

Kidney Medicare Drugs Awareness and Education Initiative ***Tuesday, August 16, 2005***

Medicare: How it's Changing to Help More People Teleconference

Understanding Part D: Overview and Low-Income Subsidy for Medicare Beneficiaries with Limited Income and Resources

Speakers

Dolph Chianchiano; National Kidney Foundation; Senior Vice President, Health Policy & Research

Teri Arthur Browne; National Kidney Foundation's Council of Nephrology Social Workers; Moderator

Janice Mosby; Social Security Administration; Deputy Associate Commissioner of External Affairs

Susie Butler; Centers for Medicare and Medicaid Services; Division of Partnership Development

Presentation

Dolph Chianchiano: **[Slide 1]** Thank you, and hello. My name is Dolph Chianchiano. I am the Senior Vice President of Health Policy and Research for the National Kidney Foundation, otherwise known as NKF.

NKF and 35 other kidney organizations have come together under the umbrella of the Kidney Medicare Drugs Awareness and Education Initiative to provide information to patients and professionals on changes in Medicare coverage that could significantly impact the lives and health of people with kidney disease.

I'd like to welcome you the first of six teleconferences in our series entitled, Medicare—How It's Changing to Help More People.

Today's program will focus on an overview of the new Medicare Prescription Drug Coverage, also called Medicare Part D, and helping people with low income and assets get help through Medicare's low-income subsidy.

We're glad to have those of you who could join us today. We encourage all of you to visit our website, www.KidneyDrugCoverage.org where you can download a PowerPoint presentation of today's teleconference. Later, you will be able to download a transcript and/or listen to this teleconference there as well.

Medicare is changing significantly by adding a new drug benefit called Medicare Part D. Part D can help many people, including those with kidney disease, to save on their drug costs and to be able to afford to take the medications they need. Ultimately, our goal, through this initiative is to help those with kidney disease and kidney failure have the opportunity to live long, healthy and full lives.

This teleconference is one of the many ways that we're attempting to do this. You can find more resources on our website, www.KidneyDrugCoverage.org. Check back regularly, as we'll be adding to the site over the next few months.

I'd like to introduce you to our moderator for the day, Teri Arthur Browne, the Chairperson of the National Kidney Foundation's Council of Nephrology Social Workers. She will introduce our other speakers. Teri?

Teri Arthur Browne: **[Slide 2]** Thank you, Dolph. I'm excited to be here today to moderate this teleconference on Medicare Part D. I have with me today, Susie Butler, of the Division of Partnership Development for the Centers for Medicare and Medicaid Services, who will talk with us about the ins and outs of Medicare Part D.

I also have Janice Mosby, the Deputy Associate Commissioner of External Affairs from the Social Security Administration, with us today. Janice will talk with us about the low-income subsidy.

We're here to discuss the upcoming changes to Medicare, the government-sponsored health program for the elderly and people with disabilities or kidney failure. I'm sure you have questions about how those changes are going to affect the benefits your patients receive, particularly those with limited income.

Some patients may be asking questions already. We're here to help you help your patients to understand these Medicare changes. Although Medicare is a federal program, benefits depend on the beneficiary's unique circumstances, such as the type, date and place of a transplant, when dialysis started and the types of dialysis the patient is doing, other insurance he or she might have and for the first time because of recent changes in Medicare, income and assets.

So each patient you talk to could have a totally unique circumstance and Medicare experience, which means you have to take a lot of individual circumstances into account when advising them about Medicare Part D. By staying on top of Medicare and how it's changing, you'll be in the best position to help your patient.

Medicare is one of the most helpful patient programs available for people with disabilities, the elderly and those with kidney failure. If people use it to its full potential, it can even save their lives, and certainly make their lives a whole lot easier.

Today we'll talk about the nuts and bolts of Medicare and changes we expect to occur due to the Medicare Prescription Drug Improvement and Modernization Act of 2003. And more importantly, we'll talk about how those changes will affect your patients.

In the next 30 minutes, we hope to give you the information you need to help your patients understand what will happen, before the Medicare Part D program becomes fully operational. We'll also talk about how Medicare can help people with limited

income and resources.

We've got a lot to cover in only 30 minutes, so let's get started.

Susie, since you work with CMS, why don't you tell us about what's changing with Medicare?

Susie Butler: **[Slide 3]** Well, I'd be happy to. As you know, Medicare Part A covers hospitals, skilled nursing facilities, hospice and some home health costs. Medicare Part B covers outpatient care, including doctors and dialysis. As the primary payer, Medicare pays 80% of the allowed charge for Part B covered services. This means patients are on their own for the remaining 20%.

