

Medicare Prescription Drug Plan — Part D

What is “Part D”?

“D” stands for Drugs and is prescription drug coverage through Medicare. There are two ways to receive this benefit: 1) as a Stand-Alone Part D plan (PDP) that works with Original Medicare or 2) as a Medicare Advantage Drug Plan (MAPD) that is part of a Medicare Part C (HMO/PPO) plan. Part D plans are offered by private insurance companies that contract with Medicare. No plan can deny coverage (underwriting). Each PDP or MAPD sets its formulary and co-pays; some have a deductible and premium. These one-year contracts change costs and coverage every year.



There is a Tool on Medicare.gov called **PlanFinder**, which considers the prescription drugs you take and all the variables of each plan to find the lowest Out-of-Pocket plan unique to you and your meds. This is a one-click process through your Medicare account. HICAP will help you during Fall Medicare Open Enrollment (10/15-12/7) for coverage on January 1 if you need it.



Open Enrollment is the time to assess your Part C or Part D plan for changes next year. Compare your current plan with two different plans each year using PlanFinder or come to HICAP to have the comparison done and explained. Though you may change your Medigap any time with Underwriting, your birthday is when to shop for Medicare Supplement (Medigap) plans.

Do I Need a Part D Plan?

If you have CREDITABLE COVERAGE (coverage as good as Medicare) through an employer, union, or retiree health plan, you delay enrollment in a Part D plan **until that coverage stops**. Then, you have 63 days to enroll in a Part D plan to avoid Late Penalties. If you receive VA benefits or Tri-Care for Life through the military, those plans are considered CREDITABLE. You could receive all your prescription drugs through them instead of a Medicare Part D plan without penalty.



For each year you are 65 and older, request a letter from your non-Medicare health plan stating you have Creditable Coverage. Keep this documentation until you know you will not be assessed a Late Enrollment Penalty.

Penalty???

Everyone 65 and older should have a Prescription Drug plan even if you take ZERO drugs. If you fail to enroll when first eligible for Medicare, and you enroll later, you are subject to a LATE ENROLLMENT PENALTY. The penalty is calculated by multiplying the “NATIONAL BASE BENEFICIARY PREMIUM” (\$34.70 in 2024) by 1% and multiplying that by the number of months you were eligible for but did not have Part D or creditable coverage.

Let’s calculate that for someone who enrolled late and had no creditable coverage nor Part D plan for 22 months.



Calculation: $\$36.78 \times 1\% = \$.37 \times 22 \text{ months} = \8.10 -- This amount is added to your monthly plan premium.

The BASE PREMIUM changes each year so your penalty amount can change. Additionally, the penalty lasts forever (LIS beneficiaries are not assessed a late penalty).



- If you take no drugs, enroll in the plan with the lowest premium.
- Disagree with your late enrollment penalty? **Within 60 days** of the letter informing you of a penalty, ask Medicare for a review. To do that, complete a “RECONSIDERATION REQUEST” form available from your Part D drug plan. You need to provide proof that supports your case (for example CREDITABLE COVERAGE from employer or VA from age 65 to present).

How Does Part D work? Cost-Sharing: You and Your Plan Each Pay a Share

1. **Premium:** Is the monthly amount YOU PAY the Plan to receive benefits, including the opportunity for cost-sharing. Plans with high premiums (ENHANCED PLANS) may cover more prescriptions and may have lower copays on some drugs. High-income beneficiaries are assessed an adjustment that results in a higher premium. See HICAP’s IRMAA handout if your last filed income tax showed MAGI **\$106,001** if single and **\$212,001** if married.
2. **Deductible:** You pay the FULL NEGOTIATED RETAIL PRICE for drugs during the deductible (many plans waive the deductible for some or all generic drugs). Plans with lower deductibles usually have higher premiums or copays. In 2025 (due to *Inflation Reduction Act*) you will be able to spread the higher cost during the deductible over more months to “smooth out” the cost of your medications. You will need to **OPT-IN** to this feature.
3. **Copay/Co-Insurance:** The amount YOU PAY when you pick up your prescription. After you have met the plan deductible, you pay up to 25% of full retail, and your plan pays 75% until you have paid \$2,000 (excluding the premium).
4. **Catastrophic:** The plan, drug manufacturer and Medicare pay for drugs after you paid \$2,000. Your responsibility is \$0.



