

## Understanding Medicare Part D Prescription Drug Coverage — Frequently Asked Questions

### 1. What is Medicare Part D?

Medicare Part D, the prescription drug benefit, is the part of Medicare that covers most outpatient prescription drugs. Part D is offered through private companies either as a stand-alone plan, for those enrolled in Original Medicare, or as a set of benefits included with an individual's Medicare Advantage Plan.

Four key things that people with Medicare should know about Part D are:

- Which drugs Medicare Part D covers (see questions 2, 3, and 4)
- How much Part D costs (see questions 6, 7, and 8)
- How to choose a Part D plan (see question 10)
- When and how to enroll in Part D (see question 16)

### 2. What does Medicare Part D cover?

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

- 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®

### **3. Does Medicare Part D cover vaccines?**

If a beneficiary's provider recommends that they get a vaccine, in most cases it will be covered by their Part D plan. Part D plans must include most commercially available vaccines on their formularies, including the vaccine for shingles (herpes zoster). The only exceptions are flu, pneumonia, hepatitis B, and COVID-19 vaccinations, which are covered by Part B.

As of January 2023, all Medicare-covered vaccines should be free. This means that a beneficiary should not owe any cost-sharing, such as a copayment, coinsurance, or deductible for covered vaccines.

To avoid billing issues, it is usually best for a beneficiary to make sure that their health care provider or pharmacy administering the vaccine will bill their Part D plan. When a beneficiary gets a vaccine at their doctor's office, they should ask the provider to call the Part D plan first to find out if they can bill your Part D plan directly.

### **4. Does Part D cover insulin?**

Part D may cover insulin and related medical supplies used to inject insulin (syringes, gauze, and alcohol swabs) if a beneficiary has a prescription from their doctor. Their drug plan should cover medications and supplies they need to treat diabetes at home as long as they are on the plan's formulary. As of January 2023, Part D-covered insulin copays are capped at \$35 per month, with no deductible. A beneficiary should contact their Part D plan for information about its exact costs and coverage rules for insulin.

Medical supplies used to inject insulin (syringes, fillable pens, non-durable patch pumps like the Omnipod, gauzes, and alcohol swabs) can be covered by Part D with a prescription, as long as they are on the plan's formulary. This equipment is not subject to the \$35 per month cap and a deductible may apply. The \$35 cap applies to the insulin the beneficiary puts into these supplies.

If a beneficiary uses an insulin pump, the insulin and the pump may be covered under Part B as durable medical equipment (DME). Part B covers DME at 80% of the Medicare-approved amount, but as of July 2023, copays for Part B-covered insulin products are capped at \$35 per month, with no deductible.

## 5. What is a transition fill?

A transition refill, also known as a transition fill, is typically a one-time, 30-day supply of a drug that an individual was taking:

- Before switching to a different Part D plan (either stand-alone or through a Medicare Advantage Plan)
- Or, before their current plan changed its coverage at the start of a new calendar year

Transition refills let individuals get temporary coverage for drugs that are not on their plan's formulary or that have certain coverage restrictions (such as prior authorization or step therapy).

Transition refills are not for new prescriptions. An individual can only get transition fills for drugs they were already taking before switching plans or before their existing plan changed its coverage.

The following situations describe when an individual can get a transition refill if they do not live in a nursing home (there are different rules for transition refills for those living in nursing homes):

1. An individual's current plan is changing how it covers a Medicare-covered drug they have been taking.
  - If their plan is taking their drug off its formulary or adding a coverage restriction for the next calendar year for reasons other than safety, the plan must either:
    - Help the beneficiary switch to a similar drug that is on the plan's formulary before January 1
    - Or, help them file an exception request before January 1
    - Or, give them a 30-day transition fill within the first 90 days of the new calendar year along with a notice about the new coverage policy.
2. The individual's new plan does not cover a Medicare-covered drug they have been taking. If a drug an individual has been taking is not on their new plan's formulary, this plan must give them a 30-day transition refill within the first 90 days of their enrollment. It must also give the individual a notice explaining that their transition refill is temporary and informing them of their appeal rights.

If a drug an individual has been taking is on their new plan's formulary but with a coverage restriction, this plan must give them a 30-day transition refill free from any restriction within the first 90 days of their enrollment. It must also give the individual a notice explaining that their transition refill is temporary and informing them of their appeal rights.

