Authorization”: Prior authorization means that the client will need prior approval from the PDP before filling a prescription. If a drug has a prior authorization requirement, the client will need to work with the plan and the prescribing doctor to either obtain the prior authorization or an exception to prior authorization requirement. To determine if a plan has prior authorization

requirements, consult the PDP's section on Plan Details. Knowing whether there are prior authorizations before going to the doctor's office may save the client time at the pharmacy counter. Medicare Part D plans cannot require prior authorization for HIV medications but can require it for most other classes of drugs.

“Step therapy”: Plans may require the client to first try one drug before they will cover another drug for that condition. For example, if Drug A (generic) and Drug B (brand name) both treat the client's medical condition, a plan may require the client's doctor to prescribe Drug A first. If Drug A does not work to treat the client's condition, then the plan will cover Drug B. Medicare Part D plans cannot require step therapy for HIV medications but can require it for other classes of drugs.

“Quantity Limits”: For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time.

Once enrolled in a PDP, clients will receive a member identification card from the PDP and information about how the plan works, such as cost-sharing, the appeal process, etc. The client should use this identification card at the pharmacy to fill prescriptions.

TIP: Clients can opt to have the PDP monthly premium taken from their Social Security benefit by checking the appropriate box in the online application. Clients on SPBP should not opt for premiums to be taken out, as SPBP will pay this cost.

For clients who need assistance enrolling in a prescription drug plan, please see Note on the APPRISE Program in § 4.9.

ACTION: clients can also enroll in a Medicare prescription drug plan by visiting [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan)

§ 4.11c Types of Medicare Part D Plans

There are three types of Medicare Part D plans that have been approved by Medicare:

(i) **Standard Plan**: This is the basic plan and has to meet the following fixed requirements:

- **Monthly premiums**: Monthly premiums may differ from plan to plan. The Part D Base Beneficiary Premium for a standard plan is **\$32.74** for 2020.

- **Annual Deductible:** Annual Deductibles for all plans are fixed for each year. This means plans cannot charge more than this amount. The annual deductible is **\$435** for 2020. This is the amount that recipients must pay before the drug plan starts paying. Plans can set their own deductible amount not to exceed the \$435.
- **Initial Coverage Period:** During the Initial Coverage Period, the client will pay 25% of the drug costs for each prescription until the total drug cost has reached **\$4,020** (in 2020). The PDP pays 75% of the drug costs.
- **Coverage Gap:** After completing the Initial Coverage Period the client will continue to pay 25% of the drug costs for each prescription until the total out-of-pocket cost (TrOOP) has reached \$6,350 (for 2020). At this stage, the drug costs will be divided between clients, the PDP and drug manufacturers, until the total drug costs have reached \$9,719.
 - For brand-name drugs, clients continue to pay **25%** of drug costs, plans pay 5%, and drug manufacturers provide a 70% price discount in 2020.
 - For generic drugs, clients pay **37%** of drug costs and plans pay 63% in 2020.
- **Catastrophic Coverage:** Upon completion of the coverage gap (including what clients paid and the drug manufacturers' discount value), clients enter into a catastrophic coverage period which will last until the end of the calendar year, during which clients pay the **greater** of either 5% of drug costs or \$3.60 (generic)/\$8.95 (brand). The PDP will pay 15%, and Medicare will pay 80%.

NOTE: TrOOP means the portion of the cost sharing incurred by the client in a health plan. Under the Medicare Part D program, TrOOP will be counted to determine when a client reaches the coverage gap and when a client qualifies for catastrophic coverage. TrOOP includes expenses the client incurred out of pocket, non-premium costs paid by SPBP, charitable organizations, family members, and so forth.

- (ii) **Basic Alternative Plans:** These are Medicare Part D plans that are able to create their own coverage package and do not have to meet the fixed requirements in the standard plans. Basic alternative plans must be actuarially equivalent to defined standard plans, but they are allowed to

have different deductible and cost-sharing structures.

- (iii) **Enhanced Alternative Plans:** Enhanced Alternative Plans can offer a more comprehensive level of coverage, with lower cost-sharing and/or additional coverage of certain drugs excluded from the Standard Plan and Basic Alternative Plan. Premiums may be higher for these plans, but offer more coverage. Part D subsidies (see § 4.10e) only pay the portion of an enhanced plan premium that is attributable to the defined standard elements of the plan.