Medicare can be a secondary payer when someone has an employer group health plan. Medicare Part B pays for a few prescribed drugs, like EPO for those with chronic kidney disease and those on dialysis and anti-rejection medicines for transplant patients.

When a Medicare primary patient gets Part B drugs, Medicare Part B pays 80% of the approved drug cost. And this can be helpful, but Medicare doesn't pay for most take-home drugs. So, the beneficiary may not be able to take those drugs that they need.

Teri Arthur Browne: Isn't it true that Medicare will only cover 80% of the cost of anti-rejection drugs if the patient had Medicare at the time of the transplant?

Susie Butler: Well, you're right, right now. A transplant patient must have Medicare Part A at the time of the transplant. The transplant must be performed at a Medicare approved transplant program and the patient must have Medicare Part B at the time he or she wants Medicare to pay for the anti-rejection drugs. Most hospitals that perform kidney transplants are Medicare approved. However, some hospitals are not Medicare approved to perform other transplants.

Going on a little bit, Medicare Part A is free for most people. Medicare Part B is optional and has a monthly premium that changes every year. In 2005, that premium is \$78.20. Your patients should learn about the Part B when they enroll in Part A.

Teri Arthur Browne: About 93% of those with kidney failure are eligible for Medicare. Patients who don't have it can contact their local Social Security Office or call 1-800-772-1213 to apply.

Susie Butler: **[Slide 4]** Most Medicare beneficiaries have original Medicare or fee for service Medicare. They can choose where they get their healthcare, but patients may start dialysis or have a transplant while covered by a Medicare Advantage Plan, also known as HMO and PPO plans. Medicare Advantage Plans limit patient choices, but may have extra benefits.

Original Medicare will not pay for routine physicals, dental, vision or hearing exams. In

2006, some Medicare Advantage Plans may offer these services. However, Medicare Advantage Plans vary.

Teri Arthur Browne: I thought that people with ESRD are generally not eligible to join a Medicare Advantage Plan once they have kidney failure. Is this true?

Susie Butler: True, but someone with a successful transplant may be able to join a Medicare Advantage Plan if they still have Medicare. Their transplant program can send a letter to the Medicare Advantage appointment. If your patients want more information on Medicare Advantage Plans, help them to call 1-800-MEDICARE. In the future, dialysis patients may be able to join Special Needs Medicare Advantage Plans.

Teri Arthur Brown: Now that we know how Medicare works today, we need to talk about how it's changing on January 1st, 2006.

Susie Butler: **[Slide 5]** Well, on January 1st, 2006, Medicare will begin paying for prescription drugs. That doesn't mean that the drugs are free for beneficiaries. This coverage is not automatic. Beneficiaries must make a decision to get this extra help or this prescription drug coverage. How much they save depends on income and assets if they're applying for extra help and we'll hear more about that later. It also depends on marital status, how much they spend on drugs now and if the plan that they choose covers most or all of these drugs.

What the government hopes is that the Medicare Drug Coverage will help more people take the drugs that they need to stay healthy. At the same time, it should save you time you normally spend helping people who have no unlimited drug coverage right now.

[Slide 6] Like Part B, Medicare Prescription Drug Coverage is optional for all, except for those on Medicare and Medicaid, those with supplemental security income, or SSI, and those whose states pay all or part of their Medicare premiums through Medicare Savings Programs. Everyone else must join a prescription drug plan to receive these benefits. And there will be a monthly premium of around \$32 on average, in 2006.

Premiums are expected to go up each year. Premiums will be deducted from Social Security checks and billed to beneficiaries who don't get checks.

[Slide 7] Medicare has approved the plans that private insurance will sell. In October, each will publish the list of drugs that that plan will cover. These lists of covered drugs are called formularies. Formularies are very important for patients, because they describe what a Medicare Prescription Drug Plan, or you might see it referred to as a PDP, will and won't cover.

Medicare Advantage Plans can also offer Medicare Prescription Drug Coverage and establish formularies. Your patients may want help to make important decisions. To start, they will have to choose which Prescription Drug Plan they want and then they should make that decision based on which formularies work best for them.

Teri Arthur Brown: **[Slide 8]** Our patients need to think not only of what formularies work best for them right now, but for drugs that they might need in the future if their health changes or if they change treatment modalities. This is something that doctors, nurses and dieticians can help them think about.

