Choosing Your Medicare Part D Plan

When choosing a Medicare plan each year, it is important to look beyond the monthly premium. Plans vary greatly in Medicare and many times, ***choosing a plan with the lowest monthly premium does not necessarily mean you are choosing the least expensive plan***.

Medicare Part D and Medicare Advantage plans tend to change from year to year so evaluating these plans before choosing is very important. A good habit to develop is to check your plan ***every year*** for needed coverage and benefits prior to re-enrollment.

This document is designed to serve as a guide and a general reference tool to help you understand and navigate the process of a choosing a healthcare plan within Medicare. This is by no means an exhaustive or all inclusive guide, however, and you should always research and understand your plan and your benefits prior to choosing any healthcare plan.

First, what is a plan?

When we refer to a plan, we are simply speaking about the particular set of benefits you have chosen within the Medicare family of plans. Medicare offers many options for healthcare plans including Medicare Part D, Medicare Advantage plans and many others.

So What are the A,B,C,D's of Medicare Plans?

Medicare Part A, which is sometimes referred to as original Medicare generally covers inpatient care in facilities such as hospitals and skilled nursing facilities. Medicare Part A also covers hospice care and limited home health care. In most cases, beneficiaries do not have to pay a premium for Medicare Part A.

Medicare Part B is medical insurance that covers doctor visits, medically necessary services and supplies, preventive services, and certain other items and services. Beneficiaries typically have to pay a premium to receive Part B coverage.

Medicare Part C is more commonly referred to as a Medicare Advantage Plan and these plans represent another way you can get your Original Medicare, Part A and Part B, coverage. Most Medicare Advantage plans include prescription drug coverage. Medicare Advantage plans are often managed by private insurance companies and may be modeled after private insurance plans such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans etc. Medicare Advantage plans may have lower costs than Original Medicare and may provide additional benefits; details vary among insurance companies and individual plans.

The Medicare Part D program provides prescription drug coverage. You can sign up for a stand-alone Medicare Part D Prescription Drug Plan to work alongside your Original Medicare coverage, or you can get all your Medicare coverage through a Medicare Advantage Prescription Drug plan.

If you enroll in a stand-alone Medicare Prescription Drug Plan (or a Medicare Advantage Prescription Drug plan), make sure you choose a plan that covers your medications. Every Medicare Prescription Drug Plan has a formulary that lists the drugs it covers, and many plans make their formularies available online. A plan's formulary may change at any time

What is the Coverage Gap or Donut Hole?

Most Medicare Part D plans have a coverage gap, which is often referred to as the "donut hole". While this coverage gap is being phased out and will be eliminated by 2020, it is still important to understand how you may be affected by this policy. In 2017, the coverage gap or donut hole works like this:

- Once you and your Part D medication plan have spent $3,700 for covered medications, you will be in the donut hole. In 2017, while you are in the donut

hole, you pay up to 40% of the cost of a covered brand-name prescription medication and 51% of the cost of a covered generic medication.

- The donut hole continues until your ***total*** out-of-pocket cost reaches $4,950. Your out-of-pocket cost is the amount you spend on things like your yearly deductible, copay, and coinsurance amounts. Also included in this amount, is the manufacturer's discount payment on the medications that you get while in the coverage gap.
- When you spend more than $4,950 out-of-pocket in 2017, the coverage gap or donut hole ends and your medication plan now pays most of the costs of your covered medications for the remainder of the year. Medicare refers to this stage of coverage as “catastrophic coverage.” At this point in the year, you will normally be responsible for a small copay or coinsurance according to the design of your individual plan. It is important as always to check on the cost of your particular medications even in this stage of coverage.

In summary, in 2017, the coverage gap or “donut hole” starts when you have spent $3,700 on medication and ends after you've spent $4,950. Every month that you fill a prescription, your plan mails you an Explanation of Benefits (EOB) notice, which tells you how much you have spent on covered medications and if you've reached the coverage gap. Keep in mind that the exact dollar figures for these programs change from year to year.

