

What's New in Medicare Part D for 2008?

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Learning Objectives:

Pharmacists:

After completing this lesson, pharmacists should be able to:

- Discuss general enrollment, formulary, and coverage changes for 2008, including vaccine coverage and options for individuals who qualify for low income subsidies.
- Review commonly used medications in 2007 and expectations for utilization in 2008.
- Discuss individuals' cost sharing obligations in 2008 and name mechanisms for pharmacies to assist individuals reduce costs.
- Discuss how new focus areas for the benefit, including the impact of the new focus on plan compliance, quality assurance for medication utilization, and electronic prescribing will impact pharmacies. Describe the pharmacists' direct role and responsibilities with these new focus areas.
- Consider the potential for changes to the Medicare Part D law and the impact on pharmacies.

Pharmacy Technicians:

After completing this lesson, pharmacy technicians should be able to:

- Discuss general enrollment, formulary, and coverage changes for 2008, including vaccine coverage and options for individuals who qualify for low income subsidies.
- Review commonly used medications in 2007 and expectations for utilization in 2008.
- Discuss individuals' cost sharing obligations in 2008 and explore mechanisms for pharmacies to assist individuals reduce costs.
- Discuss how new focus areas for the benefit, including the impact of the new focus on plan compliance, quality assurance for medication utilization, and electronic prescribing will impact pharmacies.
- Consider the potential for changes to the Medicare Part D law and the impact on pharmacies.

The Medicare Part D program, implemented in 2006, continues to undergo changes each year as the program matures. Changes impact program administration for pharmacies and the patients served by these pharmacies. Other changes directly affect individuals' medication coverage, costs, or access to program information. Pharmacists and pharmacy technicians should also understand new focus areas in 2008 designed to assess the quality of the program and medication utilization under Part D, plan, and pharmacy compliance with Medicare Part D policies and regulations, and electronic prescribing. This program will provide pharmacists and pharmacy technicians with current information regarding Medicare Part D in 2008 that will help them better serve their patient population and the pharmacies where they work.

I. Introduction

Despite many skeptics' concerns regarding success of the Medicare Part D program, 2007 proved that the program is working to achieve its goals of ensuring access to comprehensive prescription drug coverage for seniors and disabled individuals. The Medicare Part D program accounted for 15% of all prescriptions, or 486 million, filled in the United States in 2006. Nearly 90% of Medicare-eligible individuals now have prescription drug coverage through Part D, employer or retiree sponsored programs, or other private insurance, an increase from 70% in 2005. As of January 2007, the Centers for Medicare and Medicaid Services (CMS) reported that three-quarters of eligible individuals, or 23.9 million, enrolled in the program. Overall, eligible individuals, particularly those without previous health insurance benefited the most and reduced out-of-pocket costs for prescription drugs by nearly 60%, although out of pocket costs continue to rise and many individuals have experienced financial difficulty in paying for medications during the coverage gap.

While Medicare did not make major substantive policy changes to the Part D program for 2008, pharmacists and technicians should understand several key updates and changes that will impact program administration and access to benefits. These key changes include: individuals eligible for extra-assistance, known as low-income subsidies (LIS) will have fewer plan options in 2008 and many will be shifted to new plans; individuals will see some changes in coverage parameters, including formularies, tiered copayment structures; specialty tiers; and gap coverage through the doughnut hole; and updates and changes to payment policies for Medicare Part D covered vaccines.

Medication therapy management (MTM) programs have been implemented but their use and effectiveness is limited. This article briefly considers the MTM programs and CMS' and the pharmacy community's

collaborative efforts' to implement policies and systems that improve quality and promote cost effectiveness in Medicare.

The pharmacy community received disappointing news at the end of 2007 when Congress failed to pass much-anticipated changes in Medicare Part D that would have improved the program. The hoped-for changes, described in further detail later in this article, included prompt payment provisions that would have required plans to pay pharmacists within 14 days; expansion of coverage for some currently excluded medications such as benzodiazepines; clarification of policies related to off-label medication use; required coverage of medications in six classes; and improved enrollment procedures to match dual-eligible individuals with plans that meet their medication needs. Congress could consider these provisions again in early 2008.

