Helping Clients Afford Prescription Drug Costs – Frequently Asked Questions

1. What does Medicare Part D cover?

Medicare Part D covers outpatient prescription drugs. Each Part D plan has its own formulary, which is the list of drugs that a plan covers. The law requires all Part D plan formularies to cover at least two drugs for most categories—or classes—of drugs, and substantially all drugs in the following six categories:

- Immunosuppressants, which are used to prevent an individual's body from rejecting an organ after a transplant
- Antidepressants, which are used to treat depression
- Antipsychotics, which are used for schizophrenia and bipolar disorder
- Anticonvulsants, which are used to treat epileptic seizures
- Antiretrovirals, which are used to treat HIV and AIDS
- Antineoplastics, which are used to prevent the development of tumors

Some drugs are excluded from Medicare coverage by law and cannot be covered by any Part D plan. These include:

- Drugs used to treat anorexia, weight loss, or weight gain; however, Part D may cover drugs used to treat physical wasting caused by AIDS, cancer, or other diseases
- Fertility drugs
- Drugs used for cosmetic purposes or hair growth
- Drugs that are *only* used to treat cough or cold symptoms
- Drugs used to treat erectile dysfunction
- Drugs that have not been approved by the Food and Drug Administration (FDA)
- Prescription vitamins and minerals, except for prenatal vitamins and fluoride preparations
- Most over-the-counter drugs, like Tylenol® and Advil®

Part D does not cover drugs that are covered by Medicare Parts A and B, such as drugs a beneficiary receives as part of inpatient hospital treatment (Part A), chemotherapy drugs (Part B), or certain vaccines (Part B).

2. Who provides Part D coverage?

An individual can receive Part D coverage either through a stand-alone Part D plan or a Medicare Advantage Plan. Both stand-alone Part D plans and Medicare Advantage Plans are provided by private insurance companies. A stand-alone Part D plan works with Original Medicare, which is Medicare coverage provided directly by the federal government. Most Medicare Advantage Plans offer Part D benefits in addition to Part A and Part B benefits.

3. What does Part D cost?

There are a number of costs associated with a beneficiary's Part D plan. A beneficiary may have a monthly premium, an annual deductible, and coinsurance or copayments (copays) for their covered drugs.

- **Premium:** The amount a beneficiary pays monthly to have drug coverage. In 2018, the average Part D premium is $35.02.
- **Deductible**: The amount a beneficiary pays annually before their plan begins to cover their prescription drugs. Not all Part D plans have a deductible. In 2018, the maximum deductible is $405.
- **Coinsurance or copay**: The amount a beneficiary pays out of pocket for their covered drugs. A coinsurance is a percentage of the cost of the drug. If a plan charges a 15% coinsurance for covered generic drugs, that means the beneficiary pays 15% of the cost each time they fill a generic prescription. A copay is a set amount, such as a $20 copay for a covered generic drug.

Many Part D plans use tiers to price drugs listed on their formularies. Drugs on lower tiers are less expensive, and drugs on higher tiers are more expensive. A sample tier structure may be:

- Tier 1: Generic drugs
- Tier 2: Preferred brand-name drugs
- Tier 3: More expensive brand-name drugs
- Tier 4: Specialty drugs

Note: These are not official drug tiers. In practice, some plans may place generic drugs on higher tiers.

4. What are Part D coverage phases?

Part D coverage phases (sometimes called periods) are different times during the year that determine how much a beneficiary pays for their covered prescription drugs.

The first phase is the deductible period. If a beneficiary's Part D plan has a deductible, they begin the year in the deductible period. During this time, the beneficiary pays the full cost of their drugs out of pocket until they have met their plan's deductible. While deductibles vary from plan to plan, no plan's deductible can be more than $405 in 2018, and some plans have no deductible.

The next phase is the initial coverage period, which begins once a beneficiary meets their deductible, if they have one. During this period, a beneficiary pays a portion of the cost of their drug, which is their plan's coinsurance or copay for covered drugs. How long a beneficiary is in the initial coverage period depends on their total drug costs (how much the beneficiary and plan pay) and their plan's benefit structure. Most plans' initial coverage periods end when a beneficiary has accumulated $3,750 in total drug costs. This amount includes the beneficiary's deductible, coinsurances, copays, and the amount that the plan paid for the individual's covered drugs.

The next phase is the coverage gap, or donut hole. A beneficiary enters the coverage gap after reaching $3,750 in total drug costs. During this period, the plan does not pay for the individual's drugs, but there are federally funded discounts that help cover costs. In 2018, a

beneficiary pays 44% of the cost of covered generic drugs, and 35% of the cost of covered brand-name drugs. The coverage gap will be phased out by 2020, at which point beneficiaries will typically pay no more than 25% of the cost of their drugs at any point during the year, after they meet their deductible.

