Functional project background:

What is Part D?

Medicare Part D is a federal program administered through private insurance companies. These companies offer retail prescription drug coverage to Medicare beneficiaries. Prior to 2006, when the Medicare Part D began, tens of thousands of Medicare beneficiaries in America had little help with retail drug costs. They would often spend thousands of dollars each year paying for their medications out of pocket.

Beneficiaries can enroll in a standalone Part D drug plan that goes alongside their Original Medicare benefits, or they can choose a Part D drug plan that is built-in to a Part C Medicare Advantage plan.

What is Part D and how does it work?

Medicare Part D is simply insurance for your medication needs. You pay a monthly premium to an insurance carrier for your Part D plan. In return, you use the insurance carrier's network of pharmacies to purchase your prescription medications. Instead of paying full price, you will pay a copay or percentage of the drug's cost. The insurance company will pay the rest.

There are 4 stages to a Part D drug plan, as follows:

1. **Annual Deductible**

   Deductible is $435. Plans may charge the full Part D deductible, a partial deductible, or waive the deductible entirely. You will pay the network discounted price for your medications until your plan tallies that you have satisfied the deductible. After that, you enter initial coverage.

2. **Initial Coverage**

   During this stage of Part D drug coverage, you will pay a copay for your medications based on the drug formulary. Each drug plan will separate its medications into tiers. Each tiers has a copy amount that you will pay. For example, a plan might assign a $7 copay for a Tier 1 generic medication. Maybe a Tier 3 is a preferred brand name for a $40 copay, and so on. The insurance company tracks the spending by both you and the insurance company until you have together spent a total of $4020 in 2020.

3. **The Coverage Gap**

After you've reached the initial coverage limit for the year, you enter the coverage gap. During the gap, you will pay only 25% of the retail cost of your medications. (This is so much better than in 2006 when many people had to pay 100% of their drugs in the gap.) Your gap spending will continue until your total out of pocket drug costs have reached $6350 in 2020.

4. **Catastrophic Coverage**

After you've reached the end of the coverage gap, your plan will kick in to pay 95% of the costs of your formulary medications for the rest of the year. This feature in Part D drug plans helps you limit your potential spending if you have expensive medications.

Drug utilization rules that affect your Part D coverage

Medicare allows drug plan carriers to apply certain rules for safety reasons and also for cost containment. The most common utilization rules that you may run into are:

- **Quantity Limits** – a restriction on how much medication you can purchase at one time or upon each refill. If your doctor prescribes more than the quantity limit, then the insurance company will need him to file an exception form to explain why more is needed.
- **Prior Authorization** – a requirement that you or your doctor must obtain plan approval before allowing a pharmacy to dispense your medication. The insurance company may ask for proof that the prescription is medically necessary before they allow it. This usually affects medications that are expensive or very potent. The doctor must show why this specific medication is necessary for you and why alternative drugs might be harmful or ineffective.
- **Step Therapy** – the plan requires you to try less expensive alternative medications that treat the same condition before they will consider covering the prescribed medication. If the alternative medication works, both you and the insurance company save money. If it doesn't, your doctor to help you file a drug exception with your carrier to request coverage for the original medication prescribed. He will explain need to explain why you need the more expensive medication when less expensive alternatives are available. Often this requires that he show you have already tried less expensive alternatives that were not effective.

What is Part A, B,C,D

- **Part** A provides inpatient/hospital coverage.
- **Part B** provides outpatient/medical coverage.
- **Part C** offers an alternate way to receive your **Medicare** benefits (see below for more information).
- **Part D** provides prescription drug coverage.

Data

Cell suppression Policy:

Suppression policy sets minimum thresholds for the display of CMS data. The policy stipulates that no cell (e.g. admissions, discharges, patients, services, etc.) containing a value of 1 to 10 can be reported directly.

CMS standards for minimum cell sizes aim to protect the confidentiality of Medicare and Medicaid beneficiaries by avoiding the release of information that can be used to identify individual beneficiaries.

Example: Beneficiary age group (65+) has count is 6 ,It is easy to identify the person.