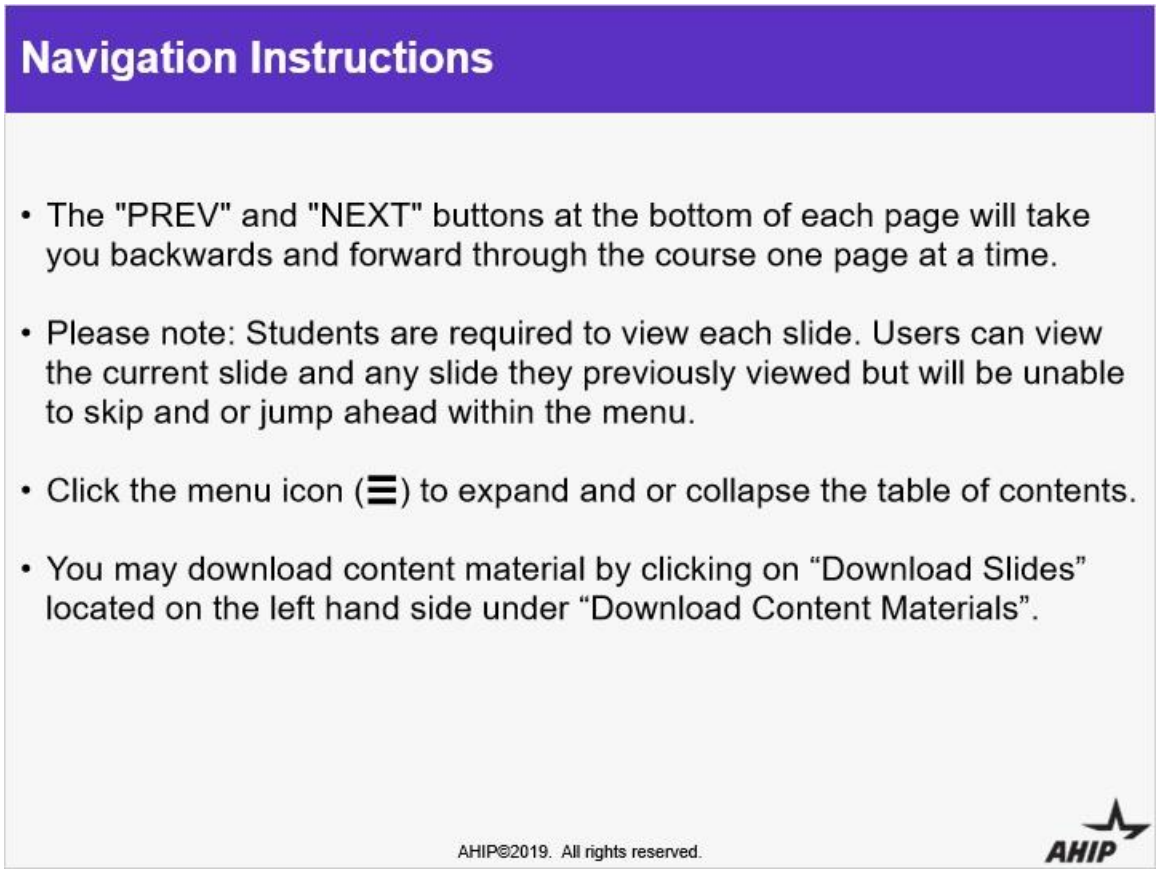
Module 3-Medicare Part D Prescription Drug Coverage

