

## 10 Factors to Consider When Choosing a Medicare Drug Plan

Choosing a Medicare drug plan (Medicare Part D) requires evaluating more factors than just the cost of the monthly premium. In fact, a beneficiary may conclude that the plan with the cheapest monthly premium may not be the best value. Moreover, the experience with Medicare Advantage (private Medicare managed care plans) suggests that premiums will change in future years as plan sponsors abandon their least profitable plans.

The following checklist of factors to consider is based on a similar checklist developed by the Center for Medicare Advocacy. After you've reviewed the checklist, use our Medicare Drug Plan Comparison Worksheet to compare drug plans side by side. To access the Worksheet, click [here](#).

1. **Formulary:** The “formulary” is the roster of drugs the plan covers and will pay for. Does the plan include the particular prescription drugs that the beneficiary needs - or anticipates needing - and how much will they cost? Of course, a beneficiary cannot predict drug needs for unanticipated medical conditions. Although drug plans may discontinue coverage or increase the cost of any particular drug, they must continue to cover participants currently taking a discontinued drug until the end of the year.
2. **Exceptions process:** A plan may grant an “exception” to its formulary if a beneficiary is using or is prescribed a medically necessary drug that is not on the plan’s formulary. What is the plan’s process for granting such exceptions?
3. **Transition process:** What are the plan’s rules for temporarily providing drugs that are not covered by the plan during a “transition” period? How long is this period?
4. **Utilization management tools:** To what extent does the plan attempt to steer beneficiaries to lower-cost drugs? For example, does the plan require that a beneficiary try certain medications before covering a costlier drug prescribed by the beneficiary’s doctor? Does the plan charge different co-payment amounts for generic and brand-name drugs or for different drugs? What are the cost-sharing requirements for the beneficiary’s current drugs?
5. **Quantity limitations:** Is there a limit on the number of prescriptions a beneficiary may receive in a month? Are there limits on the number of pills or other dosages available in a single prescription?
6. **Deductible:** Will the annual deductible be the standard two hundred fifty dollars (\$250) or lower? Does the total cost of the drugs that the beneficiary currently takes at least meet the deductible plus a year’s worth of premium payments?
7. **Pharmacy:** Will the beneficiary be able to buy drugs covered under the plan at his

or her customary pharmacy? If the beneficiary is in a long-term care facility, is the facility's pharmacy included in the plan's network? Does the plan have preferred and non-preferred pharmacies within its network and does it require beneficiaries to pay more for using a non-preferred pharmacy?

8. **Mail order option:** Are beneficiaries allowed or required to use mail-order? Is there a price difference for mail-order purchases?
9. **Plan sponsor:** Is the plan sponsor a known, reliable entity?
10. **Coordination with state program:** How do the plan's benefits coordinate with Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) and the PACE Needs Enhancement Tier (PACENET)?