In both of the above cases, if a drug an individual has been taking is not on their new plan's formulary, they should be sure to see whether there is a similar drug that is covered by their plan (they should check with their doctor about possible alternatives) and, if not, to file an exception request. (If the request is denied, the individual has the right to appeal.)

Note: If an individual files an exception request and their plan does not process it by the end of their 90-day transition refill period, their plan must provide additional temporary refills until the exception is completed.

Remember: All stand-alone Part D plans and Medicare Advantage Plans that offer drug coverage must provide transition fills in the above cases. When an individual uses their transition fill, their plan must send them a written notice within three business days. The notice will tell the individual that the supply was temporary and that they should either change to a covered drug or file an exception request with the plan.

## 6. How much does Medicare Part D cost?

There are a number of costs associated with an individual's Part D plan.

- A premium is an amount the individual pays monthly to have coverage. In 2023 the national base premium is \$32.74.
- An annual deductible is the amount an individual must pay out of pocket before their plan begins to cover some of the cost of their prescription drugs. Not all Part D plans have a deductible. In 2023 the maximum deductible a Part D plan can have is \$505.
- A coinsurance or copayment is the amount an individual pays out of pocket for their covered drugs. A coinsurance is a percentage amount of the cost of the drug. If an individual's plan charges a 15% coinsurance for a covered brand-name drug, that means the individual pays 15% of the cost of that drug. A copay is a set amount, such as a \$20 copay for a covered generic drug.

Many Part D plans use tiers to price the drugs listed on their formularies. Typically, drugs in lower tiers are less expensive and drugs in 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. Some generic drugs may be in higher tiers.

When selecting a Part D plan, it's important for an individual to consider how much they will be paying each month for their drugs. This includes noting if their drugs are in lower or higher tiers on the plan's formulary and what their copayment or coinsurance charge will be.

### 7. What is the Part D insulin savings program?

Since 2021, Medicare Advantage and stand-alone Part D plans have been able to participate in the Part D Senior Savings Model. Under this program, plans charge no more than \$35 copays for a month's supply of insulin. Not all plans participate in this program, and the copays do not apply to all types of insulin. A beneficiary should contact a plan to learn more about whether it participates in the program, and if so, for which prescriptions.

### 8. What are the phases of Part D coverage?

Throughout the year, an individual may notice that they are paying different amounts for their drugs. This is because Part D plans have coverage phases throughout the year, during which an individual pays different amounts for their covered prescription drugs.

These coverage phases are:

- **The deductible phase.** If an individual's plan has a deductible, they start off the year in the deductible phase. During this time, they pay out of pocket for the entire cost of their drug.
- **The initial coverage period.** After an individual meets their deductible (if they have one), they move on to the initial coverage period. During this time, the individual and their plan share the cost of prescription drugs. The individual will pay the plan's copays or coinsurance amounts at the pharmacy.
- **The coverage gap (also known as the donut hole).** After an individual's total drug costs reach a certain amount (\$4,660 for most plans in 2023), they enter the coverage gap, also known as the donut hole. This amount includes an individual's copays or coinsurance amounts as well as the amount that their plan has paid for drugs. This is important to note, as low pharmacy copays do not necessarily mean an individual will not reach the coverage gap.

The donut hole closed for all drugs in 2020, meaning that when an individual enters the coverage gap they will be responsible for 25% of the cost of their drugs. In the past, individuals were responsible for a higher percentage of the cost of their drugs during this period. Although the donut hole has closed, an individual may still see a difference in cost between the initial coverage period and the donut hole. For example, if a drug's total cost is \$100 and an individual pays their plan's \$20 copay during the initial coverage period, they may be responsible for paying \$25 (25% of \$100) during the coverage gap.

- **Catastrophic coverage.** The last coverage phase is catastrophic coverage. In 2023, once an individual has paid \$7,400 in out of pocket costs for covered prescription drugs, they will move out of the coverage gap and into catastrophic coverage. This \$7,050 amount includes the individual's deductible, copays or coinsurance amounts they paid during the initial coverage period, and almost the full cost of brand-name drugs (including the manufacturer's discount) purchased during the coverage gap. Any amount paid by the individual's plan **does not** count to get them into catastrophic coverage. The individual's monthly premium and the cost of non-covered drugs also do not count. During catastrophic coverage in 2023, an individual will pay 5% of the cost for each of their drugs, or \$4.15 for generics and \$10.35 for brand-name drugs (whichever is greater).