1. Module 3-Medicare Part D Prescription Drug Coverage

1.1 Medicare Part D Prescription Drug Coverage

1.2 Navigation Instructions



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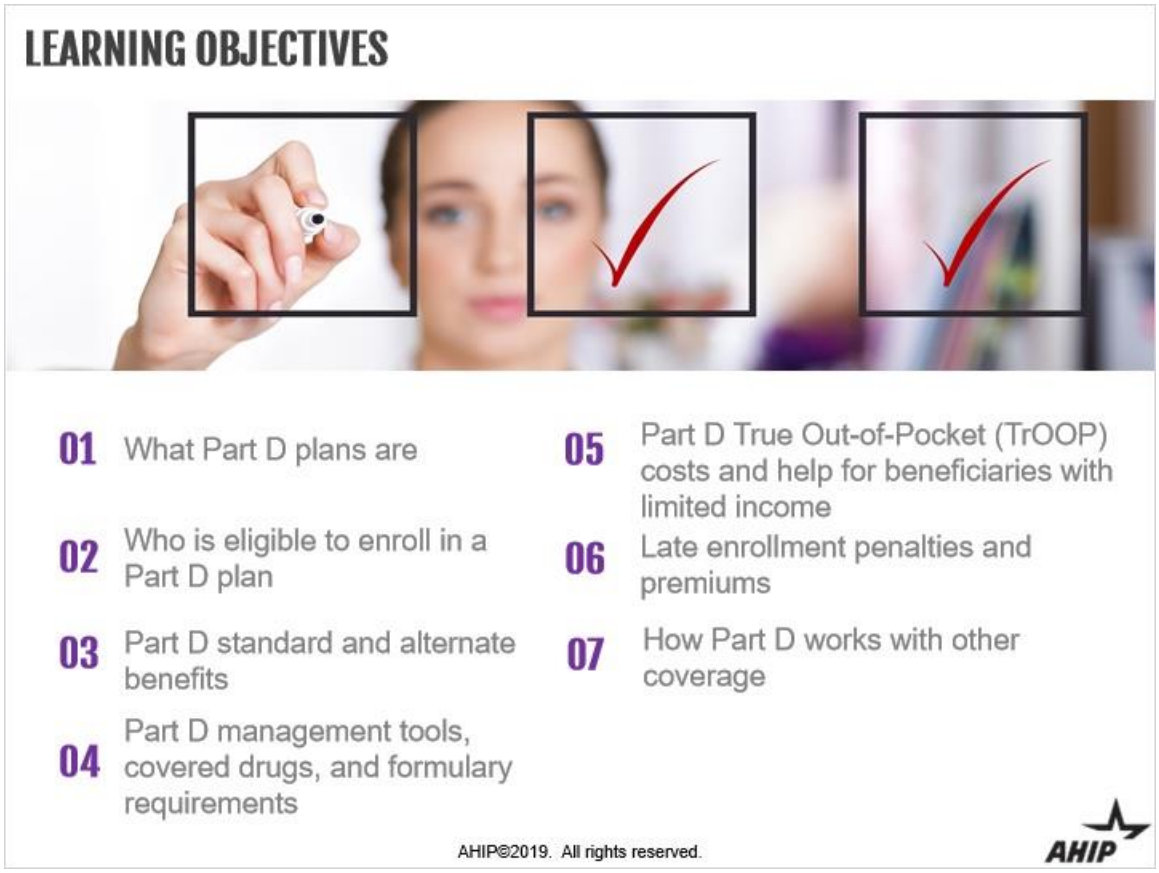
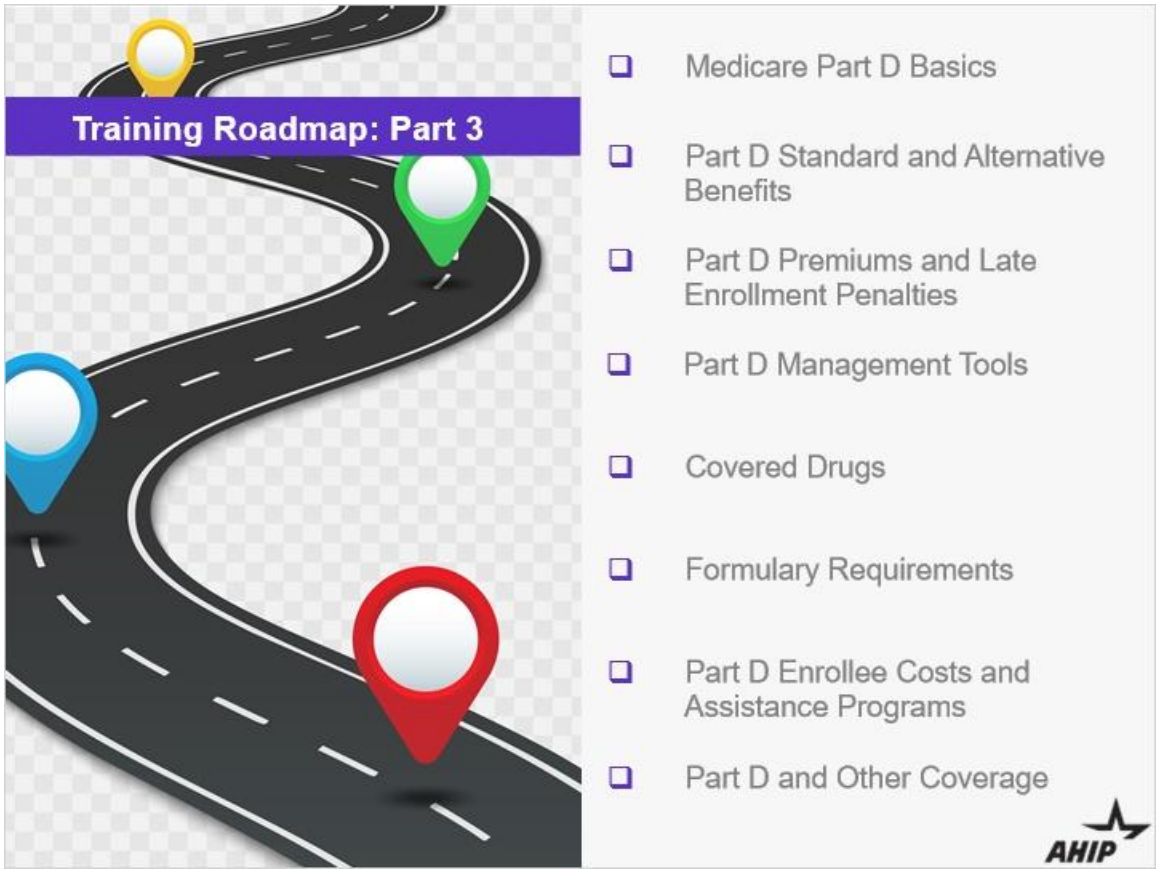
1.4 LEARNING OBJECTIVES



1.5 Training Roadmap: Part 1



1.6 Medicare Part D Prescription Drug Program Basics

Medicare Part D Prescription Drug Program Basics

- Coverage of Medicare Part D benefits is provided only through private companies. There is no fee-for-service Part D benefit.
- The types of Part D plans are:
  - Stand-alone Prescription Drug Plans (PDP)
  - Medicare Advantage-Prescription Drug (MA-PD) Plans:
    - MA health plans that also cover Part D prescription drugs.
  - Cost-PD Plans
    - Medicare cost plans that cover Part D prescription drugs as an optional supplemental benefit.
- Part D coverage is also included under PACE plans, Medicare-Medicaid Plans, and may be included under other Medicare health plan demonstrations.

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1.7 Medicare Part D Prescription Drug Program Basics, continued

Medicare Part D Prescription Drug Program Basics, continued

Only beneficiaries enrolled in Original Medicare, an MA MSA, a PFFS plan or a Cost plan may enroll in a standalone PDP to receive Part D benefits.

- Beneficiaries enrolled in a MA HMO or PPO may only obtain Part D benefits through their HMO or PPO plan. (Employer group plan enrollees may have additional choices).
- Beneficiaries enrolled in a MA MSA may only obtain Part D benefits through a standalone PDP.
- Beneficiaries enrolled in a Cost plan or MA PFFS plan may obtain Part D benefits through their plan (if offered) or through a standalone PDP.
- Beneficiaries enrolled in a Medicare-Medicaid plan may only receive Part D benefits through that plan.
- PACE plan beneficiaries may only receive Part D benefits through that plan.

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1.8 Medicare Part D Prescription Drug Program Basics - Examples

Medicare Part D Prescription Drug Program Basics - Examples

Ms. Jones has enrolled in an MA MSA plan. If Ms. Jones wants Part D coverage, she must also enroll in a PDP.

Mr. Page has Original Medicare and gets his Part D coverage through a standalone PDP. During the Annual Election Period, he wishes to enroll in an MA HMO. If Mr. Page chooses an MA HMO, he may no longer get his Part D benefits through a standalone PDP and must choose a plan through the HMO that includes Part D benefits (an MA-PD) if he wishes to maintain prescription drug coverage.

