2025 Agent Quick Reference Guide

Part D Overview

2025 Program Changes

For 2025, there will be changes to the Part D program as a result of the Inflation Reduction Act, impacting both stand-alone Part D and Medicare Advantage Prescription Drug Plans.

It is important that you are informed on these changes to help members understand how they may be impacted and be prepared to support them.

Inflation Reduction Act

The Inflation Reduction Act (IRA) was signed into law on August 16th, 2022. The law includes provisions that are focused on lowering prescription drug costs for people with Medicare and reducing costs to the Federal Government.

These regulations include a redesign of the Part D program for 2025, which will be described in detail on the following pages.

2023-2025 IRA Changes to Part D

2023

- $0 cost-sharing for adult vaccines
- $35 cap on Part D Insulin cost-share
  - Part D Start: 1/2023
  - Part B Start: 7/2023
- Inflationary rebates for Parts B and D
  - Start: 10/2022

2024

- Pharmacy network DIR at point-of-sale changes
- Annual increase in national average premium cap (through 2029)
- Expansion of low-income cost-sharing and premium subsidy eligibility (from 135% FPL to 150% FPL)
- Member pays $0 in the Catastrophic stage

2025

Part D Benefit Redesign:

- Elimination of the Coverage Gap (“donut hole”)
  - › See page 2
- Reallocation of costs in the Catastrophic stage
  - › See page 2
- $2,000 maximum true out-of-pocket (TrOOP)
  - › See pages 3-5
- New Manufacturer Discount Program
  - › See page 5
- Medicare Prescription Payment Plan
  - › See page 5

The following does not apply to Part B or non-Part D medications (i.e. bonus drug list, vitamins, erectile dysfunction med)

- Medicare Prescription Payment Plan (M3P)
- $2,000 maximum true out of pocket amount

