Medicare Part D: Things People With Cancer May Want to Know

Medicare Part D prescription drug coverage

This information is designed to help you decide whether to enroll in a Medicare Part D drug plan and how to decide which plan is best for you. To choose the right plan you have to look closely at your needs and the drugs you take.

People with Medicare who are being treated for cancer or who are cancer survivors have a number of special issues to think about. These issues are discussed here.

Also included are answers to some of the frequently asked questions about the Medicare drug benefit.

What is the Medicare Part D drug benefit?

Medicare Part D is the prescription drug benefit, which is offered to people who qualify for Medicare insurance. People who have Medicare are called *Medicare beneficiaries*.

Part D coverage may help you lower your prescription drug costs. It may also help protect you from higher costs in the future. It can also give you greater access to the drugs you need to stay well or treat an illness.

To get Medicare Part D drug coverage, you must enroll in a plan that is approved by Medicare. If you join a Medicare drug plan, you usually pay a monthly premium. You're given a Medicare Part D plan ID card to use when you get prescriptions filled.

If you decide not to enroll in a Medicare drug plan when you are first eligible (able to join), you might have to pay a penalty when you enroll later, and every month after that for as long as you're enrolled in Part D.

If your income and resources are limited, you might qualify for Extra Help paying Part D costs. We will cover this later in the section called "Making a Part D plan decision."

Each year, the plans vary in cost and which drugs are covered. You can log on to www.Medicare.gov to use the plan finder to compare the available drug plans, find out

whether the drugs you need are on the formularies, and learn about costs and any restrictions in coverage.

As a cancer patient, your annual drug costs may be high, so it is even more important that you look at all of the available plans to find the one that best meets your needs. Look carefully at the drugs each plan covers and how much you'll have to pay (this is called "cost-sharing"). Medicare has an online tool to help you choose, at www.medicare.gov/find-a-plan.

What is the coverage gap, and what do I pay?

The coverage gap (also called the "donut hole") starts when you reach a certain level of drug expense for the year. It's the amount you must pay each year for your own prescription drugs, with some discounts. Once your total drug costs (what you **and** the plan pay for your prescriptions) reach a pre-set dollar amount for that year, you're in the donut hole, where you pay more for drugs.

While you're in the donut hole, you still get some price breaks. There are manufacturer discounts on brand name drugs, and the federal government covers a portion of generic drugs to cut down the amount you pay (see example below). You'll still pay much more of your drug costs until your total out-of-pocket cost reaches another pre-set amount.

Reaching this second amount triggers what is called *catastrophic coverage*. After that, Medicare Part D will cover most of your drug costs and you will pay a small co-pay for covered drugs for the rest of that year.

A 2014 example: If your drug costs (what you and the plan pay for your prescriptions) add up to more than $2,850 in 2014 (this applies only after you've paid the annual $310 deductible), in most Part D plans you'll hit the coverage gap. At this point you will pay a large percentage of your drug costs:

- No more than 72% of the plan's cost for generic drugs
- 47.5% of the plan's cost for eligible brand name drugs

The amount you pay for drugs, plus any discounts paid by the drug companies, will count toward your total out-of-pocket costs. You do not need to do anything to get these discounts other than use your Part D plan card. Your pharmacy will give them to you automatically.

Once your out-of-pocket costs reach $4,550, or your total drug costs hit $6,687.50, you're out of the donut hole and into the *catastrophic benefit period*. After that, you will pay a co-pay of $2.55 for generic drugs. For brand-name drugs you'll pay $6.35 or 5%, whichever is greater.

These dollar amounts change from year to year, so you will need to check this every year.

Avoiding, minimizing, or delaying the coverage gap

The Affordable Care Act lays out a plan to put an end to the coverage gap (donut hole) by the year 2020. Until then, there are some ways you can avoid or delay entering the gap, and save money on drug costs while in the gap:

- You may be able to switch to generic drugs or other less costly drugs. Ask your doctor about generic alternatives that work just as well. Even though many cancer treatment drugs do not have generics, the savings in non-cancer drugs may help a lot.
- Keep using your Medicare drug plan card, even if your drug expenses fall into the coverage gap. Using your drug plan card ensures that you'll get the drug plan's discounted rates and that the money you spend counts toward your catastrophic coverage.
- Look into Patient Drug Assistance Programs that may be offered by the company that makes the drug you take. You can learn more about this in our document called *Prescription Drug Assistance Programs*.

You can find out more about saving money by using mail-order pharmacies, generic, or less-expensive brand-name drugs online at www.medicare.gov.

Do I have to purchase Part D coverage?

The drug benefit is optional – you do not have to enroll. But if you decide to take part, you must do so during the open enrollment period (from October 15 to December 7 every year). You must enroll in one of the Medicare private drug plan options in your area, or you can enroll in a Medicare Advantage plan that offers prescription drug coverage. You can change from one plan to another during open enrollment periods.

If you do not enroll in a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, and you don't get Extra Help, you'll likely pay penalties for a long time if you ever do enroll in Part D. (See "Getting help to pay Medicare Part A and/or Part B premiums (the Medicare Savings Programs)" for more on Extra Help.)

How does the Part D benefit help people with cancer?

The Part D drug benefit is good for Medicare beneficiaries who have been diagnosed with cancer, especially those who do not have any other way to pay for their prescriptions. Part D coverage helps pay for prescriptions purchased at a pharmacy. And Medicare Part D drug plans must accept all who apply and are eligible – no matter their age or health status.

The coverage under this benefit does have some gaps that require you to pay out of your own pocket. And not every drug on the market will be covered by every Medicare-approved drug plan. Carefully review your drug plan options and compare each plan's covered drugs with the drugs you need. Keep in mind the plan can change, and you may need to look around again next year.

Special things people with cancer need to think about

In deciding whether to go with Medicare Part D and, if so, which Part D plan to join, cancer patients have some special things to think about.

As noted before, most prescription drugs are covered through the Medicare Part D benefit. This includes drugs used to treat high blood pressure, high cholesterol, arthritis, depression, and other health conditions. These medicines can be pills or liquids taken by mouth, suppositories, inhaled drugs (like those used to treat asthma), and drugs that are injected by patients (like insulin for people with diabetes). A general rule is that Part D covers medicines prescribed by your doctor that you get at your local pharmacy.

Many cancer drugs will still be covered under Part B, not Part D

Medicare Part B covers doctor visits and outpatient hospital services. Part B also covers the drugs that are infused (given in a vein through an IV) or injected (given as a shot) in a doctor's office or treatment center. Many chemotherapy (chemo) drugs and the anti-nausea drugs used along with chemo are given by IV infusion in a doctor's office or clinic. This means they are still covered under Part B.

The difference in coverage for cancer drugs under Medicare Part B and Medicare Part D is blurred when it comes to chemo drugs given by mouth and anti-nausea drugs given by mouth (these are often called *oral drugs*). Some of these drugs are covered under Part B, but others are covered under Part D.

Cancer treatment drugs taken by mouth

Some cancer drugs are taken by mouth as part of chemo. For the most part, these drugs are covered under Part B if they are used instead of the same drug that could be given through an IV in your doctor's office. In other words, if your doctor has a choice between giving you drug by mouth or the same drug as an IV, the oral drug is covered under Part B.

In contrast, oral cancer drugs that cannot be given by IV are covered under Part D.

Anti-nausea drugs taken by mouth

Anti-nausea drugs are often used as part of chemo. The rule for anti-nausea drugs taken by mouth is much the same. If your doctor has a choice between giving you an anti-nausea drug by mouth or through an IV and the drug is given within 48 hours of chemo, then the oral drug is covered under Part B.

Oral anti-nausea drugs that cannot be given through an IV are covered under Part D, not Part B. (If an anti-nausea drug is prescribed for a patient who is not known to have cancer, the drug is covered under Part D, not Part B.)

Sorting out Medicare Part B and Part D

Many people find the rules for the difference between Medicare coverage under Part B and Part D hard to understand. For people with cancer, the rules can be even more confusing because some cancer drugs are already covered under Part B.

As a general rule, drugs that patients can inject on their own without help from a doctor or nurse, or that are not taken as part of chemo are covered under Part D.

If you have more questions, your doctor and his and her office staff should be able to help you sort through the coverage rules. They can help you figure out whether a drug is covered under Medicare Part B or Medicare Part D.

Why do I need to know if a drug is covered under Part B or Part D?

It's important to understand the difference between drug coverage under Part B and coverage under Part D because your out-of-pocket costs will vary depending on which part covers each drug.

For services covered under Medicare Part B, patients must first pay the annual deductible that is set by Medicare each year. After that, Medicare pays 80% of all costs. This means that under Part B, patients must pay 20% of the drug's cost no matter how high their total medical bills run. (Many people with Medicare have supplemental or *Medigap* insurance to cover their out-of-pocket costs under Part B.)