Finally, pharmacists and technicians should look for additional efforts in 2008 to encourage electronic prescribing for prescriptions. The Medicare Modernization Act (MMA) enacted electronic prescribing standards for Medicare Part D. Legislation introduced but not acted upon in 2007 builds upon the standards included in the MMA and provides additional, stronger incentives to encourage electronic prescribing under Medicare Part D.

Appendix One provides information and resources for pharmacists and technicians to better understand the Medicare Part D program and also to assist individuals in making more informed choices about plan options.

This article does not serve as a primer for the Medicare Part D program. Pharmacists and technicians whose goal is to learn about the basics of the Medicare Part D program should consider other continuing education programs first and then use this program to understand 2008 updates.

II. Plan overview for 2008

More than 10 million of the individuals enrolled in Part D are in stand-alone prescription drug programs (PDPs), including nearly all of the 9.3 million Medicare and Medicaid dually eligible individuals. In 2008, seventeen PDPs will offer coverage on a national basis, defined by CMS as plans that offer benefits in all 50 states and the District of Columbia. In 2007, nineteen plans offered national plans. *Appendix Two* provides the entire list of 2008 national plans. The total number of plans offered across the country will be 1,824, comparable to the number offered in 2007.

Standard Medicare benefits in 2008 and plan offerings

A "standard" Medicare PDP in 2008 requires enrollees to pay a \$275 deductible and then co-insurance of 25% for prescription drug costs up to \$2,510 with

catastrophic coverage beginning when an individual's out-of-pocket spending reaches \$5,576. Only 12% of national plans actually offer the standard benefit with most offering enhanced benefits for individuals. Enhanced benefits mostly focus on offering tiered copayments, lower deductibles, and different cost sharing parameters than the standard benefit.

More than half of PDPs offer plans with no deductibles and most offer tiered co-payments for medications rather than requiring individuals to pay 25% of costs. Most plans do not provide coverage during the gap, colloquially known as the "doughnut hole" and those that do generally cover generics only. *Section IV* below provides a more in-depth analysis of the changes in coverage and formularies in 2008 and the implications for pharmacists and technicians.

The average monthly premium for 2008 is \$27.93. An August 2007 CMS press release regarding 2008 premiums indicated that the targeted premium amount, then estimated to be approximately \$25 per month, was 40% below initial projections developed in 2003. While this projection is true, an independent analysis shows that individuals who remain in the most popular plans will actually experience premium increases of 21%. The analysis shows that most individuals remain in the plan originally chosen upon initial enrollment and now this loyalty has caused individuals to face increasing costs. The plans with the most enrollment, including United AARP, WellCare Standard, Humana Standard, and WellCare Signature will all experience increases of between \$5-\$10 per month. Despite the noted increase, individuals in every state will have access to at least one plan with a premium of less than \$20 per month.

Overall, pharmacists and technicians will likely see patients who do not qualify for LIS remaining plans in which they already enrolled in the past. Pharmacists and technicians should be aware of trends in cost sharing, coverage, and formulary changes that individuals might experience. These are described in further detail below.

III. LIS Changes in Store for 2008

Only one plan, Wellpoint, Inc., will offer low-income subsidy (LIS) coverage to individuals in all regions. Individuals eligible for LIS will have much more limited options than in the past. Pharmacists and pharmacy technicians should expect to see LIS-eligible individuals shift plans that could create problems with billing for at least the first several months of 2008. CMS estimates that 1.6 million LIS-eligible individuals will have to change plans in 2008 compared with only 250,000 in 2007.

The number of individuals who will shift plans in 2008 is expected to create chaos in some pharmacies. Some pharmacists believe that the shifts could create problems similar to those experienced when the Part D

program was implemented in 2006. These problems include incorrect plan information, improper coverage information, phone calls to plans with the potential for long hold times, and general confusion among beneficiaries. Pharmacists and technicians should be prepared for this scenario by ensuring that pharmacies have an appropriate number of staff with an understanding of the impending changes.