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1.9 Medicare Part D Eligibility

Medicare Part D Eligibility

- Individuals entitled to Part A and/or enrolled under Part B are eligible to enroll in Part D plans.
- The beneficiary must live in the plan's service area.
  - Part D plan coverage is provided through network pharmacies in the Part D plan's service area, except that PFFS plans are not required to use a pharmacy network but may choose to have one.
- PDPs must enroll any eligible beneficiary who applies regardless of health status.
- MA-PD plans are subject to the MA program rules, and thus may not enroll certain individuals (e.g., certain beneficiaries with ESRD or those who do not meet the eligibility criteria of a chronic care SNP).

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1.10 Medicare Part D Eligibility: Examples

Medicare Part D Eligibility: Examples

Mr. Bradley is age 65, still working, and eligible for Medicare. Mr. Bradley does not enroll in Part B since he has similar coverage through his employer's plan. He is interested in Medicare Part D because he believes he can obtain coverage that better meets his needs. Mr. Bradley is eligible to enroll in Part D since he is entitled to Part A.

Mr. Singh is single, still working, and recently turned age 65. He has not contributed to the Social Security or Medicare programs for a sufficient number of quarters to be eligible for Part A for free. He would have to pay a premium for Part A coverage and has decided not to do so. He is eligible for Part B and has enrolled in that program. He would also like to enroll in Part D. Mr. Singh can enroll in Part D since he has opted to enroll in Part B even though he is not entitled to Part A.

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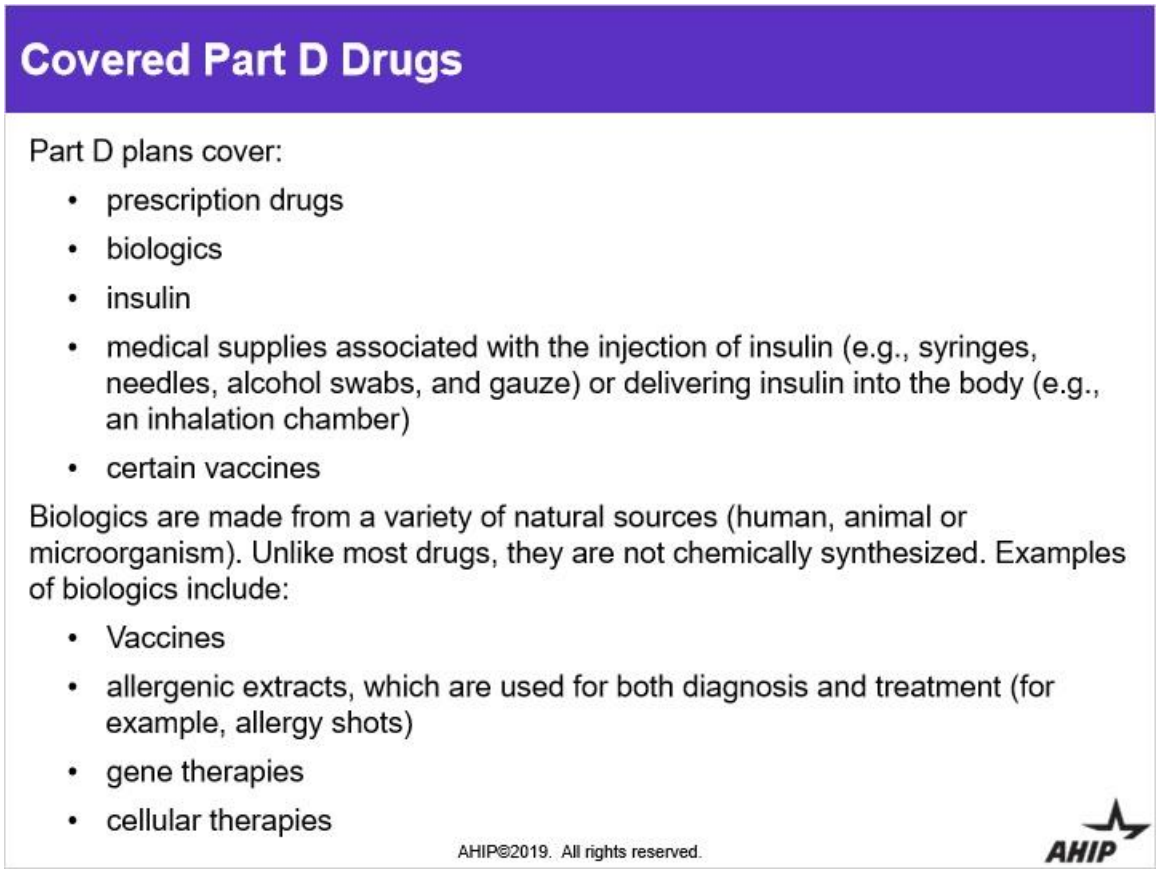
1.12 Covered Part D Drugs



1.13 Covered Part D Drugs, continued

Covered Part D Drugs, continued

- Many Part D plans do not cover all of these drugs because in some cases several similar drugs are available to treat the same medical condition.
- Part D plans include the Part D drugs they will cover on a list known as a "formulary."
  - Formularies are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
  - At least two drugs in each therapeutic category
  - Generic and brand-name drugs.

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1.14 Drugs Excluded from Part D Coverage

Drugs Excluded from Part D Coverage

By law, Part D plans are not permitted to include the following under their Part D covered benefits:

- drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds;
- vitamins;
- medical foods formulated to be consumed or administered enterally under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act;
- erectile dysfunction drugs (when used for sexual dysfunction);
- non-prescription drugs;
- some off-label use drugs; and
- drugs covered under Part A and B (even if an individual does not have such coverage).
- Part D plans are permitted to offer supplemental benefits that cover certain drugs not covered under Part D, such as erectile dysfunction drugs.

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1.15 Part D Standard and Alternative Benefits

1.16 Part D Plan Benefits Standard

Part D Plan Benefits Standard

Part D plans must cover at least the Part D standard benefit or its actuarial equivalent.

