2016 Medicare Advantage and Prescription Drug Overview

Module 2

UPMC *for Life*

UPMC Health Plan Medicare Program

Medicare Advantage

Section 1

Medicare Advantage

- **Three types of Medicare Advantage Plans:**
  - **Coordinated Care Plans which include:**
    - Health Maintenance Organizations (HMOs)
    - Provider Sponsored Organization (PSO)
    - Preferred Provider Organizations (PPOs)
    - Special Needs Plans (SNPs)
  - **Private Fee-For-Service Plans (PFFS)**
  - **Medical Savings Account Plans (MSAs)**
- **Coordinated Care Plans**
  - Coordinated care plans include a network of providers and often include cost saving utilization requirements such as: primary care physicians (PCPs), referrals or prior authorizations, utilizing network providers for services (except for emergencies, urgent care, or out-of-area dialysis). The coordinated care plans also include disease/medical management of chronic conditions.
    - Network providers have a signed contract with the Medicare Advantage organization to provide covered health care services to the plan's Medicare enrollees.
  - Coordinated care plans that include medical and prescription drug coverage are referred to as Medicare Advantage Prescription Drug (MA-PD) plans.

Medicare Advantage

- **Medicare Health Maintenance Organization (HMO) Plan**
  - Benefits must be obtained from network providers with the exception of emergency, urgent care, and out-of-area dialysis services.
    - There is no coverage for out-of-network non-emergent services or care.
  - Primary care physicians (PCP) are typically required.
  - Cost-sharing can include both copays and coinsurance. The total out-of-pocket expense for a member is normally less than Original Medicare cost-sharing.
  - Medicare Advantage plans must include an annual out-of-pocket limit (e.g., $3,400) on member cost-sharing. Once this limit is met the HMO plan will pay 100% for medically necessary care for Part A and Part B covered services.
  - Referrals or authorizations may be needed for certain services.
    - The majority of HMO plans do NOT require PCP referrals prior to obtaining care from specialists. (UPMC for Life HMO plans do NOT require a referral to see a specialist)
    - Prior authorizations are typically required for some medical benefits, such as inpatient stays, skilled nursing care, transplants, and durable medical equipment.

Medicare Advantage

- **Medicare Preferred Provider Organization (PPO) Plan**
  - A PPO is a plan that has a network of providers and also provides the option for members to obtain services out-of-network.
    - Services from network providers will be paid at the highest benefit level (in-network) and the provider will accept his or her contracted rate.
    - Emergency, urgent care, and out-of-area dialysis services are paid at the in-network cost-sharing level.
    - Out-of-network services typically have a higher cost-sharing (e.g., copay or coinsurance).
    - Primary care physicians (PCPs) are NOT required but plans still encourage members to coordinate care through one primary physician.
  - Authorizations can **only** be required for in-network medical services in a PPO.
    - A plan can only suggest that authorizations are obtained out-of-network and cannot penalize the member if an authorization is not obtained.

Medicare Advantage

- **Medicare PPO Plans *(continued)***
  - **Two types of PPO plans:**
    - Regional PPOs (RPPOs)
      - The Regional PPOs serve an entire CMS designated regional service area (within the U.S.) and often provides a Medicare Advantage plan option to more rural areas.
      - Regional PPOS must cover more than one state.
      - Regional PPO plans must offer the same uniform plan benefits across the entire service region.
    - Local PPO
      - It is a PPO plan with a more defined service area that is less than a region, such as a county or several counties within a state.
        - Our UPMC *for Life* PPO plans are examples of a Local PPO plan that is offered in a defined area in Western Pennsylvania (28 local counties).
    - PPO plans must also include an annual out-of-pocket limit (e.g., $6,700 or $10,000) on member cost-sharing for in- and out-of-network services. Once this limit is met the PPO plan will pay 100% for medically necessary care for Part A and Part B covered services.