An individual's plan should keep track of how much money they have spent out-of-pocket on covered prescription drugs and which coverage period the individual is in. This information should be printed on the individual's monthly statements, known as an Explanation of Benefits (EOB).

## 9. What are coverage restrictions?

Coverage restrictions, also known as utilization management tools, are rules that a beneficiary has to follow before their plan will cover their drug. There are three main types of coverage restrictions: prior authorization, step therapy, and quantity limits.

- **Prior authorization** means that a beneficiary must get approval from their Part D plan before the plan will pay for the drug. A beneficiary's provider is often part of this process and can provide the documentation needed to prove that the medication is medically necessary.
- **Step therapy** means that a beneficiary's plan requires that they try a cheaper version of their drug before it will cover the more expensive one.
- **Quantity limits** restrict the quantity of a drug a beneficiary can get per prescription fill, such as 30 pills of Drug X per month.

## 10. What questions should a beneficiary consider when choosing a Part D plan?

There are many things an individual should consider before choosing a Part D plan. Depending on their needs, their financial situation, and their preferences, some of the following questions and guidelines may be more important to an individual than others.

- **Does this plan cover the individual's drugs?**
  - If an individual takes a lot of prescription drugs, then choosing a plan that has their drugs on its formulary is an important first step. If a plan does not include an individual's drug or drugs on its formulary, then they may end up paying out of pocket for the entire cost of the drug. An individual should create a list of the names of the prescriptions they take, their dosages, and whether they are brand-name or generic. This can help an individual then sort through plans and choose the ones that cover their drugs.
  - An individual should also find out if there are any restrictions on their covered drugs, such as prior authorization, step therapy, or quantity limits (see question 8). An individual can do so by contacting the plan or looking at the plan's details in Medicare's Plan Finder tool (see question 12). It is important to note these as they may affect an individual's ability to access their drugs at the pharmacy and may require the individual work with their doctor before the plan provides coverage.
- **What are the costs associated with this plan?**
  - If an individual chooses a plan with a deductible, they will have to pay that amount out of pocket before their plan begins to cover their prescription drugs. Some people prefer to have a deductible if it means their monthly premium will be lower, while others prefer to pay a higher monthly premium instead of paying out of pocket to meet the deductible. An individual should also think about the most they can and want to spend on the drug plan's monthly premium.
  - It can be difficult to predict the exact cost of pharmacy copays and coinsurance amounts because a drug plan can make some changes to coverage mid-year, and the negotiated price can change. However, an individual can still evaluate plans based on their estimated out of pocket costs.
- **Are the individual's pharmacies preferred and in-network?**
  - Many drug plans include both preferred and non-preferred pharmacies in their networks. An individual generally pays less for their drugs at preferred, in-network pharmacies than at non-preferred pharmacies. If an individual goes to a pharmacy that's close to their home or easy to get to, it may be beneficial for them to look for a plan that categorizes that pharmacy as a preferred and in-network pharmacy.
  - Plans may have a mail-order option that may have cheaper prices than the individual's retail pharmacy. If an individual prefers to pick their drugs up at the

pharmacy, they should be find out of the drug plan has a mail order option and if it will affect their coverage in any way. For example, some plans may require an individual to opt out of mail order before they can pick up their drugs at the pharmacy.

- **What is the plan's star rating?**
  - Medicare uses a star rating system to measure how well Part D plans perform in different categories, including quality of care and customer service. Ratings range from one to five stars, with one being the lowest and five being the highest rating. Medicare reviews plan performances each year and releases new star ratings each fall. An individual can find a plan's star rating by using the Plan Finder tool.
  - Star ratings are not the only factor an individual should consider when looking for a plan. Even though a plan has a high star rating, it may not be the right fit if it does not cover the drugs an individual needs. However, star ratings can be a factor an individual considers once they find the plans that will provide the best coverage for their situation.

### **11. What are some tips for accessing Part D coverage?**

An individual should make sure they follow their Part D plan's coverage rules when getting prescription drugs covered. This is the best way to avoid additional expenses and other issues.

Before they go to the pharmacy, an individual should find out if their drug is on their plan's formulary. If possible, they should ask their doctor to check that their prescription is covered. Otherwise, they can call the plan directly or check their plan's website.

