



2017 MEDICARE PRESCRIPTION DRUG ANNUAL OPEN ENROLLMENT

The Annual Open Enrollment for Medicare prescription drug coverage (Part D) is October 15, 2016 – December 7, 2016 for coverage beginning January 1, 2017. Certain people with Medicare can also change plans at other times (see question #13). Plans make changes to benefits and costs, and there are also new plans in many areas of the country. In 2017, people who enter the coverage gap (“donut hole”) will pay 40% of the cost of brand-name drugs on their plan’s formulary while they are in the gap and 51% of the cost of generics on their formularies while they are in the gap. With these changes, your current plan may or may not be the best plan for you in 2017.

It is very important to use this time period to compare your plan choices and find the plan that best meets your prescription drug needs at the lowest cost. All plans will make changes in 2017.

On the next page are answers to some important questions that can help you during the Annual Open Enrollment.

1 Will my Medicare Part D plan be the same in 2017 as it was in 2016?

No. All Medicare Part D plans will change in 2017. Use this annual open enrollment time to compare plans and find the plan that best meets your prescription drug needs at a cost you can afford.

2 In what ways could my plan change?

Your current plan may have changed:

- the monthly premium
- the annual deductible
- your share of the costs (co-payment or coinsurance)
- the list of the drugs it covers (formulary)
- additional coverage, if any, it offers beyond the discounts in the coverage gap
- use of policies that may restrict access to certain drugs, such as:
 - requiring your doctor to justify why you need a certain drug before the plan will pay for it (called prior authorization)
 - requiring your doctor to prescribe a different drug in the same class of drugs first (called step therapy)
 - only letting you buy a certain amount of a drug at a time (called quantity limits).

Your plan may also decide not to participate in 2017. If you are one of the few people whose plan is not participating in 2017, your plan sent you a letter in October explaining that you will need to select a new plan. You

can pick a new plan between October 2016 and February 28, 2017 as part of the Special Enrollment Period.

3 How do I know what changes my plan is making in 2017?

You should have received a letter from your current plan called an “Annual Notice of Change/Evidence of Coverage” by September 30. This letter explains some of the important changes to your plan, including changes to the name of the plan, to the premium, the drugs covered (formulary), the cost of the drugs, and any restrictions used that limit the access to drugs. It is very important to read this letter as these changes can have a large impact on the cost of your drugs. If you did not receive the Annual Notice of Change/Evidence of Coverage letter, call your plan immediately.

While very important, this letter probably does not have all the details you need to determine if your current plan is the best plan for you in 2017. You also need to know how these changes apply to the drugs you use. You can find this information by looking on the plan’s website or in the Medicare Prescription Drug Plan Finder at www.medicare.gov or by calling the plan or 1-800-MEDICARE; (1-800-633-4227/TTY: 1-877-486-2048).

You may have received a summary of the formulary with the Annual Notice of Change/Evidence of Coverage letter. If you did not receive a copy of the formulary, call the plan and they will send you a copy or tell you if your drugs are covered. The phone

number for the plan’s customer service department is included in the letter you received. You may also get information about the formulary from the plan’s website, by using the Medicare Prescription Drug Plan Finder at www.medicare.gov, or by calling 1-800-MEDICARE (TTY: 1-877-486-2048).

4 Should I compare my plan with other plans available in my area?

Yes, this is very important to do. Other plans may provide you with better or less costly coverage for the drugs you need. Often the single most important factor in choosing a plan is comparing the drugs you take to the plan’s formulary. The lack of coverage for one drug for a chronic condition can be the most important factor in terms of what your drug costs will be. The best way to compare your current plan with other plans is to use the Medicare Plan Finder at <https://www.medicare.gov/find-a-plan/questions/home.aspx>.

The Plan Finder Tool will allow you to complete either a personalized or general search for drug coverage and estimated costs for plans in your area in 2017. In addition, the Plan Finder tool will allow you to compare coverage and costs with other plans in your area. Estimates are based on drug prices on the date you compare plans; your actual out-of-pocket costs may vary.