Part D is different. After you pay a certain deductible for your drugs, you must pay a set copay, or a percentage of your drug costs for the rest of the year, or until you reach the donut hole. Again, this deductible amount is set each year. In 2014, the deductible amount for Part D is set at $310. For donut hole information and a 2014 example, see "What is the coverage gap, and what do I pay?" in the section called "Medicare Part D prescription drug coverage."

Because some cancer drugs are clearly covered under Part B, like those given through an IV in your doctor's office, you might not be able to find all of your cancer treatment drugs on a Part D plan's formulary. (The list of drugs that are covered under a plan is called a *formulary*; see the section "Formularies and drug coverage" for more on this.) If you are deciding whether to enroll in a drug plan and you don't see a drug you need on a plan's formulary, call the plan. You'll want to ask if they might cover the drug and how you can go about getting it covered.

What about off-label drugs and Part D?

What is off-label drug use?

When the Food and Drug Administration (FDA) approves a new drug, it means the federal government has found the drug to be safe and effective for a certain disease or condition. The label information printed in the official prescribing information and in the package insert explains the use for which the FDA has approved the drug. It describes the approved dose and way the drug should be given (as a pill, injection, infusion, etc.) But in some cases, doctors – based on their knowledge and new information – may prescribe a drug for a use that is **not** approved by the FDA. The use of a drug for a disease the FDA did not approve it for, or in a dose or by a route that is not listed on the label, is called "off-label" use of the drug.

Off-label drug use is legal in the United States and in many other countries. But drugs used off label are only covered under Part D if the use is cited in one of the reference standards for prescription drugs (called a *compendium*) named in the Medicare law. Part B may cover off-label use of cancer drugs, but Part D drug plans cannot cover any use not listed in one of the approved reference standards.

Why is this important to a cancer patient?

The National Comprehensive Cancer Network estimates that about half of all uses of drugs in cancer care in the United States are off label. If you would like to learn more about this, please see our document called *Off-label Drug Use*.

Who should enroll in Medicare Part D?

Medicare Part D was created to give prescription drug coverage to Medicare beneficiaries who do not already have drug coverage that is as good as or better than the Part D plan. Your first step in deciding whether to enroll is to figure out what, if any drug coverage you have now. Do you have prescription drug coverage from an employer or union? Do you have drug coverage through the Veterans' Administration or the military? Do you get your drugs through your state Medicaid program?

Employer and union drug coverage

If you or your spouse has health benefits from a former employer or union that covers prescription drugs, you should get a letter from that insurer that tells you if your coverage is better than Medicare Part D.

If your current coverage is as good as or better than the Part D coverage, you can and should keep those benefits. You don't need to enroll in a Medicare Part D plan. If your employer or union benefits are reduced or stopped sometime in the future, you can then enroll in a Medicare Part D plan without any penalty for late enrollment. Be sure to keep the letter about your former plan as proof that you had "as good or better" coverage.

If your employer or union plan does not offer drug benefits that are at least as good as the Medicare drug benefits, then you might want to enroll in a Medicare Part D plan. If you choose not to enroll right now, but change your mind later, you may face a late enrollment penalty. The penalty is equal to 1% of the "national base beneficiary premium" ($32.42 in 2014) for each month you delay enrollment. And it's not a one-time penalty. You will pay the penalty each month along with your premium for as long as you have a Medicare prescription drug plan.

Carefully read all the information you get from a former employer or union about your existing drug and health coverage before you decide to join a Part D plan. In some cases you may not be able to drop just the drug coverage from your retiree coverage. You may have to drop all coverage, including health benefits, which could mean that you may not be able to get them back.

Some people enroll in a Part D plan and also have some drug coverage from an employer or union plan that is not as good as the Medicare benefit. This is OK, but payments from the private plan for drugs will not count toward out-of-pocket expenses to meet a plan deductible or reach the out-of-pocket spending limit.

If you are unsure whether to keep your employer or union drug benefits or join a Medicare Part D plan, you should get more information. Your former employer or the union sponsor of your retirement plan should be able to help you. Also, each state has a health insurance counseling organization that gives free help. (Contact information can be found under "State Health Insurance Assistance Programs" in the "Where can I get more help?" section.)

TRICARE, Veteran's Administration, and Federal Employees Health Benefits Program drug coverage

If your current drug coverage is through any of the groups listed here, the drug benefits are as good as or better than Medicare Part D coverage:

- TRICARE (military dependent or retiree health care)
- The Veteran's Administration (VA)
- Federal Employees Health Benefits Program (FEHB), administered by the US Office of Personnel Management (OPM)

This means it will almost always be best to keep your current coverage. But, in some cases, adding Medicare Part D can give you extra coverage. Sometimes it can also lower your co-pays. Get more information from your benefits administrator or your insurer before making any changes. If you lose your TRICARE, VA, or FEHBP coverage and your Medicare drug coverage begins within 63 days of the loss, in most cases, you won't have to pay a penalty.

Medicaid

If you have full Medicaid benefits and qualify for Medicare, you are already enrolled in a Medicare Part D drug plan. (Not all Medicaid beneficiaries are eligible for Medicare.) Medicare, not Medicaid, covers most prescription drugs.

If you did not choose a Part D drug plan, Medicare chose one for you. This means you may not be in the plan that has the best formulary for you. (We go over this in detail in the section called “Formularies and drug coverage.”)

If you have Medicaid and find that you would do better in another Part D plan, you can switch to another plan at any time. You do not have to wait for open enrollment.

Medigap

A Medigap policy is health insurance sold by private insurance companies to fill the “gaps” in your Medicare coverage. These policies help pay some of the health care costs that Medicare doesn’t cover. You may be able to choose up to 12 different standardized Medigap policies (These are called Medigap Plans A through L). Medigap Plans H, I, and J cover prescription drugs.

If you have a Medigap Plan that covers drugs, you have 2 options. You can keep your Medigap plan with the drug coverage or you can enroll in Medicare Part D – but you cannot have both. If you do enroll in Medicare Part D, you can still keep your Plan H, I or J, but the drug coverage will be removed from the Medigap policy and the premium will be adjusted to reflect the change.

If you keep your plan H, I, or J drug coverage, you may face late enrollment penalties if you later decide to enroll in Part D.

Making a Part D plan decision

If you have decided to enroll in Medicare Part D, how do you decide which plan to join? No matter where you live in the United States (including Puerto Rico), you have a wide range of choices.

First, you need to decide whether to

- Stay with standard Medicare (Part A and Part B, which cover your doctor, hospital, and some other services) and enroll in a stand-alone Medicare Part D plan

or

- Enroll in a private health insurance plan that has contracted with Medicare to provide the full range of Medicare covered health care, including drug benefits (this is called *Medicare Advantage*)

In a Medicare Advantage plan, you get all of your Part A and Part B coverage, as well as your prescription drug coverage (Part D). Medicare Advantage plans may be health

maintenance organizations (HMOs), preferred provider organizations (PPOs), or private fee-for-service plans. There are also some Medicare Advantage Plans designed for people with special needs, such as long-term care needs. The Part D drug benefit offered with a Medicare Advantage plan is known as a Medicare Advantage Prescription Drug Plan or MA-PD.

You can learn more about Medicare Advantage in *Medicare & You 2014* which you can find at www.medicare.gov. To get a copy of this handbook sent to you, call 1-800-633-4227 (1-800-MEDICARE)

Before you choose a stand-alone Part D plan or a Medicare Advantage Plan that includes Part D prescription drug coverage, you should look at all your options. Your coverage will be different based on who you are insured through.

Your drug coverage options

The options you have when looking at Medicare Part D and other types of drug coverage depend on the type of medical plan you have.

If your current plan is through an employer, a union, or the military

- Check with your benefits administrator about your options.
- The plan you have must be "as good as or better than" the standard Part D plan.

If you decide to keep your current coverage, be sure to get and keep a letter as proof of creditable coverage (proof that your coverage is as good as or better than Medicare Part D). You will need this letter to avoid future penalties if you later enroll in Part D.

If you lose your coverage, or decide to switch to Part D, you must join a Part D plan before going 63 continuous days without coverage. If you lose creditable coverage, you can join a Part D plan even if it's not during open enrollment time. But if you go more than 63 days, you may have to pay a late enrollment fee. The late enrollment penalty is not a one-time fee; it will raise the cost of your coverage for as long as you have it.

If you have Medicare Part A, Part B, or both

If you are new to Part D, you must enroll during your first enrollment period unless you have "as good as or better" coverage as discussed above. You have 7 months to join Part D: 3 months before you turn 65, the month you turn 65, and the 3 months after you turn 65. If you **do not** join when you are first eligible, you will have to pay a late enrollment penalty for as long as you have Medicare. This penalty raises your premium for the rest of your life.

