BENEFICIARY PROTECTIONS

The new drug benefit includes rights and protections similar to those beneficiary rights and protections assured in other parts of Medicare, so all beneficiaries have access to medically necessary treatments at lower costs.

The Medicare Modernization Act (MMA) incorporates substantial beneficiary rights and protections similar to those in original Medicare and from the Medicare Advantage program. It also creates new rights and protections that are specific to the drug benefit.

- Guaranteed issue – Prescription drug plans and the Medicare Advantage plans generally have to accept all eligible enrollees who reside in their service area, regardless of age or health status.

- Uniform benefits and premiums –Plans must provide all enrollees with the same benefits and charge a uniform premium.

- Formulary protections – Plans' formularies must include at least two drugs from every therapeutic category and class, with only a few exceptions. They must also develop the formulary with the help of a pharmacy and therapeutic committee consisting of practicing pharmacists, physicians, and experts in geriatric and disabled care, using best practices that have worked in prescription drug coverage for seniors and beneficiaries with a disability. This committee is to use best scientific evidence on drug safety and efficacy, including side effects, to enhance quality while controlling costs.

- Grievance, coverage determination and appeals requirements – Plans are required to have a timely and straightforward grievance, coverage determination and appeals processes that provide plan enrollees with access to medically necessary Medicare-covered drugs. Physicians and appointed representatives such as a family member can help beneficiaries file a grievance or request a coverage determination or an appeal. As required in the MMA, the enrollee or an appointed representative can file an external appeal.

  As an initial step, enrollees may request their plan to make a coverage determination in certain circumstances, such as when their plan does not pay for a Part D drug. Each plan must have a procedure for making timely coverage determinations on standard and expedited requests made by enrollees. The exception process is a type of coverage determination that is unique to the drug benefit, was created to ensure enrollees receive the drugs they need. An exception process allows an enrollee to request, under certain conditions, a non-formulary drug to be covered, or a non-preferred drug to be covered under the terms applicable for a preferred drug.

The appeals process is a dispute resolution mechanism for enrollees to file formal complaints about their plan's decision. Once a plan makes an unfavorable coverage determination such as denying an exception request, the enrollee or his or her appointed representative may appeal the plan's decision. The grievance process is used for other issues such as administrative concerns. For example, concerns about plan hours or availability of specialists would be handled through the grievance process.

- Information – Plans must provide a wide range of information to beneficiaries, including how the formulary works, what the plan benefits are, and how the plan's medication therapy management program works. They must also provide information on the grievance, coverage determinations, reconsiderations, exception process, as well as appeals rights and procedures. Information on how the plans have performed in this area must be provided, upon request. Medicare will also provide standardized information on drug payments, participating pharmacies, less expensive generic medicines and other information that can be used by beneficiaries to get the most out of their drug coverage. Medicare support will be available through 1-800-MEDICARE customer service line, personal counseling from state health insurance assistance programs (SHIPs) and other beneficiary support organizations and the Internet.

- Customer service – Plans must respond to beneficiary questions in a timely manner, including responses through a toll-free telephone number and by placing information on the Internet. They must also provide beneficiaries with a clear explanation of benefits, which is an individualized report detailing how much prescription drug spending the beneficiary has incurred for the year, as well as how close the beneficiary is to the catastrophic coverage cap and benefit. Medicare will oversee drug plans, respond to beneficiary complaints and take enforcement actions when warranted to assure that plan assistance and customer service meets Medicare standards.

- Pharmacy access – Plans must assemble broad networks of retail pharmacies to provide convenient access to beneficiaries, no matter whether the beneficiary lives in an urban, suburban, or rural area. Plans are required to contract with Indian Health Care Providers and enrolled pharmacies will count in meeting their network requirements.

- Cost management – Plans are required to have cost management programs that save beneficiaries money through use of tools such as generic and therapeutic substitution to more cost-effective therapies.

- Therapy management – Plans must have medication therapy management programs to help beneficiaries who have multiple, chronic conditions and who use multiple drugs and expect to have high drug costs, to make sure they are taking safe combinations of drugs and using the drugs properly. CMS recognizes that Therapy management is a strong component of what Physicians and Pharmacies

within the Indian Health Care Provider network currently offer.

- Generic drug information – Plans' network pharmacists are required to inform the beneficiary if he or she could save money by using a generic drug instead of a more expensive brand name drug.

- Privacy – Plans must maintain privacy and confidentiality of patient records.

- Collecting satisfaction data – Plans are also required to participate in consumer satisfaction surveys, which allow enrollees to rate their experience with plans. The ratings will be published in Medicare's comparative plan brochures and provide key information for beneficiaries to use when choosing plans.

- Risk Adjustment of Medicare Payments – Medicare will adjust payments based on the demographic characteristics, diagnoses, low-income status and institutional status of beneficiaries to provide appropriate payments and incentives for the drug plans to provide effective care for beneficiaries with high expected drug costs.