An important feature on the Plan Finder is an estimate of your total monthly costs over a 12-month period for each of the plans that you are considering. If you have entered the

drugs you take, this information appears in a chart near the bottom of each plan's *Drug Costs & Coverage* tab in a section titled Estimated Monthly Drug Costs.

5 What happens if a drug I take is not on a plan's formulary?

You must pay the **full** cost for any drug not on the formulary. **The money you pay for these drugs does not count toward the total amount that you must spend to qualify for catastrophic coverage.** That is why it is important to make sure that your drugs, especially the most expensive ones, are on the formulary of the plan you select. You, your authorized representative or your doctor can ask for a "coverage determination" (exception) to get your plan to cover a drug when it is not on the plan's formulary.

6 What is the "coverage gap"?

The coverage gap is also called the "donut hole." It is a period during which you have to pay a larger portion of the costs for your drugs and continue to pay your monthly premium to keep your coverage.

If you get Extra Help (Low-Income Subsidy) paying your drug costs, you won't have a coverage gap. However, you will have to pay a small co-payment or coinsurance amount for each prescription until you reach catastrophic coverage.

7 How does the coverage gap work?

The coverage gap begins after you and the plan together have spent a certain amount (no more than \$3,700) on drugs that are included on the plan's formulary and bought at a pharmacy in the plan's network.

The coverage gap ends after you, your plan and drug manufacturers together have spent \$8,071 in total drug costs paid. **Only money spent on drugs on the plan's formulary that are bought at a pharmacy in the plan's network counts toward the coverage gap totals.** After \$8,071 has been spent, you qualify for catastrophic coverage—at which time you will pay only your monthly premium and up to 5% of your drug costs. [See the chart on the next page for more details.]

* None of these amounts include what you spend on your monthly premiums.

8 Has the coverage gap changed?

Yes. In 2017, you will get a 60% discount on brand-name prescription drugs on your plan's formulary while you are in the coverage gap. You will get this discount at the time you buy the drugs. The costs of the discount are covered by the drug's manufacturer. Your plan will also cover 10% of the cost for brand-name drugs while you are in the coverage gap. You will be responsible for 40% of the cost. In 2017, all plans will also cover 49% of the cost of generic drugs on their formularies

during the coverage gap. These changes do not apply if you already receive Extra Help.

9 What does it mean if a plan offers "coverage in the gap"?

Some plans provide coverage in the coverage gap in addition to the 49% coverage for generic drugs and 50% discount /10% coverage for brand-name drugs. Plans with additional coverage in the gap may charge a higher monthly premium. Before enrolling in such a plan it is important to check with the plan to make certain the drugs you need are covered in the gap. *The Drug Costs & Coverage* tab on the *Your Plan Comparison* page on the Plan Finder will show your estimated monthly costs for each plan you are considering, how those costs will or will not change during the coverage gap, and by how much. Depending on your prescription drug needs, plans with additional coverage in the coverage gap may not save you money and may end up costing you more due to higher premiums and cost sharing.

10 What do I have to do if I decide that I want to stay in my current plan for 2017?

Nothing. You will stay enrolled in your current plan unless you sign up for a new plan.

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT

The amounts below do not include monthly premiums.

Beneficiary pays no
 more than 5%

CATASTROPHIC COVERAGE:

Plan pays: 15%
 Medicare pays: 80%

\$8,071 in total drug costs
 (\$4,950 out-of-pocket) costs

Beneficiary payment
 amount varies

\$4,950 COVERAGE GAP ("DONUT HOLE"):

Brands (50% discount)
Plan pays: 10%
 Beneficiary pays: 40%

Generics
Plan pays: 49%
 Beneficiary pays: 51%

Beneficiary pays
 25% or \$825

**INITIAL COVERAGE
 PERIOD:**
Plan pays: 75% or \$2,475

\$3,700 in total drug costs

Beneficiary pays
 100%, or \$400

\$400 Deductible

BASED ON: "Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage Gap," Kaiser Family Foundation, March 2010.
 2017 Medicare Part D Final Call Letter.