If you already have Part D, review your coverage every open enrollment period (October 15 to December 7). If you want to switch plans you **must** do so during this time except in certain situations (if you move or go into a nursing home, for instance). If you

are happy with your coverage and its premium, and the plan is still offered in your area, you don't have to do anything to keep the same coverage.

If you have a Medigap policy, in most cases drug coverage under Medigap is not as good as coverage under Medicare Part D. If you don't join a Part D plan when you are first eligible you may have to pay late enrollment penalties if you choose to join later. You can't have Medigap prescription drug coverage and Medicare prescription drug coverage at the same time.

If you have a Medicare Advantage Plan

These may be HMOs, PPOs, private fee-for service, and Medical Savings Account (MSA) plans.

- If you belong to a Medicare Advantage HMO or PPO, you can only get prescription drug coverage from that plan. If you join a Part D plan you will automatically be removed from your Medicare Advantage HMO or PPO.
- If you have a private fee-for-service plan or a Medicare MSA plan that doesn't offer drug coverage, you may join a Part D plan.

Be aware that you can join or switch Medicare Advantage Plans:

- When you first become eligible for Medicare (this 7-month period starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65).
- If you get Medicare due to a disability, then you can join during the 3 months before to 3 months after your 25th month of disability.
- During annual open enrollment (October 15 to December 7)

If you're in a Medicare Advantage Plan (MAP), you can make one type of change after December 7. Between January 1 and February 14, you can leave your plan and switch to standard Medicare. If you switch to standard Medicare during this period, you will have until February 14 to join a Medicare Prescription Drug Plan. Your coverage will begin the first day of the month after the plan gets your enrollment form. This is the only change you can make after December 7.

As with other Medicare coverage, in certain situations (such as if you move or go into a nursing home), you are allowed to join, switch, or drop a Medicare Advantage Plan.

There's also a 5-Star Special Enrollment Period. Starting December 8, 2013 through November 30, 2014, you can switch to a 5-star Medicare Advantage Plan (MAP) at any time during the year. A 5-star rating is considered excellent. The star ratings can help you compare plans based on how good they are and how well they perform. (Plan ratings can be found online at www.medicare.gov/find-a-plan.) You can only use this special enrollment to switch to a 5-star MAP once a year, and you can only join a 5-star MAP if one is available in your area. Note that if you move from a MAP that has drug coverage to a 5-star MAP that doesn't, you may lose your prescription drug coverage. Then you'll

have to wait until the next open enrollment to get coverage, and you may have to pay late enrollment penalties.

If you have Medicaid

- If you have both Medicaid and Medicare, you are said to be *dual eligible*. If you do not join a Part D plan, Medicare will automatically enroll you in a plan. You will get a letter telling you about the plan you have been enrolled in and when your coverage begins.
- If Medicare enrolls you in a plan, you may switch Part D plans at any time. It's a good idea to look at the plans available to you and be sure you are in the one that best meets your needs.

Getting help to pay Medicare Part A and/or Part B premiums (the Medicare Savings Programs)

You may be able to get help paying for your Medicare coverage.

Some states have programs that can help you pay for premiums, deductibles, and co-pays. These programs help people with Medicare who have low incomes and limited resources (see note below). The names of the programs and how they work vary from state to state. In most cases, to qualify for one of the Medicare Savings Program in 2014, you must do all of these:

- Have Medicare Part A
- If you are single, have monthly income less than $1,313 and resources* less than $7,080
- If you are married and living together, have monthly income less than $1,765 and resources* less than $10,620

> *Note: These amounts are for 2014 and change each year. Many states figure your income and resources differently, so you may qualify in your state even if your income is higher than listed here.*
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> **Resources** *include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, burial expense accounts up to your state's limit, furniture, or other household items.*

Call or visit your state Medicaid office to get information on Medicaid Savings Programs. Another option is to call the Department of Health and Human Services at 1-877-696-6775. You'll be asked to enter your area code to be connected to your state. You can also go online at www.medicare.gov/publications to read the brochure called "Get Help With

Your Medicare Costs: Getting Started." Or call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you.

The low-income subsidy or Extra Help

Medicare's low-income subsidy (LIS) program, also called Extra Help, can help you pay for your prescription drug costs if you have a limited income. Call Social Security to find out if you qualify for this help (contact information is in the "Where can I get more help?" section). You can apply for Extra Help at any time.

If you qualify for Extra Help and join a Medicare drug plan, you will get:

- Help paying your Medicare drug plan's monthly premium, yearly deductible, co-insurance, and co-payments
- No coverage gap
- No late enrollment penalty

You **automatically** qualify for Extra Help if you have Medicare and one of these:

- Full Medicaid coverage
- You get help from your state Medicaid program paying your Part B premiums (in a Medicare Savings Program)
- You get Supplemental Security Income (SSI) benefits

If you automatically qualify for Extra Help, Medicare will mail you a purple letter that you should keep for your records.

Some other things you should know about Extra Help:

- If you aren't in a Part D plan, you must join one to use the Extra Help.
- If you qualify for Extra Help and don't enroll in a Part D plan, Medicare may enroll you in one. If this happens, you will be sent a yellow or green letter telling you about the plan you are enrolled in and when coverage begins.
- Different plans cover different drugs. Check to see if the plan you are enrolled in covers the drugs you use and the pharmacies you use. You may need to check out other plans in your area.
- If you're getting Extra Help, you can switch to another Medicare drug plan anytime – not just during open enrollment. Your coverage will be effective the first day of the next month.
- If you get a letter from Medicare saying you no longer automatically qualify for Extra Help, you can reapply by calling Social Security.

Formularies and drug coverage

A *formulary* is a list of the drugs covered by the prescription drug plan or other insurance plan that offers drug coverage benefits.

Will my drugs be covered?

Medicare Part D prescription drug plans are required by law to cover a wide range of generic and brand-name drugs. In order for any drug to be covered by Medicare, it must be approved by the US Food and Drug Administration (FDA) as safe and effective. Plans have a lot of freedom when deciding which drugs they will cover. Most plans have a formulary, which is a list of drugs covered by the plan. A small part of a plan formulary is shown in Table 1.

As a general rule, plans will cover most of the commonly prescribed drugs used by Medicare beneficiaries. Very few plans include all drugs approved by the FDA on their formulary. If they do cover all or almost all FDA-approved drugs, you'll probably have higher co-pays, especially for the drugs that cost a lot.

Medicare drug plans are required to cover almost all cancer drugs, but it's very important to make sure your drugs are on your plan's formulary.

How can I find out if a plan covers my drugs?

There are many ways to find out if a plan covers your drugs, but since many plans are likely be available in your area, this will take some time. The first step is to make a list of all your prescription drugs. For each drug, you need to know the exact name, the dose (such as 20 mg), and the number or quantity that your doctor usually prescribes (for instance, 2 per day or 60 per month). Then you need to check the information on the Part D plan options in your area.

You can get specific information on Part D plan formularies by:

- Contacting the plan for its current formulary, or visiting the plan's website
- Visiting www.medicare.gov/find-a-plan online
- Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Have your Medicare card, a list of the drugs you use, and the name of the pharmacy you use ready when you call.
- Getting a free copy of the booklet Your Guide to Medicare Prescription Drug Coverage (CMS Pub. No. 11109), on www.medicare.gov, or by calling 1-800-MEDICARE (1-800-633-4227). It's also available in Spanish.
- Calling your State Health Insurance Assistance Program. Getting contact information for each state is covered in the section called "Where can I get more help?"

- Checking for local events that offer help enrolling. Contact your local Office on Aging. For the telephone number, visit www.eldercare.gov. Or, call the Eldercare Locator at 1-800-677-1116 to learn how to reach your state office.

Once you figure out which plans cover all or most of your drugs, you need to find out which tier your drugs are on (explained in “What is a formulary tier?”). This is different with each prescription drug plan.

Table 1: Sample formulary

	Tier	**Other limits**
Alkylating Agents		
CEENU	2	
Leukeran	2	
Cyclophosphamide	1	Prior authorization*
Matulane	3	Prior authorization
Antimetabolites		
Hydroxyurea	1	
Megestrol acetate	1	Prior authorization
Methotrexate	1	
Purinethol	1	
Thioquanine	1	
Immune Modulators and Vaccines		
ACEL-IMUNE vial	2	
ACTHIB/DTP vaccine vial	2	
Aldara	3	Prior authorization
Arava	3	Prior authorization
Attenuvax vaccine w/diluent	2	
Avonex	4	Prior authorization
Azathioprine	1	
Betaseron 0.3 mg vial	4	Prior authorization
BIAVAX II vaccine w/diluent	2	
Cellcept	2	Prior authorization

Cholera vaccine vial	2	
Tier 1 is a generic drug; tier 2 is a preferred brand drug; tier 3 is a non-preferred brand; and tier 4 is a specialty drug.		
Source: Adapted from a Part D Plan Formulary		

** Prior authorization means that your doctor must explain that the drug is medically necessary.*

What is a formulary tier?

