Medicare Part D: A Primer for Pharmacists
By Scott Thomas, PhD, and Michelle Matthews

Upon successful completion of this continuing education activity, the pharmacist should be able to:
1. List (in order) the four stages of beneficiaries' Part D coverage.
2. Determine whether a vaccine is covered by Medicare Part B or Part D.
3. Explain what the drug utilization tool “step therapy” is.
4. Describe the first step a patient should take when a drug plan denies coverage of a medication.
5. Refer patients to where they can apply to the program known as Extra Help that assists with prescription drug costs.

INTRODUCTION
Pharmacists are a valuable source of information for their patients who have Medicare prescription drug coverage. They can help explain why some medications are covered and others are not, why the amount patients pay for their medications can change during the year, and how patients can make an appeal if a medication they have requested is denied by their drug plan. The following article will discuss the basic structure of Medicare and the details of Medicare prescription drug coverage.

MEDICARE
Medicare is a federal government program that provides health insurance to people who are 65 or older and people who are under 65 and have a disability or have endstage renal disease (ESRD). People of every income level can receive Medicare. Those receiving Medicare are often referred to as beneficiaries. It is important to note that Medicare is different from Medicaid. Medicaid is a state and federal program that has few age restrictions and offers health insurance to people with very low incomes who fall into certain categories.

Medicare is broken into three “parts.” Part A is inpatient insurance which covers hospital stays, skilled nursing facility stays, and other inpatient services. This is the part that most people get for free if they have worked at least 10 years in the United States.

Part B is generally known as outpatient insurance, which includes doctors’ services, ambulatory services, mental health services, and more. This part has a monthly premium. People can choose not to receive Part B. However, before deciding to decline Part B, it is important that beneficiaries get careful counseling. If they decide to decline Part B just because they do not want it but then decide at a later time to enroll, they may incur large premium penalties. They will also be able to enroll only at certain times of the year. In some cases, people must wait as long as 15 months to get Part B. In contrast, if they decide to decline Part B because they have sufficient coverage, they will have a time-limited right to enroll at a later time without penalty and without regard to the time of the year. Sufficient coverage is a complicated issue and usually requires careful assessment and counseling to determine. One common mistake is to believe that your retirement insurance or COBRA is considered sufficient coverage. This is just one of the many issues that must be clarified before a person makes a choice about Part B enrollment.

The most recent addition to Medicare is Part D, which covers outpatient prescription drugs. Part D is also not required, but again, beneficiaries should consider a number of factors before choosing not to enroll in a Part D plan. These factors should include their drug costs, if they would be eligible for programs that might be able to help...
them with their costs, and if they have creditable coverage. Creditable coverage is coverage that is as good or better than Medicare drug coverage. When a beneficiary loses creditable coverage, they have a time-limited right to enroll in Part D without penalty and at any time of the year.

There are two ways that people can receive Medicare benefits. The first is directly from the federal government. This is known as Original Medicare. Everyone who has Medicare receives a “red-white-and-blue” Medicare card. This is the card that patients usually show when they receive health care services if they have Original Medicare.

The second way a patient can receive Medicare benefits is through a private health plan. This is often referred to as Medicare Advantage. Medicare Advantage (MA) plans combine Medicare Parts A (hospital insurance) and B (outpatient insurance). Many Medicare Advantage plans include Part D (prescription drug) benefits as well and may be referred to as MA-PD plans. There are several different types of Medicare Advantage plans, including Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-For-Service (PFFS), Special Needs Plans (SNP), and Medical Savings Accounts (MSA). Private plans may have premiums in addition to the Part B premium, and they may also cover additional benefits that Original Medicare does not cover such as routine dental and vision care.

**PART D**
Medicare’s outpatient prescription drug benefit is referred to as Part D. It was created as part of the Medicare Prescription Drug, Improvement, and Modernization Act, which was signed into law in 2003 and began offering coverage to Medicare beneficiaries in 2006. Unlike Parts A and B, there is no Part D plan that is offered directly by the federal government. Beneficiaries who want a Part D plan must purchase a plan through private insurance companies.

