MEDICARE OPTIONS FOR PHARMACY 2026

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KPhA works with the Kentucky Pharmacy Education and Research Foundation, Inc. to certify its courses. ACPE UAN 0143-9999-26-061-L99-P/T
KPERF is accredited by ACPE as a provider of continuing pharmacy education.

DISCLOSURES

Faculty

Linda Turley and Tatsuya Hidano, faculty for this activity, have no relevant financial relationship(s) with ineligible companies to disclose.

Linda Turley, faculty for this activity, has been a volunteer Certified Counselor with Senior Health Insurance Counseling of Kansas (SHICK) since August, 2021.

Planners

None of the planners for this activity have any relevant financial relationships with ineligible companies to disclose.

PHARMACIST OBJECTIVES

- Differentiate which Medicare Part(s) pays for prescriptions and which vaccines.
- Differentiate between Medicare Parts B and D drug coverage in common clinical scenarios.
- Differentiate between Medicare Part B and Medicare Part C (Advantage Plans in common scenarios.
- Identify key benefits of the Low-Income Subsidy (LIS/Extra Help) program for Medicare beneficiaries..
- Identify key indicators of the Medicare Savings Program (MSP) for Medicare Beneficiaries.
- Identify roles of pharmacists and assistants in helping patients evaluate drug plans during Open Enrollment.
- Express the known details and qualifications for the new Medicare GLP-1 Bridge Program for weight loss.

TECHNICIAN OBJECTIVES:

- Explain the functions and differences between the Parts of Medicare to clients.
- Explain the pharmacy technician's role in assisting clients during Medicare Open Enrollment.

PRE-TEST

Who likes pepperoni pizza? Raise your hand.

Those who like Pepperoni pizza find someone who doesn't like pepperoni pizza, give them a high five.

Exchange names and where you each work and position.

Answer the Pre-Test questions on the page in front of you together.

DISCUSSION TOPICS

What is Medicare and who is eligible

Original Medicare

- Part A and B
- Part D
- Medigap (supplement insurance)
- Part C – Medicare Advantage Plans

How to get help paying for Medicare costs

GLP-1 Medicare Bridge Program

Medicare Open Enrollment

WHAT IS MEDICARE & ELIGIBILITY

Medicare is federal insurance covering approximately 80% of Hospital and medical costs.

Does not include routine:

- Dental
- Vision
- Hearing

Eligibility

- Persons age 65 or over
- Under 65 if on SS Disability Income
- Have end stage renal cancer
- Have ALS/Lou Gehrig's Disease

ORIGINAL MEDICARE PARTS A & B

Part A – Hospital Insurance

- Inpatient Hospital
- Skilled Nursing – limited time
- Hospice Care
- Cost: $0 - $565/ month

Part B – Medical Insurance

- Healthcare Providers
- Medical Equipment
- Labs and Tests
- Outpatient Hospital
- Care in a clinical setting
- Cost: $202.90 - $689.90/ month
- $283 Annual Deductible

MEDIGAP/SUPPLEMENT INSURANCE

Offered by private insurance companies to pick up 20%

- Plans A-N (not the same as Medicare Parts A-D)
- Fills gaps in Original Medicare
- May pay copays, coinsurance, and deductibles
- DOES NOT cover prescription drugs
- Initial purchase with Guaranteed Issue Right – no health questions

MEDICARE PART D PRESCRIPTION DRUGS

Drug Coverage Approved by Medicare
Optional, through Private Insurance

January-December each year
May pay penalty w/o credible plan

Requirements:
- Have Part A,B or both
- Live in plan service area
- Purchase regardless of health status
- Only have one Part D plan
- Will cost more for higher incomes – Add $14.50-$91.00/ month

Things to Consider:
- Does not cover all drugs. No OTC
- 2026 Premiums $0-$147 / month
- Copays $0-$600+ depends on drugs
- Deductibles (retail paid first)
  Annual Deduct $615 for most
  Max (Deduct + Copays) $2,100/ yr.

