

Medicare Part D — The Short Course

Beginning in 2006, all people with Medicare have access to a prescription drug benefit. The following is a list of the top things you need to know regarding this program.

- The open enrollment period for the Medicare Part D benefit is currently from October 15 through December 7, each year. In addition to the open enrollment period, all **new** Medicare beneficiaries have a 7-month period to enroll in the benefit, which includes the 3 months prior to their 65th birthday, the month of their birthday, and the 3 months following their birthday.
- The benefit is offered by private plans that have been approved by Medicare. There are two basic types of plans:
 - Medicare Prescription Drug Plan (PDPs) — which is a free-standing drug plan that complements original Medicare, some Medicare Cost Plans, some Medicare Private fee-for-service (FFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
 - Medicare Advantage Plan (like an HMO or PPO) — which provides drug coverage as part of a complete healthcare coverage plan and is delivered through a managed care entity (e.g. HMO, PPO). Medicare Advantage Plans with prescription drug coverage are sometimes called MA-PDs. Patients must have Part A and Part B to join a Medicare Advantage Plan.
- The PDP drug plan sponsors typically offer several different plan options in each local area that may include:
 - The standard option — with a benefit structure consisting of a \$320 deductible, a 25 percent copayment for the next \$2930 of covered prescription drug costs, then a coverage gap until out-of-pocket drug expenses reach \$4700, at which point the patient begins to pay no more than a 5 percent copayment and the program pays at least 95% for all remaining prescription drug costs for the year.
 - An actuarially equivalent option — with a benefit structure different from the standard option. Plans are free to offer a different deductible, copayment, and/or coverage gap as long as it is actuarially equivalent to the standard option.
 - An enhanced option — with a benefit structure that provides more coverage than the standard option.
- The coverage gap (aka donut hole), begins once a patient reaches their Medicare Part D plan's initial coverage limit, \$2930, and ends when they spend a total of \$4,700. In 2012, Part D enrollees will receive a 50% discount on the total cost of brand-name drugs while in the donut hole. Enrollees will pay a maximum of 86% co-pay on generic drugs while in the donut hole.
- Beneficiaries are able to choose among a large number of drug plan options offered by a variety of different sponsors in most local areas. The drug plan options differ in many ways including monthly premium, deductible, copayments/coinsurances, coverage gaps, formulary, pharmacies employed and whether it is a PDP or MA-PDP.
- Medicare has developed multiple resources to help beneficiaries learn about the new benefit and to provide assistance in choosing a drug plan. These resources include calling 1-800-Medicare, visiting [here](#), reading their Medicare and You 2012 Handbook, or contacting the local State Health Insurance Assistance Program (SHIP) or local Department of Aging. The phone numbers for these local agencies can be found at 1- 800-677-1116 or [online](#).
- Beneficiaries with incomes below \$16,755 (single) and \$22,695 (couple) with limited assets will qualify for help to pay for the Part D benefit. These values represent 150% of Federal Poverty Guidelines. These individuals should contact Social Security at 1-800- 772-1213 or [online](#) to apply for this extra help. Dual eligibles — beneficiaries who qualify for both Medicare and Medicaid — will pay no monthly premium, have no deductible or coverage gap and pay only a very low co-payment.
- It is important for Medicare beneficiaries to consider enrolling in a Medicare drug plan when they become eligible if they do not already have “creditable” drug coverage from another source. Medicare beneficiaries who chose not to enroll in a Part D plan during the open enrollment period or who do not enroll during the 7-month enrollment period corresponding to their 65th birthday and do not have drug coverage at least equal to the standard Medicare Part D benefit (i.e. creditable

coverage) will have to pay a penalty if they later decide to enroll in a Medicare drug plan. The late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" (\$31.08 in 2012) times the number of months the beneficiary delayed joining a Part D program and is applied to the monthly premium. The penalty will stay in effect as long as the beneficiary remains in a Part D plan.

- Physicians can obtain information on the formularies in the drug plans in their area by visiting the drug plan's website or by using the CMS formulary [website](#), which indicates the plans in your local area that cover specified drugs. In addition, Part D formularies are currently available at no cost through [Epocrates](#) both in web and PDA format.
- All Part D drug plans are required to have an exception/appeal process that provides enrollees with the opportunity to challenge the exclusion of a particular drug from a plan's formulary or the placement of a drug on a high cost-sharing tier. The exception/appeal can be requested by the beneficiary, the prescribing physician or the beneficiary's legal representative. Generally, plans must grant the exception/appeal if they determine that it is medically appropriate based on the information provided by the prescribing physician. Emergency appeals must be addressed within 24 hours. There are procedures for independent exception/appeal determinations if the plan denies the request. A standard physician exception/appeal form accepted by all Part D plans is available at (http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf)
 - Beginning in 2008, Part D plans are responsible for paying for all vaccines (and their administration) that are not covered under Medicare Part B. At this time, physicians will typically need to bill the beneficiary for the cost of the vaccine and its administration, and the beneficiary will submit the bill to their Part D plan for reimbursement. The beneficiary is responsible for the difference between what the Part D plan reimburses and the physician's billing. More information regarding this issue is available at (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0727.pdf>)
- Physicians are expected to provide unbiased, objective general information regarding the Part D drug plans that is in the best interest of their patients. They are encouraged not to direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. They also cannot receive compensation directly or indirectly from a plan for beneficiary enrollment activities. These guidelines are particularly relevant if the physician is under contract with a Prescription Drug plan or a Medicare Advantaged plan that offers prescription drug coverage.

The College offers the following resources to help understand and deal with problems concerning the Part D benefit.

An ACP Medicare Part D [website](#) contains practical information for you, your staff and patients regarding the Part D benefit. There is also an ACP Member Part D [website](#) in which ACP staff will help those College members who e-mail descriptions of specific problems about the Part D benefit. Or, if you prefer, you can call the ACP member Part D "Help Center" at 800-338-2746, ext. 4535.