1. Module 3: Medicare Part D Prescription Drug Coverage

2. Navigation Instructions

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4. Learning Objectives

- After reviewing "Part 3 - Medicare Part D Prescription Drug Coverage" you will be able to explain:
    - What Part D plans are
    - Who is eligible to enroll in a Part D plan
    - Part D standard and alternate benefits
    - Part D management tools, covered drugs, and formulary requirements
    - Part D True Out-of-Pocket (TrOOP) costs and help for beneficiaries with limited income
    - Late enrollment penalties and premiums

5. Training Roadmap: Module 3

- Medicare Part D Basics and Eligibility
- Covered Drugs
- Part D Standard and Alternative Benefits
- "True Out-of-Pocket" Costs (TrOOP)
- Part D Premiums and Late Enrollment Penalties
- Part D Drug Management Tools and Formulary Requirements
- Part D Enrollee Rights
- Part D Assistance Programs

6. Overview of Changes for 2023 and 2024

As part of the Inflation Reduction Act, Congress made several changes to the Part D program that will be further addressed in this training. Those changes include:

- Capping beneficiary cost sharing for covered insulin at $35 beginning in 2023
- Eliminating cost sharing for certain Part D covered adult vaccinations beginning in 2023
- Eliminating the 5% coinsurance requirement in the catastrophic coverage phase beginning in 2024
- Expanding eligibility for full low-income subsidies to beneficiaries with incomes up to 150% of the Federal poverty level beginning in 2023

The legislation also imposed certain requirements on drug manufacturers that may reduce the cost of Part D drugs.

7. Title Page- Part D Basics and Eligibility

8. Medicare Part D Prescription Drug Program Basics

- Medicare Part D covers certain prescription drugs, diabetic supplies, and vaccines.
- Coverage of Medicare Part D benefits is provided only through private companies. There is no fee-for-service Part D benefit.
- The types of Medicare plans that include Part D benefits are:
    - Stand-alone Prescription Drug Plans (PDPs)
    - Medicare Advantage-Prescription Drug (MA-PD) Plans:
        - MA-PDs are MA health plans that also cover Part D prescription drugs.
    - Cost-PD Plans
        - Cost-PDs are Medicare cost plans that cover Part D prescription drugs as an optional supplemental benefit.
    - Medicare-Medicaid Plans
    - PACE plans

9. Medicare Part D Eligibility

To be eligible for Part D, individuals must be:

- entitled to Part A **and/or** enrolled under Part B (not including enrollment Part B solely for coverage of immunosuppressive drugs); and
- a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination).

Individuals meeting the above criteria are generally eligible to obtain Part D benefits through any PDP offered in the area in which the individual permanently resides, depending on how they receive their Medicare benefits. PDPs must enroll any eligible beneficiary who applies regardless of health status.

- To obtain Part D benefits from other types of Medicare health plans, such as an MA-PD, Medicare-Medicaid Plan, or PACE Plan, the individual will have to meet the additional eligibility criteria for those plans. For example, to enroll in an MA-PD, individuals must be both entitled to Part A and enrolled in Part B.

10. Medicare Part D Prescription Drug Eligibility

Individuals' eligibility to enroll in a stand-alone PDP also depends on how they receive their medical benefits.

- Generally, only beneficiaries enrolled in Original Medicare, an MA MSA, a PFFS plan or a Cost plan may enroll in a standalone PDP to receive Part D benefits.
  - Beneficiaries enrolled in a MA MSA may only obtain Part D benefits through a standalone PDP.
  - Beneficiaries enrolled in a Cost plan or MA PFFS plan may obtain Part D benefits through their plan (if offered) or through a standalone PDP.
- Beneficiaries enrolled in a MA HMO or PPO may only obtain Part D benefits through their HMO or PPO plan.
  - In some cases, employer group plan enrollees may have additional choices.
- Individuals enrolled in a Medicare-Medicaid Plan or PACE plan may only receive their part D benefits through their plan.

11. Medicare Part D Eligibility: Examples

Ms. Singh just became eligible for Medicare. However, she is not eligible for premium-free Part A. She has chosen not to pay the premium to obtain Part A but will enroll in Part B. She asks her broker whether she can get coverage for her prescription drugs as well. Her broker correctly advises her that she is eligible to enroll in Part D and may choose among the free-standing PDPs available in the area in which she lives.