The last coverage phase is catastrophic coverage. A beneficiary enters catastrophic coverage after paying $5,000 in out-of-pocket costs (regardless of their total drug costs) for covered drugs. The costs that help a beneficiary get out of the coverage gap and into catastrophic coverage include:

- Their deductible (but not their premiums)
- The amount they paid during the initial coverage period (but not the amount their plan paid)
- Almost the full cost of brand-name drugs (including the manufacturer's discount) during the coverage gap
- Amounts paid by others, including family members and most charities
- Amounts paid by State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs, and the Indian Health Service

When a beneficiary is in catastrophic coverage, they pay either a 5% coinsurance for the cost of covered drugs or a copay of $3.35 for generic drugs and $8.35 for brand name drugs, whichever is greater.

Not all beneficiaries reach the coverage gap or catastrophic coverage. If a beneficiary only takes a few inexpensive drugs, they will likely be in the initial coverage period until the end of the calendar year, at which point the coverage phases reset. On the other hand, if a beneficiary takes expensive drugs, such as chemotherapy drugs, they will likely enter the coverage gap and then catastrophic coverage earlier in the year.

If a beneficiary qualifies for Extra Help (see question 5), they will not experience the coverage gap.

5. What is Extra Help?

If a beneficiary's income and assets are below a certain level, they may qualify for Extra Help, also known as the Low-Income Subsidy (LIS), a federal assistance program that helps pay for prescription drug costs. There are two types of Extra Help: full Extra Help and partial Extra Help.

Full Extra Help eligibility and costs:

- A beneficiary qualifies for full Extra Help if their income is up to $1,386 ($1,872 for couples) per month and their assets are up to $9,060 ($14,340 for couples).
- If a beneficiary is enrolled in a Medicare Savings Program (MSP) or Medicaid, they are automatically enrolled in full Extra Help.
- A beneficiary with full Extra Help pays nothing for their monthly premium and deductible as long as their Part D plan has a premium at or below the Extra Help premium limit for their area. This is called the benchmark amount, and it varies by state. The beneficiary pays a $3.35 copay for generic drugs and an $8.35 for brand-name drugs.

Partial Extra Help eligibility and costs:

- A beneficiary qualifies for partial Extra Help if their income is up to $1,538 ($2,078 for couples) per month and they have up to $14,100 ($28,150 for couples) in assets.
- A beneficiary with partial Extra Help pays a monthly premium based on their income, and they have an $83 deductible or their plan's standard deductible, whichever is cheaper. The beneficiary pays a 15% coinsurance for their drugs or the plan copay, whichever is cheaper.

Extra Help has a few other benefits. If a beneficiary does not already have Part D, enrolling in Extra Help will automatically enroll them in a Medicare Part D plan. The beneficiary can change plans later, if they wish, as Extra Help gives beneficiaries a Special Enrollment Period (SEP) to change their coverage once per month. Extra Help also eliminates any Part D penalty a beneficiary has if they delayed Part D enrollment and did not have creditable coverage.

6. What are other resources for prescription drug cost assistance?

Some states—but not all—have a State Pharmaceutical Assistance Program (SPAP) that helps pay for an individual's drugs. Each SPAP has specific eligibility requirements, application instructions, and rules and conditions that a beneficiary must follow in order to get the benefit.

One way to learn whether your client's state has an SPAP is to contact your State Health Insurance Assistance Program (SHIP) or visit www.medicare.gov/pharmaceutical-assistance-programs/state-programs.aspx.

A second option is to explore Patient Assistance Programs (PAPs), which are pharmaceutical assistance programs that provide discounts on certain drugs. There are a variety of different PAPs, and each generally offers discounts on a specific type of brand-name or generic medication. These discounts are provided by drug manufacturers, not by the state or federal government. In addition, some programs may not be available for beneficiaries who already have Medicare prescription drug coverage. Visit www.needymeds.org or www.rxassist.org to search for a beneficiary's needed drug and learn if there are any PAPs available to them. NeedyMeds also shows you if there are coupons, charities, and/or inexpensive generic options available for the drug(s) you entered.

7. How does a beneficiary appeal to their Part D plan to lower the cost of their drug?

If a beneficiary's drug is too expensive, they may be able to appeal to their plan to lower the cost of their drug, depending on the circumstance. The two types of appeals we'll discuss here are tiering exceptions and formulary exceptions.

