CALIFORNIA HEALTH ADVOCATES

Medicare Part D: An Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the MMA) created voluntary prescription drug insurance through Medicare. It is commonly referred to as "Medicare Part D."

This drug coverage is available to everyone who is enrolled in Medicare Part A **or** Part B regardless of income, health status, or how their prescriptions were previously covered. To get this benefit, a Medicare beneficiary has to enroll in a Medicare prescription drug plan, either a stand-alone Part D plan (see below) or a Medicare Advantage plan with prescription drug coverage (see below), offered by private insurance companies. As a plan enrollee, you pay the plan's premium, deductible and cost-sharing. If you have limited income, you may apply for Extra Help to cover some of the prescription drug plan costs. See our fact sheet titled "Extra Help for Part D Costs."

Types of Plans and Plan Costs

Plans approved by Medicare that cover only prescription drugs are referred to as stand-alone Medicare Part D or prescription drug plans (PDPs). For 2011, there are 33 stand-alone Medicare PDPs available throughout California. The premiums range from $14.80 to $114.80. The insurance company or plan sponsor sets the premium in advance—it is not based on your health condition. In addition to the premium, you may also have to pay a deductible and/or a copayment or coinsurance for every prescription you fill.

Instead of joining a stand-alone Medicare PDP, you also have the option of joining a Medicare Advantage plan with prescription drug coverage (MA-PD). MA-PD plans have hospital and medical benefits as well. Thus, in addition to the 33 stand-alone PDPs, you may have MA-PD plans available depending on where you live. To enroll in a Medicare Advantage plan, you must have both Medicare Parts A and B and get all of your Medicare-covered services through that plan. See the fact sheet, "Medicare Advantage Plans: An Overview."

Medicare Part D has a set standard benefit design. (See chart below.) Plans can either follow this design or offer a variation with different cost-sharing structures. The standard plan has an annual deductible and 4 cost-sharing 'phases.' In the first phase, before you meet the deductible, your cost-sharing is 100% of drug costs. When you have met the deductible, the second phase, Initial Coverage, begins. During the Initial Coverage phase, your cost-sharing is 25% of your total drug costs, and the plan pays for the other 75%. When your total drug costs (what you and your plan pay combined) exceed $2,840, the standard Initial Coverage Limit for 2011, the coverage gap begins.

Before 2011, the coverage gap or "donut hole" was so called because a beneficiary had to pay 100% of drug costs. The new health law passed in March 2010 shrinks the "donut hole" and changes the definition since a beneficiary no longer pays 100% of costs for covered drugs.

Starting 2011, beneficiaries who exceed the Initial Coverage Limit will receive a 50% discount on covered brand name drugs and a 7% subsidy on generics. The discount and subsidy will gradually increase until 2020 when you pay just 25% of your drug costs throughout the year.

After January 1, 2011, once you're in the "donut hole," you will receive the discount or subsidy immediately when paying for your drugs at the pharmacy. You won't have any delays or forms to fill out. The 50% brand-name drug discount applies to all "applicable" Part D covered drugs on your plan's formulary and drugs granted an exception by the plan. You pay 50% of the brand name drug's cost, plus a small dispensing fee charged by the pharmacy which is not discounted. The 7% subsidy applies to all generic and other non-brand name Part D covered drugs on your plan's formulary and drugs granted an

exception Thus you pay 93% of the cost of generic drugs.

The coverage gap phase ends, and catastrophic coverage begins, when you reach the out-of pocket threshold. In 2011, the annual out-of-pocket threshold is $4,550. During this last phase, your cost-sharing is the greater of 5% of the covered drug cost **or** $2.50 for covered generics or $6.30 for covered brands. Your plan picks up the remainder your covered drug costs during this phase.

The annual out-of-pocket threshold determines when catastrophic coverage begins. In other words, you won't spend more than this amount out-of-pocket to reach catastrophic coverage. The out-of-pocket threshold is the sum of the deductible, the 25% coinsurance during the Initial Coverage Period, and your drug costs during the coverage gap.

Not all out-of-pocket expenditures are counted to determine if the threshold is reached. For example, the premium is an out-of-pocket expense, but it is not counted. Out-of-pocket expenses that are counted toward the threshold are called TrOOP, or True Out-Of-Pocket costs, and include the deductible and cost-sharing for drugs on your plan's formulary that you purchase at one of your plan's contracted or network pharmacies. In other words, if you pay for a drug that is not in your plan's formulary or you don't buy it at a network pharmacy, your payment may not be counted as TrOOP to determine if you have reached the threshold.

As of January 1, 2011, if you're in the "donut hole," the total cost of your covered brand name drug(s) will be counted toward your TrOOP, not just the 50% you pay. For generics, however, only the amount you pay, which in this case includes the dispensing fee, will count toward your TrOOP.

Companies may vary from the standard design outlined below as long as the beneficiary's out-of-pocket costs before reaching catastrophic coverage remain at $4,550 or are lower. For example, a company may offer a plan with no deductible, or more coverage and additional drugs for a higher monthly premium.