LIS coverage offers premium assistance and prescription drug subsidies to Medicare eligible individuals whose income and assets are at or below current federal standards for poverty levels. In 2007, assistance was available to individuals whose income and assets were at or below \$11,710 for singles \$23,410 for married individuals. Assistance varies based on assets and income. Medicare Part D LIS assistance includes free or reduced monthly premiums and reduced cost sharing for individuals who qualify. Individuals who are eligible to receive full Medicaid benefits receive greater assistance in cost sharing and do not pay monthly premiums.

The most critical concern for pharmacies in 2008 is to ensure that an individual's enrollment information is correct and that he or she is enrolled in a plan that accepts individuals eligible for LIS. Otherwise, the individual could be subject to greater cost sharing.

Plans that accept individuals who qualify for LIS must have premium levels that fall below the regional benchmark established by CMS after reviewing plan bids for a given year. Dual-eligible individuals who do not select their own plan are randomly assigned a plan that meets the regional benchmark standard. In 2007, CMS implemented a "de minimis" rule that allowed for individuals enrolled in plans with premiums within \$2 of the regional benchmark to remain in their existing plan. For 2008, the de minimis standard was reduced from \$2 to \$1 of the regional benchmark. This will result in LIS losses for many of the largest plans, including UnitedHealth, Humana, and WellCare. Dual eligible individuals who were randomly assigned to these plans will be reassigned. Individuals who self-selected plans but whose existing plans no longer accept LIS individuals must select a new plan.

CMS notified affected individuals of this change in November 2007. However, pharmacists and technicians should be aware that individuals might not fully understand the impact of this change and also must be aware that individuals could experience formulary and coverage changes. Pharmacists and pharmacy technicians should refer to CMS' 2008 Pharmacists' Reference Guide and the Medicare Drug Benefit Manual for further information regarding CMS' guidelines for transition supplies. These links are both provided in this article.

Pharmacists and technicians may find information regarding an autoenrolled individual's status in one of two ways: by contacting the TrOOP facilitator in an online, real-time transaction or by contacting 1-800-MEDICARE. Use of the TrOOP facilitator will result in pharmacies incurring a transaction cost while calls to the Medicare hotline are free.

CMS recently implemented a system to minimize the need for pharmacies to submit reversals to plans for individuals who are not eligible for LIS benefits. Individuals who claim to be eligible for Medicaid or LIS but do not provide proper proof at the point of sale in the pharmacy will automatically receive a letter from the Wellpoint/NextRx facilitator indicating that they must provide proof of need or be required to reimburse Medicare for any costs improperly incurred.

LIS-eligible individuals will also see increases in costs associated with prescription drug coverage in 2008. The overall impact of formulary changes and cost sharing provisions are considered below.

IV. Formulary, Generic Utilization, and Individual Cost Sharing for 2008

A. Formularies and Utilization Management Techniques

According to an analysis by Avalere Health Care, a policy consulting firm located in Washington, DC, in 2008 individuals, pharmacists, and pharmacy technicians will see a general reduction in the overall number of products on formularies, but this does not necessarily mean a reduction in the availability of drugs to seniors. CMS officials note that the reduction is attributable to a CMS mandate that no longer allows plans to cover approximately 1,500 obsolete national drug codes (NDCs). Some of the discontinued items will include product package sizes that are no longer eligible for Medicare coverage. Pharmacists and pharmacy technicians should be careful to review PDP messages that might reject NDCs for certain product packaging sizes or types but continue to cover the product.

According to the same Avalere report, plans with the largest enrollment have actually increased the percentage of basic reference drugs that CMS recommends for coverage. However, many plans have reduced the number of formulary covered items to reduce individual cost-sharing and become more cost competitive with other plans.

Plans continue to refine utilization management techniques that can often result in confusion for individuals with Medicare and pharmacists and technicians. For example, in 2006, plans generally used a four-tiered system: tier 1, generic; tier 2, brand; tier 3, non-preferred brands; tier 4, specialty and injectables. In 2008, plans will use further sub-classification systems for generics in tiers 2 through 4. These classifications

include value generics; preferred and non-preferred generics; and specialty generics. CMS gives complete discretion to plans to define the meaning of these subclassification systems and placement of products into these tiers. The Center for Medicare Advocacy, a consumer advocacy and watchdog organization for individuals with Medicare, finds that these subclassification systems will increase the costs of generics for individuals and result in further confusion when comparing plans and costs using the Medicare plan finder tool. Pharmacists and technicians should do their best to understand the availability of these subclassification systems and be able to provide individuals with the best objective information about plans and costs.