Medicare Part D

Part D Benefit Cost Periods	Costs and Who Pays	Beneficiary Pays (TrOOP)	Plan Pays	Total Amount Spent on Plan-Covered Drugs
Initial Deductible	Beneficiary pays 100%	Up to $615	$0	$615 (Amount spent on deductible, before ICP begins)
Initial Coverage Period (ICP)	Costs of covered drugs are shared: 25% by beneficiary, 75% by plan	Up to $1,485 (max a person would pay for covered drugs with no deductible)	$4,455	$2,100 True Out-of-Pocket (TROOP) maximum *(Includes what the beneficiary pays plus the 10% manufacturer discount on brand-name drugs during the Initial Coverage Phase.)*
Catastrophic Benefit Period	When an enrollee's total out-of-pocket spending reaches $2,100, they hit the catastrophic benefits period. After this point, the beneficiary does not have to pay anything for their prescription drugs for the rest of the year.	$0	100%	Beneficiary will remain in the Catastrophic Benefit Period through Dec. 31, 2026. Part D benefit will reset on Jan. 1, 2027, starting again with a deductible.

Source: Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements

Additional Part D Information

•Deductible is annual.
- You pay the **plan retail cost** for your medications until the deductible is met.
- If your plan has **no deductible**, initial coverage starts with your first fill.
- Some plans offer at least one drug tier with No Part D Deductible.

•Catastrophic max out-of-pocket:
- $2,100 (includes deductible)
- If a drug is **not covered**, its cost **does not count** toward any Part D phase totals.

•Medicare Prescription Payment Plan:
- Optional. You pay the **plan**, not the pharmacy.
- Spreads drug costs over the year (does **not** lower the cost).

WAYS TO HAVE YOUR MEDICARE

How do you want to get coverage?

Original Medicare 2026
(Your Primary Insurance) **80%**

Part A: Hospital $0 monthly
Part B: Medical $202.90/ mo. most
Annual Deductible $283

Part D: Drug Coverage AD $615
(Private Insurance) $0-147/ mo.
Co-pay $0-600/ mo. $2,100 Max.

Medigap or Supplement Coverage
(Private Insurance) **20%**
$0-632/ mo.

Medicare Advantage Plans $
HMO, PPO, PFFS
MOOP $

Part C of Medicare
Combines Hospital, Medical *and possibly*
Prescription Drug Coverage

You can't use or be sold a Medicare Supplement (Medigap) policy.

MEDICARE PART C - ADVANTAGE PLANS

Another way to get Parts A & Part B Coverage

- Run by private insurance companies, that company is in charge
- Usually includes Part D coverage, most with annual deductible & yearly maximum
- May offer extra benefits:
  - Dental
  - Vision
  - Hearing
  - OTC drugs, transportation and a gym membership

MEDICARE PART C – ADVANTAGE PLANS

How they work

- Receive services through the plan, all Part A- & B-covered services.
- May have to use in-network providers, hospitals and pharmacies.
- Health Maintenance Organizations (HMOs) – smaller group of providers and only pay costs for In Network providers
- Preferred Provider Organizations (PPOs) – larger group of providers and pay up to 50% of Out of Network providers

MEDICARE PART C – ADVANTAGE PLANS

Advantage Plan Costs

- Must have Medicare Part A and Part B and pay the monthly premiums for each($202.90 or more for Part B). No additional monthly plan premium.
- May differ from Original Medicare in benefits and cost sharing
- "Pay-as-you-go" with copays, coinsurance, deductibles, percentage of cost of procedures until the annual Max Out of Pocket amount met.
- Max In Network: $3,500 – $9,250, Max Out of Network $5,700 - $12,000

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Medicare Advantage Plans $0
Part C of Medicare
Combines Hospital, Medical *and possibly*
Prescription Drug Coverage

HMO, PPO, PFFS LOCAL
Part A & B Premiums plus Annual MOOP
In Network $3500-9250 Out: $5700-12,000
With Copays, coinsurance, deductibles and %s

You can't use or be sold a Medicare Supplement (Medigap) policy.

MEDICARE PARTS A & B VS PART D

Original Medicare Parts A & B

Patient takes Prolia as injection at doctor's office quarterly, covered by Medicare Part B and Medigap Plan F.

Provider Charged	Medicare Allowed	Patient Cost
$4,816	$1,927	$0

Part D Drug Plan

Same patient told to pick up Prolia at pharmacy and self inject or "have pharmacist do it". (Pharmacy not considered a "clinical setting".) Plan has a $615 deductible which none has been paid this year. Cost???