There are two ways to obtain Part D coverage from a private company. A beneficiary who has Original Medicare can purchase a stand-alone Part D plan (PDP) from one of many private companies that offer PDPs. If a beneficiary is in a Medicare private health plan, the Part D plan is usually provided as part of the same plan (MA-PD). Plans are required to cover drugs in each therapeutic class or category but have flexibility to establish preferred drug lists, or formularies. However, to be part of Medicare, every formulary is required to cover all or substantially all of the drugs within certain classes. These six classes of drugs include antiretrovirals, antidepressants, antipsychotics, anticonvulsants, antineoplastics, and immunosuppressants. There are some important limits to this protection. For example, plans do not have to cover every formulation of these drugs. Also, plans cannot apply utilization restrictions to drugs in these classes if beneficiaries are refilling old prescriptions. However, except for antiretroviral drugs, plans can apply these restrictions to new prescriptions in these protected classes. Finally, when new drugs come to market in these classes, plans have up to 90 days to add them to their formularies.

**DRUG COVERAGE EXEMPTIONS**
There are some drugs that Medicare Part D plans cannot cover because Medicare law excludes them from coverage. The plans may elect to cover these drugs, but these are usually offered at a much higher cost because the plans may not use any Medicare-subsidized funds toward the drug. Some drugs are excluded only when used for certain purposes. For example, weight gain drugs are listed as excluded, but weight gain drugs used to treat AIDS-related wasting or cachexia are not excluded by law. Refer to the list of excluded drug classes in the provided chart.

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<thead>
<tr>
<th>Drug Classes Excluded by Medicare Law</th>
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<tr>
<td>- Barbiturates</td>
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<td>- Benzodiazepines</td>
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<td>- Drugs to treat anorexia</td>
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<td>- Weight loss drugs</td>
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<td>- Weight gain drugs</td>
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Drug plans also may not cover drugs that have not been approved by the Food and Drug Administration (FDA). This includes older drugs that never underwent FDA approval. Additionally, any drugs prescribed for use other than that approved by the FDA are excluded. This is called “off-label use.” The only exception to this is when off-label use of a drug is listed in
one of three Medicare-approved drug compendia, or medical encyclopedias of drug uses. Medicare also accepts indications of drug use for anticancer chemotherapeutic regimens from additional compendia and other peer-reviewed medical literature. If the off-label use cannot be found in the compendia or other approved literature, the plan is unlikely to grant an exception for coverage.

Finally, Medicare will not allow coverage of drugs that don’t meet the FDA’s Drug Efficacy Study Implementation (DESI) standards. DESI evaluates the effectiveness of drugs that have been approved as safe, and those that are considered "less than effective" are categorized as "DESI-LTE" and are excluded from Part D coverage.

**DRUG PLAN RESTRICTIONS**

Prescription drugs that are not on a plan’s formulary are not covered and the beneficiary must pay out of pocket for those prescriptions. Additionally, plans may put restrictions on all their drugs, both those that are required to be covered and the ones they choose to offer. These restrictions include prior authorization, step therapy, and quantity limits. Pharmacists can play an important role in educating and assisting their patients when these restrictions affect the medication they were prescribed.

*Prior authorization* is when a plan must give permission in advance before it will cover a particular prescription. *Step therapy* is when a plan requires a beneficiary to first try other drugs to treat their condition before allowing them to use the drug that was originally prescribed. The drug that the plan wants them to start with is usually less expensive than the prescribed drug. Quantity limits are when a plan limits the quantity of a certain drug on its formulary that a beneficiary may receive.

A pharmacist can be of great help to a patient when it comes to these restrictions. This help can take the form of both explanation and support. It may not be immediately clear to a patient that even though a drug has been denied, they can still take steps to receive that medication. A patient who has had a drug initially denied is likely to be upset and unable to understand the reason for the denial. This is especially true if the patient is told only to call the drug plan to see what the problem is without further explanation or support. Taking time to explain what prior authorization or step therapy is will help the patient understand what to do or say when calling the drug plan. Many pharmacies will offer to contact the doctor and start the prior authorization process for patients to help expedite it.

Explaining the process can also give patients the confidence they need to obtain the requested documentation from their doctor. Many patients are hesitant to question or feel burdensome to their doctor. This can be especially true for older adults who receive Medicare. They may be hesitant to go back to their doctor and ask for a letter they can give their drug plan that states why a specific medication is required. However, patients may be more likely to take action if a pharmacist reassures them that it is not uncommon for a plan to require something like prior authorization and that most doctors know what to do in these cases.

**FORMULARY CHANGES**

Plans can generally change their formularies at any time after the first 60 days of the plan year. Remember that in most cases beneficiaries can change their plan only at certain times of the year. Plans also may remove drugs subject to approval from the Centers for Medicare & Medicaid Services (CMS), although the agency discourages them from doing this too frequently in the middle of the year.