For 2020, the standard benefit requires the beneficiary to pay:

- $435 deductible
- 25% of prescription drug costs between $435 and $4,020 = $896.25
- Part of the costs in the "Coverage Gap" - From a beneficiary perspective, there is no longer really a coverage gap. After total spending on drugs by the beneficiary, by certain subsidy programs and by the plan reaches $4,020 (known as the initial coverage limit) the beneficiary pays for 25% of generic drug costs and 25% of brand name drug undiscounted costs.

- However, spending after the initial coverage limit during the so-called gap remains relevant, because, during this period of drug spending, drug manufacturers pay 70 percent of the cost of the drug. This 70 percent is attributed to beneficiary out-of-pocket costs, even though beneficiaries do not pay it.

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1.17 Part D Plan Benefits Standard, continued

Part D Plan Benefits Standard, continued

Nominal costs under catastrophic coverage:

- Once beneficiary out-of-pocket costs (including the 70 percent drug manufacturer discounts) reach a total of $6,350, the beneficiary is through the "coverage gap" and reaches catastrophic coverage.
  - The out-of-pocket costs that count toward reaching the catastrophic limit are known as "true out-of-pocket" costs or TrOOP. In some instances amounts not directly paid by the beneficiary count toward TrOOP.
- After reaching the catastrophic coverage threshold, the beneficiary pays either a co-pay of $3.60 for generic drugs or $8.95 for brand name drugs or a co-insurance of 5%, whichever is greater.

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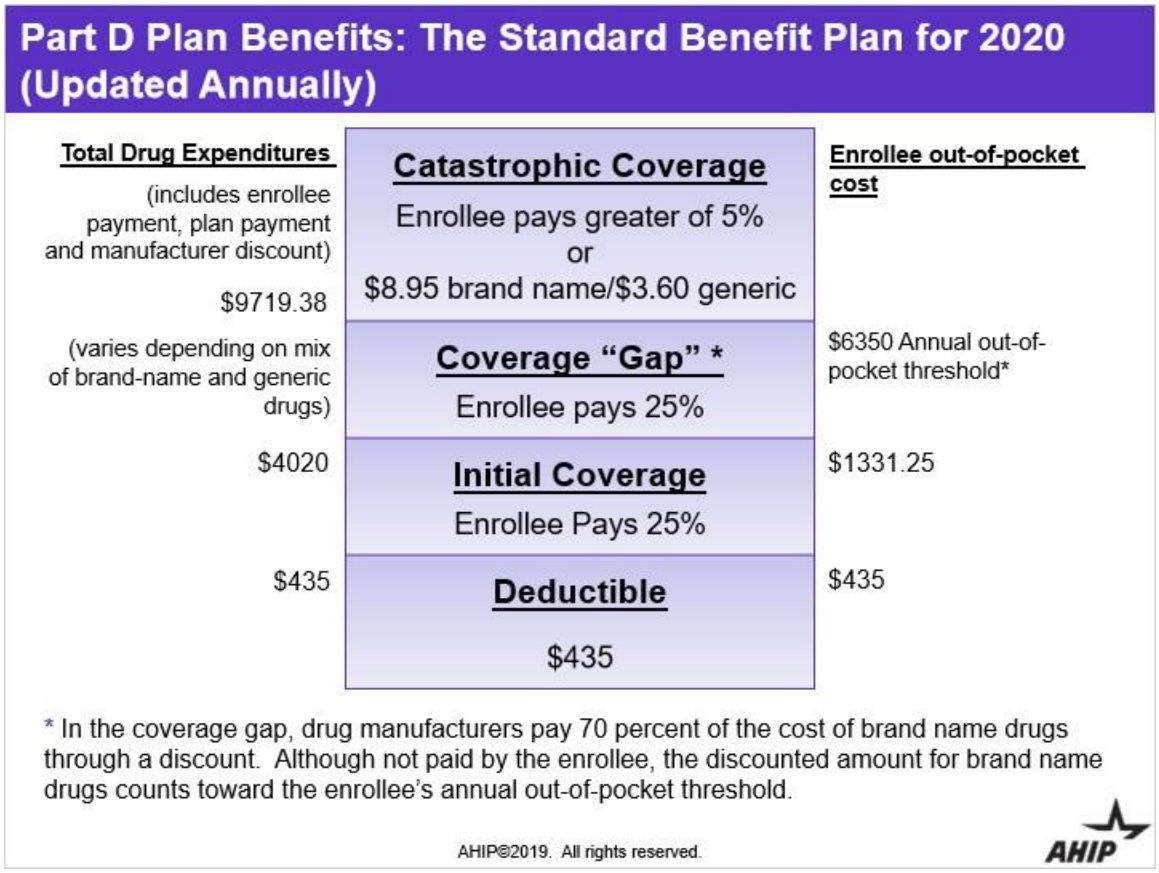
1.18 Part D Plan Benefits: The Standard Benefit Plan for 2020 (Updated Annually)



1.19 Examples - Beneficiary Expenditures Standard Benefit Plan

Examples - Beneficiary Expenditures Standard Benefit Plan

Example 1
Ms. Baker has Part D coverage that follows the standard benefit plan.

Ms. Baker takes several maintenance drugs that are covered under her plan. In a year, the total cost of drugs taken by Ms. Baker is $2400. Ms. Baker pays $926.25. ($2400 (total drug cost) -$435 (deductible) = $1,965 x .25 (initial coverage cost-sharing percentage) = $491.25 + $435 (deductible) = $926.25)

Example 2
Mr. Davis has Part D coverage that follows the standard benefit plan.

Mr. Davis takes several drugs that are covered under his plan. All of his drugs are generic. In a year, the total cost of drugs taken by Mr. Davis is $5,500. Mr. Davis pays $1,701.25. ($5,500 - $4,020 (initial drug coverage limit) = $1,480 x .25 (coverage gap generic cost sharing percentage) = $370 + $435 (deductible) + $896.25 (initial coverage cost sharing amount) = $1,701.25)

1.20 Part D Plan Benefits Alternative

Part D Plan Benefits Alternative

- Part D plan benefits frequently differ from the standard benefit under specific Medicare rules.
- In all cases the value of Part D benefits must be at least the same as the standard coverage.
- Some Part D plans may also include enhanced coverage for an additional monthly premium.