HICAP recommends paying your premium directly to the plan either by check or bill-pay through your bank. Having your premium automatically deducted from Social Security has been a problem for some beneficiaries when they change plans.

Plan Restrictions and Coverage Rules

Formulary: The FORMULARY is a list of drugs the plan covers. If your doctor prescribes a drug that is “Not on Formulary”, the pharmacy will charge the monthly FULL RETAIL COST of that drug. Each plan’s formulary is different. PlanFinder’s total out-of-pocket estimate when running a comparison includes the retail cost of Medicare-approved, non-formulary drugs.



Plans have COVERAGE RULES to make sure certain drugs are used correctly and only when medically necessary:

1. **Prior Authorization:** Before your plan will cover a drug with this rule, your doctor must first contact your plan and show there is a medically necessary reason why you must use THIS drug and not another in the same class.
2. **Step Therapy:** With this restriction, you must first try less expensive drugs that have been proven effective for most people with your condition before you can move up a “step” to a more expensive drug. If you have already tried the similar, less expensive drugs and they didn’t work, or if your doctor believes your condition makes it medically necessary for you to be on the more expensive drug, he can contact your plan to ask for an EXCEPTION. He will provide details of the medical necessity and list the other drugs you tried and their outcomes.
3. **Quantity Limits:** For safety and cost reasons, plans may limit the number of pills covered in a month. If you need more, you will pay full cost for quantities over the limit or you need an EXCEPTION (see next page). Some drugs that can cause addiction may be limited to 30 days and may perhaps require you to pick it up in person.

Requesting an Exception

1. If your plan does not cover a certain drug you need, and none that they do offer will help you, obtain a "COVERAGE DETERMINATION" form from your plan.
2. Ask your plan for an "EXCEPTION." When you ask for an EXCEPTION, your doctor must give your plan a supporting statement that explains the medical reason for the request. You may ask for an EXCEPTION for these reasons:
 - Your doctor believes you need a drug that is not on the plan's FORMULARY.
 - Your doctor believes that one of the three coverage rules (listed on page two) should be waived.
 - You believe you should get a non-preferred drug at a lower co-pay because you cannot take any of the alternative drugs on your plan's list of preferred drugs.



Your pharmacist can give you information on how to contact your plan to make your request. Requests should be made in writing. If you disagree with your plan's decision, you have the right to APPEAL. Your plan will tell you how to appeal when it sends their decision.

Some Prescription Drugs Are Covered by Part A or Part B

- Medicare Part A covers medications given to you in the hospital.
- Medicare Part B covers certain medications administered in doctors' offices and other outpatient settings (i.e., chemotherapy, infusion treatment and some injections).
- Part D covers most prescriptions you fill at a pharmacy or through mail-order.

Part D Does NOT Cover Every Drug

Part D includes prescription drugs in each TREATMENT CLASS. However, some drugs are EXCLUDED from Medicare by law. Examples include drugs for:

- Symptom relief of colds, like a cough or stuffy nose
- Prescription meds for cosmetic purposes or hair growth
- Weight loss
- Fertility
- Prescription vitamins, minerals and supplements
- Non-prescription, over-the-counter (OTC) drugs

