



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, offered by private insurance companies, and 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 the fact sheet titled “Extra Help for Part D Costs” at cahealthadvocates.org.

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 (PDP). For 2009, there are 51 stand-alone Medicare PDPs available throughout California. The premiums range from \$18.30 to \$129.30. 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 a stand-alone Medicare PDP, you may receive Medicare prescription drug benefits through a Medicare Advantage plan with prescription drug coverage (MA-PD). MA-PD plans also have hospital and medical benefits. Thus, in addition to the 51 stand-alone PDPs, you may have the option of joining an MA-PD plan depending on where you live. If you enroll in a Medicare Advantage plan, you must get all of your Medicare-covered services through that plan. See the fact sheet, “Medicare Advantage Plans: An Overview” at cahealthadvocates.org.

Medicare 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 different cost-sharing ‘phases.’ For instance, in the standard plan, before you meet the deductible, your cost-sharing is 100% of drug costs. When you have met the deductible, the Initial Coverage phase 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 \$2,700, the Initial Coverage phase ends and the coverage gap begins.

In the coverage gap phase or “donut hole,” you must pay 100% of your drug costs. The coverage gap phase ends when you have paid \$4,350 out-of-pocket since the plan year started. Then catastrophic coverage begins. During this phase, your cost-sharing is 5% and your plan covers the other 95% of your total drug costs.

The \$4,350 is the 2009 annual out-of-pocket threshold, the amount which 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 expenditure, but it is not counted. Out-of-pocket expenditures that are counted toward the threshold are called TrOOP, or True Out-Of-Pocket costs, and include the deductible and cost-sharing for drugs covered 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 is not counted as TrOOP to determine if you have reached the threshold.

Companies may vary from the standard design as long as the beneficiary’s out-of-pocket costs

remain at least the same or lower than \$4,350. 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 2009

Coverage	Part D Plan Pays	Beneficiary Pays
Annual Deductible (\$295)	\$0	\$295
Initial Coverage Period (\$2,405)	75% of \$2,405 (\$1,804)	25% of \$2,405 (\$601)
No Coverage (“Donut Hole”) (\$3,454) Once your total drug costs (what you and your plan pay) exceed \$2,700 (\$295 + \$2,405), you are in the ‘donut hole.’ <i>You must cover \$3,454 in drug costs before catastrophic coverage begins.</i>	\$0	100% (\$3,454)
Catastrophic Coverage This begins once you’ve reached your ‘out-of-pocket threshold’ of \$4,350 in 2009. (\$295 deductible + \$601 initial coverage + \$3,454 ‘donut hole’)	95% of remaining costs	Greater of 5% of remaining costs or \$2.40 for generic drug or \$6.00 for 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 always 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 thinks you need a drug that is not on the list, or feels 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” at cahealthadvocates.org.

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

For people who are new to Medicare, the Initial Enrollment Period (IEP) for Part D lasts for 7 months: beginning 3 months prior to the month you become eligible and ending 3 months after the month you become eligible. For example, if you turn 65 years old on September 13, your IEP begins June 1 and ends December 31, during which you may enroll in a Medicare Part D or MA-PD plan.

If you are enrolled in Medicare Part A or Part B, 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 PDP is during the Annual Election Period (AEP). This period is from November 15 through December 31 of each year with your coverage becoming effective the following January 1.

Late Enrollment Penalty

If you do not join a plan AND do not have creditable coverage for your drugs, you may incur a penalty of 1% of the national average premium for every month you were eligible and did not sign up. The national average premium in 2009 is \$30.36, and it changes each year. This penalty is added on to your drug plan premium.

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.

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 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 or go on the Medicare website.

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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.