A formulary tier tells you how much, if any, you will have to pay for a drug. Plans differ in the number of tiers they use. Most plans use 3 tiers; some use 4, and some have specialty tiers. In most cases, plans define the tiers like this:

- Tier 1 – Generic drugs. Tier 1 drugs usually cost the least.
- Tier 2 – Preferred, brand name drugs. These are brand name drugs which cost more than tier 1 drugs.
- Tier 3 – Non-preferred, brand name drugs. These are also brand name drugs but are "non-preferred" in much the same way that a doctor might not be included in the list of "preferred" doctors on a managed care plan's roster. Tier 3 drugs cost more than tier 1 and tier 2 drugs.
- Tier 4 – Some plans use this tier for specialty drugs, while others have a separate "specialty" tier. The drugs in these tiers are often very high-cost, name-brand drugs. Many times chemo drugs that you take by mouth can be found in these tiers.

How do formulary tiers affect what you have to pay out-of-pocket?

Each formulary tier is linked to either a flat dollar co-pay or a co-insurance percentage.

Table 2 is an example of the range of plan tier co-pays and co-insurances for 4 different prescription drug plans in one area of the country.

In this example, Plan A has 4 tiers. For a 30-day supply of a generic (tier 1) drug, the beneficiary pays $5. If the prescription is for a preferred brand (tier 2), the beneficiary pays $28. If it's a non-preferred drug (tier 3), the co-pay jumps to $55. For a tier 4 drug, the beneficiary generally pays 25% of the plan's cost for the drug.

Table 2: Example of Part D plan formularies' tiered cost-sharing requirements in different plans

Prescription Drug Plan	**Tier 1 (generic)**	**Tier 2 (preferred brand)**	**Tier 3 (non-preferred brand**	**Tier 4 (specialty)**

Plan A	$5	$28	$55	25%
Plan B	$2	$20	$40	N/A
Plan C	$10	$25	50%	25%
Plan D	$4	$17	75%	25%

Without any prescription drug coverage, specialty drugs, including many cancer drugs, could cost thousands of dollars a month. Many drugs are not made in generic forms. Even with Medicare's prescription drug benefit, out-of-pocket costs may be high because of the way drug plans have set up their formularies.

An example using Plan A in the above formulary in 2014

Let's say you need a cancer drug that is on tier 4 of your plan formulary, which means you pay 25% of the cost. The drug costs $1000 a month. This means it will cost you $250 per month after you have paid the plan's deductible, and until you and the plan have paid a total cost of $2,850. Reaching this limit puts you in the coverage gap (donut hole), which in this case will be about 3 months into the year if this is your only drug.

While in the coverage gap you will have to pay 47.5% of the cost ($475). So, it will cost you $475 a month until your out-of-pocket costs reach $4,550 or your total drug costs hit $6,687.50, at which point you reach the catastrophic benefit level. The total cost will reach $6687.50 nearly 7 months into the year.

Once the catastrophic benefit is triggered, your monthly out-of-pocket cost may still be about $50 per month until the end of the year. (See "What is the coverage gap, and what do I pay?" in the section called "Medicare Part D prescription drug coverage" for details on how these costs are calculated.)

Another possibility is that a name-brand cancer drug may be in the formulary's specialty tier. Only Part D drugs that cost more than $600 per month may be placed in the specialty tier. And many Medicare Part D plans require prior authorization for coverage of these drugs. This means your doctor must explain why you need that particular drug before you can get it (see "Prior authorization" below).

What if I need a drug that isn't on the formulary or is only covered at a higher cost?

Each Medicare drug plan must have its own *exceptions process* through which a beneficiary may ask the plan to cover a drug that isn't listed on the plan's formulary. This process may also be used to ask the plan to reduce the cost to the patient for a formulary drug. In either case, the beneficiary is asking the plan to make an exception to its formulary requirements. If the plan turns the Medicare beneficiary down, the beneficiary has the right to appeal that decision.

Note: The exceptions process does NOT apply to drugs that are already on the formulary's **specialty** tier.

If the exceptions request is to reduce the patient's cost for the drug, the plan may agree to cover the Part D drug at a lower cost if the doctor can show that any of these 3 conditions are true:

- The preferred drug for treatment of the same condition would not work as well as the non-preferred drug
- The preferred drug would have a harmful effect on the patient
- Both (the preferred drug wouldn't work as well **and** it would harm the patient)

If the beneficiary asks the plan to cover a drug that's not on the formulary at all, the beneficiary's doctor may be asked for more information. The doctor would need to show that none of the drugs on the plan's formulary would work as well as the non-formulary drug, or that the formulary drug would harm the patient, or both. If one of these conditions is met, the plan may cover the drug.

Examples of exceptions you can request

You can ask for an exception to a drug plan's coverage rules. There are many types of exceptions you can ask for, but there are also limits on what you can ask. For instance:

- You can ask to have your drug covered even if it's not on the formulary. If an exception is allowed, you would get your drug at the tier 3 co-pay (if your plan uses tiered cost-sharing). But if the plan grants your request to cover a drug not on the formulary, you may not ask the plan to cover it as a tier 2 or tier 1 drug (see below).
- You can ask to have coverage restrictions or limits lifted from the drug you need. For example, if the drug has a step therapy requirement (see the next section), you can ask to have this requirement removed.
- You can ask for lower cost tier coverage for your drug. If your drug is usually considered a tier 3 drug, you can ask that the plan cover it as a tier 2 drug instead. If the plan agrees, this would lower the amount you must pay for your drug. Most plans don't allow an enrollee to request that a drug in the specialty tier (usually the 4th tier) be covered at a lower-cost tier.

You may be at the pharmacy when you first find out that the drug your doctor prescribed isn't on your plan's formulary. Or you may find it's on your plan's formulary but at a high cost-sharing tier. If this happens, you should be able to get a Medicare-approved form from your plan. You will need to give this form to your doctor to ask for an exception from your plan. Sometimes the plan's network pharmacies can give you the form. Generally, the plan must make a decision within 72 hours of the exception request.

If the plan denies your request for an exception, you can appeal the plan's decision. The appeals system includes a review of your plan's decision by an outside reviewer who is not part of your plan. You or someone you choose (for example, your son or grand-

daughter) can begin the appeals process, as can the doctor who prescribed the drug. Contact your plan to find out exactly how to file an appeal.

Are there other conditions or limits on my Medicare drug coverage?

Medicare drug plans use many tools to manage prescription drug costs. As explained in greater detail below, the cost management tools used by Medicare drug plans may include:

- Requirements for prior authorization
- Limits on the quantity of drugs available in any given period (most often one month)
- Step therapy requirements

Enrollees and their doctors generally have the right to ask a Medicare drug plan to make an exception to these requirements.

Prior authorization

Prior authorization means that before the plan will cover the drug, your doctor must contact your drug plan and let them know that the drug is medically necessary. Some drugs cost more than others, and often a cheaper drug might work just as well. Still other drugs may be safe, but work only for limited amounts of time. To be sure certain drugs are used correctly and only when really needed, Medicare drug plans may require a prior authorization.

These requirements may help to ensure that drugs are used properly and that they work as intended. But they require your doctor to take extra steps when prescribing the drug, and it may take longer for you to get the drug from your pharmacy. Because each insurance plan varies, doctors sometimes don’t know that a drug requires prior authorization. Like you, your doctor may only find out after you go to the pharmacy and then you or the pharmacist call the doctor back.

Note: Prior authorization is often needed for drugs used to treat cancer and control nausea.

Quantity limits

A drug plan may limit the number of pills or the number of days a prescription may cover. For example, a plan might limit a person to a certain number of migraine medicines per month. The limit may be based on research showing that more frequent use means the drug isn’t working as it should. Or it may be unsafe to take more than a certain number in a month.

Note: Medicare drug plans may limit quantities of some drugs used in cancer treatment.

Step therapy

Also referred to as a *fail-first* requirement, the step therapy restriction denies payment for a drug unless certain other drugs have been tried first.

For example, the plan may cover a drug like esomeprazole (Nexium®) for heartburn only if the patient did not respond well to cheaper drugs. So a patient might first be treated with generic omeprazole (Prilosec®). If this drug doesn't work well, coverage for a more expensive prescription dose of generic lansoprazole (Prevacid®) might be approved. And only if those drugs have been tried and didn't work would coverage be approved for a brand-name drug, like Nexium.

