Choosing a Medicare Drug Plan

Prescription drug coverage is available to all Medicare beneficiaries, but all beneficiaries do not need to choose a plan. If you currently have drug coverage through an employer, union, government agency or other organization that is "as good as" the Medicare benefit, you may not want to sign up for a Medicare drug plan. In fact you may be penalized and lose other benefits if you do. Each September, you should receive a letter or booklet from your current provider indicating if your coverage is "as good as" Medicare Prescription Drug coverage. You will need to decide if you are happy with your current plan or whether you want to get your drug coverage through Medicare.

All plans usually make changes each year. If you (or a family member) enrolled in a drug plan for the current year, you should have received a letter explaining what changes have been made for next year. It is important to review the changes, especially the list of covered drugs ("formulary") to make sure the plan is still best for you. Anyone choosing a drug plan should consider the following factors

Important Change to Medicare Drug Coverage: Medicare is continuing to work to eliminate the coverage gap (Donut Hole) by 2020, In 2016 Medicare will cover more that 50% of the cost of name brand medications and will provide some help with the cost of generic medications

Key things to consider
All plans are not the same. Here are important factors to consider when choosing a plan:

- Will the drug plan pay for all or most of the drugs you take now?
  Each plan has a list of drugs for which it will pay. This is called a formulary. Are your current drugs on the plan's formulary?

- Does the plan cover the doses of the drugs that you take? Check the plan formulary to make sure it covers the actual doses that you take. Plans may not cover a certain dose on their formularies although you can file a formal request (called an "exception") and ask the plan to cover it.

- Do the plan's rules or policies limit coverage of your drugs and /or your more costly drugs by requiring "prior approval" or by requiring you to try a less expensive, similar drug ("step therapy") before the plan will pay for your drugs(s)? Are there limits on the number of pills that a prescription may cover ("quantity limits") over a specific period of time?

- What will the plan cost you?
  Compare the monthly premiums for each plan, the annual deductible and cost sharing for each drug you currently take that is covered by the plan. For an additional premium, some plans will provide some additional drug coverage in the coverage gap ("donut hole"). Remember, if one or more of your drugs is not on

the plan's formulary, you may have to pay the entire cost of the drug(s) yourself. This is especially important because the cost-sharing for Medicare beneficiaries has increased significantly in many drug plans.

- Be sure to compare all of the costs for each plan, including the deductible, co-payments or co-insurance, not just the amount of the monthly premiums.

- Is my local pharmacy in the plan's pharmacy network?
  For each plan, find out if your pharmacy is in the plan's network. If it is in the network, find out if it is a "preferred" pharmacy. For some plans, your co-payments may be less if you buy your drugs from a "preferred" pharmacy.

- If you prefer to use mail order for your drugs, does the plan offer it as an option and how does the cost compare to purchasing through a local pharmacy?

Review your current plan, compare it to other plans and make a decision
Take your time and consider the information about the drug plans and evaluate your choices. Call the provider to confirm all the information you have about the plan before you make a decision. If you are staying with your current plan, you don't have to do anything. If you decide to change plans, you need to complete the enrollment form by phone, online or mail.

Where to get plan information
Get the information necessary to make your decision from several sources:

- Medicare's Web site at www.medicare.gov. It has information about which plans are available in each state and which drugs each plan will cover. It also has several tools to help individuals decide which plan is best for them.

- Medicare's toll-free number at 1.800.MEDICARE. Call for information about the plans available in each state.

- Each plan's Web site or customer service telephone number. You can get this information www.medicare.gov or1.800.MEDICARE.

Additional Resources
EPIC Helpline 1-800-332-3742 (TTY 1-800-290-9138) EPIC Questions, Medicare D Billing when EPIC paying premium and possible assistance with enrolling in a Medicare D Plan

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Social Security Agency (Oneonta office) 1-877-628-6581 "Extra Help" for Medicare D costs, Medicare B payment assistance issues and Medicare D premium deduction issues

StateWide Senior Action Council 1-800-333-4374

Office for the Aging - Oneonta 607-432-9041 Cooperstown 607-547-4232

Questions and Answers
For some Medicare beneficiaries, there are some special considerations to think about before choosing a drug plan.

Q. Will the Medicare drug plans cover Alzheimer drugs?
A. Yes. All Medicare drug plans are required to cover and have at least two cholinesterase inhibitors and memantine on their formularies (list of drugs the plan covers). Each plan will decide which drugs to cover and what the co-payment amount is for each drug. Plans are allowed to charge different amounts for different drugs. Consumers will need to check with each plan to find out the specific amount of the co-payment for specific drugs.

Q. Can a Medicare drug plan put restrictions on access to drugs even if the drugs are on the formulary?
A. Yes. The Medicare drug plans can require that individuals get prior approval from the plan for specific drugs before the plan will pay for it. This is called "prior authorization."

In addition, plans can require that an individual try a different, less expensive drug before agreeing to pay for the one originally prescribed by the doctor. This is often called "step therapy" or "fail first." However, an individual can request that step therapy or fail first not be required if the individual or the treating doctor can prove that there would be adverse effects or the prescribed drug would be more effective.

Some health plans have specific policies on how much of a drug is covered by limiting the number of pills or number of days a prescription may cover. This is called "quantity limits."

Q. If a Medicare Beneficiary does not have the capacity to sign up for a plan, who can do it for him/her?
A. Medicare rules allow an individual who has legal authority under state law to act on behalf of the beneficiary to enroll or disenroll the beneficiary from a Medicare drug plan. Depending on the state law where the beneficiary lives, this may include attorneys-in-fact or agents who have authority under a durable power of attorney document, guardians appointed by the court or individuals authorized to make healthcare decisions under state health care consent laws.

Q. My father takes several medications and is stable. If one or more of his current drugs are not on his drug plan's formulary, is there anything he can do to get the drugs paid for by his plan?
A. Yes. Your father, his authorized representative or his treating physician can ask the plan to cover the non-formulary drug for him. This request is called an "exception" and generally requires a physician's statement in support of the request. You can get specific information about the exceptions process from the drug plan organization.