Susie Butler: **[Slide 9]** That is an important distinction that people with chronic illnesses need to consider. Starting in October, private insurance companies offering Prescription Drug Plans will mail information about their plans and formularies to Medicare beneficiaries in their area. This should help your patient see their options.

In the fall of 2005, those with Medicare will also receive the *Medicare & You 2006* handbook in the mail. It will include information about Medicare Prescription Drug Plans available in their area. Everyone should have at least two options, but there will probably be more, especially in some areas.

The Medicare website, www.Medicare.gov has information about the new prescription drug coverage. However, on October 13th, 2005, the website will post a Medicare Prescription Drug Plan finder tool to help Medicare beneficiaries with their plans.

Teri Arthur Browne: So it sounds like we'll have a lot of resources to answer our own and or patients' questions about the new plan, including the website, www.KidneyDrugCoverage.org.

Susie Butler: Yes. And those who don't want to use the web can call 1-800-MEDICARE or those who use a TTY can call 1-877-486-2048 to get more information now about Medicare Prescription Drug Coverage and in October they can get more help to choose a plan.

Another resource is your State Health Insurance Assistance Program, or SHIP. Every state has one. Its process is to help Medicare beneficiaries manage their costs and coverage and appeal Medicare decisions. The *Medicare & You 2006* handbook lists the phone numbers for your local SHIP.

Teri Arthur Browne: SHIP agencies may be able to advise our Medicare patients about Medicare Part D and choosing a plan. They might even be able to visit a clinic to talk with patients.

Susie Butler: **[Slide 10]** The most important thing for your patients to understand is that how much they save on drugs depends entirely on how much they spend on drugs now and in the future, whether these drugs are covered by the Prescription Drug Plan, and whether they qualify for the low-income subsidy, also called "extra help."

[Slide 11] Those who do not qualify for the low-income subsidy, which Janice is going to discuss in a few minutes, must pay the premium, which is estimated to be around \$32 a month, or about \$384 a year. They must pay the first \$250 of their drug costs each

year, called a deductible. After they spend \$250 on drugs, they pay 25% of their drug costs, up to \$2,250. From \$2,251 to \$5,100—another \$2,850—they must pay 100% of their drug costs. You might have heard this called a “coverage gap.”

Once someone buys \$5,101 worth of drugs, which translates into spending \$3,600 out of pocket, Medicare pays 95% of the cost of their covered drugs for the rest of the year. The \$3,600 that patients must spend out of pocket to get this coverage is referred to as the “true out-of-pocket,” or TrOOP. This will be tracked for patients.

Teri Arthur Browne: **[Slide 12]** So, if I understand correctly, in 2006, if a patient has \$2,250 in covered drug costs, Medicare Part D will pay \$1,500, or two-thirds of that. If that patient has \$5,100 in covered drug costs, Medicare Part D still pays \$1,500, or 29%. I read that that Medicare Rights Center estimates if people have no drug coverage now and their drugs cost \$70 a month, as long as those drugs are covered by the PDP, they will save money on Part D.

It seems like those who will get the most help from Medicare Part D are those on home dialysis, who are not in a clinic to get the Part B covered drugs that are delivered in a clinic and must take oral ones instead, and those whose annual drug costs are less than \$2,250 or more than \$5,100.

Later in this teleconference, Janice is going to talk about the low-income subsidy and in a future teleconference, we'll discuss other sources that might help patients pay all or part of the \$3,600.

Susie Butler: **[Slide 13]** Yes. And let me give another example. The \$5,100 only includes drugs on the Plan's formulary. If a person in the Medicare Prescription Drug Plan buys a drug that's not on that Plan's formulary at his or her own expense, this cost does not count toward the \$3,600 that triggers Medicare payment at the 95% level. The 20% co-payment for drugs covered under Medicare Part B doesn't count, nor do payments for drugs bought outside the United States. And of course, the premium doesn't count for true out-of-pocket expenses.

[Slide 14] Medicare Prescription Drug Coverage Plans or Medicare Prescription Drug Plans must cover at least two drugs in each class of drugs. So some drugs that patients need may not be covered in all PDPs' standard packages.

Some PDPs may offer optional benefits beyond what the standard plan offers. PDPs may charge a higher premium for them or the patient's cost share on those drugs may be higher.

Teri Arthur Browne: The kidney community is paying close attention to which drugs are included on the formularies. We'll talk in a future teleconference about getting these drugs covered.

Susie Butler: And you should note that PDPs will cover both brand name and generic

drugs.

