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Prescription Drug Coverage Reference Guide

UnitedHealthcare
Medicare Solutions

2016 Prescription Drug Coverage Reference Guide

This guide is all about Medicare Part D prescription drug coverage and includes answers to common questions and how to prevent complaints or errors when enrolling consumers in a stand-alone Prescription Drug Plan (PDP) or a Medicare Advantage Plan that has integrated prescription drug coverage (MA-PD).

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Medicare Part D and Consumer Eligibility

Medicare Part D

Medicare Part D is a government program that helps Medicare beneficiaries cover the cost of prescription drugs. To obtain Medicare prescription drug coverage, consumers must enroll individually in a plan offered by a private insurance company or other private company approved by Medicare. Benefits, such as the drugs covered, and costs can vary by plan and can change from year to year. Do not confuse prescription drug coverage with pharmacy discount card programs.

A consumer, who wants Medicare Part D benefits, can meet their prescription drug coverage needs in two ways:

1. Medicare Prescription Drug Plans, also known as PDPs, are stand-alone plans that add prescription drug coverage to Original Medicare, some Medicare Cost Plans, and some Medicare Private Fee-for-Service (PFFS) Plans. Remember, when a consumer has Original Medicare and a stand-alone PDP, they can also have a Medicare Supplement Insurance Plan.
2. Medicare Advantage Plans with prescription drug coverage, also known as MA-PDs, offer Medicare prescription drug coverage in addition to medical coverage. Consumers enrolled in these plans receive all their Medicare Part A and Part B coverage as well as their prescription drug coverage (Part D) from the plan.

Consumer Eligibility

To enroll in a stand-alone PDP, the consumer must:

- Be entitled to Medicare Part A, **or**
- Be enrolled in Medicare Part B*, **or**
- Be entitled to Medicare Part A and enrolled in Part B*

To enroll in an MA-PD, the consumer must be entitled to Medicare Part A **and** enrolled in Part B*

In addition, the consumer must live in the plan's service area **and** have a valid election period.

* A consumer enrolled in Medicare Part B must continue to pay their Part B premium in addition to any plan premium.

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Enrolling in a PDP or MA-PD may affect the consumer’s membership in other insurance plans. Before enrolling a consumer in a new plan, you must understand:

- The consumer’s current plan coverage
- If the consumer can combine a Medicare Part D plan with their existing coverage

For example:

1. A consumer enrolled in an MA or MA-PD will be automatically dis-enrolled from that plan and returned to Original Medicare upon enrolling in a stand-alone PDP (with the exception of PFFS plans that do not have prescription drug coverage).
2. A consumer enrolled in an employer or union-sponsored health plan may lose coverage for themselves and their dependents upon enrollment in a stand-alone PDP or MA-PD and may not be able to reenroll in the employer or union plan at a later date. Consumers should contact their benefits administrator for more information before making any changes to their coverage.

A common complaint members make to Medicare is that they were enrolled in an unsuitable plan. To avoid this complaint, be sure to do the following when presenting a stand-alone PDP or MA-PD to consumers:

- Conduct a thorough needs assessment to understand the consumer's current medical and prescription drug coverage, current prescription medications, and financial considerations and personal preferences.
- After advising the consumer of their options, present and/or recommend a plan that is equal to or better than their current coverage.
- Make sure the consumer understands what the plan covers, such as medical coverage, prescription drug coverage, premium, deductible, coinsurance or copayment.
- Carefully indicate on the enrollment application the plan selected by the consumer.
- Look up all the consumer’s medications to ensure the plan covers them by using the formulary or drug cost estimator tool (see Formulary section for more information).

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Cost Sharing and Drug Payment Stages, including the Coverage Gap

All Medicare Prescription Drug Plans must meet the standard Part D benefit defined by Medicare, regardless if it is a standalone plan or in conjunction with a Medicare Advantage plan. As long as Medicare Prescription Drug Plans have met the standard Part D benefit, they can then offer features and benefits that vary by plan, such as:

- The monthly plan premium
- Copayment/coinsurance levels
- Different drugs on the formulary or drug list
- Different drug coverage by tier
- Different pharmacies in their network
- Deductibles
- Benefit levels in the coverage gap

It is important that you understand cost sharing elements and drug payment stages and are able to clearly explain them to a consumer.

