MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

Medicare Part D is an optional prescription drug coverage available to everyone with Medicare. It can be obtained through two options- a Medicare drug plan or bundled with a Medicare Advantage Plan. Before selecting, it is important to consider factors such as formulary coverage (are your medications covered and if so at what cost), out-of-pocket costs, pharmacy options, and coverage phases. Once you choose a plan, you must stay in it until the next Open Enrollment period each year on October 15th.

Medicare Part D helps pay for prescription medications. It is optional, but even if you don't have any prescribed medications, it's a good idea to consider purchasing drug coverage.

Medicare Part D is available to everyone with Medicare, and the plans are managed by Medicare-approved private insurance companies. Each stand-alone plan has different costs and a list of covered drugs called a formulary. All plans must cover both brand name and generic drugs, but the specific drugs covered, and the cost structure may vary. **If you decide not to join a Medicare drug plan when you're first eligible, you may have to pay a penalty if you join later.**

You can get drug coverage through either a Medicare drug plan OR a Medicare Advantage plan:

- Medicare drug plans add drug coverage to Original Medicare. You must have Medicare Part A and/or Medicare Part B to join a separate Medicare drug plan.
- Medicare Advantage Plans (or other Medicare Health Plans) bundle all your coverage into one plan. It includes Part A, Part B, and drug coverage. However, not all Medicare Advantage Plans offer prescription drug benefits. If you choose a Medicare Advantage Plan, make sure to ask about drug coverage and review the formulary to see if your prescribed medicines are included before you enroll.

If you don't apply for drug coverage when you are first eligible, you can apply during the annual Open Enrollment Period which runs from October 15 to December 7.

Your coverage will start on January 1 of the following year. During this time, you can:

- Join a Medicare drug plan
- Switch from one Medicare drug plan to another Medicare drug plan
- Drop your Medicare drug coverage completely

If you want to join, leave, or switch plans outside of open enrollment, you may be able to if you:

- Move into a nursing home or skilled nursing facility
- Relocate out of your plan's coverage area
- Lose medication coverage (like if your employer benefits end)
- Have Medicaid (If you are enrolled in a Low-Income Subsidy program you can change plans 3 times a year)
- Want to switch to a plan with a higher star rating

Medicare rates Medicare Advantage and Part D plans by using a star ranking system. A 5-star rating is the best, while a 1-star rating is the worst. The rating is based on many factors, including plan participants' ratings, quality of care, and member complaints. Star ratings can be found at Medicare.gov/plan-compare. You can use the ratings, along with considerations such as cost and coverage, to choose the right plan for you.

Part D plans must also cover most vaccines (except for just a few that are covered by Part B). Vaccines are free under Medicare, which means there should be no copay, coinsurance, or deductible charges.

MEDICATION QUESTIONS TO ASK DURING OPEN ENROLLMENT

- Are the medications I'm currently taking covered?
- How much will I pay monthly for my medications included in the formulary?
- How much will I pay monthly for my medications not included in the formulary?
- Can I choose my pharmacy?
- Is there a mail-order pharmacy option?
- What other out-of-pocket costs should I be aware of?
- Does the plan offer coverage in multiple states?

DRUG CATEGORY

A drug category is a group of drugs that treat the same symptoms or have similar effects on the body. All Part D plans must include at least two drugs from most categories and must cover all drugs available in the following categories:

- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for seizure disorders
- Immunosuppressant drugs
- Anticancer drugs (unless covered by Part B)

Part D may cover insulin and medical supplies used to inject insulin (like syringes, gauze, and alcohol swabs), if your doctor gives you a prescription for these items and they are on the plan's formulary. Part D-covered insulin copays are capped at $35 per month with no deductible.

All plans are required to cover a wide range of brand-name and generic prescription drugs, including most drugs for conditions like cancer and HIV.

Each plan has its own list of covered medications called a "formulary," and the covered drugs can vary. Plans often categorize drugs into different tiers on their formularies, with lower-tier drugs costing less than higher-tier drugs. Plans can make changes to their formularies after you enroll to keep up with new drugs or medical information.

Your Part D plan may also send you a denial (called a coverage determination) stating that your drug does not meet Food and

PART D PLAN RULES THAT LIMIT MEDICATION COVERAGE

PRIOR AUTHORIZATION

You and/or your prescriber (a doctor or other healthcare provider who is allowed to write prescriptions) must contact the drug plan before you can fill certain prescriptions. You may need to show that the drug is medically necessary for the plan to pay for the medication.

QUANTITY LIMITS

These indicate the maximum amount of medication you can get within a specific time period (e.g., per month).

STEP THERAPY

You may need to try lower-cost drugs before the plan covers a prescribed drug.

If you think these coverage rules shouldn't apply in your situation, you can ask for an exception by working with your prescriber and completing the necessary forms.

Drug Administration (FDA) standards. The FDA is a federal agency responsible for protecting public health by ensuring medications, biological products, and medical devices are safe, effective, and secure. Drugs that are found to be less than effective by FDA's evaluation are excluded from coverage by Part D. If your doctor prescribes medication on your plan's formulary for a reason other than the use approved by the FDA (or listed in one of Medicare's three drug compendia, a kind of medical encyclopedia), your drug may not be covered.

If the medication your provider has prescribed is not on your drug formulary, you have a few options. You can work with your physician to ask for an exception or file an appeal, or you can pay out of pocket for the medication yourself.

