# MED D - 2025 Blue MedicareRx (NEJE) Negative Tier Change and Tier Cost Increases

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**Description:** This document provides information to assist a beneficiary who calls with Tier Change Questions.

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| General Information |

Medications can change formulary tiers throughout the year and from year to year. Medications can change tiers for a number of reasons, such as a new generic is available, clinical requirements, safety warnings and cheaper alternatives being available.

Beneficiaries should have received an Annual Notice of Changes (ANOC) in September. This is an important letter that explains changes to their plan for 2025. It shows their prior year’s benefits side by side with next year’s benefits so the beneficiary can easily see what’s changing. The changes could be new benefits, services that won’t be covered, or changes to what you’ll pay.

In addition, medication costs are always changing and this can impact a beneficiary’s plan cost/benefits. If there is an increase in drug costs, the beneficiary should discuss lower cost alternatives with their doctor. This may save them in annual out-of-pocket costs throughout the year.

For additional information on drug prices the beneficiary can visit go.medicare.gov/drugprices and click the “dashboards” link in the middle of the second note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that the plan benefits will determine exactly how much their drug costs may change.

Tier changes has also been a driver for complaints because beneficiaries do not understand why the tier changes occurred and/or and who made the decision to change the medication tier. Blue MedicareRx (NEJE) has a committee called P&T (Pharmacist and Therapeutics) consisting of medical directors and clinical pharmacists who review medications, making the decision.

In 2025, there have been changes in the copay structure for Value Plus, also Tier 2 medications are applied towards the deductible in 2025:

* The copay for a Tier 1 (Pref. Generic) medication decreased at Preferred Retail Pharmacy to $1 for a 30 day supply, $2 for a 60 day supply, and $4 for a 90 day supply. For Mail Order, it decreased to $ 1 for a 30 to 90 day supply. For Standard Retail, it decreased to $6 for a 30 day supply, $12 for a 60 day supply and $18 for a 90 day supply.
* The copay for a Tier 2 (Generic) medication decreased at Preferred Retail Pharmacy to $5 for a 30 day supply, $10 for a 60 day supply, and $15 for a 90 day supply. For Mail Order, it decreased to $5 for a 30 day supply and $10 for a 60 or 90 day supply. For Standard Retail, it decreased to $10 for a 30 day supply, $20 for a 60 day supply and $30 for a 90 day supply.
* The co-insurance for a Tier 3 (Non-Pref drugs) replaces the copay amounts 22% at Preferred Retail and Mail, and 25% at Standard Retail Network Pharmacies. The co-insurance for a Tier 4 (Non-Pref drugs) decreased at all network pharmacies to 35% for all day supply.

Refer to the below FAQs to assist with beneficiary questions.

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| FAQs |

Refer to the following:

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| **Question** | **Answer** |
| 1. Why is the beneficiary’s medication changing tiers for 2025 and who makes this decision? | * We update our formularies on a regular basis based on changes in the health care and prescription drug industries. * These changes can result in drugs being moved to a different tier. For example, a generic drug enters the market and is added to the formulary and the brand name version of this drug may move to a higher tier because there is a less expensive (generic) available. * We do a very comprehensive review our formularies every year to prepare for the upcoming plan year. We review changes in the health care and prescription drug industries. We also look at the number and types of drugs we have to treat various medical conditions. The end result is that some drugs are moved to a different tier. |
| 1. Why is the coverage of my medication changing? | * Our formulary changes year to year because:   + Drugs come on and off the market regularly   + Clinical requirements change   + Medical literature updates including new medical evidence, safety warning or clinical practice guideline updates   + Government guidance related to formulary requirements can be revised * This means that certain drugs that were included on the formulary in the current year may not be included in the subsequent year.   + Also, certain drugs may have a utilization management requirement added or removed.   + Additionally, drugs that were in a preferred cost sharing tier may move to a non-preferred cost sharing tier and vice versa. * With that said we have:   + Added some new drugs to the list and removed others.   + Added some new drugs that became available.   + Replaced some brand name drugs with new generic drugs.   + Replaced some expensive drugs with less costly drugs that have been shown to work just as well or better   + Removed edits that demonstrated low clinical value. |
| 1. Why are you removing drugs from the formulary? | * We update our formularies on a regular basis based on changes in the health care and prescription drug industries. * These changes may result in drugs being added to the formulary (Example: New drugs available to the market) or removed from the formulary (Example: Drugs removed from the market by the FDA due to safety concerns). * We do a very comprehensive review our formularies every year to prepare for the upcoming plan year. We review changes in the health care and prescription drug industries. We also look at the number and types of drugs we have to treat various medical conditions. We try to make sure we have the right mix of drugs on our formulary. The end result is that some drugs are removed from formulary while others are added. * We also make changes to our formulary on a monthly basis to keep current with package size changes, new generic drugs, etc. |
| 1. Was I notified of this Tier change? | Tier change letters were previously generalized, simply stating that a drug filled by the beneficiary in the past year is moving to a higher tier. Beneficiaries were instructed to check their formulary and call with questions. These Tier change letters were sent during the fall of 2024. |
| 1. I can’t afford the cost of my medication, now with this change. | Verify if the beneficiary has or may qualify for LIS.   * If the beneficiary doesn’t currently have LIS, refer to the appropriate document:   + **Compass process:** [Compass MED D - Low Income Subsidy (LIS) Informational Overview](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=93b72be9-06a0-4bd8-9177-7f2c41653f9e). * If the beneficiary wants to change or look at other plan options, transfer to an Enrollment Agent. Refer to [MED D - Guide to Transferring a Call](file:///C:/Users/C337799/Downloads/TSRC-PROD-029866). |

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