MEDICARE IN 2024 & 2025

Important Updates to Out-of-Pocket Medication Costs

How Medicare Part D changes may impact patients

Mitsubishi Tanabe Pharma America

BEGINNING IN 2024

Inflation Reduction Act (IRA) & prescription drug price reform

The highlights:

- As of January 1, 2024, changes to Medicare Part D cost-sharing will create lower out-of-pocket (OOP) costs for enrollees.[1,2]
- Changes that affect patients—including a cap on their total OOP medication costs—will depend on each patient's Medicare Part D plan.
- Patients' OOP costs may change from month to month, based on their plan's OOP maximum amount.[1,3]
- It's important to run a new benefit verification. This will provide the information each patient needs to understand their total annual OOP cost.

An in-depth look:

Before the IRA went into effect, patients with drug costs high enough to exceed the catastrophic threshold were required to pay 5% of their total drug costs above the threshold until the end of the year.[1]

Now, the 5% requirement has been eliminated, which means enrollees will not have to pay anything in the catastrophic phase.[4]

The effect on co-pays

Important Medicare Part D Prescription Drug Coverage changes*:

- Maximum OOP drug costs in 2024 are estimated to be **$3,250**[4,5]
- When patients reach that cap, their OOP costs will be **$0**[1]

Here's an example† of what a patient might pay to reach the cost cap:

Deductible	+	Initial Coverage	+	Coverage Gap	=	
$545		$1,110		$1,595		$3,250

If a patient is prescribed multiple medications—including more than one branded medication[1]:

- Enrollees' co-pays for each medication will be based on the order they are submitted for payment, up to their Part D OOP maximum
- After the co-pay maximum is reached, the patient won't face any additional OOP costs for their medications

*Premiums vary by plan and patients are still responsible to pay their monthly premiums.[3]
†Example is for illustrative purposes only.

BEGINNING IN 2025

Patients' OOP costs may change again[1]

Starting in 2025, Medicare Part D and Advantage Part D plans will be required to provide enrollees with the option to partake in the Medicare Prescription Payment Plan. This plan will allow enrollees' payments to be made in capped, monthly installments over the plan year. So, instead of potentially facing outsized OOP costs at the beginning of the plan year, enrollees may opt to "smooth" those cost-sharing payments across the plan year.[4]


Actor portrayals.

3-year cost changes implemented by the Inflation Reduction Act[5]

	2023	2024	2025+
Deductible	**Patient paid: 100%**	**Patient pays: 100%**	**Patient pays: 100%**
Initial coverage	Part D plan paid: 75% **Patient paid: 25%**	Part D plan pays: 75% **Patient pays: 25%**	Part D plan pays: 65% Drug manufacturer pays: 10% **Patient pays: 25%**
Coverage gap	Part D plan paid: 5% Drug manufacturer paid: 70% **Patient paid: 25%**	Part D plan pays: 5% Drug manufacturer pays: 70% **Patient pays: 25%**	**Patient pays: 0%**
Estimated OOP spending	**≈ $3,100**	**≈ $3,250‡**	**$2,000‡**
Catastrophic coverage	Part D plan paid: 15% Medicare paid: 80% **Patient paid: 5%**	Part D plan pays: 20% Medicare pays: 80% **Patient pays: 0%**	Part D plan pays: 60% Medicare pays: 20% Drug manufacturer pays: 20% **Patient pays: 0%**

‡The patient's spending depends on their Medicare Part D plan.

▶ **Note: The patient is still responsible for paying their monthly premium.**

Potential changes to formulary tiers each year may impact patients' ability to receive their prescribed therapy[6]

Depending on the Medicare Part D plan, patients and prescribers may find that access to prescribed medications requires an exception request.

When making an exception request, keep in mind that Part D plans use tiers to categorize prescription drugs. **Each plan sets its own tiers, and plans may change their tiers from year to year.**[6]

It's important for you to be aware of tiering requirements and exceptions procedures, as plans may place certain drugs in different tiers in 2025.[6]

Formulary tiers[7]

TIER 1	Lowest co-payment: most generic prescription drugs
TIER 2	Medium co-payment: preferred, brand-name prescription drugs
TIER 3	High co-payment: non-preferred, brand-name prescription drugs
SPECIALTY TIER	High co-payment: high-cost prescription drugs

When patients need exception support

The patient may ask their prescriber for help when requesting **either a formulary exception or a tiering exception** from their health plan.[8]

Formulary exception[8]

When the patient is prescribed a Part D medication that is not covered by their health plan, they can request a formulary exception.

This type of exception request can also be made if the health plan has a certain requirement that the patient wants waived—for example, a step therapy requirement or prior authorization requirement.

Tiering exception[8]

A tiering exception can be requested to lower the patient's cost-sharing responsibility for their prescribed medication. For example, if the health plan has the medication listed on a non-preferred tier, the patient and their prescriber might ask the health plan to lower the cost to what the patient would pay for a preferred tier.

Documentation that drugs on lower tiers for the condition are ineffective or contraindicated for the patient must be included in a tiering exception request.

1	**Prescribers may fill out a Model Coverage Determination Request Form[8] (see the link at the bottom of this page).**
a.	All plans must accept this form.
b.	Some plans have their own preferred forms.
c.	If a patient files a request over the phone, the plan can still require a written support statement from their prescriber and may not process the phone request until it gets the written version.
d.	In addition to the letter, the patient's medical records and a letter of medical necessity are usually submitted.
e.	Both the prescriber and patient should sign the letter.
2	**The patient's plan must decide within 72 hours of receiving the request.[8]**
	However, if the prescriber feels that the patient's health could be seriously harmed by waiting the standard time for a decision, they can request a fast (expedited) appeal, and the plan must decide within 24 hours.

Download the Model Coverage Determination Request Form here.

Actor portrayals.

Find key information on the following inside:

- What the Inflation Reduction Act means for patients enrolled in a Medicare Part D plan in 2024
- Facts about the new cap on prescription out-of-pocket costs
- Considerations if a patient requests an exception
- Preview of 2025 Medicare Part D changes

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For more information, visit medicare.gov.

Mitsubishi Tanabe Pharma America

For US healthcare professionals only.
Mitsubishi Tanabe Pharma America, Inc.
525 Washington Boulevard, Suite 1100
Jersey City, NJ 07310