If the change does not involve generic substitution or safety concerns, the plan must automatically continue to cover refills of the drugs for plan beneficiaries (at the same cost-sharing level) for the remainder of the calendar year. Beneficiaries may receive a notice indicating that change in formulary, but it should indicate that their coverage will stay the same. If the change involves substitution of a generic drug for a brand-name drug, the plan must either give affected individuals 60 days notice (by mail) before the change affects them or give them a 60-day refill and notice at the pharmacy. The notice must include the reason for the change, the names of similar drugs that are covered and their cost-sharing, and information about filing an appeal. Beneficiaries will need to file an exception, as more fully explained as follows, if they want to maintain coverage as before. If the change
is based on safety concerns, the change will be effective immediately and no prior notice or refills are required. Plans must provide notice as soon as possible after the change takes place, however.

If plans intend to remove drugs from their formulary or add utilization management tools for the next calendar year, the plans either must help beneficiaries change to a therapeutic equivalent or complete an exception request before Jan. 1, or must provide beneficiaries a 30-day transition fill of the medication and notice of appeal rights during the first 90 days of the new plan year. Plans can deny quantities or doses based on safety issues, but they must provide a transition fill up to the minimum dose or quantity and help beneficiaries file an exception if they have not already done so.

MEDICARE PART B VERSUS PART D

Some drugs are covered through Medicare Part B, the outpatient insurance benefit, and are not available as Part D drugs. These are physician-administered drugs that are typically not self-administered, such as immunosuppressant drugs, anticancer drugs, antiemetic drugs, and some dialysis drugs.

Which part of Medicare that vaccines and immunizations are covered under depends on the reason for administration. In general, when a beneficiary is at an immediate and high risk for a disease or illness, or if the vaccine or immunization is required to treat an illness or disease, then it would be billed under Part B. Part B always covers the flu shot, including both the seasonal flu shot and the H1N1 flu shot, the pneumonia vaccine, and the hepatitis B vaccine if a patient is at medium to high risk. When a beneficiary steps on a nail and receives a tetanus shot, for example, it is billed under Part B because the vaccine is necessary to prevent an imminent infection. If the beneficiary is getting his decennial tetanus booster, then Part D covers both the immunization and the administration of the shot because it is simply a routine shot. In other words, Part D covers vaccines and immunizations that are routine in nature, such as the shingles vaccine. All Part D plans must cover any commercially available vaccine that is not covered by Part B. Part D plans must pay for the vaccination itself and for its administration. Plans must cover these vaccinations whether they are received at a network pharmacy or at a physician’s office.

In addition to inpatient services and some prescription drugs, Part B also covers durable medical equipment (DME). DME includes items that are medically necessary, can withstand repeated use, and are appropriate for use in the home. This includes items such as walkers, wheelchairs, and portable oxygen equipment. Some nondurable items are billed as DME under Part B under the home health care benefit when they are needed, such as intravenous supplies, gauze, and catheters. Finally, for those with diabetes, Part B will cover some medical supplies, like lancets and test strips, as a preventive care benefit.

APPEALING DENIAL OF DRUG COVERAGE

It is important for pharmacists to know about a patient’s right to appeal a denial of drug coverage by a Part D plan. Patients with Medicare have the right to appeal whenever they disagree with a plan’s decision to deny a drug for coverage. Some of the reasons patients appeal include the drug not being on the plan’s formulary, not being “preferred” by the plan, requiring step therapy, needing a higher quantity or dosage than the plan allows, and the drug being at a high copayment tier (“tiering exception”). If beneficiaries have their doctors’ support and sufficient evidence, then they may have a strong case to win the appeal.

However, for drugs excluded by Medicare law, it is very difficult to win an appeal. This includes the seven excluded categories, drugs classified as DESI-LTE (or drugs labeled as “less than effective” by the FDA), and off-label prescriptions that lack support in the Medicare-approved compendia. While beneficiaries have the right to appeal these decisions, they are very difficult cases to win.

The process for appealing is the same whether the beneficiary is in a Medicare Advantage Part D plan (MA-PD) or a stand-alone Part D plan (PDP). First, the beneficiary and their doctor must submit a formulary exception (or tiering exception) request to the plan. The plan has 72 hours to make a decision. If the plan denies the
request, the plan will send a Notice of Denial, which details how to continue the appeals process and lists the reason for denial. At this point, the appeals process begins, and beneficiaries have 60 days to submit their appeal. Redetermination is the first step, and the beneficiary should address the reason for denial by sending in documentation to the plan’s appeals department listed on the Notice of Denial. The plan has seven days to respond. In the case of an emergency, a doctor may request an expedited appeal, in which case the plan has 72 hours to respond.