Other trends in utilization management are worth noting. In 2007, the number of prior authorizations remained near 2006 levels, but plans reduced the percentage of formulary items with quantity restrictions, and slightly increased the number of products requiring step therapy. Pharmacists and technicians can expect that this trend will continue in 2008.

B. Generic Utilization: An Important Benchmark to Determine Cost Effectiveness in Medicare Part D

CMS and others use generic utilization as an important mechanism to evaluate cost effectiveness under Part D. A recent evaluation by the United States Office of the Inspector General for the Department of Health and Human Services (HHS-OIG) found that in 2006, generic substitutions occurred in 88% of cases when a generic is available. These findings are consistent with generic substitution rates in the Medicaid program using 2004 data. CMS and OIG and credit pharmacies with making the substitutions at the point of sale that make these figures possible.

Approximately 37% of all Medicare Part D prescriptions are written for single source products, compared to approximately 41% of products dispensed by Medicaid programs. Overall, 56% of products dispensed in 2006 were for generics. The OIG report concluded that plans should continue to focus efforts on increasing the number of prescriptions for multi-source generic products.

The trend in encouraging the use of multi-source generic products will likely continue as more generics will be available over the next 2-3 years. In 2007, the Food and Drug Administration (FDA) approved a record of 682 generic abbreviated new drug applications and between 2007-2009, many of the most popular single source brand name products for conditions such as diabetes will lose patent protection. Independent consumer research organizations and government agencies that examine cost effectiveness and safety of medications often encourage the use of well-studied

generic medications over newer, more expensive brand name products. Pharmacists and technicians must ensure that they understand the availability of generic medications and pharmacists should strive to encourage generic utilization when appropriate.

C. Specialty pharmacy tiers

One of the most significant trends in the Medicare program since the 2006 inception is the increased use of specialty tiers by PDPs. Use of specialty tiers as a utilization management technique has nearly doubled over the past two years and will become even more common in 2008. CMS requires plans to cap specialty pharmacy product coinsurance to 25% of costs. However, plans can modify this provision and charge higher cost sharing if individuals are charged lower deductibles. Trends suggest that more plans opt for the modified cost sharing. Most medications on the specialty tier are costly and therefore this cost sharing technique could mean greater expense for individuals. However, many individuals that require specialty products have little choice but to incur the additional costs.

CMS' basic requirement for specialty tiers in 2008 is that the medications must cost more than \$600 per month compared to \$500 in 2007. CMS also permits plans to implement separate injectable tiers but does not set the same cost threshold for these tiers. In 2007, the Medicare Payment Advisory Commission found that 150 drugs or 12% of all Medicare Part D drugs were included on a specialty tier. Products most commonly placed on specialty tiers are tumor necrosis factors used to treat rheumatoid arthritis; five hormonal agents that treat cancer, Paget's disease, and osteoporosis; and Nimotrop® (nimodipine, Bayer HealthCare), a calcium channel blocker used to treat patients with ruptured cerebral aneurysms. Pharmacists and technicians should be familiar with patients who require these specialty medications and educate individuals on plan options available. Furthermore, pharmacists and technicians might want to consider assisting these individuals in identifying additional public and private assistance programs that might help cover costs. Information and resources for pharmacists and technicians to assist these individuals with extra assistance are available in *Appendix One*.

D. Medicare Part D beneficiary cost sharing for individuals eligible for LIS

Individuals with LIS coverage will generally have to pay more for medications in 2008 compared to 2007. Full benefit, dual-eligible individuals whose income is less than 100% of the federal poverty level who receive medications from community or mail-order pharmacies will pay \$1.05 for each prescription for a generic or a preferred item, a 5% increase over 2007. Costs for non-

preferred drugs will continue at 2007 levels, \$3.10 per prescription.