11 If I decide to change plans, how and when should I do it?

You can enroll in a new plan by contacting the plan you want to enroll in or by calling 1-800-MEDICARE (TTY: 1-877-486-2048) or by visiting www.medicare.gov.

You can change your plan for 2017 by enrolling in a new plan between October 15 and December 7, 2016. However, it is best to make the change as early as possible to ensure that you can get the prescriptions you need without delay on January 1, 2017. There is no fee for changing to a new plan. After enrolling in the new plan for 2017, you will be automatically unenrolled from your 2016 plan. You should not notify your 2016 plan of the change.

12 If I'm in a Medicare Advantage Plan, but am not happy with the health coverage, can I drop my Medicare Advantage Plan and return to Original Medicare by itself and add a drug plan?

Yes, you can switch plans during the Part D Annual Open Enrollment Period from October 15 through December 7, 2016. You can also switch plans during the Medicare Advantage Disenrollment Period from January 1 through February 14, 2017. During this period, you can only switch from your Medicare Advantage plan with drug

coverage to Original Medicare but you must also join a separate stand-alone drug plan if you want prescription drug coverage. The booklet Medicare & You 2017 has important information about Medigap protections for people switching from Medicare Advantage plans to Original Medicare.

13 What if I change prescription drug plans, but find that I don't like my new plan?

In general, you can only switch to another plan from October 15 to December 7 each year. However, there are a few special exceptions that allow you to change to a new plan during 2017, such as if you move out of the service area, lose your employer drug coverage, enter or leave a nursing facility, or if you qualify for Extra Help. That is why it is so important to review your options before enrolling. There is also a special enrollment period for plans that receive the highest possible quality rating from CMS.

14 What is the special enrollment period for "5-star" plans?

CMS rates plans for quality using a stars system. The best possible score is 5 stars. In October 2016, CMS will release a list of 5-star prescription drug plans and Medicare Advantage plans for 2017. The Medicare Plan Finder includes the "Overall Plan Rating" in the

listing for each plan. You can sort the plans in your area based on "Overall Plan Rating" to easily find those with a 5-star rating.

Under the special enrollment period for 5-star Medicare Advantage and stand-alone prescription drug plans you can switch into a 5-star plan at any time during the plan year. This enrollment period will start on December 8, 2016, after the open enrollment period ends. You can make this change only once during the plan year.

Very few plans receive the 5-star rating and there may not be a 5-star plan in your area. The 5-star plans in your area may not be the best options for you in terms of cost, network providers and coverage. You should compare the 5-star plans to your current plan to make sure that you have the same coverage and access to your doctors and other health providers before making the switch to a new plan.

15 If I previously qualified for Extra Help (Low-Income Subsidy), do I qualify in 2017?

Some plans provide coverage in the coverage gap in addition to the 49% coverage for generic drugs and 60% discount coverage for brand-name drugs. Plans with additional coverage in the gap may charge a higher monthly premium. Before enrolling in such a plan it is important to check with the plan to make certain the drugs you need are covered in the gap. *The Drug Costs & Coverage* tab on the *Your Plan Comparison* page on the

Plan Finder will show your drug coverage. The 2017 Federal Poverty Level guidelines determine the income level requirements for people applying for extra help. If you are below 150% of FPL (\$17,820) and have resources below \$13,640 as an individual or if you are married and your household income is below 150% FPL (\$24,030) and have resources below \$27,250, you might qualify for extra help. If you applied and qualified for Extra Help at any time and are receiving Extra Help now, Social Security may have contacted you to review your eligibility status for 2017. In late August 2016, Social Security mailed letters to people who were selected for review and included a form to complete called “*Social Security Administration Review of Your Eligibility for Extra Help*” (Form SSA-1026). You had 30 days to complete and return this form. Any changes in the amount of Extra Help you will receive will be effective in January 2017.

