The following changes to what is called the "standard" Part D prescription drug model have been made for 2024.

The standard design of the Medicare Part D benefit has four distinct phases, where the share of drug costs paid by Part D enrollees, Part D plan carriers, drug manufacturers, and Medicare varies. [The Part D enrollee shares indicated below reflect costs by enrollees who are not receiving low-income subsidies (also known as "extra help."] **Note**: All Part D plans must cover at least the Part D standard benefit or meet the requirements for "alternative benefits." Benefit structures that are not standard but instead are actuarially equivalent are known as "alternative" coverage.

- The first stage is called the deductible phase. The "standard" Part D deductible has been increased from $505 in 2023 to $545 in 2024. **Note** that not all Part D plans have deductibles, some have lower deductibles, and some have deductibles only for certain tier levels and no deductible for generic tiers or the lowest-tier generic drugs.
- Once the deductible (if any) is met, the enrollee enters the initial coverage phase. Carriers are permitted to charge 25% for medications under the standard model, but in 2024 most carriers charge copays for lower-priced medications and coinsurance (to a maximum of 50%) for higher- priced medications.
- The coverage gap (formerly also referred to as the "donut hole") phase starts once the enrollee's total cost of medications reaches $5,030 in 2024 (up from $4,660 in 2023). During this phase, the member's cost for medications changes to 25% coinsurance. **Note**: some carriers provide what is called gap coverage, which means the cost for many generic drugs will remain at the same level as they were before the initial coverage limit (i.e., the coverage gap) is reached. Also, carriers are permitted to start the coverage gap at an amount greater than $5,030.
- The catastrophic phase starts once the "out-of-pocket" threshold reaches $8,000 (increased from $7,400 in 2023). If a person reached the out-of-pocket threshold in 2023, he or she would have paid the greater of 5% or $4.15 for generic drugs; or the greater of 5% or $10.35 for brand name drugs. **Once the out-of-pocket threshold is reached in 2024 there will be NO cost for any covered medications.**

Note that entry into the coverage gap phase is based on the **total cost** of the enrollee's medications in the deductible and initial coverage level phases, whereas a **different** calculation [called "true out-of-pocket" costs (TrOOP)] is used for calculation of the "out-of-pocket" threshold. Generally, TrOOP includes **enrollee** (i.e., NOT the total) payments for Part D prescription drugs, including the annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold. The following items are also included in TrOOP:

- Drug manufacturers' discounts for brand name drugs (70%) which are paid during the coverage gap count toward TrOOP.
- Generally, for drug costs to count toward TrOOP, drugs must be on the plan's formulary and be purchased at the Part D plan's participating network pharmacy.
- Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service count toward TrOOP.
- Amounts paid by or through qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, health savings accounts, flexible spending accounts, and medical savings accounts count toward TrOOP.

There is NO CHARGE for medications once the enrollee meets the catastrophic phase in 2024. According to the Kaiser Family Foundation once an enrollee personally pays approximately $3,300 in 2024 he or she will have no further costs for covered medications in 2024. (This number will vary according to the actual medications an individual takes and in many cases will be lower than the Kaiser Family Foundation projection. We have software that can project when a beneficiary will meet the catastrophic threshold in 2024 based on his or her list of medications; please contact us at **561-734-3884** and we can make these projections for you.)

Part D carriers previously paid 15% of the cost of medications in 2023 once the out-of-pocket threshold was met. In 2024 carriers will be required to pay 20% of the cost of medications once this threshold is met; Medicare pays the balance of the cost.

Individuals on expensive medications will be greatly benefitted by this change to the catastrophic coverage stage. For example, the ***Kaiser Family Foundation*** has reported

that enrollees on one of the top five high-cost, commonly used cancer drugs will be reduced by thousands of dollars in 2024. For example, those on Pomalyst will save $8,500; while those on Revlimid, Imbruvica, Jakafi, and Ibrance will save $6,400, $6,400, $5,900, and $5,000, respectively.

Because of this change to the catastrophic phase in 2024, those who buy some medications outside of the plan (e.g., from Good Rx or other non-plan resources) and who otherwise would meet the out-of-pocket threshold should consider changing their strategy and buy all their medications through the plan in 2024, as this could result in lower costs. This recommendation will be even more important in 2025 because of the changes being made to drug plans next year.

Drug formularies (the list of covered medications) differ between all carriers and even between different plans offered by the same carrier.

Other Changes For 2024

- People with Medicare who have incomes up to 150% of the Federal Poverty Level (FPL) and resources at or below the limits for partial low-income subsidy benefits will be eligible for full benefits under the Part D Low-Income Subsidy (LIS) Program. This program is also referred to as the "Extra Help" program, and this link from the Medicare.gov site contains more information and an application to apply for the program.. The Inflation Reduction Act eliminates the partial LIS benefit currently in place for individuals with incomes between 135% and 150% of the FPL. Nearly 300,000 low-income people with Medicare currently enrolled in the LIS program stand to benefit from the program's expansion. **Up to 3 million people could benefit from the Low-Income Subsidy program but aren't presently enrolled.** See this **Fact Sheet** for more information.
- Future increases in the national average monthly PDP premium will be limited to 6% from the prior year. Previously, there was no cap on this premium. This premium is utilized to calculate late enrollment penalties for those who have gone 63 days or more without what is called "creditable drug coverage" since becoming eligible for Medicare. (The late enrollment penalty is calculated by multiplying 1% of the national average PDP premium for the year by the number of months the enrollee has not had creditable drug coverage, and this is a MONTHLY penalty that is payable the entire time the Medicare beneficiary Medicare drug coverage.) The 6% cap applies to calculating the national average

monthly PDP premium BUT does not apply to individual plans; individual Part D premiums can increase more than 6%.