

Medicare Changes: Part D

The prescription drug benefit

Medicare began providing prescription drug coverage through Medicare Part “D” in 2006. Enrollment in Medicare Part D is optional, but you may pay an additional premium if you do not enroll in the program within a certain time period after becoming eligible unless you have other “creditable coverage.” Private companies, contracted by Medicare, offer the Part D benefit, but there is no separate application process – application is made directly through Medicare. Over-the-counter medications are not covered by the Part D benefit – only prescription medications.

Medicare Part D in 2012

Reforms implemented under the Affordable Care Act of 2010 made great strides to simplify Medicare Part D and also begin to close the coverage gap, also known as the “donut hole.” The average monthly premium for 2012 Medicare Part D coverage is \$39.40 (approximately \$473 annually), which is deducted from your Social Security benefit check each month. Plans may not charge a deductible of more than \$320. Thus, a plan basically costs an average of \$793 in 2012. Your monthly premium may be higher if your income is above \$85,000 for an individual, \$170,000 for a couple.

Medicare has established a formulary to calculate your benefits (see “Formulary Defined,” page 2). After you have met the deductible (if your plan has a deductible):

- You pay your co-payment for prescription drugs (25 percent), and your insurance plan pays its share (75 percent) until combined expenditures reach \$2,930 (not counting your monthly premiums).
- After combined expenditures reach \$2,930, you will receive a 50 percent discount on brand-name drugs covered by the plan’s formulary and a 14 percent discount on generic drugs covered by the formulary until your out-of-pocket spending reaches \$4,700. Out-of-pocket spending includes the amount of the discount.
- When your out-of-pocket spending reaches \$4,700, you will then pay a co-payment (5 percent) for each drug through the end of the year, and your plan pays the rest (95 percent).

Example 1 – Annual Spending Does Not Exceed \$4,700

Let’s assume you take Lipitor (\$86/month)*, Plavix (\$152/month), Nexium (\$164/month), and Metformin Extended Release (\$19/month [generic]) – for a total annual expenditure of \$5,052. Your plan has a \$39.40 monthly premium, a \$320 annual deductible, and all your drugs are covered by the plan’s formulary.

Example 1: Annual Spending Does Not Exceed \$4,700

	Monthly Premium	Annual Deductible	Expenditures up to \$2,930	Expenditures between \$2,930 and \$4,700	Expenditures Exceeding \$4,700
You Pay:	\$472.80 ((\$39.40/ monthly premium × 12 months =)	\$320	\$632.50 ((\$2,930 – \$320 [deductible] = \$2,610 × 25% [your out-of- pocket expense for prescriptions] =)	\$1,101.32 (amount is based on you paying 50% for covered brand-name drugs and 14% for generic drugs while in the coverage gap)	\$0.00 [‡] (amount is based on you paying 5% for each prescription once your out- of-pocket spending reaches \$4,700 for the year)
Coverage Gap Discount:	\$0.00	\$0.00	\$0.00	\$1,020.68 [‡]	\$0.00
Plan Pays:	\$0.00	\$0.00	\$1,957.50	\$0.00	\$0.00 [‡]

*Median monthly drug prices from Kaiser Family Foundation: <http://www.kff.org/medicare/upload/8095.pdf>. Last accessed Nov. 7, 2011.

†This figure represents the discount provided during the coverage gap, not expenditure by the plan.

‡Annual expenditures did not reach the catastrophic coverage level.

For this example, you paid approximately \$2,546.62 for your prescription drugs (including your monthly premiums and annual deductible); your insurance paid \$1,957.50, and you received a \$1,020.68 discount while in the coverage gap. **You saved approximately \$2,505.38 over the course of the year for your prescription drugs.**

Example 2 – Annual Spending Exceeds \$4,700

Let's assume you take Lipitor (\$86/month)*, Plavix (\$152/month), Nexium (\$164/month), Metformin Extended Release (\$19/month [generic]), Lexapro (\$86/month), Aricept (\$198/month), and Seroquel

(\$155/month) – for a total annual expenditure of \$10,320. Your plan has a \$39.40 monthly premium, a \$320 annual deductible, and all your drugs are covered by the plan's formulary.