§ 4.11d Part D Drug Coverage/Formulary

Medicare Part D Plans are required to cover at least two drugs in every therapeutic class or category in its formulary, but Plans can drop or add drugs to their formulary each year. If a Plan decides to drop a drug from its formulary, it must give all enrollees using that drug at least 60 days’ notice. Clients must also be given notice if a Plan decides to change the costs of a drug.

In most cases, if the client is taking a formulary medication, the client will be able to continue on it for the full calendar year. Clients who need a drug that isn't on a plan’s formulary may seek a formulary exception (For information on applying for a formulary exception see below details in this section).

Additionally, Medicare requires that all Part D plans cover all drugs in the following six categories:

- (i) HIV/AIDS (antiretrovirals)
- (ii) Antidepressants
- (iii) Antipsychotics
- (iv) Anticonvulsants
- (v) Anticancer drug
- (vi) Immunosuppressants

NOTE: Over the counter medications are not covered by Medicare.

Drugs on the plan’s formulary are often organized into different drug “**Tiers,**” or groups of different drug types, usually depending on their costs. Generally, the higher the drug in the tier system, the higher the copay or coinsurance will be. It may be useful to check, at the time of enrollment, the tier level of the drug to avoid higher copays. Generally, drugs are placed in the following tier structure:

- ✓ Tier 1 - covers most generic drugs; low cost-sharing
- ✓ Tier 2 - covers “preferred” brand name drugs, medium cost-sharing
- ✓ Tier 3 - covers “non-preferred” brand name drugs, high cost-sharing

- ✓ Specialty tier - very high cost prescription drugs, highest cost-sharing

If a drug that the client has been prescribed is not in the plan's formulary or if the client wants the plan's tier structure of a specific drug changed, the client can ask for an exception, which is known as the "**exception process.**" The exception process is explained below.

Applying for an Exception to the Plan's Formulary: When a drug is not on the plan's formulary, a client may obtain coverage for the uncovered drug by filing a request for an 'exception' to the plan's formulary to have that drug approved. Clients, authorized representatives, or doctors can file for an exception. When filing for an exception, the client has to include a statement (called a letter of "medical necessity") from the prescribing doctor asserting that the drug is required to treat the client's condition. The medical provider should also include in the statement why the client's condition cannot be treated with any other drug in the market.

Exception to the Plan's Tier Structure: When a drug is covered by a plan, if the client wants a lower copay, the client can file an exception to the plan's tier structure and obtain the drug at the lower tiered copay.

§ 4.11e Low Income Subsidy ("Extra Help")

Under the standard Part D plan, clients have considerable out-of-pocket expenses, which include monthly premiums, deductibles, and copays/coinsurance. However, for low-income clients, there is "Extra Help" from Medicare to help pay for these out-of-pocket expenses. This extra help is called the Low-Income Subsidy (LIS).

There are two levels of LIS: (i) 100% full subsidy and (ii) partial subsidy. Eligibility for either LIS depends on a client's income and resources.

NOTE: Individuals on Medical Assistance and/or Buy-In programs automatically qualify for 100% full LIS subsidy and do not have to separately apply for LIS.

Eligibility for full subsidy: the following persons qualify for full LIS.

- Persons receiving benefits from any Medical Assistance programs, including those beneficiaries who receive assistance paying for their Medicare Part B premium through SLMB and QI-1, regardless of whether they meet Extra Help's eligibility requirements;
- Persons whose countable income is below 135 % of the FPIG (\$1,561/individual, \$2,114/couple in 2020) and have

resources less than \$14,390 (individual) and \$28,720 (couple). Not all assets are countable when assessing a client's resources to determine their eligibility (see below for details on which resources are countable).

Eligibility for partial subsidy: the following persons qualify for partial LIS.

- Persons whose countable income is between 135–150% of FPIG (for a household of one in 2020, this is \$1,435.50 - \$1,595 per month) FPIG and have resources less than \$11,010 (individual) and \$22,010 (couple) in 2020.