Note: Step therapy requirements are unusual for drugs used to treat cancer.

How does this affect cancer drug coverage?

Medicare requires Part D drug plans to cover almost all anti-cancer drugs in use today. If you have been doing well on a covered anti-cancer drug before you enroll in a Part D plan, you probably will not need to get prior authorization for the drug. You also are not likely to be asked to try and fail with a cheaper drug before the original drug will be covered by the Part D plan.

Where can I use my Part D drug coverage to fill my prescriptions?

Medicare requires that each Part D drug plan be sure that its Medicare enrollees have easy access to a local pharmacy that accepts the plan. Medicare drug plans may also offer a mail service option so you can get the medicines you will take for a long time sent right to your home.

Pharmacies

To get the best prices for their enrollees, drug plans usually set up contracts with a group of pharmacies. Those that give them the best prices will become part of the drug plan's *preferred network of pharmacies*.

Some plans will allow you to use other pharmacies, but if they do, you may have to pay more out-of-pocket. These may be called *non-preferred pharmacies*.

If you buy your drugs at a pharmacy that's neither a preferred nor non-preferred pharmacy, the plan may require you to pay the full cost of the drug. In other words, your Medicare drug card will not be accepted at that pharmacy. It's a good idea to know which pharmacies work with each plan before you sign up for one.

Table 3: Where you buy your drugs will affect how much you pay

Type of pharmacy	Will my drugs be covered by my Medicare drug plan?
Community (local) pharmacy	
Preferred network	Yes, with the plan's usual cost-sharing amounts
Non-preferred network	Yes, but you may pay more than the plan's usual cost-sharing amounts
Non-network	No, you will have to pay the full cost of the drug
Mail service pharmacy	
Preferred network	Yes, with the plan's usual cost-sharing amounts
Non-preferred network	Yes, but you may pay more than the plan's usual cost-sharing amounts
Non-network	No, you will have to pay the full cost of the drug

Medicare drug plans have different-sized pharmacy networks. Some plans, and all national drug plans (those offering Medicare drug coverage in all 50 states), include preferred pharmacies throughout the United States. But other drug plans only cover some regions of the country.

Drug plans serving a smaller region may not contract with pharmacies outside of those areas. If you need your prescription in an emergency, you may have to pay the difference between the cost at a preferred pharmacy and the non-preferred pharmacy. An example of an emergency might be if you are traveling and run out of your medicine or if you become ill and cannot get to a network pharmacy. You may also have to pay the full retail price for the drug at the non-network pharmacy, and then fill out a claim form to be paid back by your drug plan.

Mail service

Many Medicare drug plans offer a mail service option that you can use instead of your local pharmacy. Mail service works best for medicines that you don't need right away, which can be mailed right to your home. Mail service often costs less because plans tend to sell through the mail at a lower price than local pharmacies charge. But you usually have to buy in 60- or 90-day quantities, so you need to decide whether you can afford larger amounts at a time.

Mail service is best for drugs that you will be using for a long time, such as drugs that help you stay healthy. Examples include drugs to treat diabetes, high blood pressure, and drugs that are taken for a long time to help keep cancer from coming back, like tamoxifen.

Some drugs that may seem to be good for mail service need special handling (such as refrigeration) which can take away the mail option. Mail service also may not be good for

an antibiotic or other drug that you need right away, or for a drug you will be taking for only a short time. Your doctor should be able to help you decide whether mail service is a good option for your prescriptions.

Mail service may not be available under some Medicare drug plans. Or you might prefer to buy your drugs at a local pharmacy in your plan's network.

You should know that plans vary on whether they allow you to fill prescriptions at a local pharmacy for more than a 30-day supply. Most plans will allow you to fill a 60-day supply; some will allow you to fill a 90-day supply. But plans with mail service options may encourage you to use the mail by offering a better price for a 90-day supply (or some other amount) than if you buy the drug at your local pharmacy.

How much will the Part D drug plan cost?

All of the stand-alone Part D plans and most of the drug plans sold in connection with Medicare Advantage plans (MA-PDs) charge a premium for the drug benefit. The premium amount will depend on where you live and the plan you choose. This premium is in addition to any Part B premium you pay or have withheld from your monthly Social Security check.

Note: In addition to the Part D premium paid to a plan, an income-related monthly adjustment amount is collected by the federal government. For 2014, this extra payment applies only to individuals with incomes above $85,000 and couples with incomes above $170,000 on their last completed tax return. (So, in early 2014 this would be based on their 2012 tax return.)

What will my monthly prescription drug plan premium be?

Every prescription drug plan (PDP) charges a monthly premium to enroll, but the amount varies by plan. In some states, you may find plans charging as little as $10 per month. Other plans charge a lot more. Many drug plan sponsors, such as Aetna, Cigna, Humana, Prescription Pathway, and WellCare, offer more than one plan option, and price each option differently.

The higher premium plans may have a lower deductible or no deductible at all, and may offer lower co-pays. You should figure out which plans cover your drugs and also compare the co-pays for each drug. The final numbers you should look at are your total expected costs for the year after you add up premiums, co-pays, the deductible, and the risk of falling into the coverage gap.

Plans that fill in some, or all, of the coverage gap (donut hole) are also more likely to have a high premium when compared with those that don't do this. Still, premiums vary for a number of reasons, and it's not always true that higher premiums mean lower out-of-pocket drug costs or a bigger formulary. As an example, Table 4 shows the range of premiums charged by PDPs in Arizona in 2014.

Table 4: Prescription Drug Plan (PDP) premiums, cost-sharing requirements, and drug coverage: Arizona

PDPs in Arizona	34
Range of PDP monthly premiums	$12.60 to $135.10
PDPs with no premium for low-income subsidy beneficiaries	11
PDPs with $0 deductible	16
PDPs with some coverage offered in drug coverage gap (“donut hole”)	7

Information as of January 2014, accessed on www.q1medicare.com

What if I want to get my drug coverage through a Medicare Advantage plan?

Medicare Advantage plans may be health maintenance organizations (HMOs), preferred provider organizations (PPOs), or private fee-for-service plans. There are also some Medicare Advantage plans tailored to people with special needs, such as long-term care needs. Every Medicare Advantage plan must offer at least one Part D prescription drug plan. Some plans may offer options that don’t include Part D coverage. (These are designed for enrollees who may have other sources of drug coverage, such as through the Veteran’s Administration.) It’s important to know that these plans may change every year but they will send you a notice about any changes each fall. You’ll want to review this notice to be sure it still fits your needs.

You may see 2 premiums listed with Medicare Advantage plans: (1) the premium for the MA-PD (the drug premium) and (2) a total Medicare Advantage premium. The total Medicare Advantage premium includes your cost for medical care coverage such as hospital, doctor, and other non-drug services, and takes the place of the Part B premium.

How much of the premium will I have to pay if I qualify for low income assistance?

If your income is less than a certain amount that is pre-set every year, you may be able to get help paying the premium and co-pays of Medicare Part D.

If you qualify for the special low-income assistance program (called Extra Help or the low-income subsidy [LIS]), then your monthly premium may be partly or fully paid by Medicare, Medicaid, and Social Security. Your co-pays, co-insurance, and yearly deductible will go down, too.

If you choose a drug plan that has a premium at or below the amount covered by Extra Help, then you will not have to pay any Part D premium. But if you pick a drug plan that has a higher premium than the Extra Help premium amount for your state (above basic

coverage) you will have to pay the difference. How much you have to pay depends on the level of help for which you qualify and that particular drug plan's premiums.

See the section called "Getting help to pay Medicare Part A and/or Part B premiums (the Medicare Savings Programs)" for more on this. Or, you can go to www.medicare.gov/publications to read the brochure called "Get Help With Your Medicare Costs: Getting Started." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy of this brochure can be mailed to you, or to ask questions about low income help.

Things to know once you've chosen a Part D drug plan

After you have decided on a Part D drug plan, remember that changes may take place and affect your coverage and cost of your drugs. Here are some things you should watch for:

Formularies can change

Drugs may be added to or taken off a plan formulary. Most drug plans have a formulary (a list of all the drugs covered by the plan, including brand name and generic drugs). In most cases, changes to a plan's formulary are made at the beginning of a calendar year. But drug plans may add or drop coverage of certain drugs anytime during the year. If a plan removes a drug from the formulary, it must let you know about the change at least 60 days before it takes place.

Plans are likely to make changes to their formularies as new drugs are approved or if a drug is found to be unsafe. If a drug is found to be unsafe, the plan must let you know, in writing, why the drug is being removed from the formulary and give you a list of other drugs that could be used in its place. Plans are not required to let you know when they add new drugs to the formulary.