If a plan gives a favorable response to the appeal, the plan must authorize coverage no later than seven calendar days from the date it receives the appeal request (72 hours for an expedited appeal). If the plan gives an unfavorable decision, then the beneficiary has the right to escalate the appeal to an Independent Review Entity (IRE). Maximus Federal Services is currently the private contractor that handles Medicare prescription drug appeals when a plan has denied a request for coverage. Maximus is independent and is not affiliated with any Medicare private drug plan. This is the last level of the appeals process that has a short decision timeline. The beneficiary can continue to appeal to higher levels such as:

- **Administrative law judge (ALJ) hearing:** If the beneficiary disagrees with Maximus’ decision, he or she can request an ALJ hearing within 60 days of Maximus’ decision if the amount in question meets the minimum amount that Medicare sets each year ($130 in 2010).
- **Medicare Appeals Council (MAC) review:** If the beneficiary disagrees with the ALJ’s decision, he or she can appeal within 60 days of the date on the ALJ decision to the MAC.
- **Judicial review (federal district court):** If the beneficiary disagrees with the MAC’s decision or if the MAC denied the request for appeal, and the amount in question meets the minimum amount that is adjusted annually ($1,260 in 2010), he or she can request review by a federal court.

If the IRE, ALJ, MAC, or federal court decides the plan must cover the drug in question, the plan must process the coverage within 72 hours (24 hours for an expedited appeal) from the date the plan receives the decision.

**COST OF PART D DRUG PLANS**
The cost of drug plans under Medicare varies greatly and changes annually. Some Part D plans have low premiums with high deductibles, while some plans have high premiums with low copayments and no deductibles.

The standard charges for a Part D drug plan are:

- **Premium:** The amount that an individual must pay the Part D plan for coverage. Premiums are generally paid monthly.
- **Deductible:** The amount that the beneficiary must pay for prescriptions before the Part D plan begins to pay.
- **Copayment (or copay):** A flat amount that a beneficiary is required to pay for each prescription after reaching the deductible (such as $3 for generics and $5 for brand-name drugs).
- **Coinsurance:** Similar to a copayment, but it is percentage-based. For example, some plans pay 95 percent for generic drugs and 80 percent for brand-name drugs, so the beneficiary would be responsible for a coinsurance of 5 percent for generics and 20 percent for brand-name drugs.

**PART D COVERAGE STAGES AND PATIENT OUT-OF-POCKET COSTS**
The amount of money your patients pay for prescription drugs will change throughout the year, depending on what stage of coverage they are in. There are four stages of coverage in the Part D program.

- **Deductible.** If the patient’s plan has a deductible, he or she will have to pay the full cost of their drugs (100 percent) until the patient meets that amount. While deductibles can vary from plan to plan, no plan’s deductible can be higher than $310 (in 2010). Some plans have no deductible.
- **Initial Coverage Period.** This phase begins after the patient meets the plan’s deductible (if the plan has one). During this period, the patient will pay a portion of the cost of his or her drugs (coinsurance or copayment), which varies by drug and by plan, and the plan will pay the rest. How long the patient remains in this
The initial coverage period depends on the patient’s total drug costs (how much the patient pays plus how much the plan pays) and the plan’s benefit structure. Most plans’ initial coverage period ends after the patient has accumulated $2,830 in total drug costs in 2010.

- **Coverage Gap.** After the patient’s total drug costs (what the patient pays and what the plan pays) reach a certain amount ($2,830 in most plans in 2010), the patient may have to pay the full cost of her drugs until he or she reaches the catastrophic coverage stage. Some plans do not have a coverage gap.

- **Catastrophic Coverage.** In all Medicare private drug plans, after a patient has paid $4,550 in 2010 in out-of-pocket costs (regardless of the patient’s total drug costs) for covered drugs, the patient will reach catastrophic coverage. (The cost of the patient’s monthly premium is not included in the $4,550.) Then the patient will pay either a 5 percent coinsurance on the cost of covered drugs or a copay of $2.50 for covered generic drugs and $6.30 for covered brand-name drugs, whichever is greater.

