Points to Consider When Using Plan Finder

The purpose of the Medicare Prescription Drug Plan Finder (plan finder) is to allow Medicare beneficiaries to select a cost effective prescription drug plan based upon the individual beneficiary's prescription drug needs or "drug basket," as well as on other benefits and qualities that are important to the beneficiary. Prices on the plan finder generally reflect what the beneficiary would expect to pay at the pharmacy. However, because drug prices can be updated on a daily basis and the plan finder is only updated on a biweekly basis, the beneficiary may see differences between the prices on the plan finder and those at the pharmacy. In addition, the plan finder does not reflect the detailed information that is available to the beneficiary from each Part D sponsor.

The following are important points to consider when using the plan finder:

Cost

One factor that should be considered in selecting a Medicare Prescription Drug plan is the estimated annual costs. Once a user enters his/her current prescription drugs the estimated annual cost will include the plan premium, any cost sharing for covered drugs, and full costs for any off-formulary drugs. The cost sharing takes into consideration the plan's benefit, the drug costs negotiated with the pharmacies in its network, and the pharmacy dispensing fee.

By default, the plans will appear in the order from the lowest annual cost to the highest annual cost at network retail pharmacies.

The annual cost will provide an "apples-to-apples" comparison of the cost for that "drug basket" for the plans based on many factors. There will be situations, for example, where a plan with off-formulary drugs may have a lower cost than a plan where all drugs are on the formulary. The annual cost accurately takes into consideration that the beneficiary would have to pay full cost for the off- formulary drugs and that those drugs would not count towards TrOOP.

> **Note:** Outside of the information presented on the plan finder, if the beneficiary is granted an exception by the plan, and the plan decides to cover the drug for this beneficiary, the cost of that drug would count towards TrOOP.

It is also important to look at the estimated costs distributed across 12 months to see the impact of the plan's benefit on the monthly costs that may be incurred by the beneficiary. The Total Monthly Cost Estimator (bar chart) is an excellent visual means to estimate the monthly costs across the 12 months. By clicking the "show explanation of these costs" button next to the bar chart, the plan finder will show the drug-by-drug monthly costs as computed by the plan finder.

New for this year, the "Your Personalized Plan List" page includes a column for the "Estimated Annual Costs Using Mail Order Pharmacy." This new feature permits users to sort plans from

the lowest to highest estimated annual costs using this field. This helps users see the potential cost savings by getting a 90-day supply through a mail order pharmacy. Also new for this year (and similar to the bar graph for retail pharmacies), a Total Monthly Cost Estimator for Mail Order Pharmacies has been added so that the user can see the drug-by-drug cost, based on the assumption that the drugs are filled once every 3 months.

Cost is, however, only one of the factors that should be considered when selecting a plan.

Benefit

The plan's benefits should also be considered. For example, does the plan have a deductible? Does it offer gap coverage? Does the plan offer drugs via a mail order benefit? The benefits should be examined in relation to the estimated annual cost. For example, on an annual basis, how much does adding gap coverage, or joining a $0 deductible plan add to the overall annual cost? In many cases, these additional benefits are available but may cost more. In some cases, depending on the individual drugs entered, these additional benefits may result in a lower overall annual cost. The beneficiary needs to consider the trade-offs and determine the benefit that is best for his/her situation. Even when a $0 deductible or gap coverage results in a higher estimated annual cost, he/she may decide to pay more on an annual basis in return for a more even distribution of the prescription drug costs across the year or in anticipation of other drugs that may be added during the year.

Formulary

The plan's formulary should be carefully reviewed. The drug coverage information section will include information as to whether each drug is on the formulary (by displaying tier status) or off-formulary. There are footnotes that include explanatory information (e.g., whether a drug is an excluded drug). The formulary information should also be considered in conjunction with the estimated annual cost. As stated above, the annual cost estimate includes the full cost of off-formulary drugs and the fact that they do not count towards TrOOP. It is possible to have a plan with off-formulary drugs that is lower cost than a plan where all drugs are covered. In selecting a plan, the beneficiary needs to consider the likelihood that he/she will have changes or additions to their "drug basket" during the year.

If a plan has off formulary drugs, the "lower my cost" section should be reviewed. The plan may, for example, not cover a certain brand drug because there is a lower cost therapeutic equivalent drug available on its formulary. If so, the beneficiary should consider whether he/she wants to discuss the lower cost therapeutic equivalent drug options with his/her doctor.

The drug restrictions information should also be reviewed. If a drug has prior authorization or step therapy restrictions, the beneficiary will need to work with the plan and his/her doctor to obtain an exception. For prior authorization information, the beneficiary can access the plan's website to identify the specific requirements for that plan. Many prior authorization requirements can be resolved at the point of sale and do not require any additional information from the physician. If the drug has a quantity limit restriction, the beneficiary should contact the plan for more details. If the beneficiary takes one pill per day and the drug has a 30 day/month quantity limit, the impact will be minimal (i.e., he/she may not be able to refill the prescription until a few days before running out of pills). If the individual currently takes 2 pills per day and the quantity limit is 30 pills per month, the beneficiary would need to work with the plan to get authorization for the higher quantity.

Plan Ratings

Starting November 13, plan ratings will be available. The beneficiary should look at the overall plan rating, as well as the individual ratings for customer service, member complaints, member experience, and drug pricing/patient safety. The plan's ratings should be considered in conjunction with the other factors above. For example, a plan may be low cost but have poor ratings for complaints about the plan's benefit and access to drugs. The beneficiary would need to consider how important the poor ratings are in his/her overall decision as to which plan best meets his/her needs.

Pharmacy Network

The plan's pharmacy network should also be taken into consideration. The beneficiary should ensure that the plan has a pharmacy in its network that he/she is willing to use. Plans may designate network pharmacies as "preferred" if cost-sharing is lower at these pharmacies. If the same cost-sharing is available at all network pharmacies, then no network pharmacies will be designated as "preferred". If the beneficiary wants to use a specific pharmacy, he/she should use the "change pharmacy selection" button to designate the pharmacy of choice. The estimated annual cost would then be computed specific to that pharmacy.

Other Tips

The "view important notes" link will provide information specific to this plan and should be reviewed. For example, there is an important note for plans that offer national in-network prescription drug coverage. This allows the beneficiary to fill prescriptions at in-network pharmacies that are outside of the plan's service area. That may be an important factor for beneficiaries who travel.

The "lower my cost" link should also be reviewed. This provides information on State Pharmacy Assistance Programs (SPAPs) where one exists in the state and manufacturer-sponsored Pharmacy Assistance Programs (PAPs) where there is a PAP available for one or more of the beneficiary's drugs. Note that the plan finder estimated costs do not consider the impact of a person's participation in a PAP or SPAP. We do, however, provide the eligibility criteria and contact information. It is also important to note that for PAPs, the cost of drugs covered by the PAP do not count towards TrOOP. Therefore, it may or may not save money for a person who would otherwise reach catastrophic coverage during the year.