Medicare Part D – Prescription Drug Coverage

Medicare Part D provides insurance coverage for prescription medications. Under this program, insurance companies and other private firms contract with Medicare (Medicare pays most of the premium) to provide prescription drug benefits to Medicare beneficiaries.

Each eligible Medicare beneficiary must select a drug plan and pay a monthly premium to receive the drug coverage. All drug plans (the choice varies by state) must provide coverage at least as good as the standard coverage specified by Medicare. Some plans may offer extra benefits such as no deductible, higher coverage limits, or cover additional drugs, in exchange for a higher monthly premium. Individuals with limited income and resources may qualify for help in paying for drug coverage.

Making a Choice

There are a number of factors to consider in making a choice about drug plans, including:

- **Initial enrollment:** A new Medicare beneficiary may enroll in a prescription drug plan during the seven-month period beginning three months before he or she turns age 65 until three months after reaching age 65. An individual who has lost "creditable coverage" (prescription drug coverage from some other source that is at least as good as the standard Medicare prescription coverage) has 63 days to select and join a Medicare prescription drug plan. An eligible beneficiary who does not enroll in a prescription drug plan within the prescribed time limits faces a penalty for late enrollment.
- **Penalty for late enrollment:** Individuals who delay joining a Medicare prescription drug plan beyond their initial eligibility face a monthly premium that will increase by at least 1% per month for each month of delay. This increased premium applies for as long as the individual is enrolled in a Medicare drug plan.
- **Changing plans:** Each year, from October 15 to December 7, a beneficiary can change to a different prescription drug plan.

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- **Current prescription coverage:** Individuals who currently have prescription drug coverage from another source may not wish to enroll in a Medicare prescription drug program. In some cases the benefits provided under these other plans are better than those provided under the standard Medicare prescription drug plan.
- **Medication coverage:** Consider what medications are needed. Compare the needed medications with those covered by each plan. Each plan will have a list (termed a "formulary") showing the drugs (generic and brand-name) the plan will pay for.
- **Out-of-pocket cost:** A prescription drug plan can vary in how much it charges and how much coverage is provided. Issues such as the monthly premium, yearly deductible, any co-insurance or co-payments, and coverage limits must all be considered.
- **Pharmacy convenience:** Not all pharmacies will be contracted with all plans. Some plans will allow a beneficiary to receive prescriptions by mail.
- **Future health changes:** Even though an individual takes few or no medications now, joining a prescription drug plan now means paying the lowest possible monthly premium. Future health changes may require increased use of prescription drugs.

Standard Coverage

The standard coverage for 2017 as set by Medicare is shown in the following table:

	$400 Deductible	$401 to $3700	$3701 Until Out of Pocket Totals $4550	Above $4550 in Out of Pocket Costs
Individual Pays	$400.00	25% up to $825	$3,325	5%
Plan Pays	$0.00	75% up to $2475	$0.00	95%
Total Drug Expense	$400.00	$3,700.00	$7,025	

In 2017, once total drug spending reaches $3,700 (where the coverage gap begins), a Medicare Part D enrollee will pay 40% of the plan's cost for covered brand-name prescription drugs and 51% of the plan's cost for covered generic drugs. The amount paid by the enrollee – as well as the discount paid by the drug company – count as "out-of-pocket" spending, helping the enrollee get out of the coverage gap.

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Monthly Adjustment Amount

Beginning in 2011, the Patient Protection and Affordable Care Act (PPACA) required Medicare Part D enrollees whose incomes exceed the same thresholds that apply to higher-income Part B enrollees, to pay a monthly adjustment amount. High-income enrollees will pay the regular plan premium to their Part D plan and the monthly adjustment amount to Medicare. The 2017 Part D monthly adjustment amounts are shown in the following tables:

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Less Than $85,000	Less Than $170,000	$0.00
$85,001 to $107,000	$170,001 to $214,000	$13.20
$107,001 to $160,000	$214,001 to $320,000	$34.20
$160,001 to $214,000	$320,001 to $428,000	$55.20
More Than $214,000	More Than $428,000	$76.20

Married Filing Separately	Monthly Adjustment Amount
Less Than $85,000	$0.00
$85,001 to $129,000	$55.20
More Than $129,000	$76.20

For Those Who Currently Have Prescription Drug Coverage

Some retirees may already have prescription drug coverage. For these individuals a key step is to compare the current coverage with that provided through a Medicare plan. The benefits administrator or insurance carrier can provide additional information.

- **Coverage provided by employer or union:** If the drug coverage provided by an employer or union is, on average, at least as good as the standard Medicare coverage, the individual may choose to keep the current plan for as long as it is offered. If the plan is discontinued in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

- **Medicare Advantage or other Medicare health plan:** Some Medicare Advantage or other Medicare health plans cover prescription drugs. If a plan does not offer prescription drug coverage, an individual may wish to switch to another Medicare Advantage or other Medicare health plan that does cover prescription drugs, or change to the original Medicare plan and join a Medicare prescription drug plan.
- **Medigap Supplemental Insurance, with prescription drug coverage:** Medigap policies are supplemental health insurance policies designed to fill the "gaps" in health coverage provided under Medicare Parts A and B. A few Medigap policies issued before 2006 included a prescription drug benefit. However, Medigap policies issued January 1, 2006 or later do not include prescription drug benefits. Most prescription drug coverage under the Medigap plans is not, on average, at least as good as the coverage provided under the standard Medicare prescription drug plan.
- **Other government insurance:** Generally, the prescription drug benefits provided by TRICARE, the Department of Veterans Affairs (VA), Federal Employee's Health Benefits Program (FEHB), or Indian Health Services are as good as the standard Medicare prescription drug plan. In most cases it will be to the individual's advantage to keep the current plan. If coverage is lost in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

Seek Professional Guidance

The process of making decisions concerning health care insurance can be confusing and complex. The advice and counsel of trained advisers is strongly recommended. Additional information is also available from:

- **On the web:** www.medicare.gov
- **By telephone:** Contact Medicare at 1-(800) 633-4227 (TTY users: 1-(877) 486-2048)