What Are Medicare Advantage Plans?

Medicare Advantage Plans (Medicare Part C) are a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. If you chose a Medicare Advantage Plan, you will no longer have your Medicare Part A and Part B. Additionally, Medicare Advantages Plans provide Prescription Medication Coverage.

With an Advantage Plan, Medicare provides a fixed payment to the plan to cover your Medicare Part A (hospital) and Medicare Part B (medical insurance) coverage. There are usually additional copay and deductibles, depending on the type of plan you join.

These plans can also offer, for an additional price, supplemental benefits such as vision, hearing, and dental care.

Many Medicare Advantage Plans include prescription-drug coverage with no additional premium, but again, ***checking the details of the prescription plan is very important***.

One additional consideration with Medicare Advantage Plans is that these plans do not allow the use of Medigap supplemental policies. If you have or are considering a Medigap Plan, you should factor this into your decision to purchase a Medicare Advantage Plan.

What is a Medigap or Supplement Plan?

Medigap plans are supplemental insurance plans, sold and managed by private companies, that can help pay some of the health care costs that MEDICARE PART A and PART B does not cover, such as copays, coinsurance, and deductibles for Medical services. These plans do not provide coverage of Prescription Medications, thus you will need to select a Medicare Part D plan if you need prescription drug coverage.

Some Medigap plans may offer coverage for services such as medical coverage for travel outside of the United States. Each Medigap plan offers different coverage so researching your plan choices is very important.

When you have a Medigap plan, Medicare will pay its share of the Medicare-approved amount for covered health care costs, after which your Medigap policy pays its share in the same way most supplemental insurance plans work.

Two important factors to keep in mind regarding Medigap plans:

- A Medigap supplemental plan may not be used in combination with Medicare Advantage Plans (MEDICARE PART C)
- A Medigap policy only supplements your MEDICAR PART A and PART B; Medigap does not replace the Medicare PART A and B

To learn more about Medigap plans and rules, visit www.medicare.gov.

What type of changes should I consider during open enrollment?

Many changes to healthcare plans occur each year that can affect the medical and pharmaceutical coverage you receive. We have highlighted a few possible changes here that may be important in this review, but it is critical to learn as much as you can about your particular plan.

One important category of plan changes is a change to the Medicare Prescription Medication formulary - the list of medications that are covered under a plan. While a change to the formulary is not the only type of change to look for, formulary changes often create the most financial difficulty for patients.

In addition to Prescription Medication formulary changes, these are other common changes that may be seen, which may impact your access to prescription medications

- A plan may decide to restrict the amount of medication you can get per refill.
- A plan may impose a “prior authorization” requirement. Essentially, this means your healthcare provider must complete and have your insurance approve detailed forms before you can get medication.
- A plan may require "step therapy" which is a requirement that you try a less expensive or pre-determined alternative to the medication prescribed.
- A plan may drop coverage of a medication altogether.
- Many plans change the physicians and hospital networks that are covered under the plan from year to year.
- A plan may require you to fill your prescriptions at a certain pharmacy or pharmacy chain.

Considerations Before and During Enrollment

Every year from October 15th to December 7th, Medicare has an open enrollment period in which both new and existing Medicare patients are allowed to sign up for the particular set of benefits they need for the coming year. As the benefits you choose have a direct effect on the benefits you receive and how much your benefits will cost, the considerations below are provided as a guide to help you make the most of your open enrollment opportunity.

So, a few key elements to consider:

Are your medications covered?

Formulary: When choosing a plan, consider not only the monthly price you will pay, but how well the plan matches your medication needs. Carefully consider the formulary, or list of approved and covered medications, in a plan to determine if your prescriptions are covered.