NC Retail	Covers (2nd)	Assist Plan
$4,683	$998 ($549)	$0-$300??

ORIGINAL MEDICARE VS ADVANTAGE

Original Medicare Parts A & B

Patient takes Prolia as injection at doctor's office quarterly, covered by Medicare Part B and Medigap Plan F.

Provider Charged	Medicare Allowed	Patient Cost
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Part C Advantage Plan

Same patient told to pick up Prolia at pharmacy and self inject or have pharmacist do it. (Pharmacy not considered a "clinical setting".) Plan has a $3,500 MOOP which none has been paid this year. Cost???

NC D	D Covers (2nd)	Part B in Plan
$4,683	$1,153 ($947)	$1,894 (retail)

HOW CAN PHARMACY HELP?

Medicare Part A&B vs Part D

- Look for other payment/filing options
- Preferred Drug Stores
- Prescription discount card options
- Look for Manufacturer Plans
- Recommend suitable substitutions
- Medicare prescription payment plan

Medicare vs Advantage

- Review payment/filing options – MOOP
- Preferred Drug Stores
- Prescription discount card options
- Look for Manufacturer Plans
- Recommend suitable substitutions
- Medicare prescription payment plan

GET HELP PAYING PRESCRIPTION COSTS

Extra Help (Low-Income Subsidy)

- Federal Program (LIS) through Social Security
- Based on gross income and assets below 150% federal poverty level
- Benefits: $0 Plan Premiums
- $0 Annual Deductible
- Removes late enrollment penalties
- Continuous enrollment window
- Cap on Copays - $4.90 generics
  - $12.15 on Brand Name

Medicare Savings Program (MSP)

-State program through Kansas Medicaid (KanCare)
-Based on state-defined gross income & asset levels (lower than MSP levels)
-Benefits: Pays for Part B Premium
-Full KanCare pays Part A & B Premiums, and copays, deductibles, coinsurance
-If qualified, assumes getting LIS.
-Uses same LIS application.
-Handout for qualifying levels.

GLP-1 BRIDGE PROGRAM

- Short term demonstration run by CMS (managed through Humana as central processor) providing certain GLP-1 drugs for weight loss & maintenance only from 7-1-26 to 12-31-27.
- Operates outside Medicare Part D benefits and payment flow. Copays do not count toward annual deductibles or max payout.
- For patients who have not received GLP-1 through their Part D plan and do NOT have type 2 diabetes, moderate to severe sleep apnea or fatty liver disease. (Those beneficiaries continue to obtain GLP-1 prescriptions through regular Part D plan with deductibles and maximum yearly out of pocket amounts, even if they otherwise meet the GLP-1 clinical criteria.)

GLP-1 BRIDGE PROGRAM ELIGIBILITY

Clinical Requirements for All beneficiaries seeking program:

- At least 18 years of age.
- Provider must submit prior authorization request that attests beneficiary meets the criteria through CMS Central Processor:
  - Drug to reduce excess body weight & maintain weight reduction in combination with current and ongoing lifestyle modification including structured nutrition and physical activity.
  - At the time of initiation of GLP-1 therapy have a BMI greater than or equal to thirty-five (≥35) OR

GLP-1 BRIDGE PROGRAM ELIGIBILITY

Clinical Eligibility requirements continued:

- Have a BMI greater than or equal to thirty (≥30) at the time of therapy initiation with a diagnosis of one or more of the following:
  - (A) heart failure with preserved ejection fraction,
  - (B) uncontrolled hypertension (defined as systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm HG, despite concurrent treatment with two antihypertensive medications), or
  - (C) chronic kidney disease stage 3a or above, OR

GLP-1 BRIDGE PROGRAM ELIGIBILITY

Clinical Eligibility requirements continued:

- Has a BMI greater than or equal to twenty-seven (≥27) at the time of GLP-1 therapy initiation with a diagnosis of one or more of the following:
  - (A) pre-diabetes (as defined by American Diabetes Association),
  - (B) previous myocardial infarction,
  - (C) previous stroke
  - (D) symptomatic peripheral artery disease.