Cost Sharing Elements

Plan Premium

The monthly payment to the plan for prescription drug coverage. The plan premium is in addition to the member's Part B premium, which they must continue to pay. You must explain that the consumer may be required to pay a Part D income-related monthly adjustment amount if their modified adjusted gross income, as reported on their IRS tax return from two years ago, is above a certain limit. The income-related amount is paid directly to Medicare, not to the plan. For 2015, the income limit was $85,000 for individual and married filing separate tax returns and $170,000 for joint tax returns.

Deductible

The deductible is the amount the member must pay toward their prescription medications before the initial coverage stage begins (the Prescription Drug Plan begins to pay). In 2016, deductibles range from $0 to the maximum allowable deductible of $360. If the plan includes a deductible, the member must pay a deductible (amount varies by plan) before the plan starts paying benefits.

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If the plan includes a deductible, it can apply to all of a plan's drug tiers or only to a plan's specific drug tiers. For example, a plan may have a drug deductible that only applies to tiers 3-5. This means the member will have no deductible when getting Tier 1 and 2 medications but will need to meet the deductible when getting medications on Tiers 3 – 5 before the plan starts to pay.

There are also special circumstances with a plan deductible if a member switches plans mid-year. The following examples explain some of those circumstances:

Example #1: Maggie lives in Wisconsin and is enrolled in an MA-PD plan. After spending another cold winter in Wisconsin, she decides in April to move to Florida for good. Her WI MA-PD plan has a drug deductible of $210, which Maggie already satisfied. She picks a new MA-PD plan in FL that has a $280 deductible. Because Maggie already satisfied the Part D deductible for the WI plan, and she is moving to a new plan mid-year, her new plan deductible is already considered satisfied, even though it is a higher amount. Maggie will skip the deductible phase when using her new plan.

Example #2: In January, Lucy enrolled in a stand-alone PDP that did not have a deductible. Lucy is diagnosed with a qualifying chronic condition in April and enrolls in a Chronic Special Needs Plan (CSNP), which has a $250 deductible for Tiers 3 - 5 and a Tier 3 copay of $45. She takes a Tier 3 drug that costs $180. On her previous plan, Lucy paid a $95 copay for the Tier 3 drug. The $95 she spent will apply to the $250 deductible. When Lucy picks up her first prescription on the chronic plan she will pay ($250 - $95 = $155 + $25 = $180). At Lucy's next fill of this drug, she will pay the $45 copay.

Because she switched plans mid-year, her out-of-pocket costs paid on her old plan are applied to the deductible of her new plan. Her prescription is a Tier 3 drug so the deductible and copay will apply. Lucy will pay the remainder of the deductible ($250-$95=$155) plus the Tier 3 copay of $45, except that the cost of the drug is less than the total of $200. Therefore, she will only pay a $25 copay for a total cost of $180. She has satisfied the Tier 3 deductible for this plan and the next time she picks up her prescription the cost will be the Tier 3 copay of $45.

<u>Coinsurance</u>

Usually a percentage, it is the amount the member may be required to pay as their share of the cost of prescription medications. For example, a member pays 25% of the medication's cost as their share. A member's coinsurance amount or percentage may change based on the plan they are in and the pharmacy they use. See page 9: Why drug costs may change

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Copayment

Usually a set amount, it is the amount the member may be required to pay as their share of the cost of prescription medications. For example, a member pays $2.50 for any medication in the tier as their share of the medication's cost.

Prescription Drug Plan Coverage Changes for 2016

	2015	2016
Annual Deductible	$320, if applicable	$360, if applicable
Initial Coverage Stage	Ends at $2,960	Ends at $3,310
Coverage Gap	Until $4,700	Until $4,850

Drug Payment Stages

There are several drug payment stages that a member may go through while using their Prescription Drug Plan. After paying the plan deductible (if applicable), the member may move into the initial coverage, the coverage gap, and the catastrophic coverage drug payment stages. To determine when a member moves from one stage to the next, the plan keeps track of the member's TrOOP (True Out-of-Pocket) costs. Any money spent during the Deductible, Initial Coverage, and Coverage Gap stages count towards the TrOOP costs. The monthly premium does not count toward TrOOP costs. On January 1 of each year, the drug payment stages start over.