Coinsurance: Consider as you research plans, if any cost-sharing or coinsurance is required for your medications and whether any special rules apply. An example of cost sharing or coinsurance is when a patient is required to pay 20% of the medication cost and Medicare then pays the remaining 80%.

Copay: This is normally a fixed payment for a covered service, paid when you receive service. The most common examples of copay is the fixed amount you pay at the time of your doctor visit or the fixed amount you pay for your medications at the pharmacy.

Step Therapy: Plans may require you to start with an alternate medication rather than the medication your physician prescribes. This is called step therapy and is also sometimes called the “try and fail” model, meaning that you as a patient must prove that you have tried and failed an alternate therapy prior to receiving the medication prescribed for you.

Pharmacy Networks: Plans increasingly are using preferred pharmacy networks to deliver medications as a cost-control mechanism. These preferred pharmacies may be a big retailer, such as Wal-Mart (WMT), CVS Health (CVS), or Walgreens (WBA), or a delivery-by-mail option. Make sure you are comfortable with the delivery network for plans that you are considering.

Does your plan include your doctor?

It is critical to review the plan network to make sure your doctor and healthcare providers are in the plan network. Using health care providers and facilities that are out of the plan network can have a direct effect on out-of-pocket costs throughout the year.

Talk with your healthcare providers to determine which plans they participate in and whether they expect to stay in the plans long term.

Are you using the Star Rating System?

Medicare uses a 5-star rating scale to rate plans on quality and performance for the types of services they offer. A growing number of plans have achieved 4 and 5 star ratings in recent years, making it well worth the time to research these plans.

Medicare’s website offers a ***Plan Finder*** tool that lets you sort plans in your area by quality rating and also provides details on how these ratings were achieved. A number

of different measures go into the overall rating, so look at the details that are important to you.

How do I enroll?

Many experts now recommend doing your actual enrollment over the phone with Medicare **(1-800-MEDICARE)** or online in order to create an official record of your selection. Having a record may be crucial if you later find errors in your enrollment and need to work with Medicare to have them corrected.

The Medicare Rights Center maintains a free telephone hotline **(1-800-333-4114)** that can walk beneficiaries through the differences between traditional Medicare plans, prescription drug plans and Medicare Advantage Plans.

Do you qualify for Extra Help?

Medicare offers the **Low Income Subsidy** or "Extra Help" program which is designed to provide lower cost medications and benefits to patients who meet certain income criteria. In most cases, patients who qualify receive reduced premiums, deductibles and copay amounts on their prescription drugs.

To get more information on this program or to check your eligibility and apply, you can call 1-800-772-1213 or visit the website at https://www.ssa.gov/medicare/prescriptionhelp/

So, to put it all together…

When choosing a new Medicare plan or re-enrolling for a plan, ask yourself the following questions:

- ✓ What benefits do I need most in my plan?
- ✓ Does my current plan, or the plan I am considering cover the medications I need?
- ✓ What expenses will I incur through the plan I am considering?
- ✓ Is my doctor considered "in network" with the plan I am considering?
- ✓ Have I compared the benefits and costs of Medicare Part D plan versus Medicare Advantage plans?
- ✓ Is a Medigap policy right for me?

- ✓ Do I qualify for the Low Income Subsidy or Extra Help plan? If so, when will I apply?
- ✓ Does my plan have a strong rating?
- ✓ Do I have all the information I need to enroll in my chosen plan?

Medicare Terminology

Coinsurance - An insurance plan design that requires the insured patient to pay a set percentage of a medical charge or drug cost before the plan (Medicare) will pay the remaining charges. A common coinsurance plan is 80/20, meaning the patient must pay 20% of all charges before the plan will pay the remaining 80%.

Copay - This is a charge paid by the insured patient for medical services or medications. These charges may be fixed charges (ex: $25.00 for each prescription) or they may be a percentage, (ex: 20% of the cost of a hospital visit).

Deductible - A specified amount of money that the insured patient must pay before the insurance plan (Medicare) will pay its portion of a charge.