“Countable” Income and Resources

When determining “Countable Income” for LIS purposes, Medicare follows the SSI income counting methodology (see § 2.5a). Clients should report income from all sources. Medicare provides for the following exceptions:

- If a client has unearned income, \$20 will not be taken into consideration when determining countable income.
- If a client has earned income, the first \$65 and another one-half of the remainder of the income will not be counted for LIS purposes.

Likewise, not all of the client's assets are counted for LIS resource purposes. The following assets are excluded:

- Recipient's primary home where they reside
- All motor vehicles (in contrast with SSI, where only the first vehicle is excluded)
- Household items
- Burial reserves up to \$1,500 each for applicant and spouse
- Irrevocable burial trusts
- Irrevocable burial contracts
- Life insurance policy

Any assets that could readily be converted into cash will be considered resources for LIS purposes, which includes CDs, retirement accounts, saving accounts, stocks and bonds. Any real property that is not used at the client's primary residence will be counted as a resource.

The chart below explains the difference in benefits between full and partial subsidies.

Chart 4-2 Medicare Part D Low Income Subsidy Benefits		
	Full Subsidy	Partial Subsidy
1	No monthly premium as long as the client picks a plan with premium less than the “benchmark premium” for that year	Monthly premiums are reduced on a sliding scale depending on income (25%-75% reduction of client’s premium).
2	No annual deductible	Annual deductible reduced. The amount of reduction is determined each year. In 2020, reduced from \$435 to \$89.
3	No coverage gap (“doughnut hole”)	No coverage gap (“doughnut hole”)
4	Small copays during the initial coverage period. The amount of the copay will change every year. Copays for 2020 for generic/brand name are \$1.30/\$3.90 (if income less than 100 %) and \$3.60/\$8.95 (if income more than 100 %).	Reduced copays during initial and catastrophic coverage, i.e., 15 % coinsurance until the total out of pocket expense reaches the catastrophic coverage (\$6,350 in 2020)
5	No copays once client has reached catastrophic coverage (in 2020 client would have spent \$6,350 to reach this level).	After reaching \$6,350 client will pay the copays due for their income limit for that year. In 2020, \$3.60 and \$8.95 for generic and brand name, respectively.

NOTE: Clients living in a Medicaid paid long-term care facility OR receiving Long Term Services & Supports in a nursing home or Waiver/Community HealthChoices do not pay copays for medication.

LIS Advantages: The advantages of either full or partial LIS include

- (i) Limited Part D costs (generally no premiums, deductible, or copays)
- (ii) No doughnut hole
- (iii) No Late Enrollment Penalty
- (iv) Ability to change Part D plans once every quarter; and

- (v) Point of-Service process (LI-NET) at the pharmacy if clients are not enrolled in a Part D plan (see § 4.7g).

IMPORTANT: Case managers should be cognizant of enrolling every eligible client for LIS.

Applying for LIS: Medicare recipients have to apply for LIS in order to receive the subsidy. Dual eligibles do not need to make a separate application to receive the subsidy. An application for LIS can be made at any time during the year. The application can be filed in the following manners:

- (i) Submit an LIS application online
<https://www.ssa.gov/benefits/medicare/prescriptionhelp/>
- (ii) Call Social Security Administration at **1-800-772- 1213** and ask to apply for LIS;
- (iii) Walk into your SSA office and complete an application.

IMPORTANT: A client found eligible for 100% LIS will also be eligible for the Medicare Saving Program (Buy-In benefit for Part B premium payment) as the income and resources test for both programs are the same. SSA should forward any LIS applications to DHS for buy-in consideration.

Clients should save the LIS approval letter received from the SSA as this document is proof that the LIS has been approved. This letter also documents the level of LIS that the client is eligible for, either a full subsidy or partial subsidy depending on client’s income and resources.

If the client’s application for LIS is denied, and if the client is in fact eligible for LIS benefit, case managers should assist clients with filing a timely appeal following the directions in the denial notice. The client may also call the AIDS Law Project of Pennsylvania for assistance with filing an appeal and representation.

The SSA and DHS review clients’ eligibility for LIS on a regular basis. Like any other re-determination process, clients should comply and provide the SSA and DHS the required verification to continue receiving the correct level of LIS. Any changes in the client’s circumstances need to be reported. After the re-determination process, if a decision is made to discontinue the client’s LIS or to change the level of LIS, the client has the right to file an appeal.