Initial Coverage

Begins after the member has paid the plan's deductible (if applicable) and continues until total drug costs paid by the member and the plan total $3,310 (for 2016). Plan premiums paid by the member are not included in the total drug cost calculation.

Coverage Gap (Donut Hole)

Most plans have a coverage gap, which begins when the member has reached the cost limit of the initial coverage period and ends when the member has spent $4,850 (in 2016) in out-of-pocket expenses for the plan year. Exceptions may apply for consumers receiving a Low-Income Subsidy (also called Extra Help).

- The coverage gap is a temporary limit on what the Medicare plan will cover for drugs.
- Not every member will enter the coverage gap.
- The coverage gap begins when the combined amount the member and plan have spent on covered drugs reaches $3,310 (for 2016), which includes the deductible, but not plan premiums.
- Once a consumer reaches the coverage gap in 2016, they will pay 45% of the cost for most brand-name drugs and 58% of the cost for generic drugs.
- Consumers who get Extra Help paying Part D costs will not enter the coverage gap.

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Some plans offer additional coverage to a member in the coverage gap, but may charge a higher plan premium. Check with the plan first to see if the consumer's drugs would be covered during the gap.

Members often have difficulty understanding the Coverage Gap and how it may affect them. To avoid this complaint, make sure to review the following information:

- Clearly describe the coverage gap to Medicare consumers so they are aware of the costs they may incur when reaching a reduced level of coverage during the coverage gap.
- Not every Medicare consumer enrolled in a plan with Part D benefits will reach the coverage gap. Many plans have a coverage gap that starts after a member incurs $3,310 in medication spending for the year.
- Each Medicare consumer should consider their own situation when deciding on a benefit plan and the level of risk they want to assume.
- Some plans offer additional coverage through the coverage gap, usually at a higher monthly plan premium. For consumers who are unlikely to reach the coverage gap, this higher premium plan may not be suitable.
- The use of lower cost generic medications may prevent the member from reaching the coverage gap and can significantly reduce the member's costs while in the coverage gap.
- If a non-LIS eligible member reaches the coverage gap, they will have access to a Plan's negotiated pharmacy discount rate for Medicare Part D medications and receive a 55% discount* for brand-name drugs in the gap. They would also pay 58% of the cost of generic drugs in the gap. Different sponsors have different pharmacy contracts; therefore, negotiated discounts can vary.

* The manufacturer discounts brand-name drugs about 50% and the Plan must pay 5%, leaving the member with about 45% of the brand-name drug cost.

Catastrophic Coverage

Begins when the member has reached the cost limit of the coverage gap. In this stage the member will only pay a small coinsurance or copayment amount for covered drugs for the remainder of the plan year. Exceptions may apply for consumers receiving Extra Help.

Why Drug Costs May Change: Members may ask why the cost of their medications change throughout the plan year. There are only a few reasons why prescription drug costs may change. Review the below scenarios for possible explanations:

1. Drug Payment Stage: Are they in the deductible stage? Have they moved into the coverage gap? If a plan has a standard deductible, the member will pay all costs until the deductible amount is met. If a plan only has a deductible on specific tiers, the member will pay all costs in the specific tier(s) the deductible applies to until

the deductible amount is met. If the member has reached the coverage gap, the cost for their medications may change. They may be responsible for more of the cost until they reach the catastrophic coverage amount for the plan.

