Reimbursement News

Medicare Part D Primer

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One of the largest problems for the immune globulin (IG) community is inadequate reimbursement for physicians, who are then unable to afford providing intravenous immune globulin (IVIG) to Medicare beneficiaries. This has caused beneficiaries to be shifted to different sites of care, many of which are also being affected by reimbursement issues. When insurance providers eliminate access to IVIG, beneficiaries are often left in a tough position, either switching to an alternate treatment that’s not as effective (if it is at all), or paying out of pocket. In cases where patients pay out of pocket, beneficiaries often reduce their dosage and increase the time between infusions. This can be dangerous, potentially allowing the disease state to progress to the point where patients develop life-threatening infections, paralysis or even death.

Unfortunately, even with all of the efforts of the IG community to prompt Congress to fix reimbursement for Medicare beneficiaries, IVIG reform was not included in the new Medicare law. Even worse, Medicare is now recommending to further reduce reimbursement for hospital infusions. On top of that, coverage determinations are affecting more community members in both Medicare and private insurance situations. In these cases, patients who have a diagnosis that is not a Food and Drug Administration (FDA) approved indication for IVIG are being denied coverage after years of effective treatment. The reason? IVIG is now considered experimental or not medically necessary; therefore, beneficiaries are deprived of coverage.

Medicare Part D

In an attempt to provide better prescription drug coverage for Medicare and Medicaid beneficiaries, Medicare Part D was enacted under the Medicare Modernization Act (MMA) of 2003. This drug benefit, created to halt skyrocketing Medicare prices, is controlled by private health insurance plans but is reimbursed by the Center for Medicare & Medicaid Services (CMS). Although approved in 2005, Part D took effect on Jan. 1, 2006, and Jan. 1 is the first day of every Part D cycle. Part D comes as a benefit to people who already have either Medicare Part A or B, and comes at a premium to traditional Medicare, requiring the beneficiary to voluntarily enroll. In some states, beneficiaries with dual eligibility (someone with both Medicare and Medicaid) are required to accept Part D to remain with Medicaid. You must register with a Part D plan that is in your geographical region. Re-enrollment is required annually; enrollment begins Nov. 15 and ends Dec. 31, and your new plan begins Jan. 1.

For patients in the IG community, diagnosis and treatments must be considered to determine which plan best fits your needs. For primary immune deficiency disease (PIDD) patients utilizing IVIG, Part D does not cover IVIG (which is covered under Medicare Part B for all sites of care). For non-PIDD patients, most likely your diagnosis is covered under Part D, though only in the homecare setting. With due consideration to your healthcare situation, Part D may be a viable option.

Choosing a Plan

Once you decide you want Part D, you must choose a plan. This can be onerous, especially when receiving IVIG is a primary concern. The Part D plans are not required to offer all brands of IVIG, therefore patients must select a plan with care. Additionally, Part D covers IVIG only in the homecare setting. Factors to consider include the plan’s formulary, the current price of drugs you seek within the formulary, the cost of the plan, and which specialty pharmacies are within the plan’s network (this has a direct relationship with your home infusion care provider). Some plans may name CVS, Caremark or Accredo as the only company where you can get your drugs; therefore, if you are currently using another home infusion company, such as NuFACTOR, you would not be able to continue to have that choice.

Private insurers offer prescription drug benefits to Part D beneficiaries through a traditional Medicare fee-for-service stand-alone prescription drug plan (PDP) or through a Medicare Advantage plan with a prescription drug benefit (MA-PD). In some cases, Medicare Advantage special needs plans (MA-SNPs) are available, which include HMOs or PPOs and which must always offer Part D coverage. The benefit of a plan must be at least as valuable as the standard benefit; therefore, plans’ formularies differ in number of drugs covered, reimbursement rates, and most importantly, which brands of IVIG are covered. All formularies differ yet must cover all antidepressants, antipsychotic drugs, anticonvulsants, immunosuppressants, and HIV/AIDS categories as well as certain off-label drugs.

A beneficiary must be careful when choosing a plan for several reasons:

• Although a plan may cover a certain off-label drug, coverage may be discontinued at any time without notice.
• All formularies are subject to change, but you are given 60-days notice to change your plan if you are affected.
• Injectables (covered in Part B) can be covered if they do not require a practitioner to administer them. A temporary exception applies when an injectable is newly approved; it is assumed to be covered under Part D until otherwise noted and placed in Part B.