An individual should find out whether their plan places any restrictions on coverage, such as prior authorization, step therapy, or quantity limits (see question 8). If there are any coverage restrictions, the individual should make sure they address them in advance, such as asking their provider to request prior authorization.

An individual should use a preferred, in-network pharmacy to fill their prescriptions. An individual typically pays less for their prescriptions at preferred pharmacies.

### **12. What can an individual do if their drugs are not covered or are covered with high costs and/or restrictions?**

An individual can make an exception request, which is when they ask their plan to cover their drug as an exception to its rules. One specific kind of exception is a tiering exception, when they ask



their plan to cover the drug at a lower cost. Note that in most cases an individual cannot use the exception process if their prescription is excluded from Medicare coverage by law.

An individual can ask their doctor if there is a drug on their plan's formulary that they can use instead (possibly a generic or other low-cost alternative).

If there are no comparable options on their plan's formulary, an individual can also request an exception to their plan's rules. They should ask their doctor to write a letter of support explaining why they need the drug and, if possible, how other medications on the formulary that treat the same condition are dangerous or less effective for them.

If the plan does not grant the exception request, file an appeal.

If an individual qualifies, they can ask their pharmacist to give them a temporary supply of their prescription through their plan's transition refill policy (see question 4). An individual can only do this if their drug was covered before they switched plans or before their plan changed its coverage rules.

If an individual enrolled in a Part D plan after receiving misleading information from that plan, they may be able to disenroll and change plans. They should call 1-800-MEDICARE if a representative from their plan told them that their drugs would be on the formulary or covered without restrictions.

### **13. How can an individual learn about available Part D plans?**

Medicare Plan Finder is an online tool at [www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare) that can be used to compare stand-alone Part D plans or Medicare Advantage Plans. Plan Finder provides information about costs such as premiums and deductibles, drugs included on the plan's formulary, and the star rating of the plan.

To use Plan Finder, an individual should:

1. Go to [www.medicare.gov](http://www.medicare.gov) and click on the button that says "Find Plans." An individual can do a general search by clicking the "Continue Without Logging In" button. If an individual wishes to save their results and information, they can create or log in to their Medicare account.
2. Choose whether they are looking for a Medicare Advantage or Part D plan and enters zip code.
3. Enter the drugs they take if they wish to compare drug prices.

4. Choose the pharmacies they like to go to and indicate whether they are interested in a mail order option.

Plan Finder will then display results for plans that cover the individual's drugs and have their pharmacies in-network. Plan Finder also lists if the plan has a deductible and how much the monthly premium is. Initially, the plans will be sorted by "lowest drug + premium costs". This is the closest estimate to what an individual may pay out of pocket for their Part D coverage for the year. The individual can compare different plans and select "Plan Details" to find out more specifics about coverage, including any coverage restrictions.

Before enrolling, it is a good idea for an individual to call the plan directly to confirm any information they read on Plan Finder, as information may not be completely up-to-date. An individual can enroll in a plan online, by calling 1-800-MEDICARE, or by calling the plan directly. Individuals who would like help looking up plans in their area should contact their State Health Insurance Assistance Program (SHIP) by visiting [www.shiphelp.org](http://www.shiphelp.org) or calling 877-839-2675.

**14. Does an individual need Part D if they do not take any prescription drugs?**

Part D enrollment is optional, but if an individual does not sign up for Part D they may have a late enrollment penalty if they enroll at a later time (see question 17).

**15. Does an individual need Part D if they already have other prescription drug coverage?**

Not necessarily. If an individual has other prescription drug coverage, first they should find out if their existing coverage is creditable. Creditable drug coverage is coverage that has an overall value that is as good as or better than standard coverage under Part D. An individual can delay Part D without penalty if they are currently covered by creditable drug coverage.

Examples of drug coverage that could be creditable include current employer insurance, retiree insurance, military benefits, or Federal health benefits. If an individual's drug coverage is creditable they will receive notice from the plan around September each year. If they do not receive this notice they should contact their benefits manager to get this information in writing. It is important for individuals to keep these notices as they will need proof of their creditable coverage if they decide later that they want to enroll in Medicare Part D.

If an individual loses their creditable drug coverage, they have 60 days after losing that creditable coverage to enroll into a Part D plan without a late enrollment penalty.