Teri Arthur Browne: Well, generic drugs are usually cheaper and insurers often try to encourage patients to use these drugs. However, many physicians won't prescribe certain generic drugs for people with kidney disease. Furthermore, pharmacists should never switch a transplant recipient from a brand name drug to a generic drug, or from one brand of generic to another brand of generic, without notifying patients and their doctors first.

So if our patients are considering a PDP and a drug they normally take is only included in a generic form, we need to urge them to ask their doctor if that generic drug is okay to take. Our staff will need to monitor this carefully.

[Slide 15] Susie, I've heard companies can withdraw a drug from a formulary with only 60-days notice, but patients, except for those with Medicare and Medicaid can only change plans once a year. I guess this is when it helps to know your rights. A future teleconference will discuss exceptions and appeals.

Susie Butler: **[Slide 16]** Well, people may think that Medicare Prescription Drug Coverage is only for the poor, because the initial focus has been on signing up those beneficiaries for the low income subsidy. In fact, anyone who qualifies for Medicare and has Medicare Part A or Medicare Part B, can join a prescription drug plan.

Except for those with Medicare and Medicaid who will be automatically enrolled, everyone else can join a prescription drug plan from November 15th of this year through May 15th of 2006. They can do this by sending an application to the prescription drug plan that they choose or they can apply on line through the Medicare website at www.Medicare.gov. Remember, the enrollment does not start until November 15th. Those that get Medicare in the future will have six months to join a prescription drug plan as well.

Teri Arthur Browne: I've heard some patients say that they're not going to get a Medicare Part D plan, because they don't spend much on drugs right now. What should we tell them?

Susie Butler: **[Slide 17]** Well, they need to know that even if they don't join during the additional and initial enrollment period, and if they need an expensive drug soon afterwards, they would have to pay the full cost of that drug for up to a year. Also, if they enroll late, they may have to pay a higher premium, at least 1% for each month that they delay joining a prescription drug plan when they were first eligible. And this can add up pretty quickly.

Teri Arthur Browne: So it's really important that we start discussing Part D with our patients right now, so that when November comes, they can enroll with out a penalty, if that's what they want to do.

Now let's talk about what help patients with limited income and resources may get. I'd like to ask Janice Mosby, from the Social Security Administration to talk with us about this help. Janice?

Janice Mosby: **[Slide 18]** The government has made an important decision about low-income beneficiaries. Anyone who has Medicare and Medicaid, the program for those with low-income, will be auto-enrolled in Part D this Fall, so they will have Part D coverage on January 1st, 2006. On that date, Medicare Part D will replace Medicaid drug coverage for Part D drugs.

In late October, those with Medicare and Medicaid will receive a letter from CMS telling them the PDP they have been assigned to. The PDP will be selected at random, not based on the drug a person takes or what drugs are covered by the plan. Therefore, if your patients want a different plan, they must switch by December 31st to have the plan they want starting January 1st, 2006.

Those with Medicare and Medicaid are the only ones who can change plans any month. Others must wait until the next open enrollment, which is November 15th through December 31st each year.

[Post-teleconference update due to Medicare prescription drug policy change: People with Medicare Savings Programs (QMB, SLMB, and QI can also switch plans any time and their new plan will start the next month. People with SSI without Medicaid get one special enrollment period per year to switch plans with the new plan taking effect the following month.]

Teri Arthur Browne: **[Slide 19]** I've read on the CMS website that those with a Medicaid spenddown who document or state that they have enough medical bills between September 1st and December 31st in a year, will get the subsidy for all of the next year. Social workers should encourage their patients to show bills that count toward the spenddown to their Medicaid caseworkers between September and December.

Janice Mosby: **[Slide 20]** People who don't qualify for Medicaid but still have limited income and assets, may qualify for Medicare Savings Programs to help pay premiums and in some cases, Medicare covered services. As you know, the Qualified Medicare Beneficiary program or QMB, pays Medicare Part A and B premiums, deductibles and Medicare co-insurance.

The Specified Low-income Medicare Beneficiary program or SLMB, pays the Medicare Part B premiums. The Qualifying Individual program, or QI, pays part of the Medicare premium. State Medicaid offices administer these programs.

We talked about how Medicare will assign people with Medicare and Medicaid to a Part B plan this fall. Medicare will also assign those Medicare beneficiaries who do not have full Medicaid, but who get SSI checks, or any of the Medicare Savings Programs to a PDP, if they don't join a Part D plan by May 15th, 2006. Again, Medicare doesn't know what drugs they take, so it may not choose a plan that covers most of their drugs.