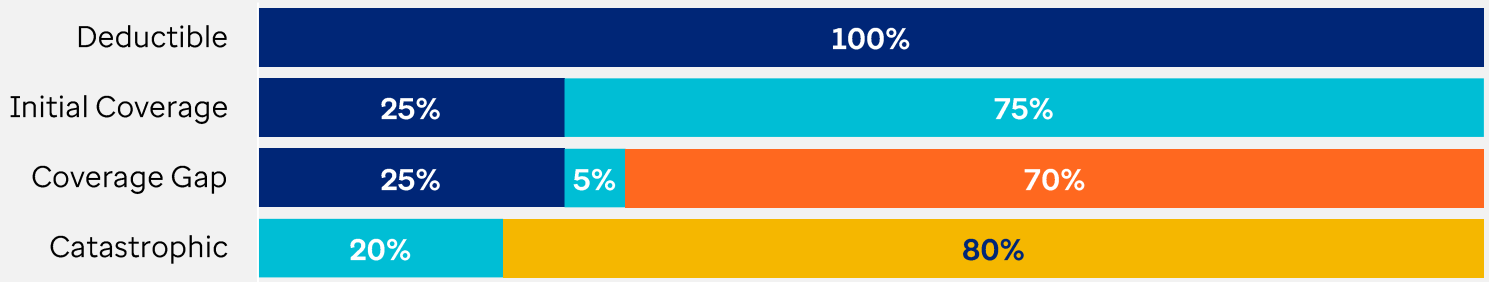
2025 Part D Overview

Elimination of the Coverage Gap

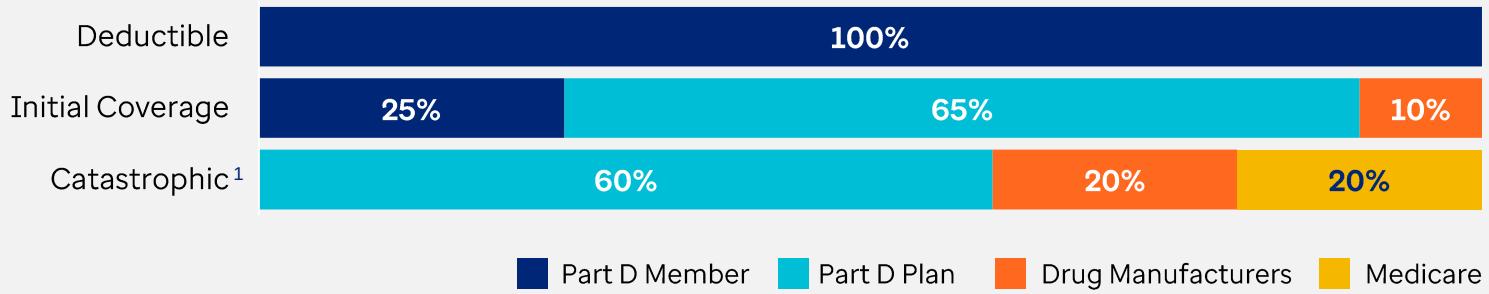
The Coverage Gap stage, or "Donut Hole", is going away in 2025. Members will now have three drug payment stages as part of their Part D benefit:

1. **Deductible Stage**: If a member's plan has a prescription drug deductible, they will pay the full cost for their drugs until they reach the deductible amount; then they move to the Initial Coverage stage.
2. **Initial Coverage Stage:** Members will pay their plan copays or coinsurance, and the Part D plan (or Drug Manufacturers) will pay the rest. Once the member, and others on their behalf, have paid a combined total of $2,000 (including any amounts paid toward a deductible), they move to the Catastrophic Coverage stage.
3. **Catastrophic Coverage Stage:** Members won't pay anything for Part D covered drugs for the rest of the plan year. The Part D plan will be responsible for most costs in this stage.

2024 Part D Benefit Design



2025 Part D Benefit Design



Reallocation of Costs in the Catastrophic Stage

For 2025, the cost responsibilities in the Catastrophic stage have shifted. Medicare will now pay a smaller portion of the costs (20% for brand, 40% for generics) and the Part D plan will be responsible for paying a higher share of the costs (60% in 2025 vs. 20% in 2024).

Members who typically reach the coverage gap may benefit from lower out-of-pocket costs in 2025.

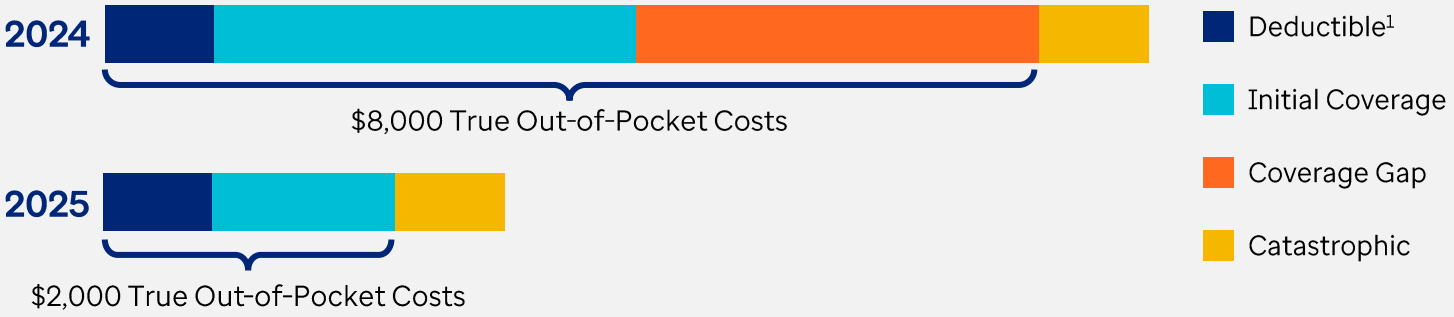
[1] *Represents Defined Standard cost sharing for brand drugs; for generics, Medicare pays 40% and Drug Manufacturers have zero responsibility.*

2025 Part D Overview

New Annual True Out-of-Pocket Maximum

In 2025, there is a new $2,000 annual true out-of-pocket maximum (TrOOP), reduced from $8,000 in 2024. TrOOP is the out-of-pocket drug cost that accumulates during the Deductible and Initial Coverage stages.

