

MEDICARE PART D PRESCRIPTION DRUG COVERAGE: WHAT GUARDIANS AND AGENTS NEED TO KNOW

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I. What Is Medicare Part D Prescription Drug Coverage?

A prescription drug coverage program called Medicare Part D is available to Medicare beneficiaries. The program started January 1, 2006, and is part of the federal law called the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

II. What Is The Role Of Guardians And Agents?

Guardians are responsible for making enrollment decisions about Medicare Part D prescription drug coverage for their wards. Because Medicare Part D involves health care and financial decision-making, both Guardians of the Person and Guardians of the Estate need to be involved in learning about Part D and in making the necessary decisions on behalf of their wards.

Similarly, financial agents under a Powers of Attorney for Finances should be prepared to make decisions about Medicare Part D if the principal is not capable of doing so. (Agents under a financial power of attorney are charged with making decisions regarding insurance and public benefits.)

Guardians and agents need to consider the following issues:

- A. Is the ward/principal eligible for Medicare Part D?
- B. Should the ward/principal enroll in Medicare Part D?
- C. When should the ward/principal enroll in Medicare Part D?
- D. Which prescription drug plan should the ward/principal enroll in?
- E. Is the ward/principal eligible for a low income subsidy?

****Every person enrolled in Medicare Part D should review plan options **annually** as new plans become available; and premiums, formularies, copays, and pharmacy networks for each plan can change each year.*



Guardians and agents should:

- A. Become knowledgeable about the program.
- B. Seek additional information and advice.
- C. Be on alert for, read and save mail they or their wards and principals receive about the program.
- D. Act as decision makers in a timely manner for the benefit of their wards and principals.

III. Who Is Eligible For Part D Benefits?

Anyone who is covered under either Medicare Part A or Part B is eligible for Medicare Part D.

IV. Who Will Provide Prescription Drug Coverage?

Part D drug coverage is available through private drug plans approved by the federal government. Drug plans are offered by insurance companies and health maintenance organizations (HMOs). Which drugs are covered, what the cost is for beneficiaries and what pharmacies are participating changes annually and varies from plan to plan. Comparative information is also available on the Medicare website at www.medicare.gov.

V. How Does A Medicare Beneficiary Signup For Part D Coverage?

Enrollment in a Part D plan occurs directly with the private Medicare Part D provider selected by the beneficiary (or by the guardian or agent acting on the beneficiary's behalf), rather than the federal government. Guardians and agents may need to provide documentation of their authority as decision makers for the beneficiary to the private Part D provider. Guardians should have available a copy of the "Letters of Guardianship" issued by the court. Agents should have available a copy of the Power of Attorney document and, if applicable, the activation certification. One may also wish to contact 1-800-MEDICARE.

VI. Is Part D Participation Mandatory?

Medicare Part D is technically a voluntary program. However, a Medicare beneficiary who does not enroll in a Part D plan when first eligible may have to pay a penalty if he or she enrolls in Medicare Part D later. But a Medicare beneficiary whose current prescription drug coverage (also called "creditable coverage") is as good as or better than Medicare Part D coverage may be able to enroll in Medicare Part D late without a penalty. Guardians and agents should retain all documents from the beneficiary's



current drug provider, particularly the “creditable coverage” notice. Examples of other coverage generally considered to be creditable include employer/retiree, VA/ CHAMPVA /Tricare, and SeniorCare.

VII. When Can Medicare Beneficiaries Enroll In A Part D Plan?

When a person first enrolls in Medicare, they have an “Initial Enrollment Period” to enroll in Part D. The initial enrollment period is three months prior to the month of their 65th birthday, the birthday month, and three months following the birthday month (for a total of seven months). If a person decides not to enroll during their initial enrollment period, they can still enroll in a Part D plan, but only during the “annual election period” (AEP). This period runs from October 15th to December 7th of every year and coverage begins January 1st. There are also some “Special Enrollment Periods” available for beneficiaries who move, lose other creditable drug coverage, become ineligible for “Extra Help,” etc.

VIII. When Can A Beneficiary Switch To A Different Part D Plan?

During the AEP (October 15 – December 7), a beneficiary will have a chance to review and switch plans for the upcoming year. Occasionally, individuals can switch plans mid-year if they qualify for a “Special Enrollment Period.” For example, if an individual moves to a new county, or moves into a nursing home, she or he can switch to a new plan. Additionally, individuals who are enrolled in both Medicaid and Medicare are permitted to switch plans on an ongoing, monthly basis.