Mr. Page has Original Medicare and gets his Part D coverage through a standalone PDP. During the Annual Election Period, he wishes to enroll in an MA HMO. If Mr. Page chooses an MA HMO, he may no longer get his Part D benefits through a standalone PDP and must choose a plan through the HMO that includes Part D benefits (an MA-PD) if he wishes to maintain prescription drug coverage.

12. Title Page- Covered Drugs

13. Covered Part D Drugs

Part D plans cover:

- Prescription drugs
- Biologics
    - Biologics are drugs made of natural sources (human, animal, or microorganism) that are not chemically synthesized, examples include allergy shots and gene therapies.
- Insulin
- Medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze) or delivering insulin into the body (e.g., an inhalation chamber)
- Vaccines not covered by Part B

14. Drugs Excluded from Part D Coverage

The following are excluded from the definition of a Part D covered drug:

- Drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
- Vitamins- Prescription vitamins and minerals with the exceptions of prenatal vitamins and fluoride preparations for certain uncommon Vitamin D analogs (Vitamins D2 and D3 are excluded from Part D coverage).
- Medical foods formulated to be consumed or administered enterally under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act
- Erectile dysfunction drugs (when used for sexual dysfunction)
- Non-prescription drugs
- Some off-label use drugs
- Drugs covered under Part A and B (even if an individual does not have such coverage)

Part D plans are permitted to offer supplemental benefits that cover drugs that otherwise meet the definition of a Part D prescription drug but are explicitly excluded from coverage, such as certain prescribed weight loss drugs.

15. Formularies

- Part D plans generally do not cover all drugs available in each category of Part D covered drugs because in some cases several similar drugs are available to treat the same medical condition.
- Part D plans include the Part D drugs they will cover on a list known as a “formulary.”
    - Formularies are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
    - At least two drugs in each therapeutic category.
    - Generic and brand-name drugs.

16. Tiering

A common feature of Part D benefit structures and formularies is cost sharing tiers.

- Tiered cost sharing means grouping Part D drugs into different cost-sharing levels within a Part D sponsor's formulary. Many plans group drugs into 3 or 4 tiers with lower tiers requiring less beneficiary cost-sharing than higher tiers, for example:
    - Tier 1: Generic drugs
    - Tier 2: Preferred brand-name drugs
    - Tier 3: Non-preferred brand-name drugs
    - Tier 4: High-cost drugs or "specialty drugs"
- Thus, in evaluating whether a Part D plan should be recommended to a beneficiary, it is important to confirm not only that the beneficiary's drugs are on the formulary, but to also evaluate which cost sharing tier the drugs fall into.

17. Title Page- Part D Standard and Alternative Benefits

18. Part D Plan Benefits

- All Part D plans must cover at least the Part D standard benefit or meet the requirements for "alternative benefits."
    - Benefit structures that are not standard but instead are actuarially equivalent, are known as "alternative" coverage.
- The standard benefit structure includes several coverage "phases" including:
    - a deductible
    - an initial coverage phase between the deductible and the initial coverage limit
    - A "coverage gap" phase between the initial coverage limit and the out-of-pocket threshold (this phase also used to be called the donut hole)
    - a catastrophic coverage phase that applies after the beneficiary reaches the annual out-of-pocket threshold

19. Part D Benefits: Alternative Coverage

- Alternative coverage is prescription drug coverage that is not standard coverage but is at least actuarially equivalent to standard drug coverage.
- Actuarial equivalent means that the value of Part D benefits must be at least the same as the standard coverage. Alternative coverage must also:
    - not have an annual deductible that exceeds the annual deductible under the standard benefit; and
    - impose cost-sharing no greater than the standard benefit once the annual out-of-pocket threshold is met.
- Alternative benefits may also be structured with some or all of the coverage phases that are part of standard benefits.
- Some Part D plans may offer enhanced coverage for an additional monthly premium (known as enhanced alternative benefits).

- Coverage enhancements may include, for example, a reduction of the deductible; coverage of excluded drugs and/or a decrease in the beneficiary coinsurance amounts.