As a result, members may reach the Catastrophic stage more quickly (where they will have no drug cost responsibility) due to the elimination of the Coverage Gap and the lower TrOOP.



2025 TrOOP

The Part D Plan will calculate the TrOOP accumulation behind the scenes to determine when a member will move to the Catastrophic stage.

The amount that is applied towards a members' TrOOP is the greater of the amount paid by a member based on their plan's benefit design OR the cost share that the member would have under Medicare's Defined Standard Part D Plan. The Defined Standard Part D Plan is CMS' minimum benefit requirement for a Part D offering (either as a stand-alone PDP or within an MAPD plan).

Many UnitedHealthcare plans offer an enhanced Part D benefit instead of a Defined Standard benefit. Members on these plans may see their TrOOP accumulation differ from their actual out-of-pocket costs. **Agents do not need to know how to calculate the TrOOP but may want to understand the logic for general awareness.**

Medicare Defined Standard Part D Plan Design:

$590
Rx Deductible

25%
Cost-Share

Example 1

Member's plan cost-share	$20
Defined Standard plan cost-share	**$40**

In Example 1, the $40 is applied to TrOOP because it is the greater amount.

Example 2

Member's plan cost-share	**$47**
Defined Standard plan cost-share	$35

In Example 2, the $47 is applied to TrOOP because it is the greater amount.

Member's TrOOP accumulation may differ from their actual out-of-pocket costs. True Out-of-Pocket (TrOOP) Costs are calculated based on the plan year. Each Medicare plan submits a record of the member's drug coverage levels to Medicare. When a member switches plans mid-year, the TrOOP and Drug Spend amounts are obtained from the member's prior plan and accumulated on the member's new plan.

[1] *The Deductible stage is only applicable if the plan includes a Rx Deductible in the plan design. Not all plans include a Rx Deductible.*

2025 Part D Overview

2025 TrOOP Scenarios

The scenarios below reflect a member's costs for a $1,000 drug under the 2024 and 2025 Part D program. For 2025, the TrOOP is calculated by comparing the member's enhanced alternative plan cost-share to the Medicare Defined Standard cost and applying the higher of the two amounts to the TrOOP accumulator.

Scenarios 1-2
Enhanced Alt. Part D Benefit
Drug Cost: $1,000
Tier 3 Copay: $47
Rx Deductible: $0 (no deductible)

Scenario 3
Enhanced Alt. Part D Benefit
Drug Cost: $1,000
Tier 3 Copay: $47
Rx Deductible: $300 (Tiers 3-5)

Scenario 4
Medicare Defined Standard Benefit
Defined Standard Rx Deductible: $590
Defined Standard Cost-Share: 25%

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
1	2024 Member Cost ($0 Rx Ded.)	$47	$47	$47	$47	$47	$250	$250	$250	$250	$250	$250	$250	**$1,985**
2	2025 Member Cost ($0 Rx Ded.)	$47	$47	$47	$47	$47	$47	$47	$0	$0	$0	$0	$0	**$329**
3	2025 Member Cost ($300 Rx Ded. T3-5)	$347	$47	$47	$47	$47	$47	$47	$0	$0	$0	$0	$0	**$629**
4	2025 Defined Standard	$693	$250	$250	$250	$250	$250	$57	-	-	-	-	-	**$2,000**
	Monthly TrOOP Accumulator	*$693*	*$943*	*$1,193*	*$1,443*	*$1,693*	*$1,943*	*$2,000*						

Jan. 2025 TrOOP Calculation:
Deductible $590 + remaining drug cost $410 * 25%
$590 + ($410*.25) = **$692.50**

Feb-Jun 2025 TrOOP Calculation:
$1,000 drug cost * 25% = **$250**

July 2025 TrOOP Calculation:
$2,000 maximum - $1,943 = **$57** remaining cost share

Scenario 1 shows the member's cost under the 2024 Part D program. The member pays the $47 plan copay until they reach the gap in June. They remain in the gap for the rest of the year paying $250/month and $1,985 in total annual costs.