Some drugs cannot be covered under Part D

Most FDA-approved prescription drugs may be covered by Part D drug plans, but certain types of drugs cannot be covered. These are:

- Drugs used for loss of appetite, weight loss, or weight gain (except for drugs to treat physical wasting from certain diseases)
- Fertility drugs
- Drugs used for cosmetic purposes or hair growth
- Drugs used to relieve cough and cold symptoms
- Barbiturates (drugs that may be used to help people sleep or calm them down), unless they are used to treat epilepsy and other serious or chronic health conditions

- Prescription vitamins and minerals, except pre-natal vitamins and fluoride preparations
- Non-prescription drugs or over-the-counter drugs
- Outpatient drugs for which the maker of the drug requires certain tests or monitoring services that must be purchased only from them or the company they choose

If you are eligible for both Medicare and Medicaid, your state Medicaid program may help you pay for some of these drugs if they are medically necessary.

Drug prices can change

A drug plan's monthly premium is fixed for the calendar year and can't be changed. But the beneficiary's cost for a drug from a plan pharmacy or from a mail service can change if a plan changes the status of a drug from preferred to non-preferred or drops coverage altogether. If such a change results in an increase in your out-of-pocket costs, the plan must notify you in writing 60 days before the change takes place.

Also, if the price of a drug changes over the course of a year, the amount you pay out of pocket may change, too. If the cost of a drug goes up during the year, your cost for the drug could go up if you are paying all or most of its cost – for example, in the deductible period or in the donut hole.

You can find out about these price changes in more than one way:

- Visit the Medicare website (www.medicare.gov)
- Call 1-800-MEDICARE (1-800-633-4227)
- Visit your drug plan's website
- Call your drug plan's toll-free customer service line

Participating pharmacies may change

As noted before, all Medicare Part D plans must have a network of pharmacies that take part in their plan throughout the area they serve. These networks must give beneficiaries easy access, taking into account the distance and travel time to the nearest plan pharmacy. The agreements between pharmacies and Part D plans are generally for at least a 1-year period. But pharmacies may choose to drop out of a plan's network at any time.

You can watch for changes in a plan's pharmacy network by visiting the plan's website or asking for a pharmacy directory from the plan's toll-free customer service line.

Switching drug plans in the future

Each year, you will be able to choose a new drug plan during the annual open enrollment period, which is between October 15 and December 7. Any changes then go into effect on January 1st of the following year. (January 1 is when your new plan starts if you chose to switch, or when your current plan takes effect for the next year.) Once they've started with the plan on January 1st, most people won't be able to switch plans until the next open enrollment period.

Note: If you are eligible for Medicaid, you can switch plans monthly rather than yearly. And if you are eligible for the special low-income assistance through the Medicare Part D program, you can switch plans up to twice a year – once during the open enrollment period and once in between enrollment periods.

Even if you are satisfied with your current drug plan, there are many reasons you might want to switch plans:

Your drug needs may change or your plan's coverage may change

In the course of a year, your prescription drug needs may change. For instance, your cancer treatment may end or your doctor may change your treatment. During the year, you also might be prescribed drugs for other health problems that aren't related to your cancer treatment – such as medicine to treat high blood pressure. You may find that your current drug plan isn't the best option for your new drug needs. Your drug plan may also change its coverage rules or formulary in a way that affects your drug coverage or your out-of-pocket costs.

As the end of the year nears, if you do nothing during the open enrollment period you will automatically be re-enrolled with the same company you were with the past year. But the plan may not be the same next year – drugs, deductibles, and premiums may change. Find out if the plan will still meet your needs before you allow yourself to be automatically re-enrolled.

If your drug needs have changed, and you find that your plan doesn't cover your new medicines, you may decide to switch drug plans. Or, if you learn that another plan in your area offers lower prices for your new drugs (while also covering the other medicines you take), you may want to switch plans. If you decide to switch, you will need to review your options, decide on a new plan, and figure out when you can make the change. (See the section called "Making a Part D plan decision" for details on when you can change plans.)

Your income may change

If your income has gone down in the course of the year, you may be able to get Extra Help, the special low-income assistance provided through the Medicare Part D program.

This program helps you pay your monthly premium, and gives you a lower yearly deductible and lower drug co-pays.

Medicare beneficiaries who are eligible for Extra Help must choose a plan with a premium that is covered by Extra Help. If you qualify but your current plan has a premium that is higher than the Extra Help coverage, then you must either switch plans or pay the difference in cost yourself. See the "How much will the Part D drug plan cost?" section to learn more about getting help with your Part D costs.

Your plan may leave the Medicare program

The Medicare drug benefit uses private plans to deliver benefits instead of a single government-based plan. These private plans can decide to join or leave the Medicare program at any time. They also may change their benefits or drug formularies. New managed care options in the Medicare Advantage program may also join or leave the program. For these reasons, the drug plan options in your area may change from year to year.

If a plan withdraws from Part D, enrollees must be notified at least 60 days before the plan's withdrawal. This notice includes a written description of other options within your service area. Enrollees then have to choose another plan under special enrollment – they don't have to wait until the next open enrollment period to switch plans.

Other factors that might make you want to change drug plans

Other factors may also affect your decision to stick with your current drug plan or switch to a new one. For example, the tools used to help people decide on a drug plan and other information to help beneficiaries may get better over time. In this case, you might find out later that a different plan would actually meet your needs better than the one you have now. If you are happy with your current plan, there might not be a need to change or even look at a different plan.

But the drug benefit is set up so that it that encourages Medicare beneficiaries to shop around – just as you would for groceries or a new car – and find the best value. So it might not hurt to compare plans each year when you have the chance to change, even if you're OK with your current plan.

Frequently asked questions

Here are answers to the Part D questions most often asked by people with cancer. The questions and answers assume that you are eligible and enrolled in Medicare Part B. But keep in mind that all Medicare beneficiaries are also eligible for Part D, whether they have only Medicare Part A or Part B, or both. The answers to these questions will be different if you get prescription drug coverage through your former employer's retiree plan or if you are enrolled in a State Medicaid program.

PLEASE NOTE: We have reviewed the laws and regulations pertaining to Part D, and we are giving you the American Cancer Society's best answers to these questions. For official answers you must contact the Centers for Medicare & Medicaid Services (CMS) directly at 1-800-MEDICARE (1-800-633-4227) or www.medicare.gov. We also encourage you to check with the Part D plans directly if you have questions. The information given here is not intended to favor one plan over another, but only to give basic answers to questions cancer patients may have about their Medicare coverage.

I have cancer and I think Part D might be able to help me with my drug costs. Can they turn me down because I already have cancer?

No. Medicare Part D drug plans must accept all eligible applicants living in their service area regardless of age or health status.

I am getting cancer treatment now. Most of my drugs are covered under Medicare Part B. If I sign up for Part D, will that change?

No. The drugs that are now covered under Medicare Part B will still be covered under Part B. These are the drugs that you get in your doctor's office as part of your chemotherapy (chemo) treatment. Part D may help you with other prescriptions that are not covered under Part B, such as certain cancer drugs you take by mouth.

I have cancer and am getting treatment. I've looked on the Medicare website and found that some, but not all, of the drugs I'm taking are included on formularies for drug plans in my area. How do I know if the rest of my cancer drugs are covered by Medicare if they aren't on the plans' formularies?

Just because a cancer drug is not listed on a plan's formulary doesn't mean the drug isn't covered by Medicare. Drugs that are covered under Medicare Part B will still be covered under Part B after you sign up for Part D.

To find out if a drug is covered under Part B (rather than under Part D), make a list of the drugs that are not on the formulary. Then check with your doctor's office to see if these are cancer drugs that you get through an IV in the doctor's office. If the cancer drugs not listed on the formulary are drugs that you get in the office, then these drugs are covered under Part B. To be sure that this is the case, call the plan's beneficiary help line (this number is usually listed on your Medicare Part D Plan ID card) and ask to speak to a customer service representative, or call 1-800-MEDICARE (1-800-633-4227). Your state health insurance assistance program (SHIP) might also be able to help you. (See the section called "Where can I get more help?" to learn how to contact your state's SHIP.)

If you find that your drugs are on a plan's formulary, you still need to check to see how much your co-pay will be and if your local pharmacy is part of the plan.

If I take a prescription for a cancer drug to the pharmacy and the drug is supposed to be covered under Part B, can the pharmacy or the drug plan deny coverage under Part D?

Generally speaking, the answer is no. But cancer drugs clearly covered under Part B might not be on a plan's formulary, and your pharmacy or drug plan may deny coverage for these drugs. Also, in some cases a drug plan may require prior authorization for certain drugs to be sure that your diagnosis or use of the drug is in line with Part D coverage.