2. Lesser of Logic: Is the member taking a medication whose cost is less than the copay? If so, the member may pay a slightly different amount each month because it's based on the average cost of the medication and the pharmacy used, but should never be more than the copay (unless they are in the coverage gap).
3. Extra Help: Has anything changed with the member's Low Income Subsidy or Medicaid status? Moving to a different level of LIS coverage can affect copay amounts. Likewise, a change in Medicaid status may affect eligibility for assistance with medications.
4. Pharmacy Differences: The pharmacy a member chooses may impact the cost of their medications. Depending on their plan type, they have different types of pharmacies to choose from:

Pharmacy Saver Program (MA-PD)

MA-PD members can access the Pharmacy Saver program. Refer to www.pharmacysaver.com (AARP branded plans) or www.unitedpharmacysaver.com (UnitedHealthcare branded plans) to access a list of pharmacies that participate in the program. The program may save members money on certain medications or offer suggestions for lower cost alternatives.

Preferred vs. Non-Preferred Pharmacies (PDP)

Stand-alone PDP members can choose to access pharmacies in the preferred pharmacy network for cost savings. Preferred pharmacies can be located using the online drug cost estimator tool and may offer savings on certain medications versus using Non-Preferred pharmacies.

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Late-Enrollment Penalty

Consumers are eligible to enroll in a Medicare Prescription Drug Plan when they become eligible for Medicare. If they do not enroll during their initial enrollment period, a penalty may be applied.

What is the Late Enrollment Penalty (LEP)?

- A member might have to pay a LEP if they did not enroll in a Medicare plan with prescription drug coverage when they first became eligible for Medicare and did not have other creditable coverage or if at any time after their initial enrollment period is over, there is a period of 63 or more consecutive days when they did not have Part D or other creditable prescription drug coverage.
- The LEP is an amount added to the member's monthly plan premium and they may have to pay the penalty as long as they have a Medicare drug plan.
- If a consumer qualifies for Low Income Subsidy, i.e. Extra Help, the LEP may be reduced or eliminated.
- The member will receive an attestation form from UnitedHealthcare and will need to attest to the exact dates they had creditable coverage as well as with whom they had creditable coverage (e.g., VA benefits).

How Does CMS Calculate the Late Enrollment Penalty?

CMS calculates the LEP by multiplying 1% of the "national base beneficiary premium" (NBBP)* times the number of months the member was eligible but did not join a Medicare drug plan (round to the nearest $.10): 1% x # of months x 33.13 (2015 NBBP) = penalty. For example, if a member did not have creditable prescription drug coverage from June 2012 – December 2014 and is adding drug coverage effective January 1, 2015, the penalty would be 1% x 31 months = .31 x 33.13 = $10.30 (10.27 rounded to nearest .10). This member would pay $10.30 each month in addition to the plan's premium.

*NBBP can change from year to year causing variance in the LEP amount.

Members may complain because they do not fully understand the Late Enrollment Penalty. To ensure your member understands how LEP may affect them:

- Ask probing questions about prior prescription drug coverage to determine if they are likely to incur a Late Enrollment Penalty.
- Agents should not attempt to estimate the LEP penalty amount. Agents should clearly explain the Late Enrollment penalty but advise that the amount of the penalty is computed by CMS.
- Advise members that the LEP (if applicable) will be in addition to any premium on the plan.

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Creditable Coverage

What is Creditable Coverage?

Creditable coverage is prescription drug coverage (for example, from an employer, union, TRICARE, Indian Health Service, or the Department of Veterans Affairs) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Consumers with creditable coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

The organization providing the prescription drug coverage must inform the consumer annually (generally in a letter or organization newsletter) if the prescription drug coverage is creditable coverage. The consumer will need this information if they later enroll in a Medicare plan that provides prescription drug coverage.

What if a Consumer Goes Without Creditable Coverage?

If a consumer does not enroll in a Medicare Advantage Plan with integrated Part D benefits or a Medicare Prescription Drug Plan when they are first eligible for Medicare Parts A and/or Part B or they go without creditable prescription drug coverage for 63 continuous days or more, they might have to pay a late enrollment penalty if they enroll in a plan at a later date.

NOTE: If your consumer is enrolling for the first time in a plan with Medicare Part D benefits or appears to have had a gap in coverage for 63 or more continuous days, advise them that they will receive a letter and attestation form from UnitedHealthcare. The consumer must fill out and return the form or call the Customer Service number indicated in the letter to attest to having creditable coverage prior to enrolling. They must provide the exact dates as well as with whom (e.g., VA benefits) they had creditable coverage. See the enrollment handbook for more details.