Medicare Advantage

- **Medicare Special Needs Plan (SNP)**
  - Special Needs Plans provide more focused health care for specific targeted groups of people.
  - Special Needs Plans (SNP) that may be offered by a plan fall into 3 categories:
    - Institutionalized SNP plans
      - Provide benefits for individuals that are institutionalized for longer than 90 days or who are living at home but require the same level of care as those who live in a nursing home.
    - Dually eligible SNP plans
      - Provide benefits to individuals who qualify for both Medicare and Medical Assistance full benefits based on their income.
    - Chronic Condition SNP plans
      - This type of SNP plan provides specialized care for select chronic conditions such as diabetes, ESRD, mental disorders and HIV/AIDS.
  - All SNP plans must provide prescription drug coverage.

Medicare Advantage

- **Medicare Private Fee-for-Service (PFFS) plans**
  - A PFFS plan is a Medicare Advantage plan that pays physicians and other providers on a fee-for-service basis.
    - The PFFS plan uses the local Medicare plan's payment rates.
    - PFFS plans do NOT restrict enrollees choices among providers that are lawfully authorized to provide services under Original Medicare; which means the provider is not excluded from Medicare participation.
    - The provider must agree to accept the plan's PFFS terms and conditions of payment and not balance bill the member.
    - Beginning January 1, 2010, PFFS plans must have a network in place to offer the PFFS plan option, so typically only national plans will be able to accommodate this type of Medicare Advantage plan.
      - Over 85% of PFFS plan left the market when the network option was added.
  - PFFS plans must cover all Medicare Part A and Part B services that are medically necessary.
  - An individual enrolled in a PFFS plan is allowed to join a standalone Prescription Drug Plan (PDP).

Medicare Advantage

- **Medicare Medical Savings Account (MSA) Plans**
  - Medical Saving Account Plans combine a high deductible health plan with a medical savings account that individuals can use to manage their health expenses.
    - This type of plan establishes a trust or custodial account for the purpose of paying qualified medical expenses of the account holder.
    - No other deposits other than the CMS defined contribution can be made into the account.
    - The maximum annual medical savings account deductible is set by law each year.
    - This plan type is NOT widely used.
  - Beneficiaries will use the money in their medical savings account to pay for their health care before the deductible is reached. Once the deductible is met, the Medicare Advantage plan will be responsible for payment of 100% of the expenses related to covered medical services.
  - A non-contracting provider with the Medical Savings Account Plan can only collect up to the payment that he or she would have received from Medicare fee-for-service.
  - An individual enrolled in a Medical Savings Account plan can join a standalone Prescription Drug Plan.

Medicare Advantage

- **Medicare Cost Plans**
  - Cost plans can be administered by HMOs or competitive medical insurance plans.
  - Medicare payments to cost plans are based on the reasonable cost of services.
  - Cost Plans are available in limited areas and often times are offered to a specialized employer group or trust fund (e.g., United Mine Workers Health & Retirement Funds).
  - Cost plans have the option of including prescription drug coverage as an optional benefit or can allow members to join a standalone Prescription Drug Plan.

- **Program of All-Inclusive Care for the Elderly (PACE) Plan**
  - The PACE program is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity.
  - The PACE program features a comprehensive medical and social service delivery system that includes care provided by an adult daycare health center that is supplemented by in-home and referral services based on the needs of the patient.
  - This type of plan should NOT be confused with the Pennsylvania PACE/PACENET program, which is a prescription drug assistance program.

Medicare Advantage

- **Employer Group Sponsored Plans**
  - Medicare Advantage employer group plans may be sponsored by an employer, labor organization (union), or the trustees of a fund established by one or more employers or unions.
  - Employer group sponsored plans' enrollment is typically restricted to individuals who are eligible retirees and the retiree's dependents, such as a spouse.

    Types of group plans:
    - **Direct contract plan** is an employer group that directly contracts with Medicare to administer their own benefit plan for retirees.
    - **Contributory plan** is a plan that the employer group sponsor pays 100% or a portion of the monthly plan premium directly to the Medicare Advantage plan.
    - **Sponsorship plan** is a plan that the employer group sponsors on behalf of their retirees; but the group does NOT pay a portion of the premium. The retiree pays the premium directly to the Medicare Advantage plan.
  - Individuals that are enrolled in an employer group plan must always be reminded to check with their employer group sponsor prior to changing plans.
    - A retiree could lose their employer group coverage and not be able to get that coverage back if he or she would just leave the group plan.