If you qualified for Extra Help in 2016, but were not selected for a review, you will not receive a form from Social Security and there should be no change in the amount of Extra Help you receive. If you are unsure of your Extra Help status, call 1-800-MEDICARE (TTY: 1-877-486-2048).

If you have been notified by Social Security that you are no longer eligible for Extra Help in 2017, you will still be enrolled in your plan. After January 1, 2017, you will have to pay monthly premiums and your share of the drug costs. However, during a one-time Special Open Enrollment period, you can change Part D plans between January 1 and March 31, 2017. This will be

an important opportunity for you to change to a new plan if you find that your existing plan is not your best option.

16 If I automatically qualified for Extra Help in 2016, will I qualify in 2017?

Your current plan may have changed if you:

- Receive both Medicare and Medicaid
- Have your Medicare Part B premiums paid by your state because you belong to a Medicare Savings Program
- Receive both Medicare and Supplemental Security Income (SSI).

Medicare beneficiaries who automatically qualified in 2016, but who will not automatically qualify in 2017, should have received a notice on grey paper from Medicare [CMS Publication No. 11198] in September 2016.

The notice explains why you no longer automatically qualify and will encourage you to complete an enclosed Social Security application for Extra Help as soon as possible. The application for Extra Help should be returned to Social Security in the postage-paid envelope provided.

17 Have the rules for Extra Help changed?

Yes. Starting in 2010, Social Security no longer counted life insurance you have as

a resource when deciding if you qualify for Extra Help. They also no longer count help you receive from others with your household expenses to decide if you get Extra Help.

You should know though that some states may still count life insurance and the help you receive from others to decide if you are eligible for your state’s Medicare Savings Program (MSP). These programs can help pay for your Medicare Part B premiums and other Medicare costs. Call 1-800-772-1213 or visit www.socialsecurity.gov or www.benefitscheckup.org.

If you apply for Extra Help, Social Security will send the information to your state’s Medicaid agency to start the process for getting you into your state’s MSP. If you do not want your information to go to the state, there is a box you can check on the application for Extra Help.

18 If I received Extra Help in 2016 and qualify again in 2017, will my drug costs change?

Maybe. Your co-payment levels will increase or decrease if you have a change in your income or assets, or if you enter or leave a nursing facility or other institution.

If you continue to automatically qualify for Extra Help and your co-payment levels are changing in 2017, you should have received a letter on orange paper from Medicare [CMS Publication No. 11199] in October telling you your new co-payment amounts.

19 What if I did not join a Medicare Part D plan when I was first eligible, but I would like to join one now?

You can enroll in a plan during the Annual Open Enrollment. You may have to pay a premium penalty if you did not have coverage that is at least as good as Medicare's coverage ("creditable coverage") during the first/initial period that you were eligible to enroll. The penalty amount is calculated based on the number of months you were eligible but did not enroll. If you have to pay a premium penalty, most people will have to pay it for the rest of their life. The penalty will be added to your monthly Medicare private Part D plan premium.

If you qualify for Extra Help with your Medicare prescription drug coverage you can enroll anytime and pay no late enrollment penalty.

20 Can I get free help to make decisions about Medicare Part D plans?

Yes. Every state has a State Health Insurance Assistance Program (SHIP) that offers free one-on-one counseling and assistance to people with Medicare and their families. SHIP offices are located throughout each state. To find contact information for the SHIP office closest to your community visit www.shiptalk.org or call 1-800-MEDICARE (TTY: 1-877-486-2048).