If this happens to you, contact your plan's helpline (see your Medicare Part D Plan ID card) or Medicare (call 1-800-MEDICARE [1-800-633-4227] or visit www.medicare.gov) to find out how to resolve the problem.

I am confused by all the different prescription drug plans offered in my state. What do I need to do first?

Deciding if Medicare Part D is right for you depends on your situation and the prescription drugs you take. Your first step should be to learn about any drug coverage you have already. Do you have prescription drug coverage from an employer or union? Do you have Medicare and a Medigap (supplemental) policy with drug coverage? Do you have a Medicare Advantage Plan (like an HMO or PPO) or another Medicare Health Plan?

If you already have prescription drug coverage from an employer, union, or a Medigap policy, you will need to figure out whether your drug coverage is as good as or better than the drug coverage you could get under Part D.

If your current coverage is as good as or better than Medicare Part D, then you can keep your current plan. If your coverage ends or you choose to join Medicare Part D sometime in the future, you can do so without paying a late enrollment penalty. But to avoid the penalty, you must join a Medicare drug plan within 63 days after your drug coverage ends or is no longer as good as that offered by Medicare.

If you become eligible for Medicare while you have drug coverage that's not as good as Medicare, you will want to find out about enrolling in Part D. Ask your insurer or your former employer whether your benefits are equal to the standard benefit under Medicare Part D. If your coverage isn't as good as Part D, you can sign up for Part D. If you don't enroll right away, you may face penalties.

If you still have questions, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov. You can also get one-on-one counseling from your State Health Insurance Assistance Program (SHIP) or your local office on aging. SHIP contact information is covered in the section "Where can I get more help?" The phone number of

your local office on aging can be found at www.eldercare.gov or by calling 1-800-677-1116.

Before I decide to enroll in Part D and drop the coverage I have through my employer or union, what do I need to think about?

If you are covered by an employer or union, before you switch to Part D, you should find out how that decision could affect other parts of your medical coverage. In some cases, if you drop your prescription drug coverage under a health plan from your employer or union, you may also lose your hospital and doctor (medical) coverage. This could affect not only your health insurance, but that of anyone else covered under your policy, such as your spouse or children.

Carefully read all information you get from a former employer or union about your existing drug and health coverage before you decide to join a Part D prescription drug plan. Once you've dropped your employer or union coverage, you may not be able to get it back.

Also, keep in mind that former employer or union coverage might work with Medicare in different ways. For example the employer or union might want their retirees to join a Medicare drug plan, and then they will provide coverage to supplement the Medicare drug plan. (This is much like the way employers and unions sometimes provide health coverage to supplement Medicare A and B for doctor and hospital coverage.)

It's important that you understand how your employer or union coverage will change if you enroll in Part D. Your former employer or union should send you a letter telling you whether your drug coverage is better or worse than the Medicare drug benefit. If you have questions, call your plan or your employer or union's benefits administrator. Medicare will not be able to tell you what changes your employer or union coverage may make if you're enrolled in Part D.

If you decide to keep your former employer or union's coverage after finding that your coverage is at least as good as Medicare, you will not have to pay a penalty if you join a Medicare drug plan later – as long as:

1. You join a plan within 63 days after your coverage ends.
2. You can produce the letter proving your plan was as good as or better than Part D.

What should I do if I am currently covered under TRICARE (military), the Federal Employees Health Benefits Program (FEHB), or if I get my prescription drug coverage from the Veteran's Administration (VA)?

TRICARE, the VA, and FEHB benefits have all been found to be as good as or better than the standard Medicare Part D benefit. So, if you have drug coverage through any of these, you should keep that coverage.

If you decide to join Part D later, or if you lose your TRICARE, VA, or FEHB coverage, in most cases you will not face a late enrollment penalty as long as you join the plan within 63 days after coverage ends.

Can I use both VA and Medicare to cover my prescription drugs?

Yes, you can have coverage under both VA and Medicare Part D, but each prescription will only be covered by a single program. You can choose, on a prescription-by-prescription basis, whether to get the drug under the VA or Medicare plan. But the prescription cannot be covered by both plans at once.

Keep in mind that VA coverage might vary from a Part D plan in terms of the medicines that each will cover. Also, keep in mind that the cost of any prescriptions paid by the VA will not count toward reaching your catastrophic coverage level under Medicare Part D if you hit the donut hole. For donut hole information, see "What is the coverage gap, and what do I pay?" in the section called "Medicare Part D prescription drug coverage."

I have Medigap, and my plan covers prescription drugs. Do I need to enroll in Part D?

If you have a Medigap policy that covers prescription drugs (Plan H, I, or J), you can keep your Medigap plan with the drug coverage or you can enroll in Medicare Part D – but you cannot have both. If you do enroll in Medicare Part D, you can still keep your Plan H, I or J, but the drug coverage will be removed from the policy. The Medigap premium will be adjusted because you are not paying for drug coverage anymore.

If you are thinking about keeping the Medigap drug coverage and not enrolling in a Medicare Part D plan, there are 2 things that you should think about:

> First, Medicare Part D will have greater dollar value than the prescription drug benefit in the Medigap plans. In Medigap, you pay the full premium, and the drug coverage is capped, meaning it will not pay for your drugs once you hit a certain dollar amount. Also, Medicare Part D will provide catastrophic coverage, which pays about 95% of your drug costs after you've spent a certain amount out of pocket. This can be very important for people being treated for cancer.

Second, in deciding whether to keep your Medigap policy, you will need to maintain *creditable prescription drug coverage* just in case you need to join a Medicare Part D plan later. (Your Medigap coverage should be as good as or better than Medicare Part D.) If your coverage does not meet this standard and you later decide to enroll in Medicare Part D, you could be charged more. Even if your coverage does meet this standard, you'll have to prove it by getting and keeping a letter from your current plan.

How do I know if the drugs I take now will be covered under Part D?

You can figure out what plans cover your drugs and also compare the co-pays. Every prescription drug plan under Medicare Part D has a formulary (a list of drugs that the plan covers). Formularies include both generic drugs and brand name drugs. Most prescription drugs used by Medicare beneficiaries will be on each plan's formulary, but the cost of each drug will vary under the different plans. And some plans with a low monthly premium may charge higher co-pay amounts.

People with cancer are often prescribed expensive medicines to treat the disease and keep it from coming back. If you're being treated for cancer, you should know that the Medicare drug plans must cover almost all cancer drugs.

The easiest way to research drug formularies for the Part D drug plans in your area is to use the Medicare Plan Finder online. You have to enter each drug by name and dose, so you'll want to start by getting all your prescription drugs in front of you. The Medicare Plan Finder is on the Medicare website at www.medicare.gov/find-a-plan. You'll enter your zip code and all the drugs you take to do a general search, then you'll get a list of plans that cover the drugs you need. Once you have this, you can go to each plan's website for information on premiums, co-pays, appeal rights, and more. The Medicare Plan Finder also allows you to do a personalized search by entering more details about yourself. This gives you a list of plans that would best meet your specific needs.

If you don't have access to a computer, or don't feel comfortable using the Internet, call 1-800-MEDICARE (1-800-633-4227). It's important that you make the most informed decision you can.

I have a limited income and few resources. How do I apply for help with my Part D monthly premiums and co-pays?

If your income is less than an amount set by Medicare every year, you may be able to get help paying your premium, deductible, and co-pays for Medicare Part D. The amount of help, called Extra Help, you get will depend on your income and resources.

If you think you might qualify, contact your Social Security Administration office or your state Medicaid office to apply. You can also apply online at www.socialsecurity.gov.

After you apply, Social Security will process your application. If your application is not complete, they will call you or write to you and ask you for the missing information. Your application will be processed as quickly as possible and you'll get a letter letting you know if you qualify.

Certain people automatically qualify for Extra Help with prescription drug costs under Part D:

- Medicare beneficiaries who also qualify for Medicaid (called *dual eligible*)
- People who get help from Medicaid to pay their Part B Medicare premiums
- Medicare beneficiaries who get Supplemental Security Income (SSI) benefits

See the section called "Getting help to pay Medicare Part A and/or Part B premiums (the Medicare Savings Programs)" for more on this. You can also call 1-800-MEDICARE (1-800-633-4227) or your State Health Insurance Assistance Program (SHIP) for more information. (See the section called "Where can I get more help?" for SHIP contact information.)

Other options for financial help

If you are not eligible for Medicaid or Extra Help, there are other ways to get help paying for the costs of drugs not covered in your Part D drug plan.

Many states have *state pharmacy assistance programs* (SPAPs) that offer prescription drugs at a deep discount to people who have incomes below a certain level. These programs must work with Part D plans by extending coverage for some drug costs that aren't paid by the Part D plan. Payments made by these SPAP programs can be counted as out-of-pocket expenses to meet a Part D plan's deductible and for meeting the limit for catastrophic coverage. Call your state Medicaid office to find out if your state has a program to help Medicare beneficiaries pay their drug costs.

