Medicare 2021 Changes Questions and Answers

The following questions & answers are from the November 6, 2020 webinar on changes to Medicare in 2021. To access a recording of this webinar and download slides, visit: https://www.ncoa.org/event/whats-new-medicare-2021/.

Medicare Part D and Plan Finder questions

I know this is about Medicare changes—can you address problems with the Medicare Plan Finder? I have found, after assisting only a few beneficiaries, that the "estimated totals" & when people enter the donut hole do not add up correctly.

We have heard reports that annual total amounts are not consistent with the monthly totals and/or the dollar amounts in the columns representing the stages of the Part D benefit. In response to the uncertainty, some grantees identify plan(s) worth considering instead of recommending a plan and/or advise beneficiaries to check with any plan before enrolling. While this is not a solution, it is the best that can be done with the plan finder tool now. The Center will continue to work with grantees to ensure that problems are reported to ACL and CMS through the designated channels.

Could it be added to the [who pays what in Part D] infographic about how some plans may have a different structure during the initial coverage such as co-pays that could make costs lower than 25% in initial coverage? This graphic is very helpful but can make it seem costs are the same in initial and "former" coverage gap phases when they really are not for most people.

Appreciate your suggestion to improve our infographic. Most Medicare prescription drug plans do <u>not</u> offer the standard benefit design but offer an alternative equal in value (actuarily equivalent). The plans vary in terms of their specific benefit design, coverage, and costs, including deductibles, cost-sharing amounts, and utilization management tools. Consequently, the 25% cost sharing in the initial coverage phase can be replaced by a lower coinsurance amount or copayment.

A hint – if you're looking at Medicare Plan Finder and see copay amounts in the initial coverage phase, you know that this plan is not following the standard benefit design.

Drug coverage & costs

See if there's help to lower costs for drugs you take.

Plans group their drug lists into tiers. The table below shows your portion of the drug cost in certain tiers based on which coverage phase you're in for this plan

Learn more about drug tiers

TIER DRUG COST FOR: Preferred retail pharmacy drug cost for 1-month

Tiers	Initial coverage phase	Gap coverage phase[1]	Catastrophic coverage phase
Preferred Generic	$4.00 copay	$4.00 copay	Generic drugs: $3.70 copay or 5% (whichever costs more) Brand-name drugs: $9.20 copay or 5% (whichever costs more)
Generic	$10.00 copay	$10.00 copay	
Preferred Brand	$42.00 copay		
Non-Preferred Drug	50%		
Specialty Tier	31%		
Select Care Drugs	$0.00 copay		

[1] For all other drugs, you pay 25% for generic drugs and 25% for brand-name drugs.

Could you run through a “real life” example of a drug, beneficiary cost, manufacturer’s discount? There is a lot of confusion on this topic and what makes up the $6,550 OOP threshold.

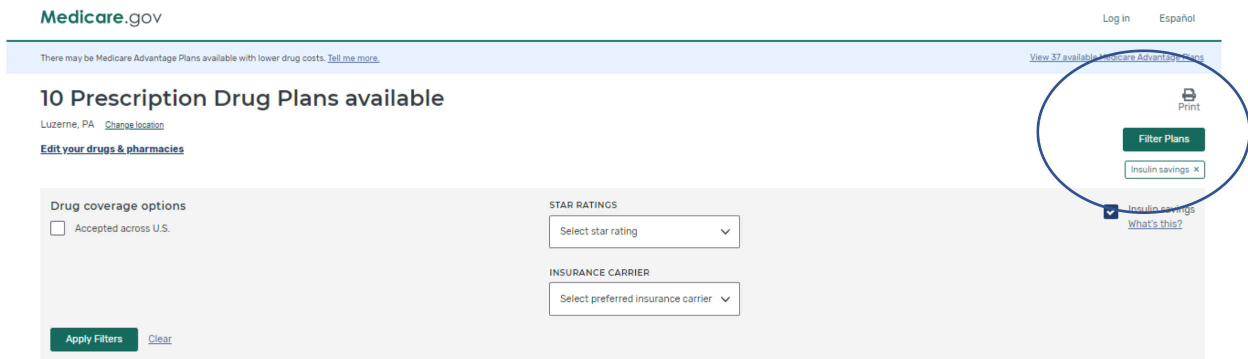
First, the $6,550 out-of-pocket (OOP) threshold is made up of a variety of payments which include payment made by the beneficiary or on behalf of the beneficiary and the manufacturer’s discount. For complete information on the costs that count toward TrOOP see section 30.1 of the Medicare Part D Manual .