Example: Mr. Bingham is enrolled in a PDP with $0 deductible and a $56 per month premium. His copayment for generic drugs is $20 and for brand name is $35. Mr. Bingham takes 5 prescription drugs. Three are generic and 2 are brand name. Mr. Bingham's annual drug cost is $1,560. (3 generic drugs = $60/mo.) + (2 brand name drugs = $70/mo.) x 12 months = $1,560. In addition, Mr. Bingham will pay $672 in premiums per year ($56 x 12 months).

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1.21 Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP)

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP)

Part D True Out-of-Pocket costs or "TrOOP" are out-of-pocket costs that count towards the annual out-of-pocket threshold to move into catastrophic coverage.

- TrOOP is calculated on an annual basis.
- Generally, TrOOP includes enrollee payments for Part D prescription drugs, including:
  - The annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold.
- After the initial coverage period, a drug manufacturer's discount for brand name drugs counts toward the true out-of-pocket costs.
- Generally, for drug cost to count toward TrOOP, drugs must be on the plan's formulary and purchased at a plan's participating network pharmacy.
- Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service also count toward TrOOP.

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1.22 Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), continued

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), continued

Some costs do not count toward TrOOP cost including:

- Costs for drugs not on a Part D plan's formulary, unless the beneficiary receives an exception under which the plan covers the drug;
- Costs for over-the-counter (OTC) and other non-Part D drugs;
- Costs for covered Part D drugs obtained out-of-network (unless the plan's out-of-network policy applies);
- Costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs (such as Medicaid), or another third party; or
- Costs for drugs purchased outside the United States.

AHIP

1.23 Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Example 1: Mr. Reynolds takes blood pressure medication. He requested a formulary exception, which was denied by his plan. He decided to continue taking the non-formulary prescription and pay for it out-of-pocket. The amounts Mr. Reynolds pays for the drug do not count toward his deductible or other out-of-pocket costs.

Example 2: To address her acid reflux, Ms. Lopez has been taking a formulary drug and an over-the-counter medication. Only the amount Ms. Lopez pays for the formulary drug counts toward Ms. Lopez's out-of-pocket costs.

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1.24 Part D Pharmacy Networks

Part D Pharmacy Networks

- Enrollees are generally required to fill prescriptions for covered drugs at network pharmacies that contract with the Part D plans.
  - Network pharmacies include retail pharmacies and may also include mail order pharmacies.
  - Within their networks, Part D plans may designate some pharmacies as "preferred pharmacies" that offer lower levels of cost-sharing than apply at other network pharmacies.
- Under certain circumstances, enrollees may fill prescriptions for covered drugs at non-network pharmacies, but possibly at a higher cost to enrollees. For example:
  - If the enrollee has an illness or loses a drug while traveling outside the service area.
  - If there are circumstances resulting in limited drug access through an in-network pharmacy.

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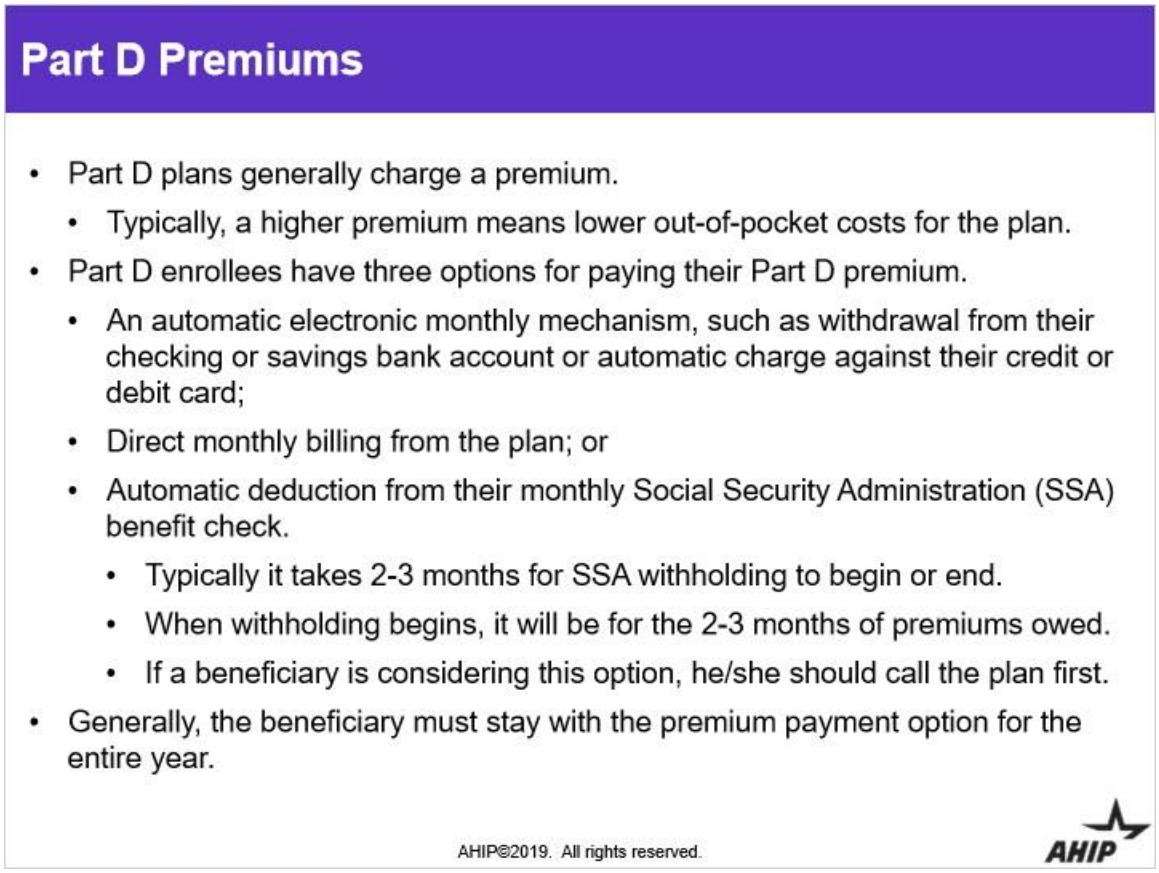
1.26 Part D Premiums and Late Enrollment Penalties

1.27 Part D Premiums



1.28 Part D Late Enrollment Penalty

Part D Late Enrollment Penalty

- Beneficiaries may have to pay a premium penalty to join a Part D plan if:
  - They do not have creditable drug coverage and do not enroll when first eligible for Part D.
  - There has been a period of at least 63 continuous days following a beneficiary's initial enrollment period for Part D during which the beneficiary did not have either Part D or creditable drug coverage.
- Creditable coverage is prescription drug coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay.
- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.