20. Standard Part D Benefits for 2024

For 2024, the standard benefit requires the beneficiary to pay:

- a $545 deductible
- 25% of prescription drug costs during the initial coverage phase – that is, between the deductible and initial coverage limit of $5030 or the actuarial equivalent to an average expected coinsurance of no more than 25 percent of actual cost during the initial coverage phase.
- 25% of the cost of generic drugs and 25% of the undiscounted costs of brand name drugs during the "Coverage Gap" phase –
    - Note that, from a beneficiary perspective, there is no longer a "gap." However, spending after the initial coverage limit during the so-called coverage gap phase remains relevant, because, during this period of drug spending, drug manufacturers are responsible for 70 percent of the cost of the drug (known as the manufacturer discount). This 70 percent is attributed to beneficiary out-of-pocket costs and counts toward the spending necessary to reach the catastrophic coverage phase even though beneficiaries do not pay it.

21. Part D Standard Benefits for 2024, Catastrophic Coverage

Once beneficiary out-of-pocket costs (including the 70 percent drug manufacturer discounts) reach a total of $8,000, the beneficiary is through the "coverage gap" and reaches catastrophic coverage.

- The out-of-pocket costs that count toward reaching the catastrophic limit are known as "true out-of-pocket" costs or TrOOP. In some instances, amounts not directly paid by the beneficiary, including the manufacturer discounts, count toward TrOOP.

After reaching the annual out-of-pocket threshold, the beneficiary pays nothing.

22. Part D Plan Benefits: The Standard Benefit Plan for 2024 (Illustrated)

Medicare Module 3 – Part D Standard Benefit Enrollee Cost Sharing

Catastrophic Coverage Enrollee pays $0
$8000 (out of-pocket threshold)
Coverage "Gap" * Enrollee pays 25% of prescription drug costs for generic and 25% of undiscounted cost for brand name
$5030 total drug costs (Initial coverage limit)
Initial Coverage Enrollee Pays 25% of prescription drug costs
$545 (deductible)
Deductible Enrollee pays 100%

* In the coverage gap, as previously noted, drug manufacturers pay 70 percent of the cost of brand name drugs through a discount. Although not paid by the enrollee, the discounted amount for brand name drugs counts toward the enrollee's annual out-of-pocket threshold. But the enrollee cost-sharing for brand name drugs is based on the undiscounted cost.

23. Applicable Measures to Determine Coverage Phases

It is important to note that there are different financial measures to determine when a new coverage phase is met.

- Progression through the deductible and initial coverage phase is determined by is based on total gross covered prescription drug costs, which refers to spending on covered Part D drugs by beneficiaries or on their behalf by any third party as well as the Part D sponsor.
- Progression through the coverage gap is determined by accumulated true out-of-pocket cost (TrOOP) spending, as explained in subsequent slides.

24. Special Cost Sharing for Insulin and Vaccines

Beginning in 2023 –

- There is no cost sharing for Part D adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), even in the deductible phase. This includes, but is not limited to vaccines for:
    - Shingles vaccines
    - Tdap vaccines (tetanus, diphtheria, and pertussis/whooping cough)
    - Hepatitis A
- The cost-sharing for a one-month supply of a covered insulin product cannot be more than $35 in any coverage phase.

25. Examples – Beneficiary Costs

Example 1

Mr. James is enrolled in a PDP with no monthly premium and a standard benefit structure. He takes multiple maintenance prescription drugs that are on the plan formulary with a total cost of $6400 annually. On an annual basis, Mr. James will pay $2008.75 for his drugs ($6400 (total drug cost) - $545 (deductible) = $5855 x .25 (initial coverage cost sharing and coverage gap percentage) = $1463.75 + $545 (deductible) = $2008.75

Example 2

Mr. Bingham is enrolled in a PDP with a $500 deductible and no premium. His only anticipated need is his monthly supply of insulin and diabetic supplies. During the deductible phase, Mr. Bingham will pay no more than $35 a month for his insulin and the full cost of his diabetic supplies until his out-of-pocket reaches $500. After the deductible is met, Mr. Bingham will pay his applicable copayment for insulin (which can be no more than $35) and his applicable copayment for his diabetic supplies.

26. Title Page- True Out-of-Pocket Costs (TrOOP)

27. "True Out-of-Pocket" Costs (TrOOP): What Counts?