Tiering exception request

- If a beneficiary's drug is on a higher tier (see question 3), they can file a **tiering exception** to ask the plan to put the drug on a lower tier, thus lowering its price. (Note that this does not apply if a beneficiary's drug is on a specialty tier, in which case they cannot request a tiering exception.) A beneficiary's doctor should contact the plan to learn how to request a tiering exception. They may have to fill out a Coverage Determination Request Form or other paperwork from the plan. The doctor should also

write a letter that explains that drugs or treatment for the individual's condition that are on lower tiers are ineffective or harmful.

- The plan must give a decision within 72 hours of receiving the request. A beneficiary can ask their doctor to request an expedited appeal if they or their doctor feel that their health could be seriously harmed by waiting the standard timeline for decisions. If the plan grants the expedited appeal request, they it must provide a decision within 24 hours.
- If the plan denies the tiering exception request, the beneficiary can appeal the decision by following instructions on the denial notice they receive. This notice is called the Notice of Denial of Medicare Prescription Drug Coverage. The beneficiary should appeal within 60 days of the date on the denial notice. Approved tiering exception requests normally last until the end of the current calendar year.

Formulary exception request

- If a beneficiary is paying the full cost of a drug out of pocket because it is not on their plan's formulary, they can appeal for a **formulary exception** to ask the plan to cover the drug. In general, a beneficiary pays much less for drugs on their plan's formulary than for non-formulary drugs. To request a formulary exception, a beneficiary should ask their doctor to contact the plan and ask for an exception. The plan will send the doctor the needed paperwork, which the doctor should complete and return. They should also include a letter of support that explains that other drugs on the plan's formulary would not be as effective as the prescribed drug, or that other drugs on the formulary would be harmful to the individual's health. The doctor generally must demonstrate that the beneficiary has tried the drugs on the formulary and has had a negative reaction to them.
- The plan must give a decision within 72 hours of receiving the request. A beneficiary can ask their doctor to request an expedited appeal if they or their doctor feel that their health could be seriously harmed by waiting the standard timeline for decisions. If the plan grants the expedited appeal request, they it must provide a decision within 24 hours.
- If the plan denies the formulary exception request, the beneficiary can appeal the decision by following instructions on the denial notice they receive. This notice is called the Notice of Denial of Medicare Prescription Drug Coverage. The beneficiary should appeal within 60 days of the date on the denial notice. Approved formulary exception requests normally last until the end of the current calendar year.

8. What are other strategies for helping clients afford drug costs?

If a beneficiary cannot use an assistance program, or appeal to lower their drug costs, there are a few other strategies you can use to try to help.

- If a beneficiary is taking a brand-name drug, they can speak with their doctor about the possibility of taking a generic drug instead. This may not be an option for all beneficiaries, but taking a generic drug could save money since generics are generally less expensive than their brand-name equivalents. The individual might also ask their plan if there are less expensive brand-name drugs on the formulary.
- Some plans offer the option to get drugs through a mail-order pharmacy, rather than going to a retail pharmacy. Beneficiaries can contact their plan to learn if it offers mail-order, and if this option would be less expensive.

- Lastly, a beneficiary can ask if their doctor could provide them with drug samples. Although this is a short-term solution, samples can provide temporary assistance while the individual seeks other ways to help pay for drug costs.

9. When can a beneficiary change their prescription drug coverage?
A beneficiary may need to change their coverage because their drug copays or coinsurances are too expensive, the plan's deductible and/or premium are too expensive, or their drug is not on the plan's formulary. There may be other plans that have lower costs and/or cover the beneficiary's needed drug(s). However, a beneficiary can only change their coverage during certain times of the year.

The first is during the **Fall Open Enrollment Period,** which runs October 15 through December 7 each year. Any changes made take effect on January 1 of the following year. During this time, beneficiaries can make changes to their stand-alone Part D plan or Medicare Advantage Plan. You can help a client find a new plan by using the Medicare Plan Finder tool on www.medicare.gov, calling 1-800-MEDICARE, or contacting the client's State Health Insurance Assistance Program (SHIP) by visiting www.shiptacenter.org or calling 877-839-2675.

A second time that a beneficiary can change their prescription drug coverage is if they qualify for a **Special Enrollment Period (SEP).** The length of the SEP and the effective date of the new coverage depend on the reason for the SEP. A full list of SEPs is available at https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances/join-plan-special-circumstances.html.

Some examples of SEPs include:

- Extra Help SEP
  - A beneficiary enrolled in Extra Help can change their drug coverage once per month.
- SPAP SEP
  - A beneficiary enrolled in an SPAP can choose a new Medicare Advantage or Part D plan once per year (unless their SPAP automatically enrolled them in a Part D plan).
- Five-star SEP
  - If there is a five-star stand-alone Part D plan or Medicare Advantage Plan in a beneficiary's service area, they can enroll in that plan.