You can request an exception to your health plan's coverage rules if:

- You need a drug that is not on your plan's formulary.
- You believe that a coverage rule, such as prior authorization, should be waived.
- You think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

Note: You cannot request a tiering exception for a drug on a specialty tier.

If your network pharmacy cannot fill a prescription, they will provide you with a notice that explains how to contact your Medicare drug plan to request an exception. This notice will include the contact information for your plan, as well as the specific steps you need to take to request an exception.

If the pharmacist does not provide you with this notice, you should ask to see it. You have the right to request an exception, and the pharmacist is required to provide you with the information you need to do so.

Over-the-counter medications that are usually not covered by Part D plans include:

- Vitamins, minerals, or supplements
- Any medications for cosmetic or weight loss purposes
- Medications used to treat cold or cough symptoms
- Most other non-prescription drugs

Medicare Part D Cost

You may notice that you pay different amounts for your medications throughout the year. This is because Part D plans have different phases of coverage, and the amount you pay depends on which phase you are in. The phases are determined by how much you and your plan have paid for medicine.

1. The deductible phase | You will begin your plan year in the deductible phase, during which you will be responsible for covering the entire cost of your medication. Deductible amounts vary based on your plan choice.

2. The initial coverage period | After your deductible is met, your initial coverage period starts. In this phase, you and your plan share the cost of your medications. You pay copays or coinsurance to the pharmacy.

3. The coverage gap (also known as the donut hole) | Once your total drug costs reach a certain amount you enter the coverage gap, also known as the donut hole. This amount changes each year and includes what you and your plan have paid for medications. When you reach the coverage gap, you must pay 25% of the price of your medications. Just because you don't pay large copays does not mean you won't reach the coverage gap, since calculating costs for this phase takes into account what you have paid as well as what your plan has paid.

4. Catastrophic coverage | Once you have paid a certain amount (the threshold) of out-of-pocket costs for covered prescription drugs, you move out of the coverage gap and into the catastrophic coverage phase. Insurance plan payments, your payments for excluded medications, and your monthly premium do not count toward the catastrophic coverage threshold.

In 2024, your out-of-pocket medication costs will be capped at $8,000, which includes what you spend out of pocket plus the value of the manufacturer price discount on brand-name drugs in the coverage gap phase. This means that once you meet this limit, you will not pay anything for your covered drugs. Additionally, the cost of brand-name drugs in the catastrophic phase will be capped at $3,300 in 2024, which means that if you only take brand-name drugs, you will only have to spend about $3,300 out of pocket, and then you will have no additional costs for your drugs. This cap is especially beneficial for patients who take more costly medications, such as drugs to treat cancer.

Your Part D plan will track how much money you have spent on drugs, which determines your coverage phase. You can find this information on your Explanation of Benefits statement or by calling the plan.

Beginning in 2025, people with Part D plans won't pay more than $2,000 per year in out-of-pocket costs for covered drugs.

Medicare Part D costs depend on the plan you choose, coverage, and out-of-pocket costs. Other factors that affect what you may pay include:

- which "coverage phase" you're in
- your annual income, which can determine your monthly premium
- the medications your doctor prescribes
- the tier the medication falls under (lower is generally cheaper)

PHASES OF COVERAGE FOR MEDICARE PART D

PHASE 01

DEDUCTIBLE

You will begin your plan year in the deductible phase, during which you will be **responsible for covering the entire cost of your medication**. Deductible amounts vary based on your plan choice.

PHASE 02

INITIAL COVERAGE

After your deductible is met, your initial coverage period starts. In this phase, you and your plan share the cost of your medications. **You pay copays or coinsurance to the pharmacy.**

PHASE 03

COVERAGE GAP

Once your total drug costs reach a certain amount you enter the coverage gap, also known as the donut hole. When you reach this phase, **you must pay 25% of the price of your medications.**

PHASE 04

CATASTROPHIC COVERAGE

Once you have paid a certain amount (the threshold) of out-of-pocket costs for covered prescription drugs, you move out of the coverage gap and into the catastrophic coverage phase. **In 2024, your out-of-pocket medication costs will be capped at $8,000.** Additionally, the cost of brand-name drugs in the catastrophic phase will be capped at $3,300 in 2024, which means that if you only take brand-name drugs, you will only have to spend about $3,300 out of pocket.

Applying for Part D

Once you choose a Medicare drug plan, you can apply for prescription drug coverage by:

- Applying on the Medicare plan finder or on the plan's website
- Completing a paper application form
- Calling the plan directly
- Calling 1-800-MEDICARE or the SHIP

When you join a Medicare drug plan, you need to provide your Medicare Number and the date your Part A and/or Part B coverage started. This information will be provided to you upon enrollment and is also printed on your Medicare card.

Before you decide on a Medicare drug plan:

- Read all the materials you get from your insurer or plan provider if you have (or are eligible for) other types of drug coverage (like an employer-provided plan)
- Compare your current coverage to Medicare drug coverage
- Ask questions about how Part D works with any other drug coverage you may have
- Choose if you want to have your monthly premium deducted from your Social Security or Railroad Retirement Board payment

It's important to choose a plan that works for your needs. Once you choose a plan, you must stay in it until the next Open Enrollment period, which starts on October 15, unless you meet a special situation (more on this on page 25).