The Buy-In program and LIS program calculate resources differently. For example:

- LIS disregards \$1,500 from each of the applicant and spouse’s resource, if they

indicate in the application that they intended to use some of their resources for funeral or burial expenses; Buy-In program has different rules regarding burial resources.

- LIS will not consider any part of a client’s life insurance policy as a resource. The Buy-In program will count life insurance policies as follows: if the total face value of a client's life insurance policies is less than \$1,500, the value of the life insurance policy is disregarded. If the face value of the life insurance policy is more than \$1,500, DHS will count any amount of the policy’s cash surrender value over \$1,000.

§ 4.11f Limited Income Newly Eligible Transition Program (LINET)

LINET program was created to provide immediate and uninterrupted temporary prescription drug coverage to low-income beneficiaries who are new to Medicare. The program prevents a lapse in coverage and is a temporary measure until Medicare enrolls the beneficiaries in a Part D plan. Humana, a Medicare-approved drug company, administers the LINET program for Medicare.

Medicare beneficiaries are eligible for LINET if they have been found eligible for LIS, including:

- Full Dual Eligible beneficiaries (individuals eligible for Medicare and Medicaid)
- Partial Dual Eligible beneficiaries (those who receive a Medicare Savings Program/Buy-in)
- Individuals who applied for Extra Help through Social Security and have received a Notice of Award letter.

LINET performs the following functions:

- (i) automatically enrolls full dually eligible persons in a Medicare Part D plan, if they are not already enrolled in one; and
- (ii) functions as a Point-of-Sale (POS) at the pharmacy, which is the safety net program for certain low-income clients who contact the pharmacy to fill drugs but are not enrolled in a Part D plan.

Auto Enrollment in LINET: Using the LINET process, Medicare recipient who do not have prescription drug coverage are automatically enrolled the first day they become a Dual Eligible beneficiary, or the first day of the last uncovered month, whichever is later. The LINET plan is responsible for all Part D covered costs incurred during the retroactive and current periods. Medicare will, thereafter, enroll the client prospectively in a zero-premium Part D plan for continuing coverage. If the client, in the meantime, enrolls in a plan, the client’s choice of plan will prevail.

ACTION: If low-income clients need immediate prescription drug coverage, case managers may call the call **LINET** at **1-800-783-1307** and have their clients enrolled in

this safety net program. Helpful instructions for pharmacists to process a POS claim are at <http://apps.humana.com/marketing/documents.asp?file=1285050>.

LINET will also be responsible for processing the reimbursement request from clients with LIS who paid out-of-pocket expenses while they were not enrolled in a plan. There is no deadline for filing for reimbursements. LINET has an open formulary with no prior authorization or network restrictions. Clients will still be responsible for the LIS copay amount.

§ 4.11g Special Pharmaceutical Benefits Program (SPBP) and Medicare Part D/Medicare Advantage

Pennsylvania's Special Pharmaceutical Benefits Program (SPBP) is a program funded by the Ryan White C.A.R.E. Act and administered by the Pennsylvania Department of Health. SPBP pays for prescription medications and some laboratory testing for people living with HIV or diagnosed with schizophrenia (see § 5.4a for more information). More information on SPBP can be found at <https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx>

For people on Medicare, SPBP provides wrap around benefits for prescription drug coverage. SPBP partners with both Medicare Part D stand-alone prescription drug plans and Medicare Advantage plans.

For stand-alone Part D partner plans, SPBP will pay all prescription drug costs not covered by the plan, including all premiums, deductibles, copays and coinsurances.

For Medicare Advantage partner plans, SPBP will pay either all or some of the monthly premiums. It will also pay all costs relating to prescription drugs, including deductibles, copays and coinsurance. It will not pay deductibles or copays or coinsurance for medical services (e.g., doctor's visits, diagnostic testing, or hospital stays).

SPBP provides coverage for a large formulary of prescription drugs and is not limited to HIV medications. SPBP provides full coverage for a drug on its formulary even if the drug is not covered by a person's Part D or Medicare Advantage plan.

Clients should make sure that their pharmacies have both their Part D and SPBP cards on file.