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1.29 Late Enrollment Penalty, continued

Late Enrollment Penalty, continued

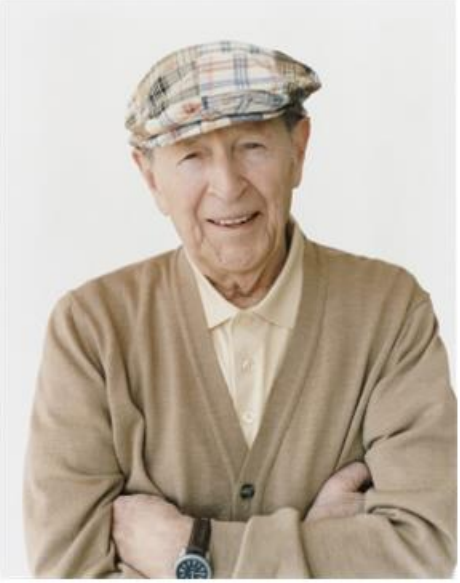
- In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty.

AHIP

1.30 Late Enrollment Penalty Examples

Late Enrollment Penalty Examples

- Mr. Russell first became eligible for Part D on December 1, 2018. He did not sign up and has not had creditable drug coverage. Mr. Russell wishes to obtain drug coverage during the Annual Election Period to be effective on January 1, 2020. He is not LIS eligible. Mr. Russell will have to pay a penalty of 13% of the national average beneficiary premium (1% for every month he did not have creditable drug coverage after becoming eligible) for every month that he stays covered under Part D.
- Mr. Smith lost his creditable drug coverage that his employer provided when he retired. Mr. Smith signed up for Part D with an effective date of 60 days after the date he lost his coverage. Mr. Smith will not be subject to a late enrollment penalty.



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1.32 Part D Drug Management Tools and Formulary Requirements

1.33 Part D Drug Management Tools

Part D Drug Management Tools

Part D plans commonly use a variety of prescription drug benefit management tools, including:

- A formulary: A list of drugs covered by the plan
- Cost sharing tiers: Drugs may be grouped together by the amount of cost sharing. Many plans group drugs into 3 or 4 tiers with lower tiers costing less than higher tiers, for example:
  - Tier 1: Generic drugs
  - Tier 2: Preferred brand-name drugs
  - Tier 3: Non-preferred brand-name drugs
  - Tier 4: High-cost drugs or "specialty drugs"

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1.34 Part D Drug Management Tools, continued

Part D Drug Management Tools, continued

Step therapy: One or more similar lower-cost drugs must be tried before other costlier drugs are tried, if necessary.

Prior authorization: Requires the doctor to contact the plan before the plan will cover these prescriptions. The doctor must show the plan that the drug is medically necessary for it to be covered.

Substitution: Part D sponsors may substitute generic drugs for brand name drugs if the generic drugs have the same or lower cost sharing and certain conditions are met.

Comprehensive Addiction and Recovery Act (CARA) programs: Plans may impose certain limitations to manage utilization for beneficiaries who are at risk of misusing or abusing frequently abused drugs, such as opioids.

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1.35 Step Therapy Example

Step Therapy Example

Step therapy is a requirement to try other medications first before a costlier drug is covered. The plan wants to determine that less expensive options do not work. Here's an example of step therapy:

- The beneficiary tries an over-the-counter medication for an allergy, but it does not provide relief from the symptoms.
- The doctor prescribes a low-cost prescription allergy drug, but it still does not provide relief.
- The doctor prescribes a third medication that is expensive but works well. The plan required that in order for this prescription to be covered, the beneficiary must first try the lower cost drugs.

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1.36 Comprehensive Addiction and Recovery Act (CARA) programs

Comprehensive Addiction and Recovery Act (CARA) programs

- Part D sponsors may adopt programs for beneficiaries who are at risk of misusing or abusing frequently abused drugs. Under such programs, sponsors identify at-risk individuals by using criteria that includes the number of opioid prescriptions a beneficiary has and the number of prescribers who have written those prescriptions.
- Tools that plans may use to manage risk include:
  - Locking the beneficiary into one pharmacy.
  - Locking the beneficiary into one prescriber.
- Lock-in may apply to both opioids and benzodiazepines.
- Certain beneficiaries are exempt from these programs and all beneficiaries have appeal rights related to the lock-in provisions.

AHIP

1.37 Medicare Part D Medication Therapy Management: An Introduction

Medicare Part D Medication Therapy Management: An Introduction

All Medicare Part D sponsors are required to have a Medication Therapy Management (MTM) program with the exception of MA Private Fee for Service (MA-PFFS) and PACE organizations. Their MTM programs must be designed:

- to ensure that covered Part D drugs prescribed to targeted beneficiaries are appropriately used; and
- to reduce the risk of adverse events, including drug interactions.

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1.38 Medicare Part D Eligible MTM Beneficiaries

Medicare Part D Eligible MTM Beneficiaries

To be eligible for the program, a beneficiary must:

- have multiple chronic diseases - (diabetes, hypertension, and asthma)
- be taking multiple Part D drugs
- be likely to incur drug costs of a specified amount (equal to or greater than $4,255 for 2020).

- Information about specific criteria is available from each Part D plan and is available on the plan's website.
- Enrollment in a Sponsor's MTM program must be done using an opt-out method. That is, a beneficiary that meets the plans targeting criteria for its MTM program would be automatically enrolled unless he/she declines enrollment.

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1.39 Mid-year Formulary Changes

Mid-year Formulary Changes

- Part D plans cannot make any negative formulary changes during the first 60 days of the contract year, unless it is in response to a drug's removal from the market or the FDA deems a drug unsafe.
- After March 1st, Part D plans may make some limited mid-year formulary changes.
- Plans may expand formularies by adding drugs to their formularies, reducing copayments or coinsurance by placing a drug on a lower cost-sharing tier or deleting utilization management requirements at any time during the year.