Part D True Out-of-Pocket costs or "TrOOP" are out-of-pocket costs that count towards the annual out-of-pocket threshold to move into the catastrophic coverage phase.

- TrOOP is calculated on an annual basis.
- Generally, TrOOP includes beneficiary payments for Part D prescription drugs, including:
    - The annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold.
- After the initial coverage period, a drug manufacturer's discount for brand name drugs counts toward the true out-of-pocket costs.

- Generally, for drug costs to count toward TrOOP, drugs must be on the plan's formulary and be purchased at the Part D plan's participating network pharmacy.
- Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service also count toward TrOOP.
- Amounts paid by or through qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, health savings accounts, flexible spending accounts, and medical savings accounts also count toward TrOOP.

28. "True Out-of-Pocket" Costs (TrOOP): What is Excluded?

Some costs do not count toward TrOOP costs including:

- costs for drugs not on a Part D plan's formulary, unless the beneficiary requests and receives a formulary exception under which the plan covers the drug
- costs for over-the-counter (OTC) and other non-Part D drugs
- costs for covered Part D drugs obtained out-of-network (unless the plan's out-of-network coverage policy applies)
- costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs, or another third party including:
  Medicaid, State Children's Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements (HRAs); or
- costs for drugs purchased outside the United States.

29. Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Example 1: Mr. Reynolds takes blood pressure medication. He requested a formulary exception, which was denied by his plan. He decided to continue taking the non-formulary prescription and pay for it out-of-pocket. The amounts Mr. Reynolds pays for the drug do not count toward his deductible or other out-of-pocket costs.

Example 2: Ms. Howard has terrible seasonal allergies. To address her allergies, she takes a prescription drug that is on the formulary and supplements it with over-the-counter drugs to address specific symptoms, such as a runny nose. Only the amount that Ms. Howard pays for her prescription allergy medication counts toward her true out-of-pocket costs. Her costs for over-the-counter drugs do not count toward TrOOP.

30. Part D Pharmacy Networks

- Part D coverage is generally provided through contracted pharmacies (network pharmacies) in the Part D plan's service area, except that PFFS plans are not required to use a pharmacy network but may voluntarily choose to have one.
- Network pharmacies include retail pharmacies, long term care pharmacies, and may also include mail-order pharmacies.

- Within their networks, Part D plans may designate some pharmacies as preferred pharmacies that offer lower levels of cost-sharing ("preferred cost-sharing") than apply at other network pharmacies ("standard cost-sharing").
- Enrollees are generally required to fill prescriptions for covered drugs at network pharmacies.
- Under certain circumstances, enrollees may fill prescriptions for covered drugs at out-of-network (non-network) pharmacies, but possibly at a higher cost to enrollees. For example:
    - If the enrollee has an illness or loses a drug while traveling outside the service area; or
    - If circumstances result in limited drug access through an in-network pharmacy.

31. Title Page - Part D Premiums and Late Enrollment Penalties

32. Part D Premiums

- Part D plans may charge a premium.
    - Typically, a higher premium means lower out-of-pocket costs for the plan.
- Part D enrollees have three options for paying their Part D premium.
    - An automatic electronic monthly mechanism, such as withdrawal from their checking or savings bank account or automatic charge against their credit or debit card.
    - Direct monthly billing from the plan.
    - Automatic deduction from their monthly Social Security Administration (SSA) benefit check.
        - Typically, it takes 2-3 months for SSA withholding to begin or end.
        - When withholding begins, it will be for the 2-3 months of premiums owed.
- Generally, the beneficiary must stay with the premium payment option they choose for the entire year.
- If an enrollee does not choose an option, the beneficiary will be billed by the Part D plan monthly.

33. Part D Late Enrollment Penalty

- Beneficiaries may have to pay a monthly premium penalty to join a Part D plan if:
    - they do not have creditable drug coverage and do not enroll when first eligible for Part D.
    - there have been at least 63 continuous days following a beneficiary's initial enrollment period for Part D during which the beneficiary did not have either Part D or other creditable drug coverage.
- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.
- In general, the penalty is in effect for as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty.