Scenarios 2 & 3 show the member's cost under the 2025 Part D program with the same plan design but applying the new TrOOP calculation and $2,000 maximum. The difference is that Scenario 2 has no Rx deductible and Scenario 3 has a $300 Rx deductible for Tiers 3-5.

- Scenario 2: In January, the member pays a $47 plan copay, however $693 would apply to the TrOOP accumulator because the Defined Standard amount is higher than the member's cost.
- Scenario 3: In January, the member pays the $300 deductible plus the plan's $47 copay, for a total of $347. Again, $693 applies to the TrOOP accumulator because the Defined Standard amount is higher than the member's cost.

In both scenarios, the member reaches the Catastrophic stage in August when the TrOOP accumulator reaches $2,000. The member pays $0 for the rest of the year even though the member's total out-of-pocket cost is below $2,000.

- Scenario 2: The member pays $329 in total Rx costs for the year; $1,656 less than in 2024.
- Scenario 3: The member pays $629 in total Rx costs for the year; $1,356 less than in 2024. Even with an Rx deductible the member has a decrease in annual Rx costs for 2025.

TrOOP calculations will happen in the background. Agents and consumers do not need to know how to calculate the costs but should know that the TrOOP accumulation may differ from what the member pays out-of-pocket.

** Examples are for illustrative purposes only.*

2025 Part D Overview

Frequently Asked Questions

What is the New Manufacturer Discount Program?

In 2025, CMS has introduced a new program that replaces the Coverage Gap Discount Program.

- 10% discount on brand name drugs during the Initial Coverage stage.
- 20% in the Catastrophic stage.
- Discounts applied at the point-of-sale.
- Members become eligible for the new discount program after they have reached the Medicare Defined standard deductible amount.
- Purchases made with discount cards are considered off-benefit and do not count toward a member's accumulator.
- Members will not necessarily know which brand name drugs will be cheaper for them under the new discount program. Applicable drugs under the discount program are Part D drugs approved under a New Drug Application (brands) or under the Public Health Service Act (biologics). Like the previous Coverage Gap Discount Program, there isn't a list of eligible medications.
- Members will not see the discount on their Explanation of Benefits (EOB), or otherwise know they benefited from a manufacturer discount.
- Manufacturer discounts do not apply to the TrOOP calculation.
- This program applies to stand-alone Prescription Drug plans and Medicare Advantage plans with prescription drug coverage.

What is the Medicare Prescription Payment Plan?

Beginning in 2025, CMS has introduced the Medicare Prescription Payment Plan offering members the option to pay $0 at the point-of-sale for their Part D drugs, and instead, pay for their prescriptions through a monthly payment program during the calendar year. This program applies to stand-alone Prescription Drug plans and Medicare Advantage plans with prescription drug coverage.

This program does not provide any savings to the member. Members will pay the same annual out-of-pocket costs but will have their prescription costs distributed differently. This option may not be right for all members and may lead to confusion and / or complaints.

UnitedHealthcare is required by CMS to proactively reach out to members who may be a good fit for the program once their coverage begins. Agents are not required to mention or explain this program. Members with questions should be directed to Customer Service.

UnitedHealthcare also has a member education website located here: What is the Medicare Prescription Payment Plan? | UnitedHealthcare (uhc.com) Also check out What's the Medicare Prescription Payment Plan? | Medicare from Medicare.gov.

2025 Part D Overview

Frequently Asked Questions

How does the Medicare Prescription Payment Plan work?

If a member opts into the Medicare Prescription Payment Plan, they'll no longer pay the pharmacy when they fill their covered Part D drug prescriptions. The plan will pay the pharmacy on the member's behalf and send the member a monthly bill for their prescription drug costs. The member will continue to receive a separate bill for their monthly plan premium if they have one.

The Medicare Prescription Payment Plan does not lower drug costs or save members money. It may be helpful for members who want to spread the payment of their drug costs across the remaining months of the year.

How does a member opt into the Medicare Prescription Payment Plan?