IX. Which Drugs Will Be Covered By Medicare Part D Plans?

Which drugs are covered depends on the “formulary” of each prescription drug plan. A formulary is the list of drugs that a plan will cover and is often divided into cost-sharing levels or tiers. Formularies vary from plan to plan. Prescription drug plan providers are prohibited from covering certain drugs such as medications not approved by the FDA, medications prescribed for an off-label use, nonprescription drugs such as aspirin and nonprescription vitamins, and some prescription vitamins. Drugs used for weight loss, weight gain and anorexia, will also not be covered. To determine which drugs are covered by plans, review annual mailings, visit www.medicare.gov or contact the resources listed below. The best plan for each person will depend on the medications he or she takes and which pharmacy he or she uses.

X. Can A Part D Plan Provider Change Which Drugs Are Covered?

Yes. A provider can change the drugs on its formulary provided it does not remove drugs from the formulary or switch drugs to a higher cost tier from the beginning of the AEP through the first 60 days of the plan contract year. During the remainder of the year, certain drugs may be removed from the plan’s formulary or the tiered cost sharing status of drugs may be changed, but only if the drug coverage provider notifies the affected plan participants in writing or provides those affected by the change with a



60-day supply of the drug. Generally, formulary changes occur during the annual open enrollment period for the following year.

XI. What If A Drug Is Not Covered By A Plan?

When selecting a plan, guardians and agents will need to decide which available plan best meets the beneficiary's prescription drug needs. Unfortunately, there may not be an available plan that covers all the drugs that a beneficiary needs. Guardians and agents with the authority to make health care decisions should work with beneficiaries' physicians to determine if prescriptions can be changed to ones covered by the plan. If a beneficiary is prescribed a drug for which there is no coverage and there is no alternate drug available that would be covered, the beneficiary (or guardian or agent) can request that the plan make an exception and cover the necessary drug. Every plan will have a formal exception process that must be described in the documents provided to the beneficiary upon enrollment.

XII. Where Can a Person Purchase Medications After Enrolling?

Plan providers will establish pharmacy networks that will fill prescriptions for participants of the plan. Many plan providers have preferred pharmacy networks in addition to in-network pharmacies. The location of pharmacies is a factor in determining which plan to choose. If a beneficiary purchases drugs from a pharmacy outside of the plan network, the plan will not pay for that drug. It is important to make sure you understand the plan's network and pricing structure.

XIII. How Much Will Prescription Drugs Cost Under Part D?

It depends. Each plan will create its own cost structure within a framework established by the federal government. Cost is a factor in determining which plan to choose. Enhanced Part D plans have higher monthly premiums but may provide better coverage or lower co-pays.

If a beneficiary who is in Family Care and receiving nursing home levels of care or the beneficiary is in a nursing home with Part D coverage, there is no cost-sharing (i.e., no copayment or coinsurance) for prescription drugs. However, one will be responsible for the cost of non-prescription drugs and bubble packing costs.

XIV. Is There Assistance For Low Income Beneficiaries?

Yes. Some Medicare beneficiaries who have low income and few assets will receive assistance with out-of-pocket costs and premium and copay assistance. Some beneficiaries will receive assistance automatically without applying for it, while others will have to apply using a form provided by the Social Security Administration. Guardians and agents can fill out this form on behalf of their wards and



principals without providing documentation of their authority. The program is called “Extra Help” or “low-income subsidy” and it subsidizes drug costs throughout the donut hole as well.

XV. What If A Beneficiary Is Also Eligible For Medicaid?

Medicare beneficiaries who also receive coverage through Medicaid must receive drug coverage through Part D. If these individuals do not select a Part D plan, the federal government may automatically enroll them in a plan. Guardians and agents should make sure that this plan meets the beneficiary’s needs and, if necessary, change to a better plan. Medicaid eligible beneficiaries will also receive assistance with Part D out-of-pocket costs. (See above.) People on Medicaid that are eligible for Medicare will not receive any drug coverage unless also enrolled in a Part D Plan. Medicaid only wraps around Part D (not employer coverage).

XVI. What are some additional or annual requirements?

Every single person on Part D should review their part D plan annually during the annual enrollment period (October 15 - December 7). The plans change formulary and pricing each year. More than one half of people in Part D are not enrolled in the best plan for their needs and instead focus on name recognition. Revisiting the Part D plan annually is the easiest way to save money on out-of-pocket medical costs. People will save significant amounts of money by choosing plans better suited for their specific needs. Name recognition is the worst way to choose a Part D plan.

XVII. Who Can Guardians And Agents Contact For Assistance?

Medicare Part D is a complex program. Beneficiaries, guardians and agents are encouraged to seek additional information from a local benefit specialist or one of the statewide helplines listed here.

The Board on Aging and Long-Term Care Medicare Part D helpline (age 60+) **1-855-677-2783**

The Board on Aging and Long-Term Care Medigap helpline **1-800-242-1060**

The Disability Rights Wisconsin Medicare Part D helpline **1-800-926-4862**



QUESTIONS? Call the Wisconsin Guardianship Support Center at 1-855-409-9410 or email at guardian@gwaar.org.

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