The example below illustrates how the purchase of a $100 brand name drug (B) or $100 generic drug (G) drug during each phase of the Part D benefit contributes to beneficiary’s true out of pocket costs or TrOOP. The example assumes standard benefit design with a 25% coinsurance for all drugs during the initial coverage phase (ICP).

Part D Drug Phase	Cost calculation	Responsible for cost	TrOOP accumulator to reach $6550	
Deductible	$100 (B and/or G)	Beneficiary	$100	
ICP	$100 x.25 (B and/or G)	Beneficiary	$25	
Former coverage gap	$100 x.25 (G)	Beneficiary	Generic $25	
	($100 x .25) (B) + ($100 x .70) (B)	Beneficiary + Manufacturer discount		Brand $25 + $70 $95 total
Catastrophic (after accumulating $6,550 costs)	Greater of 5% or $3.70(G)/$9.20(B)	Beneficiary	< 5% drug cost or $3.70	< 5% drug cost or $9.20

I couldn't find the option in Medicare Plan Finder to filter just plans that offer the insulin savings program.

The insulin savings filter can be found on the plan results page by clicking on the Filter Plan button as show on the screen shot below.



What is an example of an enhanced drug plan?

Enhanced Plans (EA) offer a benefit package more generous than the Standard Benefit. Enhanced plans often include coverage of some drugs during the coverage gap phase. While most enhanced plans have higher premiums that is not always the case. Please use the link below to download the 2021 PDP landscape files and you can find a list of all enhanced and basic PDP plans in your state: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn

How do we know what types of insulin are under the Senior Savings Model or should the client speak with their medical provider to find out more? If a client is not on the type that is reduced, how can they find the types that are less expensive?

Plans participating in the Senior Savings Model are required to cover only one of each dosing form (vial or pen) and insulin type (rapid-acting, short-acting, intermediate-acting, and long-acting) at the $35 monthly or below copayment amount. The reduced copay amount will remain constant through the deductible, initial coverage phase and coverage gap phases of the part D benefit (but not in catastrophic phase).

While beneficiary and counselors can certainly enter alternative types of insulin into the Plan Finder to determine insulins that are available at reduced costs, beneficiaries should talk with their provider to ensure that a change of insulin is medically appropriate.

Other questions

Another Prior Authorization requirement is for "planned frequent ambulance non-emergency transport". Can you confirm this?

Depending on the circumstances, Medicare may cover scheduled/regular non-emergency ambulance transportation if the ambulance supplier receives a written order from the beneficiary's doctor in advance stating that transport is medically necessary. The order must be dated no earlier than 60 days before the trip.

Please see a very thorough explanation of the planned frequent ambulance non-emergency transport issue from our partners at Medicare Right's Center: https://www.medicareinteractive.org/get-answers/medicare-covered-services/ambulance-services/scheduled-non-emergency-ambulance-transportation

Also, Medicare never covers ambulette services. An ambulette is a wheelchair-accessible van that provides non-emergency transportation. Medicare also does not cover ambulance transportation just because the beneficiary lacks access to alternative transportation.

Acupuncture: I understand that at the present time only doctors can bill for this service, not acupuncturists. Any further info?

Please see the attached CMS Decision Memo for Acupuncture for Chronic Low Back Pain which indicates that physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel (but not acupuncturists) may furnish acupuncture: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295

Currently, acupuncturists are not recognized by CMS as Medicare providers, and are not eligible to bill for acupuncture services. It is possible, however, for acupuncturists to provide acupuncture as auxiliary personnel 'incident to' a physician's service in certain settings. For details regarding 'incident to' services, see the CMS regulations and guidance.

Some Medicare Advantage plans may offer additional acupuncture benefits. It is best to contact the plan to learn about any additional benefits