Standard Part D Coverage for 2011

Coverage	Part D Plan Pays	Beneficiary Pays
Annual Deductible ($310)	$0	$310
Initial Coverage Period ($2,530)	75% of $2,530 ($1,897.50)	25% of $2,530 ($632.50)
Coverage Gap ("Donut Hole") ($3,607.50) Once your total drug costs (what you and your plan pay) exceed $2,840 ($310 + $2,530), you are in the 'donut hole.'	$0 (The 50% discount for brand name drugs comes from drug manufacturers, and the 7% subsidy for generic drugs comes from Medicare.)	50% of covered brand name drugs plus dispensing fee; 93% of covered generic drugs
Catastrophic Coverage This begins once you've reached your 'out-of-pocket threshold' of *$4,550 in 2011*. ($310 deductible + $632.50 initial coverage + $3,607.50 'donut hole')	95% or the drug cost minus the copay	Greater of 5% of the drug costs or $2.50 for a generic drug or $6.30 for a brand name drug

Drug Formularies

Medicare drug plans cover both generic and brand name drugs. Each plan has a different formulary, which is a list of drugs covered by the plan. This list must meet Medicare's minimum requirements, but it does not have to include all prescription drugs.
In some circumstances, with Medicare's approval, plans can change their formulary during the year. Two such circumstances include: if a new generic version of a covered brand-name drug becomes available; or new FDA or clinical information show a drug to be unsafe. In general, however, plans cannot discontinue or reduce the coverage of a drug you are currently taking. If a formulary change is made that affects you, the plan must let you know at least 60 days before the change takes place.

If your doctor prescribes a drug that is not on the list, or that a formulary change would adversely affect you, you or your doctor can request an "exception" with your plan. If the plan denies the request, you can appeal the decision. For information on Part D appeals, see the fact sheet "When My Part D Prescription is Denied."

Pharmacies

Prescription drug plans must contract with pharmacies in your area, but pharmacies are not required to contract with all plans. Check with the plan to make sure that the pharmacies in the plan you choose are convenient for you. Many plans will also allow you to get your prescriptions through the mail, often at a lower cost.

Enrollment

People new to Medicare may enroll in a Part D plan during their Initial Enrollment Period (IEP) for Part D. This Period is 7 months: beginning 3 months prior to the month you become eligible for Medicare Part A **or** Part B and ending 3 months after the month you become eligible. For example, if you become eligible for Medicare on September 1, your IEP begins June 1 and ends December 31, during which you may enroll in a Medicare Part D.

If you are enrolled in Medicare and have not joined a Medicare Part D or MA-PD plan, AND if you do not have creditable coverage for your prescriptions (coverage that is at least as good as the standard Part D benefit), your next opportunity to enroll in a Medicare Part D plan is during the Annual Election Period (AEP). This period is from November 15 through December 31 for 2010 but changes to October 15 through December 7 starting 2011. Enrollments made during the AEP become effective the following January 1.

Note: Depending on your situation, you may have other limited opportunities to enroll in a Part D plan. Call your local Health Insurance Counseling and Advocacy Program (HICAP) for more information.

Late Enrollment Penalty

If you are eligible to join a Part D plan but do not, AND do not have creditable coverage for your drugs, you may incur a penalty when you join later. The penalty is 1% of the national average premium for every month you were eligible but did not sign up. The national average premium in 2011 is $32.34, and it changes each year. This penalty is added on to your drug plan premium.

Income Related Part D Premium

Starting 2011, higher income Medicare beneficiaries enrolled in Medicare Part D (either a PDP or MA-PD plan) may have to pay an additional premium. This change, due to the new health law, is similar to the income-related monthly adjustment amount (IRMAA) that higher income beneficiaries pay for Part B. See our fact sheet "Original Medicare: An Overview." Like the Part B income-related premium, the additional premium that higher income Part D enrollees may have to pay depends on their modified adjusted gross income (MAGI) from their tax return 2 years ago. See table below which lists the income bracket, percentage and additional amounts.

The additional Part D premium will be deducted from the beneficiary's Social Security check or billed if the beneficiary does not receive Social Security. The premium for the beneficiary's Part D plan is separate, and billed or deducted from

the beneficiary's Social Security check, as indicated by the beneficiary.

If you receive a bill for the additional premium or the amount is deducted from your Social Security check, and you do not agree, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778) and ask how they determined the amount, or inform Social Security that your circumstances have changed.

Income Related Part D Premium for 2011

Individuals	Couples	Percentage	Additional Premium
≤$85,000	≤$170,000	No increase	n/a
>$85,000 but ≤$107,000	>$170,000 but ≤$214,000	35%	$12.00
>$107,000 but ≤$160,000	>$214,000 but ≤$320,000	50%	$31.10
>$160,000 but ≤$214,000	>$320,000 but ≤$428,000	65%	$50.10
>$214,000	>$428,000	80%	$69.10

To find and compare plans, your best local resource is HICAP, which offers free and unbiased information. You can call the statewide toll free number 1-800-434-0222 to locate the closest office to you. You can also go to the Medicare website medicare.gov or call 1-800-Medicare and speak to a customer service representative. It is important to have your list of medications, your Medicare number and the name of your preferred pharmacy available when you call HICAP or Medicare or go on the Medicare website.

###

This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.