ENROLLMENT PERIOD OVERVIEW AND OPTIONS

	OCTOBER 15 - DECEMBER 7, 2016		JANUARY 1 - FEBRUARY 14, 2017
	Part D*	Medicare Advantage (MA)*	Medicare Advantage (MA)*
If you have Medicare Part A OR Part B, but not both	Add, prescription drug coverage	Not available	Not available
If you have Medicare Part A AND Part B (i.e. "Original Medicare") and prescription drug coverage"	Maintain Original Medicare and maintain or change prescription drug plan	Join an MA plan with or without prescription drug coverage	Not available
If you have "Original Medicare and no prescription drug coverage"	Maintain Original Medicare and add prescription drug coverage	Join an MA plan with or without prescription drug coverage	Not available
If you have MA plan with Medicare prescription drug coverage	Switch to Original Medicare with the option of joining a prescription drug plan	Switch to another MA plan with or without prescription drug coverage	"Switch to Original Medicare and join a prescription drug plan"
If you have MA plan with no prescription drug coverage	Switch to Original Medicare with the option of joining a prescription drug plan	Switch to another MA plan with or without prescription drug coverage	"Switch to Original Medicare and join a prescription drug plan"

**Important Note: It is not advised to drop prescription drug coverage unless you can get other prescription drug coverage that is at least as good as Medicare's coverage (creditable coverage).*

ENROLLMENT PERIOD OVERVIEW AND OPTIONS FOR PEOPLE WITH EXTRA HELP

	OCTOBER 15 - DECEMBER 7, 2016	JANUARY 1 - MARCH 31, 2017
People who no longer qualify for Extra Help in 2017	Add, switch or drop a prescription drug plan or an MA plan or return to Original Medicare.	Add, switch or drop a prescription drug plan or join an MA plan during this special enrollment period for this group or return to Original Medicare.
People who qualify for Extra Help in 2017	Switch to another Medicare drug plan or an MA plan at any time as long as they continue to get Extra Help. Coverage will begin the first day of the month after you ask to join a plan.	

****Important Note:** It is not advised to drop prescription drug coverage unless you can get other prescription drug coverage that is at least as good as Medicare's coverage (creditable coverage).*

QUESTIONS YOU MAY HAVE AFTER ENROLLMENT

1 I enrolled in a Part D plan but I haven't heard anything. Is this normal?

No. You should have received a welcome letter and a prescription card from the plan. Contact the plan right away to confirm that you are enrolled.

2 I enrolled in a drug plan in December and got a letter welcoming me into the plan, but nothing else. I have nothing to show the pharmacist. How can I get prescriptions filled without a card?

Contact your plan immediately. If you need to get your prescription filled before your card arrives, bring the letter you received from the

plan that confirms you have enrolled with you to the pharmacy. If you don't have a letter, ask your pharmacist to call 1-800-MEDICARE (TTY: 1-877-486-2048). The customer service representative should be able to tell the pharmacist in which plan you are enrolled. If you continue to have problems, you should contact your local SHIP office. You can locate your local SHIP office by visiting www.shiptalk.org or by calling 1-800-MEDICARE (TTY: 1-877-486-2048).

3 Will my plan cover a drug that I need to take even if it is not on their formulary?

The plan must decide within 72 hours (or 24 hours for an expedited review) if they will cover the drug. If they decide not to cover the drug, they must send you a written notice. You also have a right to appeal their decision.

Note: If your drug is not on the formulary, but you are able to get it covered by the plan under the plan's exceptions process, the money you spend on the drug is counted toward qualifying for catastrophic coverage. [See question #6 in the previous section.]

4 I am having problems with my old Part D plan. I have enrolled in a new Part D plan but my old plan still deducts a premium. What should I do?

Report billing errors to 1-800-MEDICARE (TTY: 1-877-486-2048) as well as to the plan. Since your plan has not stopped billing you after you notified it of the error, you may wish to file a complaint (grievance). Ask the plan's customer service representative to send you a complaint form or tell you how to find one on the plan's website. You can also file a complaint (grievance) with Medicare by calling 1-800-MEDICARE.

MAPRx brings together beneficiary, family caregiver and health professional organizations committed to improving access to prescription medications and safeguarding the well-being of beneficiaries with chronic diseases and disabilities under Medicare Prescription Drug Coverage (Part D). This resource is co-sponsored by:



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ascp.com



arthritis.org



aafa.org



copdfoundation.org



epilepsy.com



gistawareness.org



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