Full benefit, dual-eligible individuals whose income is above 100% of the federal poverty level will pay \$2.25 for preferred and generic drugs and \$5.60 for other drugs, both represent a 5% increase over 2007 levels. Full benefit, dual-eligible individuals have no cost sharing obligations during catastrophic coverage. (Note, cost sharing for full benefit, dual-eligible individuals in nursing facilities is different from those in community pharmacy and is not considered in the scope of this article).

Individuals who receive partial LIS subsidies face a substantial increase in costs in 2008. These individuals must pay a yearly \$56 deductible, an 11% increase over 2007 levels. Then, cost sharing is the same as described above for full benefit dual eligibles whose incomes exceed 100% of the federal poverty level. After these individuals exceed the out of pocket limit, drugs will cost \$2.25 for brand and preferred and \$5.60 for others.

E. Availability of plans providing additional coverage through the doughnut hole

In 2008, no plan will provide gap coverage for all brand name medications although early analyses suggest that more plans, 529 in 2008 compared to 220 in 2007, will provide some coverage during the gap. Most plans that opt to provide this coverage will include a limited number of preferred generics. Individuals who enroll in plans with gap coverage will also pay substantially more in monthly premiums, an average of \$63. Pharmacists and technicians should be mindful of the potential for increased costs that will likely be incurred by individuals in 2008. Pharmacists and technicians should use the information and resources contained in *Appendix One* to help individuals who might require additional financial assistance find it in 2008.

F. Vaccine coverage in 2008

One of the most confusing updates to Medicare Part D in 2008 is a modification of payment for vaccine reimbursement and payment for administration. It is important for pharmacists and pharmacy technicians whose pharmacies administer and/or dispense vaccines to understand the basic coverage policies and changes for 2008.

The policies related to coverage under Medicare Part B or Part D are not necessarily intuitive, so pharmacists should clearly post information in pharmacies and pharmacy personnel should be trained to understand these provisions.

Pharmacists must refer to state laws prior to engaging in the administration of any vaccine. Pharmacists who administer vaccines must be recognized by state board of pharmacy laws and

regulations. As of December 2007, 46 states allowed this practice.

Overview of CMS' vaccine coverage policy *Vaccines covered by Medicare Part B*

Vaccines covered by Medicare Part B prior to the implementation of Medicare Part D will continue to be covered by Part B.

Vaccines always covered by Part B

- Part B will always cover influenza and pneumococcal pneumonia vaccine. In these cases, physicians and pharmacists who administer these vaccines will receive a separate administration fee under Part B.

Vaccines covered by Part B in some cases and covered by Part D in other cases

- Part B covers Hepatitis B vaccine and tetanus toxoid for individuals who are at high or intermediate risk. This means that if an individual has been exposed to someone with Hepatitis B or is in a living situation at high risk, he or she will receive the Hepatitis B vaccine under Part B. If the individual receives the Hepatitis B vaccine as part of a routine vaccine regimen purely for prevention, then the vaccine cost is covered under Medicare Part D. The same logic can be applied to the tetanus toxoid vaccine: if a patient receives the vaccine because of direct exposure, then Part B will cover costs for general prevention, coverage is under Part D.

Part D coverage of vaccines

Part D covers vaccines not otherwise covered by Medicare Part A or B that are necessary for the prevention of illness.

CMS recently clarified that the herpes zoster (shingles) vaccine is a preventative vaccine and is therefore covered by Medicare Part D.

CMS requires that Part D plans cover all existing vaccines available except those specifically covered by Medicare Part B. New vaccines for prevention of illness not on the formulary may be covered. Pharmacists and physicians should contact the plan with questions concerning coverage.

CMS' 2008 procedures for covering vaccine administration costs

Coverage of vaccine administration costs is the most problematic area for pharmacists to understand because of a little-known legislative change related to vaccine administration effective January 1, 2008. In 2007, pharmacists and physicians received payment under Medicare Part B for vaccine administration services

regardless of whether a vaccine was covered by Medicare Part B or Part D.