### Actuarial Equivalence

Part D plans generally fit into one of three categories: the standard benefit, alternative coverage that is actuarially equivalent to the standard benefit, or alternative enhanced benefits. All Part D sponsors must offer at least one drug plan that provides either the standard benefit or the

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### Case Examples

**Case Study 1**

**Problem:** Mr. H. recently changed from individual insurance coverage to Medicare. His Medicare coverage included a Part D drug plan. When he went to his pharmacy, he was told he could not get his usual medication because his Part D plan would not cover that particular medication. He was also told that he would have to pay the full cost.

**What to do:** Every Part D plan is required to have a “transition policy” to ensure that new members can access medications they have been taking regularly. The transition fill must be used within the first 90 days of the plan to get at least a 30-day supply of the medication. This is true even if the medication is not covered by the plan or has a restriction like Step Therapy.

Mr. H. went back to his pharmacy and asked the pharmacist to fill the prescription using the “transition fill policy.” The pharmacist called the Part D plan and asked for the override code so he was able to bill it correctly.

The pharmacist told Mr. H. that the transition fill was only temporary and he would need to ask his doctor to write a letter formally asking the plan for an exception to the formulary in order to obtain future refills of this medication.

Mr. H. asked his doctor to write a letter and, within 72 hours of receiving the letter, the plan informed Mr. H. and his doctor that they would cover the medication for the rest of the year. If Mr. H. decides to stay in the same plan next year, he will need to have his doctor write another letter asking the plan to continue covering the medication next year.

**Case Study 2**

**Problem:** Ms. B. has Original Medicare Parts A and B and prescription drug coverage through a stand-alone Part D plan. She takes medication to control her blood pressure. She has tried many different medications, but only one particular drug has been able to stabilize her blood pressure without any serious side effects. Two months ago, she received a letter from her plan stating that next year her medication would be moved to a higher tier of her plan’s formulary and would cost twice as much. The letter also mentioned another medication that she could take at a lower tier cost. However, it was a drug she had already tried and it was ineffective. Neither of the plan’s options would work for Ms. B.

**What to do:** Ms. B. spoke to her pharmacist to see if she had any ideas about how she could get her medication at a price she could afford. The pharmacist suggested that she ask her plan for something called a “tiering exception.” This is when the patient and doctor ask the plan to provide the medication at the lower cost tier level.

Ms. B. had her doctor write a letter in support of her request and explained why she needed to take that specific medication and not another medication.

Ms. B. heard back from the plan a few days later and they denied her request. She then decided to continue to appeal the plan’s decision by asking for redetermination. The plan denied her again at the redetermination level, and she continued her appeal to Maximus, the Independent Review Entity. Maximus decided to grant Ms. B. a tiering exception. Ms. B. will be able to continue to get her drug at the lower cost price for next year.
actuarially equivalent benefit. Each year, CMS creates guidelines that set cost-sharing for the standard benefit in Part D plans. This includes the annual deductible (which is $310 in 2010), a 25 percent cost-sharing structure during the initial coverage period, and then a zero percent cost-sharing structure during the coverage gap. The coverage gap is when the beneficiary pays 100 percent of the cost of their prescription drugs. The coverage gap is followed by a period called catastrophic coverage, where beneficiaries’ drug costs drop significantly.

Part D sponsors can also offer “alternative” Part D plans that provide coverage equal (“actuarially equivalent”) to the value of the standard benefit. Alternative plans cannot impose a higher deductible or higher catastrophic limit than the standard benefit, but they can vary cost-sharing amounts in most other ways. Finally, plans can offer alternative enhanced coverage that is greater than the standard benefit. Plans can increase the value of the standard benefit in several ways, including providing coverage of excluded Part D drugs, coverage during the coverage gap, and a reduction in cost-sharing during the initial coverage period.

Most plans decide to use alternative coverage that is actuarially equivalent to the standard benefit. They do so by setting up a tiered copayment system. For example, they might charge $5 for generic drugs, $40 for a higher-tiered drug, and then 60 percent of the negotiated price for specialty drugs. As long as this tiered structure is actuarially equivalent to the standard Part D plan, this is in accordance with Medicare requirements. The calculations can be quite complex, but it all must equal out in order to pass Medicare’s test of actuarial equivalence.

For patients, this method of using actuarial equivalence is why one plan may be much more cost-effective than another. A patient may primarily use drugs that have been placed in a lower cost tier by one plan and not another. Pharmacists can help their patients understand what their actual out-of-pocket costs will be.

