PRESCRIPTION DRUG PLANS

Benefit Structure

Ready-Agent™
A PROGRAM BY NEISHLOSS AND FLEMING

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

How Can a Consumer Get It?

Medicare Prescription Drug (Part D) Plans offer drug coverage to plans without, such as:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private Fee-for-Service (PFFS) Plans and Medicare Medical Savings Account (MSA) Plans

Medicare Advantage Plan (Part C)

- Most plans include prescription drug coverage (Part D)
- Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."
- You must have Part A and Part B to join a Medicare Advantage Plan

Out of Pocket Spending

- Medicare drug plans differ from one another in which drugs they choose to cover, how much the consumer will pay for them, and which pharmacies they can use

- To select the plan that fits your customer's needs and fits in their budget, you would review the client's list of drugs and compare against the formulary and Summary of Benefits for each

- All Medicare drug plans must give at least a standard level of coverage set by Medicare

What is the CORE Structure of the Part D Plans?

Think of Part D coverage like a set of 4 steps leading up to a landing, and keep in mind that the figures below are for a sample plan – not every plan. They are used to help you frame a reference of how the core structure works:

Step 1 – Deductible

- Your client may have to pay a deductible.
- If there is no deductible on your client's plan they automatically move to step 2.

What is the CORE Structure of the Part D Plans?

Step 2 – Initial Coverage = Co-payment or Co-insurance

- Your client pays their amount out of pocket (co-pay or co-insurance) until they reach $4,020*

Example: Example: Mary has met her $310 deductible and is now in her cost sharing phase. She pays $5.00 for her generic drugs until she has paid out $4020* and reaches the next step in coverage.

* Figures represent actual cost in 2020

What is the CORE Structure of the Part D Plans?

Step 3 – Coverage Gap OR Donut Hole

- Your client will pay 25% of their generic drug costs and 25% of their brand name drug costs until they reach an out of pocket amount of $6,350

Example: Once your client enters the Coverage Gap, they fill their generic prescription which costs $10.00 and a brand name drug which costs $50.00

- Generic Drug: They pay 25% of that cost = $2.50
- Brand Name Drug – They pay 25% of that cost = $12.50

What is the CORE Structure of the Part D Plans?

Step 4 – Catastrophic Coverage

- Once your client enters Catastrophic Coverage, they will pay much less for their drugs
  - Generic Drugs: $3.60 or 5% of the Retail Price (whichever is greater)
  - Brand Name Drugs: $8.95 or 5% of the Retail Price (whichever is greater)

- Their plan will pay the majority of expenses for the remainder of the calendar year

* Figures represent actual cost in 2020

What is the CORE Structure of the Part D Plans?

Things to remember about the core structure of Part D plans:

- Plans are different from carrier to carrier
  - Copay amounts
  - Formularies – which drugs are covered and on what Tier
  - Premium amounts
  - Pharmacy Network – where your client can fill prescriptions and use their plan benefits

Filling Prescriptions

Each company that offers a PDP has a list of pharmacies the consumer can use. If they want to continue filling prescriptions at the same pharmacy they currently use, check the pharmacy list to see if they participate.

Medicare requires plans to have network pharmacies for consumers to choose from

- Plans cannot force a client to use a mail-order pharmacy, but this option may provide significant savings to a consumer

Which Drugs are Covered?

- Each plan may cover different drugs, so there's no single drug list that fits all plans.
- All Medicare drug plans must make sure the consumers in their plan can get medically-necessary drugs to treat their conditions.
- Different carriers apply different rules, such as drug lists (formularies), prior authorization, step therapy, and quantity limits to make sure certain drugs are used correctly and only when medically necessary.

Formularies

- Each Medicare drug plan has its own list of covered prescriptions, called a formulary.
- Each Medicare Drug Plan MUST cover at least 2 drugs in each therapeutic class.

Example: In the Therapeutic Class Respiratory Agents:

- Each plan MUST cover two drugs in this category, and for example purposes, two of these drugs would be:
  - Allegra (Fexofenadine) – allergy medication
  - PROAIR HFA (albuterol sulfate) – asthma medication

- Plans cover both generic and brand-name prescription drugs.
- Medicare Drug Plans aren't required to cover certain drugs, such as:
  - Benzodiazepines
  - Barbiturates
  - Drugs for weight loss or gain
  - Drugs for erectile dysfunction

Some plans may cover these drugs as an added benefit. Also, drug plans generally don't pay for over-the-counter drugs.

Formularies

Plans are required to cover almost all drugs within these protected classes: anti-psychotics, anti-depressants, anti-convulsants, immuno suppressant, cancer, and HIV/AIDS drugs.

If you use a drug not on your plan's drug list, you'll have to pay full price instead of a copayment or coinsurance.

What are Tiers and How Do They Work?

- To help lower costs, many plans place drugs into different "tiers" on their drug lists.
- Each tier has a different cost associates with it.
- A drug in a lower tier will cost you less than a drug in a higher tier.
- Remember though, that each plan can divide its tiers in different ways.

Example:

Tier 1–Generic drugs. Tier 1 drugs cost the least.

Tier 2–Preferred brand-name drugs. Tier 2 drugs cost more than Tier 1 drugs.

Tier 3–Non-preferred brand-name drugs. Tier 3 drugs cost more than Tier 1 and Tier 2 drugs.

Tier 4 – Non-Preferred Brand Name Drugs

Tier 5 – Specialty Drugs

Penalties for late Enrollment

If a consumer enrolls after their initial eligibility period ends AND doesn't obtain other creditable coverage at that time; they will be assessed a Part D penalty charge if they enroll at a later date

- Creditable coverage could include:
  Drug coverage from a former or current employer or union, TRICARE, the Department of Veteran Affairs (VA), or the Indian Health Service

- The penalty is in ADDITION to the premium amount for the Part D plan.

Penalties for late Enrollment

- How is the penalty calculated?
  - Multiply the 1% penalty rate times the "National Base Beneficiary Premium" ($32.74 in 2020) times the number of full, uncovered months the consumer was eligible to join a Medicare drug plan but didn't (and went without other creditable prescription drug coverage)
- The final amount is rounded to the nearest $.10 and added to your monthly premium

Example:

John was eligible to enroll in a Prescription Drug Plan in December of 2015, but he didn't enroll in a plan until March of 2017. This was a period of 15 months that he was without Prescription drug coverage.

John will have a penalty of $4.90.

- 15 X $32.74 X .01 = $4.911 (rounded to $4.90)

Analyze Your Client's Needs

Consider your options when helping your client decide which PDP is the best fit
Answer these questions:

- Is their current drug coverage creditable?
- How would a certain Medicare drug plan affect their out-of-pocket costs?
- If they wait to join a PDP, would they pay higher premiums because of a late enrollment penalty?
- Does a Medicare drug plan in their area cover the drugs they take? Find out by comparing formularies of companies you sell
- Is there a specific pharmacy they want to use?
- Do they spend part of each year in another state?
    - This may be important if a plan they wish to join requires them to use certain pharmacies

Best Choice

Just remember that each client's needs are different from another's.

Helping them find the right plan is easy, if you know what to look for and where to find it.

Use online tools – such as www.MedicareCenter.com – to review a client's drugs and determine which plan best fits their needs.