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Drug Tiers, Formulary, and Coverage Rules

Consumers must understand all the characteristics of the plan's prescription drug coverage including the formulary, drug tiers, and coverage rules specific to the plan.

Drug Tiers

Many Medicare Prescription Drug Plans group covered medications into tiers. The number of tiers may vary from plan to plan. Generally, the lower the tier, the lower the cost of the drugs in the tier.

Example Plan with Five Drug Tiers

Tier	Member Pays	What is Covered?
Tier 1 Preferred Generic	Lowest copayment	Lower-cost, commonly used generic drugs
Tier 2 Generic	Low copayment	Most generic drugs
Tier 3 Preferred Brands	Medium copayment	Many common brand-name drugs and some higher-cost generic drugs
Tier 4 Non-Preferred Brands	Higher copayment or coinsurance	Generic and non-preferred brand-name drugs
Tier 5 Specialty Tier	Coinsurance	Unique and/or very high-cost drugs

Formulary

- A list of medications covered within the benefit plan; often represents the level of cost-sharing associated with various groupings of medications (Preferred Generics, Generics, Preferred Brand, Non-Preferred Brands, and Specialty). Some online formulary documents list only the preferred generic and brand-name drugs. This is called the Preferred Drug List or PDL.
- Each plan develops its formulary through a very rigorous clinical evaluation process, including physicians and pharmacists.
- CMS provides strict guidelines to the plans regarding the types of medications that must be covered. CMS also reviews and approves each plan’s formulary.

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Types of Drug Lists and Formularies:

- Abridged Drug List: Available in the Enrollment Guide for PDP plans, the abridged drug list displays an alphabetical list of the most commonly used covered drugs, but is not a full list. Drug lists do not call out special handling circumstances related to specific drugs.
- Comprehensive Drug List: Available in the Enrollment Guide for MA-PD plans, the comprehensive drug list displays a more complete alphabetical list of covered drugs. Drug lists do not call out special handling circumstances related to specific drugs.
- Abridged Formulary: Available in the Welcome Guide (PDP) or Plan Details (MA-PD) after enrollment, the abridged formulary is organized by drug class with an alphabetical index in the back. The chart displays the most commonly used medications, Tier levels, and special handling circumstances.
- Comprehensive Formulary: A complete formulary listing all covered medications by drug class with an alphabetical index in the back. The chart includes Tier levels and special handling circumstances. This PDP or MA-PD plan formulary is available for agent download on the Agent Materials Portal.
- Drug Cost Estimator Tool: Available on the Distribution Portal, prescription and plan information can be entered to estimate coverage and costs for a consumer.

NOTE: The formulary may change during the plan year. Always check for change notices if using the formulary or view the formulary on the member website.

Coverage Rules

Plans may have coverage rules that the member must follow.

Prior Authorization (PA)

The plan requires the member or their doctor to get prior authorization for certain drugs. This means the plan needs more information from their doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If the member does not get approval, the plan may not cover the drug.

Quantity Limits (QL)

The plan will cover only a certain amount of a drug for one copay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug. If the member's doctor prescribes more than the allowed amount or thinks the limit is not right for the member's situation, the member or their doctor can ask the plan to cover the additional quantity.

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Step Therapy (ST)

There may be effective, lower-cost drugs that treat the same medical condition as the prescribed drug. The member may be required to try one or more of these other drugs before the plan will cover the prescribed drug. If the member has already tried other drugs or their doctor thinks they are not right for them, the member or their doctor can ask the plan to cover the drug.

HRM = High Risk Medication

A drug may be known as a high risk medication (HRM) for patients 65 and older because it may cause side effects if taken on a regular basis. In these situations, the member is encouraged to talk with their doctor to see if another drug is available to treat them.

Note: If the member is 65 or older, they will need to get a prior authorization (PA) or formulary exception from the health plan before taking a high risk medication (HRM). If the member is under 65, the prior authorization (PA) will not apply to them until the first time they get their prescription filled after turning 65.

If the member or their prescriber feel that one of the coverage rules should be waived by the plan, they may ask the plan for an exception.