Low Income Subsidy (LIS) - This is a government program that evaluates income criteria for patients to see if they qualify for reduced financial responsibility for medical services and prescription medications. This is also referred to as “Extra Help” by the government.

Medicare Advantage Plan - This is a managed health care plan within Medicare that normally offers a prescription drug plan as part of the package. Advantage Plans are normally run by private insurance companies on behalf of Medicare and have spending limitations built in to control costs.

Medigap - This is a supplemental insurance policy for Medicare beneficiaries, which provides additional coverage for many out-of-pocket costs after Medicare pays its portion of medical bills.

Part D - This is the prescription drug plan for Medicare recipients.

PDP - Prescription Drug Plan; this acronym is often used on the Medicare website and in literature.

References and Resources:

Medicare (www.medicare.gov)

Medicare Part D (https://www.medicare.gov/part-d/)

ADDITIONAL RESOURCES			
Resource	**Service Provided**	**Contact Information**	**Website**
Benefits Check Up	This is a service provided by the National Council on Aging that helps find programs for people ages 55 and older, to pay for some of the costs associated with prescription drugs and healthcare services..	National Council on Aging 1901 L Street, NW, 4th Floor Washington, D.C. 20036 Phone: 1-202-479-1200	***www.benefitscheckup.org***
Partnership for Prescription Assistance (PPARx)	The PPARx prescription assistance program is designed to help low-income uninsured patients get free or nearly free prescription medicines through patient assistance programs. PPARx does not directly provide assistance but serves as a resource for locating available programs.	Phone: 1-888-4PPA-NOW (1-888-477-2669)	***www.PPARx.org***
Rx Assist	Rx Assist provides a directory of Patient Assistance Programs run by pharmaceutical companies. These programs provide free medications to people with financial need. available programs may be located by searching drug or manufacturer name.	**Search for available programs by drug or manufacturer name at the Rx Assist website: *www.rxassist.org***	***www.rxassist.org***

ADDITIONAL RESOURCES FOR ASSISTANCE			
RESOURCE	**DESCRIPTION**	**CONTACT INFORMATION**	**WEBSITE**
State Health Insurance Assistance Program (SHIP)	SHIP is a national program that offers one-on-one counseling and assistance to Medicare beneficiaries and their families. SHIP provides free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.	For more information about the SHIP program in each state, or to contact an area SHIP counselor, please go to: *www.shiptalk.org*	***www.shiptalk.org***

State Pharmaceutical Assistance Programs (SPAPs)	Many states offer help in paying drug plan premiums and/or other drug costs. Programs vary by state and may not be available in every state.	Search available programs by state at the Medicare.gov website. Details regarding the specific programs and their requirement are contained in the drop-down menus.	*http://www.medicare.gov/pharmaceutical-assistance-program/state-programs.asp*
MANUFACTURER COPAY ASSISTANCE PROGRAMS			
Manufacturer's Co-Pay Assistance Programs	Some pharmaceutical manufacturers offer assistance with out-of-pocket costs for the drugs they sell. Support may include savings on private insurance co-pay, deductible, and co-insurance medication costs. NOTE: Use of co-pay assistance cards is prohibited if prescriptions are paid in whole or in part by any state or federally funded programs, including, but not limited to, Medicare or Medicaid, Medigap, VA, DOD, TriCare or state pharmaceutical assistance programs (SPAPs). The Department of Health and Human Services does not consider Qualified Health Plans (QHPs) to be federal health care programs.		
EXCEPTION REQUESTS			
Payer Specific	Many o prescription drug programs allow a request for coverage determination regarding their drug. In some cases the patient's out-of-pocket may be lowered by request. Policies and specific processes may vary by plan.	Contact patient's prescription drug plan or pharmacy benefits manager (PBM).	For general information and resources regarding the Medicare Part D exceptions process: *www.cms.gov/MedPrescriptDrugApplGriev*