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1.40 Transition Requirements

Transition Requirements

- Enrollees initially enrolling in Part D, those switching plans, and current enrollees affected by formulary changes must receive coverage of a single one month fill of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.
- To the extent that a current enrollee in a long-term care setting is outside his or her 90-day transition period, the sponsor must still provide a one-month supply of nonformulary Part D drugs while an exception or prior authorization request is being processed.
- During the transition period:
  - The Part D plan does not apply prior authorization or step therapy rules.
  - The enrollee and his/her physician can request an exception to the Part D plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

AHIP

1.41 Requesting Exceptions for Drugs

Requesting Exceptions for Drugs

- Enrollees have the right to request coverage of a drug that is not on the Part D plan's formulary or to request coverage of formulary drugs at a less costly formulary tier. Such requests are known as formulary exception requests.
- If a doctor thinks an enrollee needs a drug that is not on the formulary, the enrollee or the doctor can apply for a formulary exception.
- A standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary exception.

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1.42 Requesting Coverage Determinations and Appealing Decisions

Requesting Coverage Determinations and Appealing Decisions

- Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a determination of whether the plan will cover a drug (a coverage determination) or appeal a coverage decision.
  - Enrollees may appeal coverage determinations, decisions on exceptions, or requests concerning tiering or formularies.
- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

AHIP

1.44 Part D Assistance Programs

1.45 Help for Individuals with Limited Income and Limited Resources

Help for Individuals with Limited Income and Limited Resources

If a beneficiary has limited income and resources, he/she may qualify for the low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. In 2019, to qualify for the LIS:

- Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically as follows:
  - 48 states $18,735 (individual)/$25,365 (couple) in 2019.
  - Alaska $23,400 (individual)/$31,695 (couple) in 2019.
  - Hawaii $21,570 (individual)/$29,190 (couple) in 2019.
- Beneficiaries resources may not exceed $14,390(individual)/$28,720 (couple).

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1.46 Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply for the low-income subsidy (LIS) - also called extra help - through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
  - If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
  - Or call SSA at 1-800-772-1213 (TTY users can call 1-800-325-0778) or apply online at secure.ssa.gov/i1020 to apply for help with Part D costs.
- After SSA or the State approves an application for extra help, it is effective the first day of the month in which the individual applied.

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1.47 Certain Individuals Automatically Quality for Extra Help

Certain Individuals Automatically Quality for Extra Help

Individuals automatically qualify for Extra Help from Medicare if they meet any of these conditions:

- They have full Medicaid coverage;
- They get help from their state Medicaid program paying their Part B premiums (in a Medicare Savings Program); or
- They get Supplemental Security Income (SSI) benefits.

Medicare mails these individuals a purple letter to let them know they automatically qualify. They should keep this letter for their records. They do not need to apply for Extra Help if they get this letter.