**COVERAGE GAP**

Currently, one of the most challenging aspects of Part D for consumers is the coverage gap, also known as the “doughnut hole.” This is the point at which a drug plan stops sharing any costs and the beneficiary is responsible for paying 100 percent of all prescription drug costs. The gap typically begins when a patient’s total drug spend reaches $2,830 (in 2010). This figure includes both what the beneficiary has paid and what the plan has paid. To get out of the coverage gap, the beneficiary must spend a total of $4,550 on prescription drugs. This does not include any payments to the plan such as premiums.

However, most beneficiaries who enter the coverage gap never make it out, and the costs can be overwhelming to many seniors. Recent health care reform took this issue into account. The Patient Protection and Affordable Care Act, which was signed into law in March 2010, will gradually reduce the burden the coverage gap puts on beneficiaries. Below is a timeline showing how the coverage gap will be phased out over the next decade:

1. In 2010, any Medicare beneficiary who enters the doughnut hole and does not have will receive a one-time $250 rebate check from the government.
2. In 2011, those who enter the doughnut hole will pay 50 percent coinsurance for brand-name drugs from pharmaceutical manufacturers and a 93 percent coinsurance for generic drugs through a government subsidy.
3. Starting in 2013, the coinsurance for brand-name and generic drugs will steadily decrease until 2020, when the beneficiary will be paying only 25 percent coinsurance. That 25 percent is equivalent to what beneficiaries had been paying before they reached the coverage gap.

**HELP PAYING DRUG COSTS**

If beneficiaries find themselves struggling to meet Part D costs, there are several government programs that can offer assistance. These programs are available to those who qualify based on income and asset eligibility guidelines. Extra Help is a federal program that helps beneficiaries pay for some or most of the costs of Medicare prescription drug coverage. Beneficiaries can apply for the Extra Help program through the Social Security Administration or their local Medicaid office.
As mentioned earlier in this article, Medicaid is a federal and state program that covers medical care for certain populations with low income. Medicare beneficiaries who also qualify for Medicaid are known as “dual-eligibles” because they are receiving benefits from both Medicare and Medicaid. Medicaid offers additional drug coverage, including the coverage of certain excluded drugs in some states and other drugs not included on the beneficiary’s Part D formulary. Medicaid enrollees are automatically enrolled in Extra Help and assigned to a Part D plan if they have not already chosen one themselves.

State pharmaceutical assistance programs (SPAPs) are offered in some states to help pay for prescriptions for those with limited incomes. Most SPAPs have income guidelines but do not consider assets. SPAPs have different benefit designs but many pay the Medicare drug coverage premiums. Some SPAPs may also cover Medicare cost-sharing in the coverage gap, and drugs that are excluded from Medicare drug coverage or are not included in a beneficiary’s Medicare drug plan’s formulary.

Patient assistance programs (PAPs) offer free or low-cost drugs directly from the company that manufactures them. Many companies have their own programs. In most cases, a patient’s doctor must apply on the patient’s behalf. While many patient assistance programs do not allow beneficiaries to apply if they are eligible for the Medicare drug benefit (Part D), some do.

There are additional programs for beneficiaries with limited incomes, including Medicare savings programs that help pay Medicare’s costs. People can apply for these programs through their state Medicaid programs. Charity programs such as NeedyMeds (www.needymeds.org) and medical low-cost clinics often offer drugs on a sliding scale to those who qualify. Some states also have prescription drug discount card programs.

HOW TO HELP YOUR MEDICARE PATIENTS
As can be seen from this article, there are many reasons that patients could have difficulty fully understanding their Medicare drug benefits. Not only are there many drug plans a patient can choose from, those plans can vary in regard to which exact drugs they cover and how much they charge for them. This variation is true even though they all adhere to a standard coverage requirement.

Plans can also make midyear and annual changes to the drugs that are on their formulary. This can mean that a patient may suddenly find that a drug they use is no longer going to be available to them or is going to cost more. In this case, there is always the danger that patients may go through a period of not having their medication available, or stop using it altogether, because they don’t know how to respond to this change.

There are many ways a pharmacist can help patients with Medicare drug plans get the most out of their benefits. Five important ways that a pharmacist can help are:

1. Informing patients about the Medicare Plan Finder on the Medicare.gov website (www.medicare.gov/find-a-plan/questions/home.aspx). This plan finder is a valuable resource to patients who are just starting to look for a plan or considering changing plans. It can help patients find the plan that fits best with the specific drugs they use in terms of availability and overall costs.