Teri Arthur Browne: They should talk with their doctors about the drugs they may need, so they can choose a plan that covers most or all of these drugs before May 15th, 2006.

Janice Mosby: **[Slide 21]** The government will provide help to those with Medicare and Medicaid, SSI or Medicare Savings Programs, and those whose incomes are less than 150% of the Federal Poverty Level, who have limited assets through a low-income subsidy. Those on Medicare and Medicaid, SSI or Medicare Savings Programs automatically get this help.

They should get a letter this summer from CMS telling them they qualify. The subsidy—which has a value of about \$2,000—will pay the monthly premium and yearly deductible for Part D and most of the cost of covered drugs, except for a small co-pay on each prescription filled.

[Slide 22] Others with low-income, may qualify for help too. They should get a letter from Social Security. Single people can qualify if their income is less than \$14,355 and their assets are less than \$11,500. This includes \$1,500 for burial expenses.

Couples can qualify if their income is less than \$19,245 and their assets less than \$23,000. And this amount includes \$3,000 for burial expenses.

The income levels are higher if the individual or spouse works or if they live in Alaska or Hawaii or have dependent relatives living with them. Encourage anyone you think to apply, because Social Security can help them figure out what does and does not count as income and assets for Part D.

Teri Arthur Browne: **[Slide 23]** Social workers should ask patients to bring in any government letters they get, including notices about extra help and anything they get from their current health insurer or PDP. By knowing what letters patients get and keeping a copy of these important papers, we can make sure that patients get all the help they deserve, plus we and they will have proof of what they have received or filed if questions arise later.

Janice Mosby: If you have any patients who believe they may qualify for extra help, but did not receive a letter from CMS or Social Security, they should call Social Security at 1-800-772-1213 to ask for an application. On July 1st, patients can start filling out applications in English and Spanish at www.SocialSecurity.gov. Instructions are in multiple languages, but people must use either the English or Spanish form to apply.

Teri Arthur Browne: Patients can also apply for the low-income subsidy through state Medicaid offices. What proof does someone need to document their income and limited assets?

Janice Mosby: Social Security uses the online or mail-in application to verify someone's income, assets and family size. Beneficiaries must sign the form, vouching for its

accuracy. People don't need to lug in financial documents, because Social Security and other government agencies can share information across databases.

As you said, Teri, people can also apply at their State Medicaid office. When they apply for the low-income subsidy there, the State may ask for and verify financial statements. Medicaid offices don't have access to the same databases as Social Security. Another reason why the State asks for more proof is to find out if applicants are eligible for other financial help.

If someone believes he or she should have received a low-income subsidy or a full subsidy instead of a partial one, there is an appeals process. The letter that they get telling them what they are eligible for will tell them their appeal rights.

If some of your patients are no longer eligible for Medicaid, urge them to apply for a Medicare Savings Program so they can get the largest subsidy. If they don't qualify for a Medicare Savings Program, encourage them to still apply. They may get a partial subsidy that will save them money on premiums and deductibles. The sooner someone applies for help, the sooner they will learn if they qualify.

On www.Medicare.gov you will find a Medicare Prescription Drug Benefit Subsidy Eligibility Information tool. This will help you and your patients see if they are eligible for extra help and what they need to do to get it. You can also call 1-800-MEDICARE.

Teri Arthur Browne: Well, I think that just about summarizes the main changes to Medicare and how they might affect your patients. Dolph?

Dolph Chianchiano: **[Slide 24]** I'd like to thank Teri, Susie and Janice for sharing their time and expertise with us today. We want to thank all of you for joining us and helping us inform Medicare beneficiaries about the upcoming Medicare changes. We hope this teleconference helped you learn more about Medicare's new Prescription Drug Coverage, what factors may affect savings and how and where people with low-income may apply for extra help.

To keep you up to date, we are planning additional discussions about what you need to know in the next few months when patients need to start making decisions about Part D. You can participate live, at noon Eastern Time, or access these teleconferences later, at www.KidneyDrugCoverage.org.

Our next conference will be on Tuesday, September 20th, when we'll discuss coordinating Part D benefits with Medicaid, Medicare Savings Programs, Medigap, Employer and Retiree health programs, and Union Plans.

We hope you can join us on future teleconferences. If you'd like an attendance certificate, go to www.KidneyDrugCoverage.org and complete the online evaluation. Check with your licensing agency to find out if you can get continuing education credit using this certificate.

Also, feel free to submit your questions for this and future conference topics by emailing us at Info@KidneyDrugCoverage.org.

Thank you for joining us and have a good day.