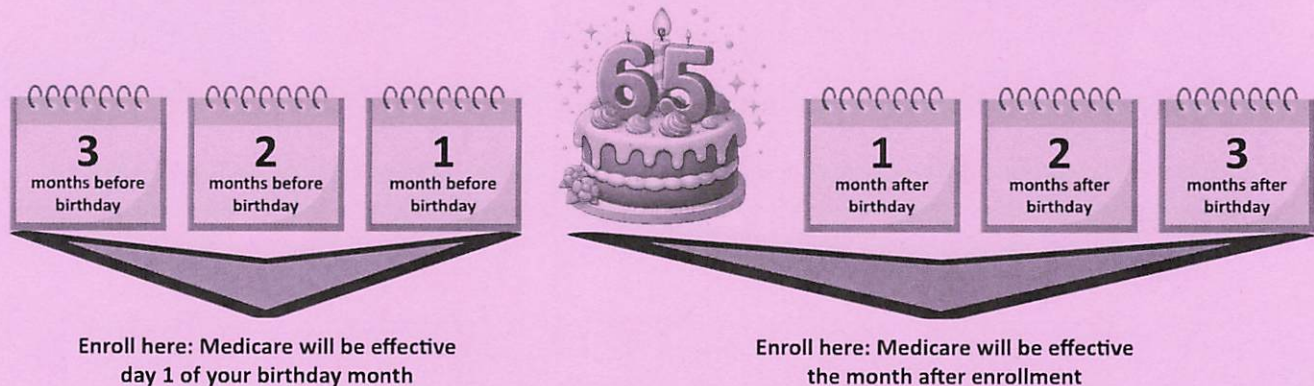


Two other conditions may **exclude** a drug from Medicare:

- If a **NON-CANCER MEDICATION** is prescribed for a reason OTHER THAN THE USE APPROVED BY THE USDA, your drug will probably not be covered unless the use is listed in one of the three Medicare-approved drug compendia (an encyclopedia for drug uses). For **ANTI-CANCER DRUGS**, your plan should accept indications of its use from additional compendia and other peer-reviewed medical literature.
- If your drug does not meet DESI (Drug Efficacy Study Implementation) standards, it may be denied. DESI evaluates the effectiveness of drugs approved on safety grounds alone. Drugs found to be less effective are excluded from coverage.

When to Enroll?

1. **Initial Enrollment Period** — You can join a drug plan (PDP or MAPD) when you first become eligible for Medicare — for example, your INITIAL ENROLLMENT PERIOD, which is three months before your birthday month, and three months after your 65th birthday, with coverage effective at 65 or the month after you enroll (beneficiaries with birthdays on the 1st are enrolled a month before their 65th birthday).



2. **Open Enrollment Period** — You can join or change a plan during OPEN ENROLLMENT (October 15 – December 7).
3. **Medicare Advantage Disenrollment Period (January 1 – March 31)** — You must have an MA plan. You may 1) leave your MA plan, and return to Original Medicare, and enroll in a Stand-Alone Part D plan (PDP) or 2) you may switch (ONCE during this time) to another MA plan. Coverage begins on the first of the following month.
4. **Special Enrollment Period** — Lasts only 63 days and occurs after you:
- Lose creditable drug coverage (i.e., employer or retiree coverage — NOT COBRA)
 - Permanently move out of your PDP or MAPD's service area
 - Enter, reside in, or leave a skilled nursing facility
 - Are released from jail
 - Newly qualify for full Medi-Cal or no longer qualify for full Medi-Cal (not Medi-Cal SOC)
 - Newly qualify for LIS/Extra Help or no longer qualify for LIS/Extra Help. More people qualify for LIS/Extra Help as Partial Extra Help is expanded to FULL Extra Help.



Enroll in Medicare Parts A & B at least one month before your 65th birthday or one month before your creditable coverage ends. You designate when you want Medicare coverage to begin. You want to be enrolled when your current coverage ends to avoid gaps in coverage.

How to Enroll?