34. Late Enrollment Penalty Examples

Mr. Russell first became eligible for Part D on December 1, 2021. He did not sign up and has not had creditable drug coverage. Mr. Russell wishes to obtain drug coverage during the Annual Election Period to be effective on January 1, 2023. He is not LIS eligible. Mr. Russell will have to pay a penalty of 13% of the national average beneficiary premium (1% for every month he did not have creditable drug coverage after becoming eligible) for every month that he stays covered under Part D.

Ms. Smith lost the creditable drug coverage that her employer provided when she retired. Ms. Smith signed up for Part D with an effective date of 60 days after the date she lost her coverage. Ms. Smith will not be subject to a late enrollment penalty.

35. Title Page – Part D Drug Management Tools and Formulary Requirements

36. Part D Drug Management Tools

In addition to formularies and cost sharing tiers, Part D plans use a variety of prescription drug benefit management tools including:

- Step therapy: One or more similar lower-cost drugs must be tried before other costlier drugs are covered, if necessary.
- Prior authorization: Requires the doctor to contact the plan and request authorization before the plan will cover the prescription drug. The doctor must show the plan that the drug is medically necessary for it to be covered.
- Quantity limits: For safety and cost reasons, Part D sponsors may limit the amount of prescription drugs they cover over a certain time period.
- Substitution: Part D sponsors may substitute generic drugs for brand name drugs if the generic drugs have the same or lower cost-sharing and certain conditions are met.
- Comprehensive Addiction and Recovery Act (CARA) programs: Plans may impose certain limitations on the prescribers or pharmacies a beneficiary can use to manage utilization for beneficiaries who are at risk of misusing or abusing frequently abused drugs, such as opioids.

37. Transition Requirements

- Part D sponsors must provide coverage of at least a one-month fill (unless a lower amount was prescribed) of non-formulary drugs to the following individuals prescribed a non-formulary drug, including Part D drugs that are on a sponsor's formulary, but require prior authorization, step therapy, or are subject to a quantity limit that is not safety-based:
    - beneficiaries initially enrolling in Part D,
    - beneficiaries switching plans, and
    - current enrollees affected by formulary changes (other than allowable substitutes of a generic drug for a brand name drug)
    - current enrollees experiencing a level of care change, if the Part D sponsor is notified of the change before or at the time of the request for the fill

38. Transition Requirements, Continued

- Beneficiaries eligible for transition fills must receive coverage of at least a one-month fill (unless a lower amount was prescribed) of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.
- To the extent that a current enrollee in a long-term care setting is outside their 90-day transition period, the sponsor must still provide a one-month supply of nonformulary Part D drugs while an exception or prior authorization request is being processed.
- During the transition period:
    - the Part D plan does not apply prior authorization, non-safety-based quantity limits, or step therapy rules.
    - the enrollee and their physician can request an exception to the Part D plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

39. Title Page- Part D Enrollee Rights

40. Enrollee Rights: Requesting Coverage Determinations and Appealing Decisions

- Part D Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a determination of whether the plan will cover a drug (a coverage determination) or appeal a coverage decision.
    - Enrollees may appeal coverage determinations, decisions on exceptions, or requests concerning tiering or formularies.
- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

41. Enrollee Rights: Requesting Exceptions for Drugs

- Enrollees have the right to request coverage of a drug that is not on the Part D plan's formulary or to request exceptions from plan rules such as prior authorization, step therapy, or quantity limits. Such requests are known as formulary exception requests.
- Enrollees also have a right to request coverage of formulary drugs at a less costly formulary tier. This is known as a tiering exception.
- Exception requests must be accompanied by a supporting statement by a physician or other prescriber explaining why the exception is necessary.
- A standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary or tiering exception. A physician or other prescriber may also request a tiering or formulary exception.

42. Enrollee Rights: Filing Grievances

- Beneficiaries may also file complaints about their Part D plan or their pharmacies. These complaints are known as grievances.
- Grievances include complaints about issues such as pharmacy wait times, a plan's failure to mail a beneficiary requested material, or the length of hold time on the plan customer service line.
- Grievances do not include complaints about a Part D sponsor's refusal to cover a drug or approve an exception request. Beneficiaries must resolve such issues through the appeals process.