Prescription Drug Coverage

Section 2

Medicare Prescription Drug

- **Prescription Drug Plans (PDPs)**
  - Prescription drug plans are available to all individuals eligible for Medicare Part A or enrolled in Part B.
  - Prescription drug coverage is available from stand-alone Prescription Drug Plans or a Medicare Advantage plan that offers both medical and prescription drug benefits, known as a MA-PD plan.

- **Prescription Drug Plans (PDP) are required to provide comprehensive prescription drug coverage.**
  - Part D plans must cover **both** generic and brand-name prescription drugs.
    - The member cost-sharing normally varies by prescription drug tiers that can include tier breakdowns by generic, brand and specialty drugs.
    - Cost-sharing may be in the form of copayments or coinsurance.
    - Plans are required to have a review process for “lower” tiering requests and non-formulary prescription drug exclusions.
  - Plans’ drug formularies must be approved by CMS and need to include at least two drugs in every drug category/classification for the various disease states.

Medicare Prescription Drug

- Prescription Drug Plans and Medicare Advantage Prescription Drug Plans are required to have a pharmacy network in place where members must obtain prescription drugs.
  - A network pharmacy is a pharmacy that has a contract with the plan to provide covered prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are covered on the plan’s drug list or formulary.
  - Many Part D plans offer national pharmacy networks where individuals can obtain prescription drugs. These national networks include many chain pharmacies and independent retail pharmacies.
    - UPMC *for Life* has a national pharmacy network provided through Express Scripts, Inc.
  - Part D plans can also provide mail-order pharmacies where members can order prescription drugs with a doctor’s prescription and have them conveniently delivered to their home.

- The plan will cover prescriptions from providers who are not in the plan’s network only in a few special circumstances. These include:
  - “Effective June 1, 2015, before drugs can be covered under the Part D benefit, CMS required that prescribers either accept Medicare or they need to file documentation with CMS showing that they are qualified to write prescriptions.”
  - Prescriptions provided with covered emergency care.
  - Prescriptions provided with urgently needed care when network providers are not available.
  - Other than these two circumstances, an individual must have approval in advance from the plan to get coverage of a prescription from an out-of-network provider.

Medicare Prescription Drug

- Prescription drug plans may also choose to have preferred and non-preferred pharmacy options within their network.
  - A preferred network pharmacy is a subset of the pharmacy network where an individual may receive lower cost-sharing for some or all of the prescription drug formulary tiers.
  - A non-preferred pharmacy is still a network pharmacy, but the individual's cost-sharing may be higher than if he or she chooses to fill their prescription at a preferred pharmacy.
    - Example: A plan has a preferred and non-preferred pharmacy network. If a member fills a generic prescription drug at ABC Pharmacy the cost for the generic drug is $5, since this pharmacy is preferred. If the member would obtain this same generic drug at XYZ Pharmacy the generic drug would cost $8, since this pharmacy is non-preferred. So the member would save $3 per month if he or she used the preferred pharmacy.

  - NOTE: It is NOT a requirement for plans to offer preferred/non-preferred pharmacy networks. UPMC *for Life* does NOT offer this pharmacy option.

Medicare Prescription Drug

- **Part D Utilization Management Programs**

  The following utilization management programs may be used with a Part D plan:

  - Step Therapy
    - Step Therapy requires an individual to try a safer or more effective drug before the plan will cover another drug.
      - For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

  - Prior Authorization
    - Prior authorization requires a provider to obtain prior approval from the plan before prescribing certain drugs. Prior authorization is used to ensure the appropriate use for certain drugs or that prescribing certain prescription drugs meet Medicare rules.

  - Quantity Limits
    - Limits are placed on certain drugs to control the amount that an individual can have prescribed within a certain timeframe.
      - For example, the plan might limit how many refills a member can get, or how much of a drug he or she can get each time the prescription is filled.