Ensure that all of the consumer's medications are reviewed to estimate costs. It is important for consumers to understand what costs and coverage rules will apply to them. Use the formulary or the online Drug Cost Estimator Tool found on the Distribution Portal. (Use the Drug Cost Estimator Tool Guide for instructions).

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Medicare Part B or Part D Coverage Determination

Depending on how a drug is used, it may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs). The member's doctor may need to provide the plan with more information about how the drug will be used to make sure it is correctly covered by Medicare.

Examples of Medications that may be billed as Part B or Part D (not a comprehensive list):

Medication	Coverage Under Part B	Coverage Under Part D
Vaccines	Flu, pneumonia, and Hepatitis B vaccines. OR If you have been exposed to a dangerous virus or disease.	All other commercially available vaccines, including the shingles vaccine.
Inhalation Drugs(provided by infusion/durable medical equipment provider)	Drugs used with a nebulizer in the home.	Drugs used with a nebulizer in a Skilled Nursing Facility (SNF) or as an inpatient in the hospital, which is not covered by Part A or the member does not have Part A. OR Drugs administered without a nebulizer (e.g., metered-dose inhalers, dry powder inhalers, nasal spray inhalers). In some cases, the inhaler itself may be covered by Part D.
Injectable Drugs	The drug generally cannot usually be self-administered. The member's doctor provides and administers the drug.	The member can buy the drug at the pharmacy and it is either administered by the member's doctor or the member administers the drug themselves.
Medications Received as a Hospital Outpatient	If they relate to the care or procedure the member is receiving in the hospital.	Medications the member usually takes and administers themselves.

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Medication	Coverage Under Part B	Coverage Under Part D
Infusion Drugs	Drugs administered by an implantable infusion pump (e.g. diabetic insulin pump). OR Drugs administered by an external infusion pump that the member uses at home and their local Durable Medical Equipment (DME) contractor covers them under Part B.	Drugs administered by an external infusion pump outside of the home (e.g., SNF or hospital) and the member's stay is not being covered by Part A or the member does not have Part A. OR Drugs administered by an external infusion pump that the member uses in the home but their DME contractor does not cover them under Part B for use in the home. OR Infusion drugs administered at home without an infusion pump at home (e.g. IV push).

Exceptions and Appeals

Occasionally, a member may not agree with the coverage determination made by the plan and can appeal that decision by asking for an exception.

An exception is a type of initial determination (also called a coverage determination) involving a Part D drug. The member, their doctor, or other prescriber may ask the plan to make an exception to its Part D coverage rules in a number of situations.

Direct members to call the UnitedHealthcare Customer Service number on their ID card to request an exception. When requesting a formulary or tier exception, the member must submit a statement from their doctor supporting the request. Generally, a coverage decision will be made within 72 hours after the doctor's supporting statement is received. The member can request an expedited (fast) exception if they or their doctor believe their health could be seriously harmed by waiting up to 72 hours for a decision. If the member's request to expedite is granted, the plan must give them a decision no later than 24 hours after the prescribing doctor's supporting statement is received.

The member must have the following information ready when they call:

- Member name
- Member date of birth
- Member ID number
- Name of the medication
- Physician's phone number
- Physician's fax number (if available)

Forms that a member may need are available for download on the Distribution Portal under the Product Information and Materials page or on the consumer website.

The plan's decision on the member's exception request will be provided to them by telephone or mail. In addition, the initiator of the request will be notified by telephone or fax.

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Low-Income Subsidy

LIS (Low Income Subsidy) is a federal subsidy program that helps low income Medicare-eligible consumers save money on their prescription costs, including monthly premium, annual deductible, and copayments/coinsurance. It is also known as Extra Help (the term used by the Social Security Administration [SSA]).

To qualify for Extra Help, the Medicare consumer must:

- Have Medicare Part A and/or Part B
- Reside in one of the 50 states or the District of Columbia
- Meet **resource** and i**ncome** limits*
- Be a member of a Prescription Drug Plan

* LIS is determined by resources (bank accounts, stocks, bonds, and other resources that can be readily converted to cash within 20 days) and income limits. These limits are set by the federal government and vary from year to year.