Payments by other drug assistance programs – for example, the patient assistance programs sponsored by drug companies or state AIDS drug assistance programs – do not count as personal out-of-pocket spending. They aren't counted towards the deductible or the limit for catastrophic coverage by a Part D plan.

Finally, if you're a Medicare beneficiary who is covered by Medicaid and you live in a nursing home, you can enroll in a Part D plan and pay no premium. You will also have no co-pays for prescription drugs under Part D for any drugs that are on the plan's formulary or approved through the appeals process. The same is true if you have joined a Program of All-inclusive Care for the Elderly (PACE).

I got a letter telling me that I will be automatically enrolled in a Medicare drug plan. What if I want to choose a different plan?

If you are a Medicare beneficiary and you also qualify for Medicaid benefits (commonly called *dual eligible*), you must be enrolled in a Medicare Part D drug plan. You may have gotten a letter telling you that you were automatically enrolled in a Medicare drug plan if you didn't choose one on your own. If you decide you would rather be in a different plan, you can switch plans as often as once a month.

I don't have a computer and can't use the Internet. How can I get information on Medicare Part D?

You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Before calling this number, you should gather information that they'll need to help you select a plan or compare plans. This information includes:

- Your Medicare claim number, which is on your Medicare card and on the Medicare Summary of Benefits form you get each time you use your Medicare card
- The dates your Medicare Part A (hospital benefits) and Medicare Part B (medical benefits) first went into effect. Both of these dates should be on your Medicare card.
- Your name, birth date, zip code, and the county you live in
- Information about any drug coverage you already have, including the number and company name, which should be on the ID card
- A list of all the prescription drugs you take and the dose, as well as number of pills you take every day for each drug

What effect will signing up for Medicare Part D have on my getting help from a patient assistance program?

If you get your cancer drugs for free or at a discount from the drug company and don't qualify for Extra Help, you may worry about whether this will change if you enroll in Part D plan. The concern for drug companies is how to continue their programs without violating federal fraud and abuse laws.

Federal law (commonly referred to as the *anti-kickback statute*) prevents drug makers from giving drugs to Part D enrollees except under certain conditions. The Department of Health and Human Services' Office of the Inspector General (OIG), which enforces the anti-kickback rules, has identified 2 main problems with patient assistance programs (PAPs):

First, drug manufacturer PAPs can lead patients to use a certain drug, even if there's a generic drug or another treatment that might work as well.

Second, the OIG believes that PAPs can increase Medicare's cost by moving enrollees through the donut hole more quickly. This means that Medicare beneficiaries would get catastrophic coverage earlier, with Medicare then picking up 95% of the beneficiary's drug costs.

The OIG has said that drug manufacturers may give free or low-priced outpatient prescription drugs to Medicare beneficiaries who do **not** enroll in Part D. But many drug companies are hesitant to help Medicare beneficiaries.

This is mostly because drug makers view their PAPs as help for people who do not have any drug coverage. Also, drug companies usually only give 1 or 2 drugs through their PAPs – they cannot give total coverage for other prescription drugs the person might need. Drug makers also know that nearly all beneficiaries will be better off if they sign up for Part D as soon as they're eligible.

Drug companies can give free or reduced cost drugs directly to Part D enrollees if certain conditions are met:

- Any help from a PAP cannot count toward a beneficiary's out-of-pocket costs.
- The PAP must notify the Part D plan that the drug is being given to the enrollee outside of the Part D benefit to ensure that no payment is made by the Part D plan for that drug.
- Drug makers must guarantee that the drug will be available for the entire coverage year, and keep accurate records.

Some drug companies do not want to run their PAPs under these conditions. Most drug companies will review applications for assistance on a case-by-case basis, so it may still be worthwhile to check with PAP programs, even if you are enrolled in Part D. But it's up to the drug manufacturer whether or not to offer a PAP and, if they do, whether they will help you.

Cancer patients enrolled in Part D who cannot find a PAP to help them get their drugs may be able to get help through charities that specialize in helping people with co-pays. Drug makers are allowed to give money to independent charities that help needy patients with medical expenses. They can't give money, though, if the charity steers patients toward a certain company's drugs. These charities can be especially helpful for patients with incomes too high to qualify for help from Medicare to pay for their Part D plan, since the charities' income restrictions are often more flexible.

Where can I get more help?

The Medicare drug benefit can be complex and confusing, and it's even more so for those with special needs like people with cancer. There are many places you can go for help.

Here's a list of sources within the federal government that can answer your questions. We also give you a list of outside organizations and how to find the SHIP office in your state.

Federal government sources for help

National Association of Area Agencies on Aging (n4a)
Toll-free number: 1-800-677-1116
Websites: www.n4a.org and www.eldercare.gov

> Has a useful questions and answers section online about the prescription drug benefit and contact info for your local office on aging

Centers for Medicare & Medicaid Services (CMS)
Toll-free number: 1-800-633-4227 (1-800-MEDICARE)
TTY: 1-877-486-2048
Website: www.cms.hhs.gov

> For complete, up-to-date Medicare information, including fact sheets, handouts, regional maps, and general Medicaid information

Website: www.medicare.gov

> Official US government site for people with Medicare. Has complete information on the Part D prescription drug benefit and easy-to-use tools to help you figure out which plans are best for you.

State Health Departments
To find your state health department to apply for Medicaid or Extra Help in your state or county, check your local government phone listings, or:

> Call the Department of Health and Human Services' toll-free number: 1-877-696-6775; you'll be asked to enter your area code to be connected to your state, or visit the DHHS Office of Family Assistance website below and select your state: http://www.acf.hhs.gov/programs/ofa/help

Social Security Administration (SSA)
Toll-free number: 1-800-772-1213
TTY: 1-800-325-0778
Website: www.socialsecurity.gov

> Has information on benefit eligibility and on getting Extra Help to pay for Medicare drug coverage

Other resources

AARP
Toll-free number: 1-888-687-2277 (1-888-OUR-AARP)
Website: www.aarp.org

Has free information on many topics, including Medicare prescription coverage

BenefitsCheckUp
Website: www.benefitscheckup.org

Sponsored by the National Council on Aging, this website helps people with Medicare and other older adults learn about and enroll in government benefits, including Medicare Part D and applying for Extra Help

Medicare Today
Website: www.medicaretoday.org

Offers information and resources online to help Medicare beneficiaries get the greatest value from their Medicare benefits

National Council on Aging
Toll-free number: 1-800-424-9046
Website: www.ncoa.org
Website with information on Medicare Part D: www.mymedicarematters.org

Helps seniors find jobs, access benefits, improve their health, live independently, and stay active in their communities

State Health Insurance Assistance Programs

For more information, call 1-800-633-4227 (1-800-MEDICARE) or contact your state health insurance assistance program (SHIP). SHIP has counselors in every state and some territories who are available to provide free one-on-one help with your Medicare questions or problems. Most offices are open only during daytime business hours.

To get contact information for the SHIP in your state, go to the State Health Insurance Assistance Program website at www.shiptacenter.org or call us at 1-800-227-2345.

Are you ready to get started?

Now that you have a better understanding of how the Medicare Part D prescription drug plan works, you may be ready to look at your options and make a decision. This list can help you be sure you've done all you can to choose the best plan for you.

- Check the plan formularies to figure out which plans cover all or most of your drugs
- Check how the formulary tiers affect what you have to pay
- Compare the plan premiums and other cost-sharing requirements (such as deductibles, co-insurance, and co-pays)
- Check for drug conditions or restrictions, such as limits, prior authorization, and step therapy requirements

- Look into whether you qualify for Extra Help (the low-income subsidy)
- Find out which of your cancer drugs are still covered under Part B
- Understand how off-label drug uses are treated under Part D
- Understand your appeal rights
- Check to see which plans offer the best drug coverage (brand name or generic) in the coverage gap (donut hole)
- Check with your doctor to see if you can use a generic drug instead of a brand name drug to reduce costs. Some plan formularies may cover the generic version of a drug, but not the brand name drug.

More information from your American Cancer Society

We have some more information that may also be helpful. You can read these materials on our website or order free copies from our toll-free number.

Health Insurance and Financial Assistance for the Cancer Patient (also in Spanish)

Prescription Drug Assistance Programs (also in Spanish)

Off-Label Drug Use

No matter who you are, we can help. Contact us anytime, day or night, for cancer-related information and support. Call us at **1-800-227-2345** or visit www.cancer.org.

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For additional assistance please contact your American Cancer Society
1-800-227-2345 or www.cancer.org