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 and/or Part B regardless of income, health status, or how their prescriptions were previously covered. To get this benefit, a Medicare beneficiary must 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 Medicare Topics section on Prescription Drugs and click on Extra Help with 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 (PDPs). For 2021, there are 32 stand-alone Medicare PDPs available throughout California. The premiums range from $7.20 to $130.40. 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, depending on the plan, and/or a copayment or coinsurance for each prescription.

Instead of joining a stand-alone Medicare PDP, you may join a Medicare Advantage plan with prescription drug coverage (MA-PD). MA-PD plans also have hospital and medical benefits. Thus, in addition to the 32 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 your Medicare-covered services through that plan. See our online Medicare Topics section on Medicare Advantage.

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, your cost-sharing is 100% of drug costs until you meet the deductible. When you have met the deductible, the second phase, called Initial Coverage, begins. During the Initial Coverage phase, your cost-sharing is 25% of your total drug costs, and the plan pays 75%. When your total drug costs (what you and your plan pay combined) exceed $4,130, the standard Initial Coverage Limit for 2021, the third phase or coverage gap (also called the "donut hole") begins.

Before 2011, the "donut hole" was so called because a beneficiary had to pay 100% of drug costs. The health care reform law passed in March 2010 shrinks the "donut hole" gradually over 10 years to be just 25% of drug costs and changes the definition since a beneficiary no longer pays 100% of the full price for covered drugs. The donut hole has now fully "shrunk" and a beneficiary pays 25% for BOTH covered brand name and generic drugs.

This means for 2021 beneficiaries who are in the "donut hole" pay 25% of their covered brand name drugs and 25% for generics, plus a $1-$3 pharmacy dispensing fee. For brand name drugs, to cover the remaining 75% of the cost, drug manufacturers provide a 70% discount and plans pay 5%. For generics, the plans pay the remaining 75%.

If you're in the "donut hole," the discount should be factored into the price you pay for covered drugs. You should not have any delays or forms to fill out.

The coverage gap phase ends and the next phase begins when you reach the annual out-of pocket threshold. In 2021, the annual out-of-pocket threshold is $6,550. During this last phase called catastrophic coverage, your cost-sharing is the greater of 5% of the covered drug cost or $3.70 for covered generics or $9.20 for covered brands. Your plan picks up the remainder of your covered drug costs during this phase.

The annual out-of-pocket threshold is the sum of the deductible, the 25% coinsurance during the Initial Coverage Period, and your costs for covered drugs 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 (or for those that are granted an exception) 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.

If you're in the "donut hole," the cost of your covered brand name drug(s) minus the 5% the plan covers is counted toward your TrOOP, not just the 25% you pay. For generics, however, only the amount you pay counts toward your TrOOP.

Companies may vary from the standard design, and most do, as long as the beneficiary's out-of-pocket costs before reaching catastrophic coverage remain at $6,550 or 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 2021

Coverage		Part D Plan Pays	Beneficiary Pays
Annual Deductible ($445)		$0	$445
Initial Coverage Period (>$446-$4,130)		75% of $3,685	25% of $3,685
Coverage Gap ("Donut Hole") Once your total drug costs (what you and your plan pay) exceed $4,130, you are in the 'donut hole.'		5% for brand name drugs. Drug manufacturers provide a 70% discount for the remaining cost. 75% for generic drugs	25% of covered brand name drugs 25% of covered generic drugs (Plus a $1-$3 pharmacy dispensing fee)
Catastrophic Coverage This begins once you've reached your 'out-of-pocket threshold' of $6,550 in 2021. ($445 deductible + $1,032.50 initial coverage + $5,072.50 'donut hole')		95% or the drug cost minus the copay	Greater of 5% of the drug costs or $3.70 for a generic drug or $9.20 for a brand name drug

Starting in 2021, some, but not all, Part D plans will participate in the new "Part D Senior Savings Model". Participating plans will offer enhanced coverage of insulins on their formulary with a maximum out-of-pocket cost of $35 per thirty-day supply per insulin prescription.

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 shows a drug to be unsafe. In general, however, plans cannot discontinue or reduce the coverage of a drug you are currently taking during the year. 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 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 our online Medicare Topics section on Appeals.

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 its network pharmacies are conveniently located 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 15, 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 October 15 through December 7. 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 current national average premium, multiplied by the number of months you were eligible for a Part D plan but did not sign up. The national average premium in 2021 is $33.06, and it changes each year. This penalty is added to your drug plan premium, and you pay the penalty for as long as you have a Part D plan.

Income Related Part D Premium

Starting 2011, higher income Medicare beneficiaries enrolled in Medicare Part D (either a PDP or MA-PD plan, including Part D offered through a retiree plan) may have to pay an additional premium. This change is similar to the

income-related monthly adjustment amount (IRMAA) that higher income beneficiaries pay for Part B. (See our online Medicare Topics section "The Basics" and click on "Part B: Medical Insurance.") 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) reported on the last tax return. See table below, which lists the income brackets and additional amounts.

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

MAGI (beneficiary filing as individual)	**MAGI** (married beneficiary filing jointly)	Additional Premium
≤$88,000	≤$176,000	N/A
>$88,000 but ≤$111,000	>$176,000 but ≤$222,000	$12.30
>$111,000 but ≤$138,000	>$222,000 but ≤$276,000	$31.80
>$138,000 but ≤$165,000	>$276,000 but ≤$330,000	$51.20
>$165,000 but <$500,000	>$330,000 but <$750,000	$70.70
>$500,000	>$750,000	$77.10

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.

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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.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See https://cahealthadvocates.org/fact-sheets/.