Medicare Prescription Drug

❑ Part D Medication Therapy Management (MTM) Program

All Part D plans are required to offer medication therapy management programs to monitor and provide assistance to individuals who would benefit from this drug management program. The MTM services include the following:

- ❑ Offer a comprehensive medication review at least annually to all targeted beneficiaries enrolled in the MTM program. All of the individual's medications, including prescription, over-the-counter (OTC) medications, herbal therapies and dietary supplements are part of this review. The review is completed to assess medication use and to identify any possible medication-related problems.

- ❑ Offer to provide individuals enrolled in the MTM program an interactive, person-to-person consultation. This interaction may include further assessment of the beneficiary's medications, history and use, or other issues that could affect medication use or outcomes.

- ❑ Complete ongoing monitoring and targeted medication reviews for all individuals enrolled in the MTM program.
  - ❑ The ongoing reviews help to assess medication use since the initial or last review, monitor whether any unresolved issues need attention, determine if new drug therapy problems have arisen, or if the beneficiary has experienced a transition in care.
  - ❑ These ongoing reviews are performed on a quarterly basis.

Medicare Prescription Drug

- **Part D Medication Therapy Management (MTM) Program *(continued)***

  - Part D plans identify individuals that would benefit from MTM program using the following criteria:
    - Individuals that have multiple chronic diseases, such as diabetes, heart failure, respiratory problems, and mental health conditions.
    - Individuals taking multiple Part D drugs (e.g., taking 6 or 8 different medications).
    - Individuals whose Part D drug costs are likely to exceed $3,000 in a calendar year.

  - Individuals that meet the MTM criteria are auto-enrolled into the program. However, if a member would choose not to participate, he or she is allowed to opt out of the program.

Medicare Prescription Drug

- **Prescription Drug – Part D Coverage Stages**

  There are four stages of prescription drug coverage including a deductible (optional), initial coverage limit, coverage gap, and catastrophic coverage stages.

  - Deductible Stage
    - Plans may have an up-front deductible that a member must meet before the plan will begin to pay for Part D prescription drugs.
    - The 2016 deductible limit is $360. A plan can offer a lower deductible limit or no deductible.

  - Initial Coverage Limit
    - The 2016 initial coverage limit is $3,310.
      - This coverage limit is a CMS defined annual limit.
      - The initial coverage limit increased $350 from $2,960 to $3,310.
    - The member's cost-sharing in the initial coverage limit stage is typically copays or coinsurance and the amounts vary per drug tier (e.g., generic, brand).
    - Both the member's cost-sharing and what the plan pays accumulates toward the initial coverage limit.

Medicare Prescription Drug

- **Prescription Drug – Part D Coverage Stages *(continued)***
  - Coverage Gap Stage
    - Once the initial coverage limit is met the member will enter the coverage gap or "donut hole" where the member is responsible for the majority of the cost for prescription drugs.
      - Beginning in January 2011, when an individual enters the coverage gap stage he or she pays a discounted amount on generic and brand name drugs.

    - The member will pay the following cost-sharing for prescription drugs once he or she reaches the coverage gap stage in 2016:

      Generic Drugs:

      - Once the $3,310, initial coverage limit is met an individual will pay **58% for generic drugs** in the coverage gap.

      Brand-Name Drugs:

      - During the coverage gap stage, the beneficiary will pay 45% plus the dispensing fee for brand-name drugs, the plan will pay 5%, and the drug manufacturer will pay the remaining balance for brand-name drugs (including brand-name specialty drugs).

Medicare Prescription Drug

- **Prescription Drug – Part D Coverage Stages *(continued)***
  - Coverage Gap Stage *(continued)*
    - The pharmacy will charge the individual the "discounted" amount (generic or brand-name) during the coverage gap stage.
    - A member will remain in the coverage gap stage until the annual out-of-pocket limit (TrOOP) is reached.
      - ONLY the member's cost-sharing for prescription drugs count toward the TrOOP amount. TrOOP includes the following drug costs:
        - Deductible, if applicable.
        - Member copays or coinsurance paid in the initial coverage stage.
        - The member's out-of-pocket cost paid for prescription drugs in the coverage gap.
        - Out-of-network prescription costs.
    - The 2016 out-of-pocket maximum (TrOOP) is $4,850.
      - This out-of-pocket maximum is a CMS defined annual limit.
      - The out-of-pocket coverage limit (TrOOP) increased $150 from $4,700 to $4,850.