You must clearly explain all costs associated with the Medicare prescription drug coverage in the event the consumer loses their Extra Help.

If a consumer does not automatically qualify for LIS, you may assist them with the application by going to the Social Security Administration Web site www.ssa.gov or refer members to My Advocate (1-866-865-3651) who will contact them and assist with the LIS enrollment electronically.

Applying for Extra Help does not automatically enroll a consumer in a stand-alone PDP. The consumer must be enrolled in an MA-PD or PDP to use their Extra Help. If a consumer, who automatically qualifies for Extra Help, does not enroll in an MA-PD or PDP, Medicare may automatically enroll them in a PDP so they will be able to use the Extra Help.

There are different levels of LIS. Consumers may question the Extra Help level and benefits they are eligible to receive. It is important to explain all the costs associated with a Medicare drug plan even if the consumer is eligible for Extra Help at the time of sale as the consumer's eligibility may change in the future and they must be aware of potential costs. Utilize the Low Income Subsidy job aid available on the Distribution Portal to learn more about coverage levels and access Sales Market specific Low Income Subsidy pricing amounts.

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Medication Therapy Management Program

Members who are in a Medicare drug plan and take medications for multiple medical conditions may qualify, at no additional cost, for a Medication Therapy Management (MTM) program. This program helps physicians and members ensure their medications are working to improve their health.

A UnitedHealthcare contracted pharmacist or other health professional will provide the member with a comprehensive medication review about drug benefits, reactions, cost concerns, medication instructions, and other questions. The member receives a medication list, action plan and a written summary of details to offer their health care providers.

The drug plan may enroll a member into this program if they meet all of the following:

1. Member has 3 or more chronic health conditions.
2. Member takes 8 or more Part D medications.
3. Member's medications have a combined cost of more than $3,507 per year. This dollar amount (which can change each year) is estimated based on out-of-pocket costs and the costs the plan pays for the medications each calendar year. The plan can help members determine if they may reach this dollar limit.

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Must List

There are many rules to follow when offering a PDP or MA-PD. Review the following list of the compliance requirements to review when offering PDP and MA-PD plans:

- Look beyond premium and cost sharing to determine whether a plan is right for the consumer. The medications on the formulary and the drug tier they are on will significantly impact the value of a plan to a specific consumer.
- Explain Low-Income Subsidy and encourage the consumer to apply if they believe they are financially eligible.
- Explain the Late-Enrollment Penalty to consumers if they are uncertain about whether it makes sense to join a plan or wait until later.
- Only enroll into a Medicare Prescription Drug Plan those consumers who are entitled to Medicare Part A and/or enrolled in Part B.
- Clearly describe the drug payment stages and coverage gap to consumers so they are not surprised if they reach this threshold.
- Ask the consumer what pharmacy they use and look up each pharmacy in the pharmacy directory to confirm it is in the network.
- If a pharmacy is not in the network, inform the consumer the costs of not going to a network pharmacy.
- Look up all of the consumer's currently prescribed medications in the formulary. Indicate if the drug is covered, the tier, cost, and any coverage rules that pertain, such as quantity limit.
- Explain that consumers can only have one plan that provides Medicare Part D coverage at a time, such as a stand-alone Prescription Drug Plan, a Medicare Advantage plan with integrated Part D benefits, or an employer-sponsored plan with prescription drug coverage. Do not enroll consumers currently enrolled in a plan with prescription drug coverage in another plan that provides Part D benefits unless the consumer intends to dis-enroll.

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Resources

Many resources and reference materials are available to assist you. The following resources can be found on the Distribution Portal under the Learning Center, Resource Center, or Product Information and Materials tabs.

- Agent Guide
- Agent Hosted Events
- Drug Cost Estimator Guide
- Election Period Booklet
- Enrollment Handbook
- Exceptions and Appeals Forms
- Focus News articles
- Glossary
- Low Income Subsidy Job Aid
- Privacy and Security Job Aid
- Quick Reference Guide:
  Compliant Sales Practices
- Scope of Appointment Job Aid

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