2. Printing out a list of the drugs that the patient currently uses. This list is very important for patients to have before they use the Medicare Plan Finder website.

3. Clearly explaining to patients why they might not be able to immediately get the drug their doctor prescribed and what steps they need to take to receive it. This explanation would address prior authorization and step therapy, as well as the right to file an exception as described in the article. A pharmacist can be especially helpful if a drug plan requires a prior authorization, by offering to contact the patient’s doctor and help start that authorization process.

4. Emphasizing to patients that they always have the right to appeal any denial by their drug plan. It is also important for them to understand that there are a number of different levels of appeal. This means that while an appeal may be denied at one level, it may succeed at another. Free packets of information that describe and help with the appeals process can be obtained by calling the Medicare Rights Center helpline at 800-333-4114.
5. Providing a copy of the resources box (below) to Medicare patients. This box includes the Web addresses for Medicare, Medicare Plan Finder, and Medicare Interactive. Medicare Interactive is a public website that provides a wealth of information on every aspect of Medicare.

**Medicare Resources**

- [www.needymeds.org](http://www.needymeds.org)
- [www.medicare.gov/find-a-plan/questions/home.aspx](http://www.medicare.gov/find-a-plan/questions/home.aspx)
- [www.medicare.gov](http://www.medicare.gov)
- [www.medicareinteractive.org](http://www.medicareinteractive.org)

Finally, pharmacists should use the Medicare Rights professional hotline if they have any questions about Part D drug benefits or anything related to Medicare. This is a free service and is unaffiliated with Medicare or any health plans. The professional hotline number is 877-794-3570.

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**CONTINUING EDUCATION QUIZ**

*Select the correct answer.*

1. Which types of drugs are excluded from Medicare drug coverage?
   a. Antidepressants
   b. Over-the-counter drugs
   c. HIV/AIDS drugs
   d. Anticonvulsants

2. Which of the following classes of drugs does Medicare exclude by law?
   a. Antidepressants
   b. Anticonvulsants
   c. Barbiturates
   d. Antipsychotics

3. COBRA is considered sufficient coverage that would allow a beneficiary to decline Part B.
   a. True
   b. False

4. When does Medicare cover drugs not approved by the FDA?
   a. Never
   b. Older drugs that never underwent FDA approval
   c. Drugs listed in one of the three Medicare-approved compendia
   d. Drugs approved outside of the United States

5. Which of the following is not a drug utilization management tool that can be used by drug plans?
   a. Step therapy
   b. Prior authorization
   c. Redetermination
   d. Quantity limits

6. If a plan substitutes a generic for a brand-name drug on their formulary, what notice do they have to give beneficiaries?
   a. 60-day notice by mail, or 60-day refill and notice at the pharmacy
   b. 30-day notice by mail and 30-day refill
   c. No notice and no refills
   d. 90-day notice by mail
7. What is the first step a patient should take when requesting a drug that is not on the plan’s formulary?
   a. Reconsideration
   b. Exception
   c. Redetermination
   d. Administrative law judge

8. Which vaccine does Part B always cover?
   a. Tetanus shot
   b. Shingles vaccine
   c. Pneumonia vaccine
   d. Meningitis vaccine

9. Mr. W. stepped on a nail and needs a tetanus shot. Which part of Medicare will cover his shot?
   a. Part A
   b. Part B
   c. Part C
   d. Part D

10. Part D covers all drugs and durable medical equipment (DME) received at a pharmacy.
    a. True
    b. False

11. The appeals process is the same whether a beneficiary is in a stand-alone Part D plan (PDP) or a Medicare Advantage Plan with drug coverage (MA-PD).
    a. True
    b. False

12. How long does a Part D plan (PDP) have to respond to a patient’s standard exception request?
    a. One week
    b. 72 hours
    c. 48 hours
    d. 24 hours

13. Where can beneficiaries apply for the Extra Help program to get assistance paying prescription drug costs?
    a. Social Security Administration or their local Medicaid office
    b. The pharmacy or 800-Medicare
    c. Their doctor’s office
    d. Their local hospital

14. Which drug-cost assistance program is offered from drug companies?
    a. Extra Help
    b. State pharmaceutical assistance programs (SPAPs)
    c. Pharmacy discount generic programs
    d. Patient assistance programs (PAPs)