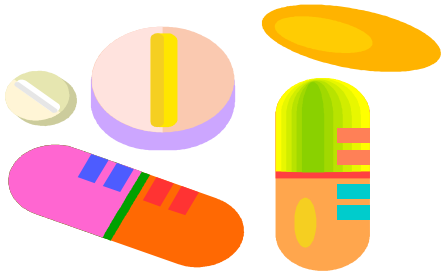
Medicare Prescription Drug

- **Prescription Drug Coverage Stages *(continued)***
  - Catastrophic Coverage Stage
    - Once the member reaches the out-of-pocket limit (e.g., $4,850) then he or she moves into the catastrophic coverage stage and will remain in this stage for the rest of the year.
    - The member's cost sharing for prescription drugs will decrease drastically when he or she reaches the catastrophic limit.
    - The catastrophic coverage cost-sharing for 2016 is:
      - The greater of 5% of the cost of the drug; OR
      - $2.95 for generic drugs or a drug treated like a generic;
      - $7.40 for all other drugs.
    - The catastrophic cost-sharing amounts are CMS defined annual limits.

Medicare Prescription Drug

- **The following types of drugs are excluded from Part D coverage:**
  - Over-the-counter medications (such as aspirin, antacids, cough syrup, vitamins)
  - Fertility and erectile dysfunction medications
  - Cosmetic medications
  - Part B covered drugs such as chemotherapy drugs or certain injections (allergy shots), are covered under the medical portion of plan.

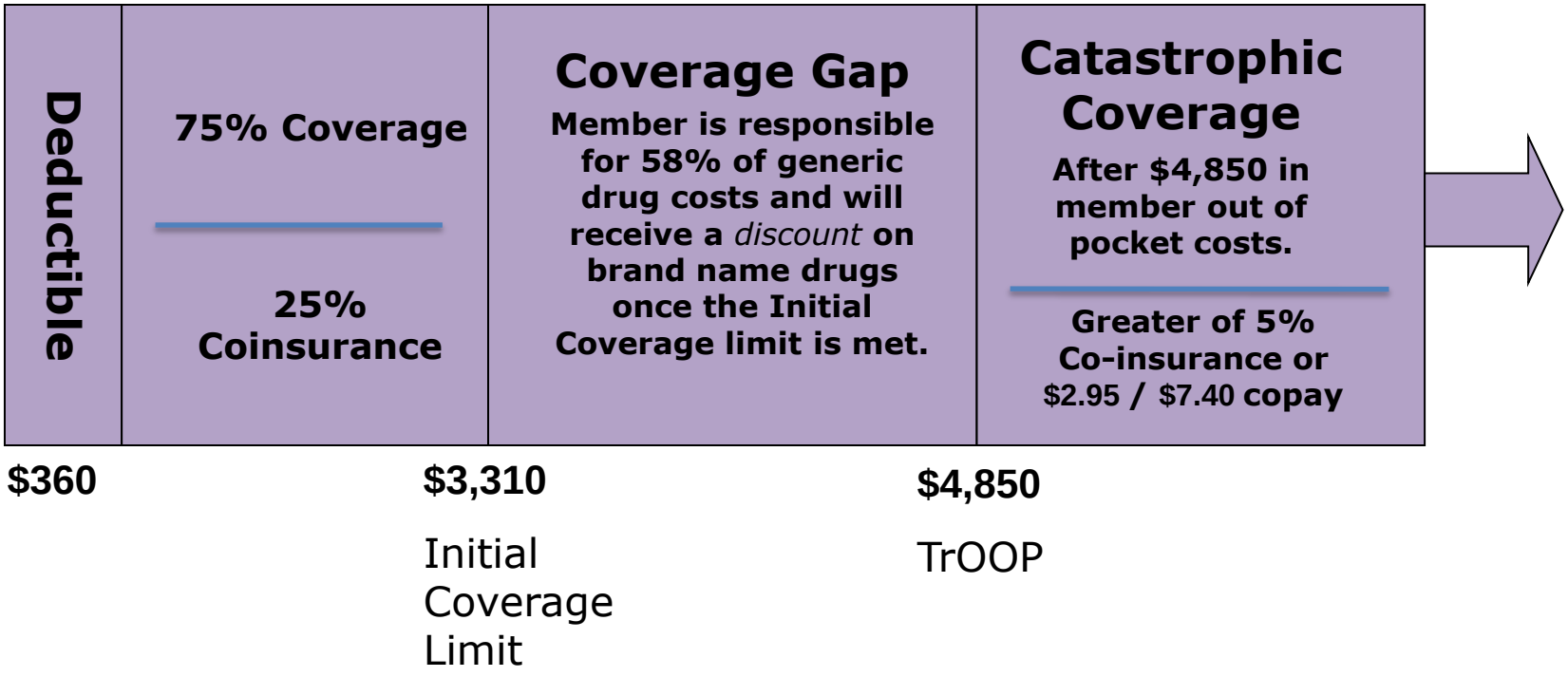
- Beginning January 1, 2013, Part D plans were required to cover barbiturates "when used to treat epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines.
  - This new coverage, including the specific health conditions for barbiturate use is part of the Improvements for Patients and Providers Act of 2008.
  - Prior to 2013, these two classes of drugs were excluded from Part D coverage.