For this example, you paid approximately \$3,526.60 for your prescription drugs (including your monthly premiums and annual deductible); your insurance paid \$5,436.40, and you received a \$1,829.80 discount while in the coverage gap. **You saved approximately \$6,793.40 over the course of the year for your prescription drugs.**

Example 2: Annual Spending Exceeds \$4,700					
	Monthly Premium	Annual Deductible	Expenditures up to \$2,930	Expenditures between \$2,930 and \$4,700	Expenditures Exceeding \$4,700
You Pay:	\$472.80 (\$39.40/month premium × 12 months =)	\$320	\$652.50 (\$2,930 – \$320 [deductible] = \$2,610 × 25% [your out-of-pocket expense for prescriptions] =)	\$1,898.20 (amount is based on you paying 50% for covered brand-name drugs and 14% for generic drugs while in the coverage gap)	\$183.10 (amount is based on you paying 5% for each prescription once your out-of-pocket spending reaches \$4,700 for the year)
Coverage Gap Discount:	\$0.00	\$0.00	\$0.00	\$1,829.80 [†]	\$0.00
Plan Pays:	\$0.00	\$0.00	\$1,957.50	\$0.00	\$3,478.90

*Median monthly drug prices from Kaiser Family Foundation: <http://www.kff.org/medicare/upload/8095.pdf>. Last accessed Nov. 7, 2011.

†This figure represents the discount provided during the coverage gap – not expenditure by the plan.

Formulary Defined...

A formulary is a list of preferred, prescription drugs that a health plan approves for use based on safety, effectiveness, and affordability. Typically, health plans only pay for medications on this “approved” list. Take a copy of your plan's formulary to your health appointments and ask your doctor if he/she is prescribing your medications from the formulary list. If he/she needs to prescribe a non-formulary drug, ask if prior authorization can be sought for the health plan to cover payment of this medication.

Each plan's formulary is organized into tiers, and the formularies and tiers may vary from plan to plan. Each tier is associated with a set co-pay amount – the lower the tier, the lower the co-pay amount. For example, Tier 1 might include generic drugs that require the lowest co-pay. Tier 2 might include preferred brand drugs with a higher co-pay, while Tier 3 might include non-preferred brand name drugs that are covered by the plan at a higher co-pay level.



Assistance for Low-Income Medicare Beneficiaries

Certain low-income Medicare beneficiaries may be able to receive additional help under Medicare Part D – programs known simply as “Extra Help.” Medicare uses the Federal Poverty Level (FPL) to compute which beneficiaries may be eligible for Extra Help. The FPL changes from year-to-year, and these figures usually change at the beginning of each year; the income limits for low-income assistance may be revised in 2012.

For 2011*, you were eligible for Extra Help paying for the Medicare prescription drug benefit if your annual income was below \$16,335 (\$22,065 for couples) and your resources were below \$12,640 (\$25,260 for couples). Even if your income or assets were above the limits, you may have qualified because certain types of income and assets may not be counted. You can apply for Extra Help at any time.

If you do not have Medicaid, Supplemental Security Income, or a Medicare Savings Program, you can apply for help paying for your Medicare drug benefit through the Social Security Administration by using either the agency's print or online application. You will also be able to apply for it at your local Medicaid office.

If you apply through Social Security, you can state your income and assets without



having to provide copies of your financial statements when you apply. If you apply at your local Medicaid office, counselors there will check to see if you qualify for other assistance programs, such as a Medicare Savings Program.

For the Most Current Information...

As with most Medicare programs, the fee structure increases yearly on a percentage basis. The new copy of *Medicare and You 2012* should arrive in the mail

in October 2011. Be sure to review these changes carefully as you will need to make an informed decision about changes you might want to make to your existing plan or enrollment in a new plan. **These changes may only be made once per year: October 15 through December 7, except under special considerations.**

As always, the most current information on this and all other Medicare programs may be accessed through Medicare either by phone at 1-(800) MEDICARE (1-800-633-4227) or via the Internet: www.medicare.gov. For more information on Medicare Part D, see:

- Social Security Administration, www.ssa.gov or 1-800-772-1213
- Texas Department of Aging and Disability Services, www.texasmedicarerx.org
- Area Agencies on Aging of Texas, www.dads.state.tx.us/services/contact.cfm or 1-800-252-9240
- 2-1-1 Texas – Dial 211 from your home telephone for information and referral to services in your area.
- Texas AgriLife Extension Service – Senior Medication Issues, http://fcs.tamu.edu/families/aging/senior_medication_issues/index.php

*U.S. Social Security Administration. (2011). Apply online for Extra Help with prescription drug costs – It's easier than learning the twist. <http://www.ssa.gov/pubs/10525.html>. Last Accessed: November 7, 2011.

Disclaimer

The examples shown in this document are for demonstration purposes only. For a more accurate cost estimation based on your personal circumstances, go to www.medicare.gov to input your specific prescription medications and other important information that is specific to you. Or you may call Medicare directly at 1-(800) MEDICARE (1-800-633-4227) to obtain assistance.

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