In order to get these cost-sharing benefits, clients must be enrolled in a partner plan. If the client is not enrolled in a partner plan, SPBP will not cover the plan's premium, but may cover the deductibles, copays and doughnut hole for SPBP formulary drugs.

SPBP recipients who are new to Medicare should enroll in an SPBP partner plan to receive the full benefits of the wraparound coverage. Clients with SBPB coverage and not in a partner plan

should switch to a partner plan during the annual election period, October 15-December 7, each year.

When choosing plans, be certain to check that your client’s pharmacy is in the plan’s pharmacy network.

Clients enrolled in SPBP can change their plan by calling **1-800-Medicare** or by enrolling online at **www.medicare.gov**. Clients or case managers should also call SPBP at **1-800-922-9384** and update SPBP with the name and member ID of the new plan, so that the client wraparound cost can be covered by the SPBP.

NOTE: SPBP coverage is for people who are not eligible for comprehensive health insurance coverage from MA. Dual eligible clients are still eligible for SPBP because MA does not provide prescription drug coverage to dual eligibles. All dual eligibles are automatically enrolled in SSA’s 100% Low Income Subsidy program and only have copays. SPBP will provide coverage for these copays.

For details of Part D and Medicare Advantage plans that partner with SPBP each year, contact the AIDS Law Project of Pennsylvania, or call SPBP at **1-800-922-9384**.

§ 4.11h Medicare Part D and PACE Plus Medicare

PACE Plus Medicare program was created in 2006 (the year Medicare Part D was signed into law) to encourage those enrolled in PACE or PACENET (see § 5.4d) to also enroll in a Medicare Part D Plan. Under PACE Plus Medicare, if a client is enrolled in a Medicare Part D plan, the Part D plan provides primary drug coverage, and PACE/PACENET pays for all costs associated with the drug coverage that are not paid for by the Medicare Part D plan. In essence, PACE Plus Medicare serves as a wraparound service for Medicare Part D coverage.

PACE/PACENET benefits are considered "creditable coverage," which means that the benefits offered through these programs are as good as or better than the prescription benefits offered through a Medicare Part D. Hence, clients on PACE/PACENET can remain on the program without enrolling in a Medicare Part D plan. However, PACE/PACENET programs are run by the Department of Aging, which encourages individuals to enroll in Medicare Part D plan since individuals may be able to save more money on their prescription drug costs. Additionally, enrolling PACE/PACENET clients in a Medicare Part D plan saves the Department of Aging money, thereby allowing the PACE program to enroll new clients.

Under PACE Plus Medicare, clients enrolled in PACE/PACENET are enrolled into a “partner plan”. The 2020 “partner plans” are *Silver Script* and *Wellcare Classics*. PACE/PACENET beneficiaries who opted for a Medicare

Advantage plan with prescription coverage or who also have a retiree with prescription coverage are not assigned to a partner plan. If a client falls into any of these categories above and is enrolled in Medicare Part D plan, you should call the PACE program and correct the error. Failure to do so will result in the client being disenrolled from their Medicare Advantage Plan or losing retiree prescription coverage through the client's retiree plan.

In addition, PACE/PACENET will also not auto-enroll new or declining current PACE/PACENET cardholders into a Part D plan. If a client on PACE/PACENET is auto-enrolled in a Medicare Part D plan and receives an enrollment letter, but does not want to be enrolled in a Part D plan, they should call the PACE program within 10 days and decline the enrollment. If the client declines the enrollment, the PACE/PACENET programs will continue to cover the client's prescription medications.

PACE Plus Medicare for PACE Members: PACE clients enrolled in a partner Medicare Part D plan will receive the following PACE Plus Medicare coverage.

- Part D plan premium paid if Part D plan has a premium assistance agreement with PACE
- PACE coverage for prescriptions for any deductibles and coverage gaps (“doughnut hole”) that the Part D does not pay.
- Cover some medications that the Part D plan does not cover as long as the medication is one covered by PACE.
- Cover any copays in excess of your PACE copay amount. PACE enrollees will only pay their current PACE copays (\$6 generic/\$9 brand) for any medication covered by the PACE program. If the Part D plan copay is lower, the client pays the lower amount.
- Pay the Late Enrollment Penalty if client enrolled late in a Part D plan

PACE enrollees will use both their Part D plan card and their PACE card at the pharmacy.