Medicare Prescription Drug

2016 Medicare "Standard" Prescription Drug Benefit

- The following chart depicts the CMS Medicare Standard Part D benefit for 2016 a prescription drug plan's benefit must be actuarially equivalent or better than this option.



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Medicare Prescription Drug

Additional Prescription Drug Assistance:

- **State Pharmacy Assistance Programs (SPAPs)**
  - An SPAP is a State program which provides financial assistance for supplemental drug coverage for Part D eligible individuals.
    - In Pennsylvania, the SPAP is PACE or PACENET.
    - Not all states offer SPAP programs.
      - Example: West Virginia does not offer a SPAP program.

- **PACE/PACENET**
  - PACE is a State Pharmaceutical Assistance Program (SPAP) for the elderly.
  - Offers comprehensive prescription coverage to older Pennsylvanians (*eligibility criteria apply).*
  - Administered by the Pennsylvania Department of Aging.
  - Funded by Pennsylvania Lottery.

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Medicare Prescription Drug

- **To be eligible for PACE/PACENET individuals must:**
  - Be 65 years of age or older.
  - Have been a resident of Pennsylvania for at least 90 (ninety) consecutive days prior to application.
  - Not be eligible for pharmaceutical benefits under Medical Assistance.
  - Meet PACE or PACENET income guidelines reflected in the chart below.

	PACE	PACENET
Single	$14,500	$23,500
Married	$17,700	$31,500
Generic Copay	$6	$8
Brand Copay	$9	$15

Medicare Prescription Drug

Advantages of being enrolled in PACE/PACENET and Part D Coverage

- Enrollees can enroll in a Medicare Advantage Plan with or without drug coverage and remain enrolled in the Pennsylvania PACE/PACENET program.

- For members with PACE their monthly plan premium is reduced by the regional benchmark amount.
  - Members with PACENET continue to pay the total monthly premium for the plan (it is not reduced). However; PACENET members no longer have a deductible to pay at the point of sale (each month), but have first dollar coverage.
  - **NOTE:** If a PACENET member joins a zero premium plan than he or she will have to pay the deductible at the pharmacy monthly.

- Members pay the lowest copayment (Pace vs. Plan's drug copayments) during the initial coverage stage.

- There is no coverage gap stage for PACE/PACENET members. The member will continue to pay the PACE/PACENET copays unless the "discounted" drug cost in the coverage gap would be cheaper.

Beneficiary Protections – Grievance and Appeals

- What is a Grievance?
  - Members have the right to file grievances, (complaints), including grievances about the quality of your care
- What is an Appeal?
  - Members have the right to request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- To File a Grievance or Appeal, contact the plan either orally or in writing.
  - Additional information for filing a Grievance or an Appeal is located in the Evidence of Coverage booklet.
    - Contact Information
    - Step by Step procedures