43. Title Page- Part D Assistance Programs

44. Help for Individuals with Limited Income and Limited Resources

If a beneficiary has limited income and resources, they may qualify for a low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. To qualify for the LIS in 2023:

- Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically as follows:
  - 48 states $21,870 (individual)/$29,580 (couple)
  - Alaska $27,315 (individual)/$36,960 (couple)
  - Hawaii $25,155 (individual)/$34,020 (couple)
- For 2023, beneficiaries' resources may not exceed $15,160(individual)/$30,240 (couple). These limits are increased by $1500 per person if the beneficiary notified the Social Security Administration that they expect to use some of their resources for burial expenses.
- Resource and income limits to qualify in 2024 will be released in the fall of 2023.

45. Individuals with Limited Income 2024 Low-Income Subsidy (LIS)

- For 2024, individuals who qualify for full LIS and are Full Benefit Dual Eligibles (FBDEs) with income at or below 100% of the Federal Poverty Level (FPL) and resources below the applicable threshold have a $0 deductible and cost-sharing of:
  - Maximum cost-sharing up to the out-of-pocket threshold of:
    - $1.55 for generic drugs
    - $4.60 for other drugs
- For 2024, individuals who qualify for full LIS and are FBDEs with (income over 100% of FPL and resources below the applicable threshold) have a $0 deductible and cost-sharing of:
  - Maximum cost-sharing up to the out-of-pocket threshold of:
    - $4.50 for generic drugs
    - $11.20 for other drugs

46. Individuals with Limited Income – LIS, continued

- For 2024, individuals who qualify for LIS but are not FBDEs have a $0 deductible and cost-sharing of:
    - Maximum cost-sharing up to the out-of-pocket threshold of:
        - $4.50 for generic drugs
        - $11.20 for other drugs

47. Other Help for Low-Income – Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low-income individuals in obtaining drugs at reduced or no costs.
- Some states have assistance programs designed specifically for their residents.
    - Some programs are "qualified" State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
    - Becoming familiar with your state's programs may allow you to help a beneficiary address cost-sharing for prescriptions.

48. Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply for the low-income subsidy (LIS) – also called extra help – through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
    - If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
    - They may also call SSA at 1-800-772-1213 (TTY users can call 1-800-325-0778) or apply online at https://secure.ssa.gov/i1020/start for help with Part D costs.
- After SSA or the State approves an application for extra help, it is effective on the first day of the month in which the individual applied.

49. Certain Individuals Automatically Qualify for Extra Help

Individuals automatically qualify for Extra Help if they have Medicare and meet any of these conditions:

- They have full Medicaid coverage
- They get help from their state Medicaid program paying their Part B premiums (in a Medicare Savings Program)
- They get Supplemental Security Income (SSI) benefits.

Medicare mails these individuals a purple letter to let them know they automatically qualify. They should keep this letter for their records. They do not need to apply for Extra Help if they get this letter.

50. Title Page-Part D and Other Coverage

51. Employer/Union Coverage of Drugs

- Employer or Union Coverage: Employers/unions will notify their employees of whether their non-Medicare prescription drug coverage is "creditable" (coverage that, on average, covers at least as much as Medicare's standard Part D covers) via an annual statement.
    - If coverage is creditable and the beneficiary keeps it, the beneficiary will not incur a premium penalty if later they lose or drop the employer coverage and join a Part D plan.
    - If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during their initial eligibility period to avoid the late enrollment penalty.
- If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, they can compare that coverage with available Part D plans to decide whether to enroll in Part D.

52. Employer Coverage of Drugs, continued

- The beneficiary should check with the employer or union benefits administrator before making changes to their employer/union coverage.
    - If a beneficiary drops employer/union prescription drug coverage, they may not be able to get it back and may also lose health coverage.
- There will be no late enrollment penalty if the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days.

53. Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don't choose a plan, Medicare will select one for them.

54. For Additional Information

Medicare's site on Part D prescription drug coverage for beneficiaries.
http://www.medicare.gov/part-d/index.html

Medicare's information site on Part D prescription drug coverage which includes plan premium information
https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin?redirect=/prescriptiondrugcovgenin/

Medicare & You Handbook
https://www.medicare.gov/medicare-and-you/medicare-and-you.html

Your Guide to Medicare Prescription Drug Coverage
https://es.medicare.gov/media/10416