Any Medicare Part D member or their legal representative can opt into the program by completing an election request form with their plan. The opt in process can be completed over the phone, online or with a paper form. They can opt into the program after they have enrolled in any Medicare Part D plan. This includes before their plan's effective date (during AEP, for example) and at any time throughout the remainder of the calendar year. Election requests will be processed within 24 hours of receipt.

New members and members switching plans will need to wait until after their enrollment is approved before they can opt into the Medicare Prescription Payment Plan.

Can an agent opt members into the Medicare Prescription Payment Plan?

No. Members enrolled into an MAPD or PDP plan can opt into the program starting October 15, 2024 and/or anytime during the plan year by calling Customer Service, visiting the member website or mailing in the election request form.

Does everyone have to participate in the Medicare Prescription Payment Plan?

No. Participation in the Medicare Prescription Payment Plan is voluntary and may not be a good fit for everyone.

Who is likely to benefit from the Medicare Prescription Payment Plan?

The program might be a good fit if a member has high Medicare-covered Part D drug costs, will hit the $2,000 annual out-of-pocket maximum amount before September and want to spread their Medicare-covered Part D drug costs throughout the remainder of the year. UnitedHealthcare is required by CMS to will proactively reach out to members who may be a good fit for the program prior to (for already existing members) and during the plan year.

Who is not likely to benefit from the Medicare Prescription Payment Plan?

- Their yearly drug costs are low and relatively the same each month
- Payments they or others on their behalf make won't hit the $2,000 annual out-of-pocket maximum
- They have a health reimbursement arrangement, health savings account or other secondary coverage
- They qualify for Extra Help or another government program to help save on their prescription drug costs
- They receive help paying for their drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a coupon program, or other health coverage

2025 Part D Overview

Frequently Asked Questions

Are all prescription drugs included in the Medicare Prescription Payment Plan?

All Medicare Part D covered prescription drugs are included in the Medicare Prescription Payment Plan. Medicare Part B drugs and bonus drugs are not eligible to be included in the program. Off-benefit drugs, paid for with a discount card or covered by a patient assistance program (PAP), are also not included.

Can a member leave the Medicare Prescription Payment Plan after they have joined?

Yes. Members can opt into or out of the program at any time throughout the year. If a member leaves the program, they are still required to pay their outstanding balance. Their Medicare drug coverage and other Medicare benefits won't be affected, and they'll go back to paying the pharmacy directly for all their drug costs.

What communications can a member expect to receive regarding the Medicare Prescription Payment Plan?

- **A likely to benefit notice:** A standard model document, required to be sent by CMS, explaining the program that all members will receive.
- **An educational flyer:** An insert explaining the program that will be sent with the member's ID card mailing and the election request form.
- **An election request form:** A paper form members can use to opt into the plan.

This is not all-encompassing list. If a member enrolls, they may receive other communications.

What happens if a member participating in the Medicare Prescription Payment Plan switches plans or insurance providers and has an unpaid balance?

If a member decides to switch plans or insurance providers, their participation in the program will end and they are still required to pay their balance. They can pay the remaining balance in full or continue to pay their monthly bills through the end of the year. If a member's plan year ends in December, for example, they will receive a bill in January. If a member has an unpaid balance, they will continue to receive monthly bills until the balance is paid in full.

A member can rejoin the program through their new plan or insurance provider. It's possible a member could be paying Medicare Prescription Payment Plan bills from 2 plans or insurance companies at the same time. If a member has a past due balance, they will not be able to rejoin the program with the same insurer until their past due balance is paid.

What happens if a member doesn't pay their Medicare Prescription Payment Plan bill?

If a member doesn't make their monthly payments, they will receive a notice of late payment. Members will have up to 2 months to make a payment for a past due balance before they will be removed from the Medicare Prescription Payment Plan. They can only rejoin the program after they pay their outstanding balance.

They should always pay their plan premium first. A member's monthly plan premium payment will never be applied to an outstanding Medicare Prescription Payment Plan balance. It's important that members always send separate payments for their program bills and their premium. They should never send one check with combined payments. Payments should always be sent separately.

If a member has questions about their bill or making a payment, please refer them to or help them contact Customer Service.