If an individual learns that their Part D coverage is not creditable, they should enroll in Medicare Part D when first eligible (see question 16).

if an individual is thinking of signing up for a Part D plan in addition to their current drug coverage, they should ask their employer or retirement benefits administrator if they can keep their coverage and have Part D at the same time. An individual could lose their employer, retiree, or other benefits if they sign up for a Part D plan. It is important to keep this in mind if an individual's plan covers a spouse or dependents because if they lose coverage, they will too, and it is unlikely they will be able to get the coverage back.

### **16. When can an individual sign up for a Part D plan?**

In order to sign up for Part D, an individual must already be enrolled in Medicare Part A (hospital insurance) or Part B (medical insurance) and live within the plan's service area. People typically sign up for Part D during their Part D Initial Enrollment Period (IEP), the Fall Open Enrollment Period, or if they qualify for a Special Enrollment Period.

The Part D IEP is usually the same as an individual's Medicare IEP: the three months before an individual's 65<sup>th</sup> birthday month, their 65<sup>th</sup> birthday month, and three months after their 65<sup>th</sup> birthday month. Once an individual enrolls in Part A and B through the Social Security Administration they can call 1-800-MEDICARE to sign up for the Part D plan of their choice.

An individual can also enroll in Part D for the first time or change their coverage during Fall Open Enrollment. If an individual is already enrolled in a Part D plan, they can make changes to their coverage during Fall Open Enrollment, which spans October 15 through December 7 of each year. Part D coverage becomes effective January 1 of the following year. Part D plans may change their costs and formularies from year-to-year, so it is important for individuals to review their current plan and Annual Notice of Change to learn if premium or deductible prices will change and if their drugs will still be covered next year. Someone can also use Fall Open Enrollment to enroll in Part D for the first time as long as they already have Part A and/or Part B.

There are also a number of SEPs that allow eligible individuals to enroll in Part D for the first time or change their Part D coverage. There are many different SEPs that apply to different situations, such as if an individual has employer drug coverage that terminated. A full list of SEPs is available on [www.medicare.gov](http://www.medicare.gov).

**17. What is the Part D late enrollment penalty (LEP)?**

For each month an individual delays enrollment in Medicare Part D, they will have to pay a 1% Part D late enrollment penalty, unless they:

- Have creditable drug coverage
- Qualify for the Extra Help program
- Prove that they received inadequate information about whether their drug coverage was creditable

In most cases an individual will have to pay that penalty every month for as long as they have Medicare. If an individual is enrolled in Medicare because of a disability and currently pays a premium penalty, once they turn 65 they will no longer have to pay the penalty.

The Part D LEP is 1% of the current year’s national base premium for every month they delayed enrollment and did not have creditable coverage. For example, if someone delayed Part D for seven months, their monthly premium would be 7% higher for as long as they have Part D. The national base beneficiary premium in 2023 is \$32.74 a month. The individual’s monthly premium penalty would be \$2.29 ( $\$32.74 \times 1\% = \$0.3274 \times 7 = \$2.29$ ) per month, which they would pay in addition to their plan’s premium.

Note: The Part D penalty is always calculated using the national base beneficiary premium. An individual’s penalty will not decrease if they enroll in a Part D plan with a lower premium.

**18. Can an individual get assistance paying for prescription drug costs?**

If an individual has limited income and assets, they may qualify for Extra Help, also known as Low Income Subsidy (LIS). Extra Help is a Federal assistance program that helps pay for prescription drug costs. Individuals with Extra Help pay low or no monthly premium and have low copays.

These are the income and asset limits for 2022. The 2023 limits have not yet been released.

Monthly income limit		Asset limit	
Individual	Couple	Individual	Couple
\$1,719	\$2, 309	\$15,510	\$30,950

If an individual thinks they may qualify for Extra Help, they should contact the Social Security Administration to apply.

Some states may also have a State Pharmaceutical Assistance Program (SPAP) that helps pay the cost of a beneficiary’s drugs. Note that not all states have an SPAP. For states that do have

an SPAP, each program may have specific eligible requirements, application instructions, and rules and conditions that an individual must follow in order to get the benefit. Visit <https://www.medicare.gov/plan-compare/#/pharmaceutical-assistance-program/states?year=2022&lang=en>.