Plan formularies can be checked on a provider’s website; by calling a toll-free customer call center; through a plan description from a sponsor; or by submitting a written beneficiary request. After doing research and finding that your drug requires too much out-of-pocket cost, you may file for an exception. (Each plan must allow an enrollee...
to request coverage for a nonformulary drug or to reduce cost-sharing for a drug already in the formulary. A doctor, who must agree that no other drug in the formulary is suitable for this condition, must request an exception. A CMS-approved form is available at www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDP

pharmacyFaxForm.pdf. If the request is rejected, an appeal begins. If the enrollee wins, he or she will be reimbursed for the nonformulary drug or for reduced cost-sharing for the current treatment.

Doughnut Hole Ahead

The standard Part D drug benefit, designed to assist Medicare beneficiaries in paying prescription drug costs, makes the plan more viable for beneficiaries with drug costs less than $2,510 or more than $4,050. The standard benefit from 2008 requires the beneficiary to pay a $275 deductible to get a coinsurance rate of 25 percent. However, this initial benefit period lasts only until drug costs reach $2,235. If a beneficiary’s costs exceed this initial benefit amount, another deductible dubbed the doughnut hole requires the recipient to pay the full cost of drugs. These out-of-pocket costs of 100 percent continue until total out-of-pocket expenses reach $275 deductible, the $558.75 (25 percent) paid during the initial benefit period, and the $3,216.25 paid in the doughnut hole. So to this point, required out-of-pocket expenses reach $4,050.

This lopsided benefit structure may impose large out-of-pocket costs early, but once a beneficiary reaches catastrophic coverage, there is a 5 percent coinsurance rate. At this point, Part D covers 95 percent, leaving you coinsured at a flat 5 percent or $2.25 for generic drugs and $5.60 for other drugs, whichever is greater. One must be careful when evaluating the out-of-pocket expenses incurred in Part D because drugs not included in a plan’s formulary do not count toward the deductible and out-of-pocket limits.

Although Part D aims to give beneficiaries prescription drug coverage, it often neglects cost savings and allows beneficiaries with poor plans to incur large expenses. IVIG users must be aware of this when choosing a plan since formularies differ from plan to plan.

There are currently 34 PDP regions and 26 MA-PD regions; these plans vary greatly depending on your region.

Resources

- Formulary Finder
  www.medicare.gov/MPDPF/Shared/Include/Formulary/FormularyFinder.asp?language=english
- Medicare Drug Plan Rating Tool

Commonly Asked Questions

1. Should I sign up for Medicare Part D?

If you have a secondary health insurance plan, not a Medigap plan, that covers your medications, including IVIG, then you probably do not need to sign up for Medicare Part D, but check with your secondary insurance to make sure that your coverage allows for access to the brand of IVIG that works best for you in the site of care that you wish to receive the therapy and that the site of care is still treating Medicare patients with IVIG.

If you have a Medigap policy, check to see if that policy will continue to cover your medications. Many Medigap policies discontinued covering medications once Medicare Part D was implemented. Also, with Medigap policies, if Medicare does not cover your IVIG, Medigap will not cover it. However, a secondary health insurance may still cover your therapy.

2. Is IVIG for my diagnosis covered under Part D?

If you have a primary immune deficiency disease (PIDD), your IVIG is covered under Medicare Part B for all sites of care: hospital, physician’s office, and homecare. However, supplies and nursing are covered only in the hospital setting.

If you are a non-PIDD patient, most likely your diagnosis is also covered under Medicare Part D; reimbursement under Part D for IVIG is currently higher than Part B. Since Part D covers only patients in the homecare setting, make sure that your physician agrees that the homecare setting is right for you if you are currently receiving IVIG in a hospital or physician’s office. You should find that there are home infusion companies able to work with you because current reimbursement under Part D is adequate. If you choose this method, make sure to ask if the cost of nursing and supplies is included in the cost of medication. Also note that under Part D, the doughnut hole still applies.

3. How can I afford my IVIG infusions under Medicare Part D with the doughnut hole and other out-of-pocket expenses?

When looking into different Medicare Part D plans in your area, get a listing of the participating home infusion companies/specialty pharmacies. Many of these companies offer financial assistance programs that you may be eligible for that will help eliminate the out-of-pocket expenses. If you are looking into a Medicare Advantage plan, some of those plans also have financial assistance programs. To see if you meet their criteria, call the plan to discuss what financial assistance is offered.