New payment policies for Medicare Part D vaccines and administration fees

Beginning January 1, 2008, the Medicare Part D negotiated rate for vaccines must include the plan's payment amount for the vaccine and the administration fee associated with billing for the vaccine. These costs will be bundled and neither pharmacies nor physicians will receive a separate payment for billing the vaccine cost and the administration fee. CMS encourages plans to establish reimbursement rates that ensure proper administration fees in addition to reasonable reimbursement rates for the vaccine product. CMS recently clarified that Medicare Part B will not pay administration fees to either physicians or pharmacists who provide Medicare Part D covered vaccines.

Pharmacies that bill Medicare Part D for vaccines and vaccine administration must ensure receipt of a valid prescriber-issued prescription.

In-network pharmacies that dispense and administer the vaccine and bill the individual's plan directly using the real time, on-line system to adjudicate the claim, the plan's computer system should respond by providing the pharmacy with the proper bundled rate for both the vaccine and the administration fee.

In network pharmacies that only distribute the vaccine to the patient, but not administer it, would bill the vaccine to the plan in the same manner that it would if it administers and dispenses. Physicians who administer the vaccine could then seek compensation from the pharmacy for the administration fee but could not separately bill Medicare Part B or Medicare Part D for those fees.

Physicians that administer and dispense Part D-covered vaccines would bill the patient for the entire charge and then the patient would submit the entire claim to the Part D plan for reimbursement. This is a similar process that is required when individuals use out-of-network pharmacies to fill prescriptions. CMS has also suggested that plans facilitate real-time on-line solutions to allow physicians will adjudicate the vaccine cost and administrative fee directly to the plan without requiring the individual to pay the entire cost. However, industry experts suggest this option will not likely be widely adopted by plans or physicians in 2008.

G. Update on Medication Therapy Management Programs and Other Medicare Part D Quality Improvement Efforts

For many pharmacists, the slow and inconsistent uptake of the much anticipated medication therapy management programs (MTMP) is a very disappointing aspect of Medicare Part D implementation. Barriers to

pharmacist-driven MTMPs include lack of clear definition of services and lack of reimbursement for these services. CMS and the pharmacy community have made concerted efforts to implement and improve existing programs to ensure quality in Medicare Part D. A successful initiative includes the establishment of a Pharmacy Quality Alliance (PQA), a broad coalition of pharmacists and pharmacy organizations, manufacturers, and quality organizations interested in improving medication utilization through pharmacy quality measures and MTMP.

Recently, the PQA announced its efforts to implement quality benchmarks to establish parameters to measure areas of plan and pharmacy performance under Medicare Part D. These efforts will be designed to help individuals make more informed choices of plans and pharmacies and also to improve overall quality in the Medicare program. CMS and PQA intend for these measures to be implemented prior to the 2009 enrollment period that begins in November 2008.

V. Improvements to Medicare Part D on the horizon?

As Medicare Part D enters its third year, individuals and pharmacies alike have reported that the program administration has improved and many express satisfaction with the program. However, community and chain pharmacies continue to experience administrative problems. Payment to pharmacies continues to be slow even as the end of the second year of the benefit approaches. These slow payments result in cash flow problems for pharmacies with already tight operating budgets. Slow payments combined with lowered reimbursement to pharmacies have resulted in closure of nearly 5% of all independent community pharmacies between 2006-2007. Beyond the pharmacy issues, beneficiaries and advocacy groups expressed concern about issues related to Part D restrictions on off-label drug use, lack of coverage for benzodiazepines and barbiturates, and the need for more measures to reduce out of pocket spending, particularly for individuals eligible for LIS.

All of these concerns led to a flurry of legislation introduced throughout 2007.

These proposals included provisions to enroll more individuals eligible for the LIS; marketing reforms requiring PDP to provide more accurate and clear information regarding coverage and payment to consumers; prompt payment measures for pharmacy and a variety of other Part D measures that revise the original Medicare Modernization Act provisions. While much activity ensued, the final 2007 Medicare package passed included only non-Medicare Part D provisions that were either set to expire or resulted in cost savings to the federal government. However, the provisions in the 2007 final Medicare package must be reconsidered by

Congress again before June 2008. Pharmacy organizations and consumer advocacy groups are hopeful that reconsideration of other Medicare provisions will result in a second look at many of the anticipated Part D changes.