15. Most people can change their Part D drug coverage at any time.
    a. True
    b. False

16. What is prior authorization?
    a. Asking a patient to try less expensive drugs before the plan will cover more expensive drugs
    b. Getting plan permission in advance before it will cover a specific prescription
    c. Allowing only a certain dosage of the prescription
    d. Allowing only a certain quantity of the prescription

17. Which is the last level of appeal that the drug plan itself can make a decision?
    a. Exception
    b. Redetermination
    c. Administrative law judge
    d. Medicare Appeals Council

18. What is the correct order of Medicare Part D coverage stages?
    a. Deductible period, initial coverage period, coverage gap, catastrophic coverage
    b. Initial coverage period, coverage gap, catastrophic coverage, deductible period
    c. Catastrophic coverage, initial coverage period, deductible period, coverage gap
    d. Initial coverage period, deductible period, coverage gap, catastrophic coverage
19. The Patient Protection and Affordable Care Act, which was signed into law in March 2010, will gradually reduce the burden the coverage gap puts on beneficiaries. Below is a correct statement excerpt from the timeline showing how the coverage gap will be phased out over the next decade:

a. In 2010, any Medicare beneficiary who enters the doughnut hole and does not have Extra Help will pay 50 percent coinsurance for brand-name drugs from pharmaceutical manufacturers and a 93 percent coinsurance for generic drugs through a government subsidy.

b. In 2010, any Medicare beneficiary who enters the doughnut hole and does not have Extra Help will receive a one-time $250 rebate check from the government.

c. In 2011, those who enter the doughnut hole will receive a one-time $250 rebate check from the government.

d. Starting in 2013, the coinsurance for brand-name and generic drugs will steadily decrease until 2020, when the beneficiary pay 50 percent coinsurance for brand-name drugs from pharmaceutical manufacturers and a 93 percent coinsurance for generic drugs through a government subsidy. That 25 percent is equivalent to what beneficiaries had usually been paying before they had reached the coverage gap.

20. Once out of the coverage gap, the beneficiary will move into what is called “catastrophic coverage,” and their drug costs drop significantly. Beneficiaries should expect to pay:

a. Only 5 percent of the cost of each covered drug, or a copay of $2.50 for generics and $6.30 for brand-name drugs, whichever is greater.

b. Only 5 percent of the cost of each covered drug, or a copay of $5 for generics and $12.60 for brand-name drugs, whichever is greater.

c. Only 10 percent of the cost of each covered drug, or a copay of $2.50 for generics and $6.30 for brand-name drugs, whichever is greater.

d. All of each covered drug, up to $150 for generics and $250 for brand-name drugs.

Medicare Part D: A Primer for Pharmacists
Sept. 1, 2010 (expires Sept. 1, 2013) • Activity Type: Knowledge-based

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Name

Pharmacy name

Address

City State ZIP

Phone number (store or home)

Store e-mail (if avail.) Date quiz taken

Quiz: Shade in your choice

1. ☐ ☐ ☐ ☐ ☐ ☐ 11. ☐ ☐ ☐ ☐ ☐
2. ☐ ☐ ☐ ☐ ☐ 12. ☐ ☐ ☐ ☐ ☐
3. ☐ ☐ ☐ ☐ ☐ 13. ☐ ☐ ☐ ☐ ☐
5. ☐ ☐ ☐ ☐ ☐ 15. ☐ ☐ ☐ ☐ ☐
6. ☐ ☐ ☐ ☐ ☐ 16. ☐ ☐ ☐ ☐ ☐
7. ☐ ☐ ☐ ☐ ☐ 17. ☐ ☐ ☐ ☐ ☐
8. ☐ ☐ ☐ ☐ ☐ 18. ☐ ☐ ☐ ☐ ☐
9. ☐ ☐ ☐ ☐ ☐ 19. ☐ ☐ ☐ ☐ ☐
10. ☐ ☐ ☐ ☐ ☐ 20. ☐ ☐ ☐ ☐ ☐

Quiz: Circle your choice

21. Is this program used to meet your mandatory C.E. requirements? a. yes b. no

22. Type of pharmacist: a. owner b. manager c. employee

23. Age group: a. 21–30 b. 31–40 c. 41–50 d. 51–60 e. Over 60

24. Did this article achieve its stated objectives? a. yes b. no

25. How much of this program can you apply in practice? a. all b. some c. very little d. none

How long did it take you to complete both the reading and the quiz? ______ minutes

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