Medicare Part D – Prescription Drug Coverage

In the original Medicare program (Part A and/or Part B), there is no coverage for prescription medications. To address this gap, Medicare Part D provides insurance coverage for prescription drugs. Under this program, insurance companies and other private firms contract with Medicare (Medicare pays most of the premium) to provide prescription drug benefits to Medicare beneficiaries.

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

Making a Choice

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

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

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- **Changing plans:** Each year, from October 15 to December 7, a beneficiary can change to a different prescription drug plan.
- **Current prescription coverage:** Individuals who currently have prescription drug coverage from another source may not wish to enroll in a Medicare prescription drug program. In some cases the benefits provided under these other plans are better than those provided under the standard Medicare prescription drug plan.
- **Medication coverage:** Consider what medications are needed. Compare the needed medications with those covered by each plan. Each plan will have a list (termed a "formulary") showing the drugs (generic and brand-name) the plan will pay for.
- **Out-of-pocket cost:** A prescription drug plan can vary in how much it charges and how much coverage is provided. Issues such as the monthly premium, yearly deductible, any co-insurance or co-payments, and coverage limits must all be considered.
- **Pharmacy convenience:** Not all pharmacies will be contracted with all plans. Some plans will allow a beneficiary to receive prescriptions by mail.
- **Future health changes:** Even though an individual takes few or no medications now, joining a prescription drug plan now means paying the lowest possible monthly premium. Future health changes may require increased use of prescription drugs.

Standard Coverage

The standard coverage for 2024 as set by Medicare is shown in the following table:

	Deductible	Initial Coverage	Coverage Gap	Catastrophic Coverage
	$545 Deductible	$546 to $5030	$5031 Until Out-of-Pocket Totals $8000	Above $8000 in Out-of-Pocket Costs
Enrollee Pays	$545	25% up to $1121	$743	$0
Others Pay	$0	75% up to $3364	$2,228	All
Total Drug Expense	$545	$4,485	$2,970	No Limit

Paying for Prescription Medication (continued)

Once an enrollee reaches the Coverage Gap, he or she will pay no more than 25% of the price of a medication. If a *brand-name medication* is involved, the manufacturer pays 70% of the price, and the Part D plan pays 5% of the cost. The 25% paid by the enrollee, plus the 70% paid by the manufacturer (totaling 95%) count as "out-of-pocket" expense, helping the enrollee quickly leave the Coverage Gap. If a *generic medication* is involved, the enrollee pays 25% of the price and Medicare pays the remaining 75%. In this case, only the 25% paid by the enrollee counts as an out-of-pocket expense toward getting out of the coverage gap.

In 2024, once an enrollee reaches $8,000 in out-of-pocket expenses, he or she will face no further copayment or coinsurance payments for Part D drugs for the remainder of the year.

Income Related Monthly Adjustment Amount (IRMAA)

In addition to the normal Part D premium, enrollees whose incomes exceed certain limits are also required to pay an "Income Related Monthly Adjustment Amount," or IRMAA. The regular plan premium is paid to their Part D plan and the IRMAA is paid to Medicare. The 2024 Part D IRMAA amounts are as follows:

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Equal to or less than $103,000	Equal to or less than $206,000	$0.00
$103,001 to $129,000	$206,001 to $258,000	$12.90
$129,001 to $161,000	$258,001 to $322,000	$33.30
$161,001 to $193,000	$322,001 to $386,000	$53.80
$193,001 to $500,000	$386,001 to $750,000	$74.20
Greater than or equal to $500,000	Greater than or equal to $750,000	$81.00

Married Filing Separately	Monthly Adjustment Amount
Equal to or less than $103,000	$0.00
$103,001 to $397,000	$74.20
Greater than or equal to $397,000	$81.00

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For Those Who Currently Have Prescription Drug Coverage

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

- **Coverage provided by employer or union:** If the drug coverage provided by an employer or union is, on average, at least as good as the standard Medicare coverage, the individual may choose to keep the current plan for as long as it is offered. If the plan is discontinued in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.
- **Medicare Advantage or other Medicare health plan:** Some Medicare Advantage or other Medicare health plans cover prescription drugs. If a plan does not offer prescription drug coverage, an individual may wish to switch to another Medicare Advantage or other Medicare health plan that does cover prescription drugs, or change to the original Medicare plan and join a Medicare prescription drug plan.
- **Other government insurance:** Generally, the prescription drug benefits provided by TRICARE, the Department of Veterans Affairs (VA), Federal Employee's Health Benefits Program (FEHB), or Indian Health Services are as good as the standard Medicare prescription drug plan. In most cases it will be to the individual's advantage to keep the current plan. If coverage is lost in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

Inflation Reduction Act of 2022

The Inflation Reduction Act of 2022 (IRA-2022), signed into law by President Joe Biden on August 16, 2022, made significant changes to the prescription drug benefit provided under Part D of the Medicare program. The Medicare program is administered by the federal Centers for Medicare and Medicaid Services (CMS).

- **Drug price negotiations:** Under this provision, the Act requires CMS to negotiate maximum prices for brand-name drugs that do not have other generic equivalents and that account for the greatest Medicare spending. CMS must negotiate the price of 10 drugs in 2026, 15 drugs in 2027 and 2028, and 20 drugs in 2029 and later.
- **Medicare Part D improvements and maximum out-of-pocket caps:** Beginning in 2023, the Act eliminated beneficiary cost-sharing above the annual out-of-pocket spending threshold (for "Catastrophic" Coverage), as well as expanding eligibility for the Part D low-income subsidy. For the period 2024-2029, the new law limits Part D premium increases to no more than 6% per year. In 2025, the Act caps an enrollee's personal annual out-of-pocket spending at $2,000 per year, (with annual adjustments thereafter) as well as creating a program under which drug manufacturers provide discounts to enrollees who have incurred costs above the annual deductible. Additionally in 2025, the new law establishes a process through which certain beneficiaries can have their personal out-of-pocket monthly costs capped and paid in even monthly installments.
- **Other miscellaneous changes:** Also beginning in 2023, IRA-2022 eliminated any cost-sharing for recommended adult vaccines, thus making them free of cost. In addition, the bill capped cost-sharing for a month's supply of covered insulin products at (1) for 2023 through 2025, $35; and (2) beginning in 2026, $35, 25% of the government's negotiated price, or 25% of the plan's negotiated price, whichever is less.

Seek Professional Guidance

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

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

Disclosure Notice

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