If a PACE enrollee has prescription drug coverage through a Medicare Advantage Plan or through a Medicare Part D plan that is **not** one of PACE's “partner plans,” PACE will still help them with some of their Part D costs.

- PACE will pay up to the annual benchmark premium towards the Part D plan's premium.
- PACE will also cover other Part D costs such as deductibles, copays above \$6/generics and \$9/brands, and coverage during the doughnuthole as described above. In addition, PACE will cover non-formulary medications

as long as the medication is covered by the PACE Program.

In order for PACE to help pay the premium for the Medicare Part D plan, the plan has to have an agreement with PACE. Individuals in Part D plans that are not “partner plans” should check with PACE to see if they have an agreement with the plan to help them pay premiums.

PACE Plus Medicare for PACENET Members: A PACENET client enrolled in a Medicare Part D plan will receive the following PACE Plus Medicare coverage:

- If the client is enrolled in a PACE/PACENET partner plan, PACENET will pay the Part D plan deductible and coverage gap. (Client will have to pay the Part D plan premium at the pharmacy).
- PACENET will pay any copays in excess of PACENET’s copay amount. For example, a client will not pay more than their current PACENET copays (\$8 generic/\$15 brand) as long as their medication is covered by the PACENET program. If the Part D Plan copay is lower, the client pays the lower amount.
- Coverage for medications that are not on the Part D Plan’s formulary as long as the medication is one covered by PACENET.
- Assistance with client’s Part D Late Enrollment Penalty, if any.

<p>NOTE: PACENET will not pay an enrollee’s Part D plan premium. Enrollees receiving PACENET coverage and not enrolled in a Part D plan will pay a \$35.63 (2020) Part D monthly premium at the pharmacy.</p>
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PACENET enrollees will use both their Part D card and their PACENET card at the pharmacy.

If a PACENET enrollee has prescription drug coverage through a Medicare Advantage Plan, or through a Medicare Part D plan that is **not** one of PACE’s “partner plans,” they will continue to pay the Part D premium. They will not have to pay the PACENET premium. PACENET will then cover other Part D costs such as deductibles, copays above \$8/generics and \$15/brands, coverage during the doughnut hole, and medications that are not currently on the Part D plan’s formulary.

More information on PACE/PACENET can be found here:

<https://pacecares.magellanhealth.com/documents/PartDQuestions-2020.pdf>

§ 4.11i Medicare Part D and Chronic Renal Disease Program

The Chronic Renal Disease Program (CRDP) helps those with end-stage renal disease

pay for their prescription drug coverage and some other costs to treat their condition. The program is run by the Pennsylvania Department of Health. CRDP is covered in more detail in the Medical Assistance chapter at § 5.4e.

CRDP coverage is not “creditable coverage” because it only covers medication to treat end-stage renal disease. Therefore, clients with chronic renal disease should be enrolled in a Medicare Part D plan when they first become eligible to avoid a penalty for late enrollment. If the clients do not enroll themselves, the state will auto-enroll them in one of the state’s “partner” Part D plans. Like the PACE program, the state should not auto-enroll persons who are already in a Medicare Advantage Plan, or in a Part D plan, or who have prescription coverage through a retirement plan.

For clients on CRDP Medicare, Part D will be the person’s primary prescription coverage and CRDP their secondary coverage.

For a client who has CRDP coverage and is enrolled in a ‘partner’ Medicare Part D plan, the following benefits will be paid for by the state:

- Annual benchmark premium toward an individual’s Part D Plan premium (\$35.63 in 2020);
- Part D Plan costs for drugs that are currently covered by CRDP (including the deductible and doughnut hole phases of the Part D Plan) so that clients pay no more than their normal CRDP copay for those medications (\$6/generic; \$9/brands). If the Part D Plan’s copay is less, the client pays the lower copay;
- If the client is taking prescriptions not covered by CRDP, then they will pay whatever the Part D Plan charges for those particular medications.

For more information on the CRDP Plus Medicare program go to the Department of Health’s website at <https://www.health.pa.gov/topics/programs/Chronic-Renal-Disease/Pages/Part-D.aspx>