With many Part D-focused bills already introduced in 2007, activity will likely begin early in January. Republicans and Democrats vying for votes from both consumers and pharmacists in the 2008 elections might prompt legislative action on measures that will improve quality without adding additional costs to the federal government budget, including the potential for prompt pay measures for pharmacies. However, at the time of this publication, the prospect for action remains uncertain.

Legislative efforts to improve electronic prescribing (ERx) are likely to see action in 2008. Many proponents of ERx tout it as a way to reduce health care costs, improve efficiency and reduce medication errors without the addition of federal budget dollars. The Medicare Modernization Act began the process of establishing a standard for ERx under Medicare, but many supporters believe that additional steps must be taken to provide incentives to physicians and pharmacies to implement ERx. One area of ERx likely to be the focus of immediate attention in 2008 is to advocate for the Drug Enforcement Administration (DEA) to allow electronic prescribing for controlled substances, a practice not currently allowed by DEA law. This prohibition by DEA is considered a major barrier to greater adoption of ERx.

VI. Summary

The Medicare Part D program has not seen significant policy changes through congressional acts or major rulemaking since its inception since 2006. However, changes and updates by CMS through sub-regulatory guidance can impact pharmacies and individuals with Medicare greatly and therefore it is important for pharmacists and technicians to remain current with Medicare policy changes. *Appendix One* provides information and resources for pharmacists and technicians to receive current Medicare Part D information.

Appendix One
Helpful Websites for Pharmacists and Pharmacy Technicians to
Understand the Medicare Prescription Drug Benefit

1. General Medicare Drug Plan Information for Consumers: <http://www.medicare.gov/>
2. CMS Website: <http://www.cms.hhs.gov/>
3. The Medicare Learning Network: A Service of CMS to Provide Health Care Professionals with Information about CMS Policies: <http://www.cms.hhs.gov/MLNMattersArticles/>
4. 2008 Medicare Part D Pharmacists Reference Guide:
<http://www.cms.hhs.gov/Pharmacy/downloads/Pharmacy%20Reference%20Document4.pdf>
5. CMS' Requirements for Formularies and Transition Supplies of Medications:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf
6. Information to Assist Individuals with Additional Pharmaceutical Assistance and Tips to Lower Medication Costs: <http://www.medicare.gov/bridging-the-gap.asp>
7. CMS' 2008 Vaccine Administration Policies:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0723.pdf>
8. CMS' Publicly Available Electronic Updates (email subscriptions available to anyone who registers): <http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/list.asp>.

Appendix Two

2008 Medicare Part D National Stand-alone Prescription Drug Plans

Data as of September 11, 2007.

Employer sponsored plans (800 series) are excluded.

National is defined as plans offered in all 50 states plus Washington, D.C.

Parent Company	Contract Marketing Name(s)
Aetna Inc.	Aetna Medicare
CIGNA	CIGNA Medicare Rx
Coventry Health Care Inc.	Coventry AdvantraRx, First Health Part D
CVS-Caremark	SilverScript Insurance Company
ENVISIONRX PLUS INC	EnvisionRx Plus
Health Net, Inc.	Health Net
Humana Inc.	Humana Insurance Company
Longs Drug Stores Corporation	RxAmerica
Medco Health Solutions, Inc.	Medco Medicare Prescription Drug Plan
Member Health Inc.	MEMBERHEALTH
NewQuest Health Solutions LLC	HealthSpring Prescription Drug Plan
Sterling Insurance Group [^]	Sterling Life Insurance Company
Torchmark Group	United American Insurance Company, First United American Life Insurance Company
United HealthCare Group, Inc.	UnitedHealthcare
Universal American Financial Corp. [^]	Pennsylvania Life Insurance Company, American Progressive Life & Health Ins Co of NY
WellCare Health Plans, Inc.	WellCare
Wellpoint, Inc.*	Blue MedicareRX, UniCare

* Indicates Low Income Subsidy (LIS) plans offered nationally.

[^] Indicates is a national plan sponsor for the first time in 2008.