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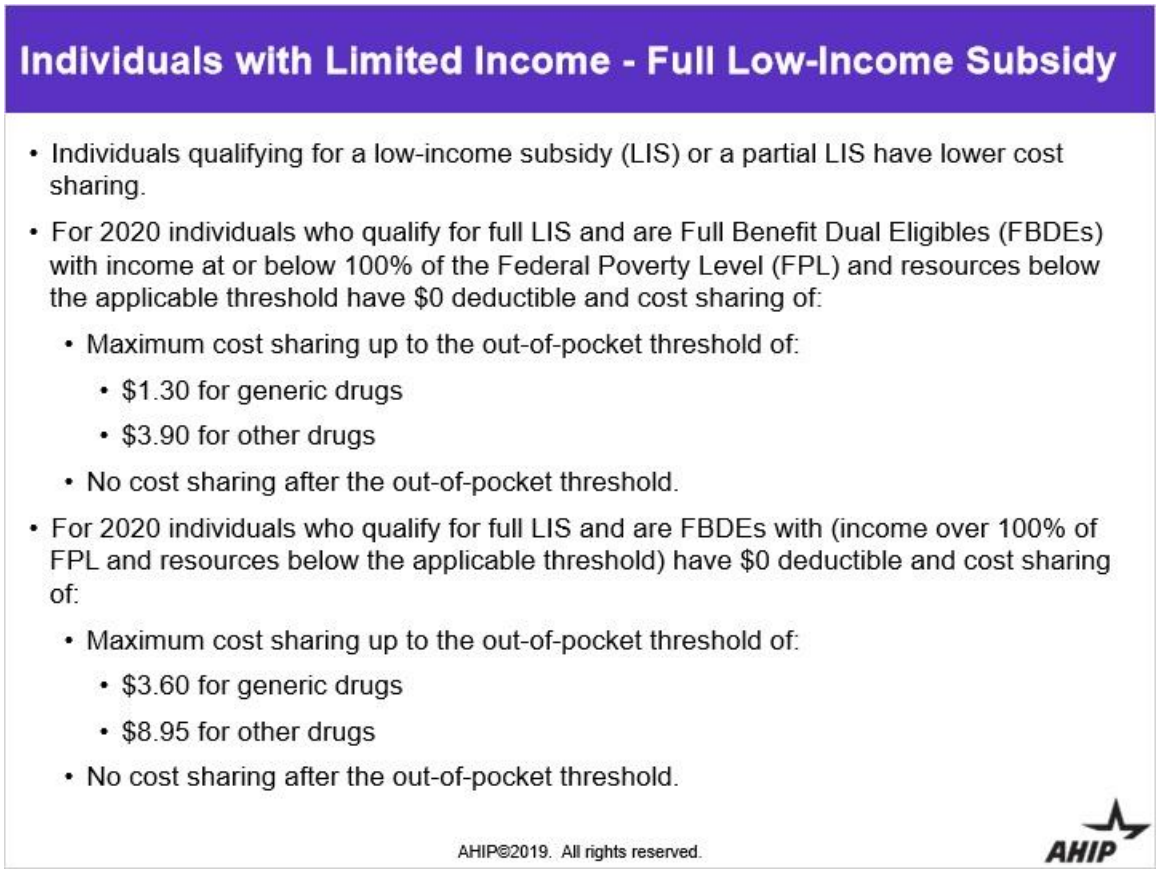
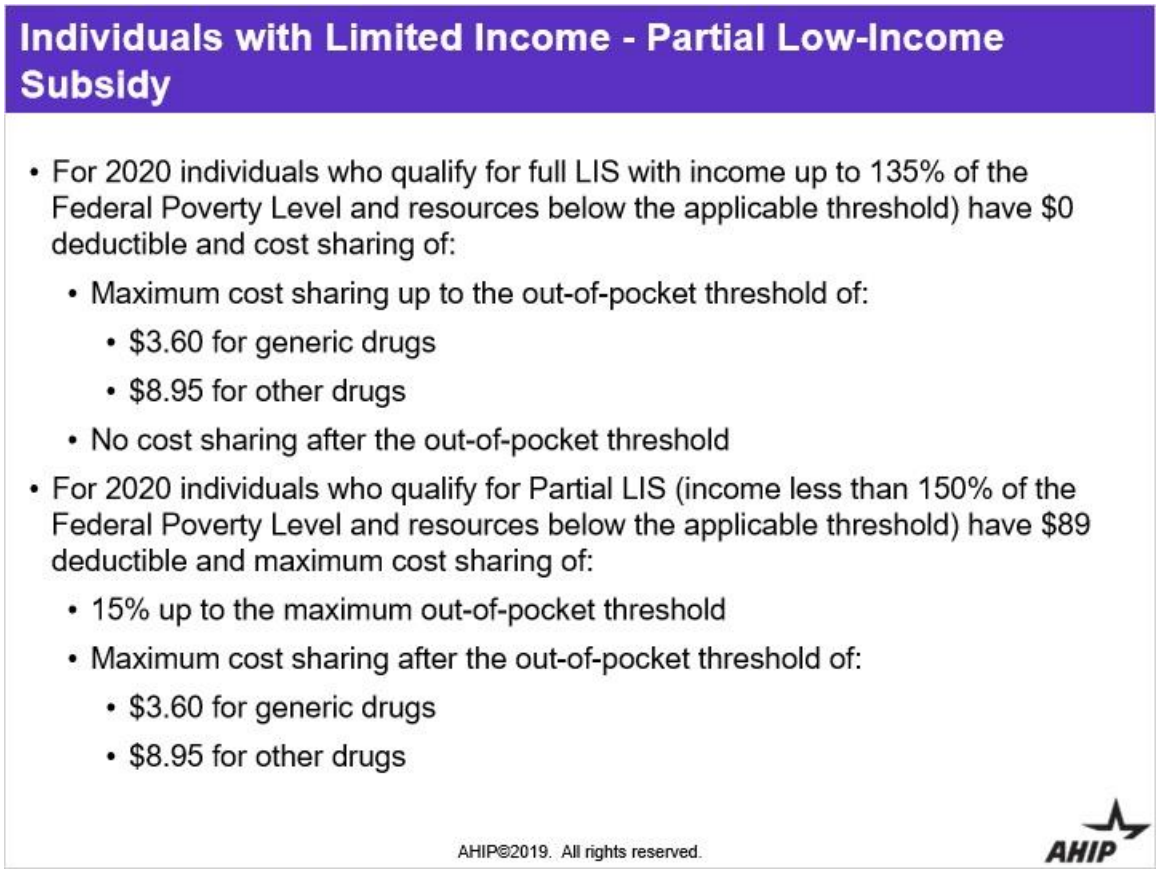
1.48 Individuals with Limited Income - Full Low-Income Subsidy



1.49 Individuals with Limited Income - Partial Low-Income Subsidy



1.50 Other Help for Low-Income - Pharmaceutical Assistance Programs

Other Help for Low-Income - Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low-income individuals in obtaining drugs at reduced or no costs.
- Some states have assistance programs designed specifically for their residents.
  - Some programs are “qualified” State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
  - Becoming familiar with your state’s programs may help a beneficiary address cost-sharing for prescriptions.

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1.51 Assistance Programs - What Counts toward TrOOP?

Assistance Programs - What Counts toward TrOOP?

Enrollees may receive assistance for Part D costs, but costs paid by many assistance programs do not count toward TrOOP cost.

- Included entities - costs do count towards TrOOP for:
  - Qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, non-government and Indian Health Service funded tribal coverage, AIDS Drug Assistance Programs, health savings accounts, flexible spending accounts, and medical savings accounts.
- Excluded entities - costs do not count towards TrOOP for:
  - Medicaid, State Children's Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements.

AHIP

1.53 Part D and Other Coverage

1.54 Employer/Union Coverage of Drugs

Employer/Union Coverage of Drugs

- Employer or Union Coverage: Employers/unions will notify their employees of whether their prescription drug coverage is "creditable" (coverage that, on average, equals at least as much as Medicare's standard Part D coverage expects to pay) via an annual statement.
  - If coverage is creditable and the beneficiary keeps it, he/she will not incur a premium penalty if he/she later loses or drops the employer coverage and joins a Part D plan.
  - If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during his/her initial eligibility period to avoid the late enrollment penalty.
- If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, he/she can compare that coverage with available Part D plans to decide whether to enroll in Part D.

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1.55 Employer Coverage of Drugs, continued

Employer Coverage of Drugs, continued

- The beneficiary should check with the employer or union benefits administrator before making any change.
  - If a beneficiary drops employer/ union prescription drug coverage, he/she may not be able to get it back and may also lose health coverage.
- If the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days, there will not be a late enrollment penalty.

AHIP

1.56 Employer/Union Coverage of Drugs: Example

Employer/Union Coverage of Drugs: Example

Mr. Diamond has employer group coverage that is creditable. During his initial Part D eligibility period, he decided not to enroll because he was happy with his drug coverage. However, a year later, Mr. Diamond loses his employer group coverage. If Mr. Diamond enrolls in a Part D plan before he has a 63-day break in coverage, he will not have to pay a late enrollment premium penalty.

AHIP

1.57 Medicaid Drug Coverage

Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don't choose a plan, Medicare will select one for them.
- Medicaid beneficiaries can change Part D plans throughout the year.

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1.59 For Additional Information