There are four ways to enroll in a Part D plan listed in the order of preference:

1. At www.medicare.gov
2. By calling 1-800-MEDICARE
3. At the plan's website
4. By calling the plan directly or on their website

Medicare.gov
The Official U.S. Government Site for Medicare

New for 2025

Out of Pocket Limit on Copays and Co-Insurance

Part D Plans will track the deductible and copays monthly as you use your plan. When you have spent \$2,000, you will STOP paying when you get your prescriptions for the rest of the year.

Medicare Prescription Payment Plan

WHO: If you pay a deductible that is hard to manage financially in the beginning of the year before the cost-sharing phase, you may like the Medicare Prescription Payment Plan (MP3 or MPPP). This program will “spread the deductible” out for the remainder of the year. It won’t mean you pay less — it will just be more manageable, especially in the beginning of the year.

HOW: You can Opt-In during Open Enrollment or early in 2025 for the most benefit. You can decide to Opt-Out as well. Your plan manages this. If you have questions or wish to participate, call your 2025 Part D plan.

NEW Process #1: Your pharmacy will be notified that you are in the MPPP and will not accept your copay for prescriptions.

NEW Process #2: Instead, the plan will add up all the drugs you purchased that month and send you a bill. You send the bill and payment to the plan. You also have a monthly PREMIUM bill to pay. Note addresses in case they are different.

Ten Ideas to Save Money on Prescription Drugs

1. **Pharmacies:** Use one of your plan’s **PREFERRED PHARMACIES** for the best cost-sharing on copays. These pharmacies are listed in the plan documents. The next-best prices are found at **NETWORK PHARMACIES**. If you go to a **NON-NETWORK PHARMACY**, you may have to pay the full price for your drug. **ASK BEFORE YOU PAY.**
2. **Mail Order:** A MAIL-ORDER program for your maintenance drugs may be convenient and sometimes less expensive. Compare prices beforehand.
3. **60- or 90-Day Quantities:** Some retail pharmacies will offer a 60- or 90-day supply for less than two or three times the monthly copay.
4. **Generic drugs:** Many former brand-name drugs have an equivalent generic drug that costs much less than brand-name drugs. Discuss this with your doctor to see if a generic will work for your condition.
5. **Ask your doctor** if there is **ANOTHER DRUG IN THE SAME CLASS** that might be less expensive.
6. **Ask your doctor** if he can give you **SAMPLES** of a drug you need.
7. **Generic Drug Programs:** Examples of pharmacies that have a program for low-cost generics include Costco, Target, Walmart and Walgreens. Some may have enrollment fees; others do not. You need to shop before filling or re-filling a prescription to get the best price. You can transfer your prescription to a new pharmacy to get the better price.
8. **NeedyMeds.org:** The free NeedyMeds Drug Discount Card may save up to 80% off the cost of your prescriptions, OTC medications, and pet prescriptions purchased from a pharmacy.
9. **Buy with Cash at Discount:** Various websites/apps (for example, GoodRx, Amazon, and RxSaver) show you the discounted cash price at pharmacies near you. Some use a coupon or card for billing you instead of using your plan. Ask to re-bill if they give you Part D price. Cash prices vary dramatically. Sometimes it is a better price than your Part D copay.
10. **LIS/Extra Help:** Many more beneficiaries now qualify for Full LIS. Individuals who have limited assets and low income may qualify for help with their premiums, deductibles, and copays through the Low-Income Subsidy (LIS) program. See the LIS handout for more detailed information.



IMPORTANT — CHECK PLANS EVERY YEAR

At the end of September, your current plan will send you an “Annual Notice of Change” (ANOC) outlining the general changes. There is a more detailed “Evidence of Coverage” (EOC) document and the Plan Formulary available by request if you call your plan. It is recommended you request these to make an informed decision about how well your plan meets your needs.



Because drug plans change every year, you want to know how those changes affect you. To know if there is a better plan next year, use PlanFinder to check this year’s plan against others for next year. PlanFinder is linked to your personal Medicare.gov account to make it very easy to do. If you need help, HICAP can answer questions and explain your report so you can make the best decision.

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