GLP-1 BRIDGE PROGRAM MEDICATIONS

THREE GLP-1 MEDICATIONS AVAILABLE FOR BRIDGE (as of 7-10-26)

- Foundayo® NDCs: 0002-4178-31, 0002-4503-31, 0002-4794-31, 0002-4803-31, 0002-4839-31, 0002-4953-31
- Wegovy® (injection and tablets) NDCs: 0169-4525-14, 0169-4505-14, 0169-4501-14, 0169-4517-14, 0169-4524-14, 0169-4415-31, 0169-4404-31, 0169-4409-31, 0169-4425-31, 0169-4572-14.
- Zepbound® (KwikPen) NDCs: 0002-3566-11, 0002-3555-11, 0002-3544-11, 0002-3533-11, 0002-3522-11, and 0002-3511-11.
- Mounjaro©, Ozempic© or Rybelsus© are NOT COVERED through the GLP-1 Bridge program.

GLP-1 BRIDGE PROGRAM COSTS

Special program with defined costs:

- Beneficiaries pay a copay of $50 per 30-day monthly supply; no less than 30, 60- or 90-day fills are not available. This program is outside Part D payment flow and coverage.
- No part of the copay counts toward deductibles and maximum out of pocket. There is NO low-income subsidy (LIS) provided. No discount coupons or discount programs may be applied.
- Pharmacies will be reimbursed at wholesale acquisition cost less copay plus a dispensing fee of $3 per claim ($5 for beneficiary residing in long-term care).

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 1, Route to Part D or GLP-1 Bridge:

- Does patient have eligible Part D plan?
- Is the prescription for Medicare GLP-1 drug?
- Does this patient have existing coverage for GLP-1s under current plan?
- Has the patient or prescriber said this prescription should go to Medicare GLP-1 Bridge?

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 2, Route to GLP-1 Bridge

- Provider sends prescription to pharmacy directing to use GLP-1 Bridge including an obesity diagnosis code (E66 family) indicating "SEND TO BRIDGE FOR WEIGHT MANAGEMENT" in note field or an annotation.
- BIN/PCN of Bridge is 28918/MEDDGLP1BR
- Need Medicare Beneficiary ID # to submit claim. If no Medicare card use last 4 digits of Social Security number to look up Medicare # via Medicare E1 transaction.

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 3, Wait for claim denial from Bridge

- Bridge assesses the patient's eligibility. If the claim fails, pharmacy gets denial and denial code with an explanation. If the claim passes the eligibility check, it's denied because a prior authorization is required.
- List of denial codes:

  https://www.cms. gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 4, Transmit PA to Provider

- Use existing processes to transmit the prior authorization request to provider. If electronic system, such as CoverMyMeds, may be automatic or manual.
- No electronic system may use fax or notify by email or phone. Provider can submit PA form via fax or electronic prior authorization (ePA).

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 5, Wait for denial or acceptance

- If PA rejected prescriber & patient notified with denial reason.
- If PA accepted prescriber & patient notified. This should occur in 72 hours.
- Pharmacy uses existing processes to find status. Electronic system may receive notification status. No electronic system may not receive notification and will need to resubmit the claim. If approved, the claim will process.

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 6, Dispense the Prescription

- Patient picks up their prescription, collect a $50 copayment, even if they normally receive Medicare Extra Help (LIS).
- GLP-1 Bridge works outside of the Part D benefit, $50 copayment doesn't count toward the Part D deductible or annual out-of-pocket maximum.
- Prescription is not eligible for the Medicare Prescription Payment Program.

GLP-1 BRIDGE PROGRAM PROCESS

Filling GLP-1 prescriptions; Step 7, Dispense refills

- After the first fill is approved, subsequent fills won't need a new prior authorization, unless the patient switches from one covered GLP-1 drug to a different one.
- Only 28-day or 30-day fills are covered under Medicare GLP-1 Bridge, not longer time periods.

For more information visit:
https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-pharmacies

MEDICARE OPEN ENROLLMENT

- Occurs every year between October 15 – December 7 to make changes for next year's drug plans. New plan effective Jan. 1 – Dec. 31.
- Only time to change drug plan due to plan changes of premiums and/or drug coverage. Don't do anything, stay on same plan.
- Medicare beneficiaries should have a Part D drug plan or an Advantage Plan that covers drugs. Some could also be covered by employer, state or federal plan, TRICARE, VA benefits. If they do not have a credible plan, they could be subject to permanent monthly penalties.

WHAT ARE SHICK COUNSELORS?

- Certified every year by State of Kansas to provide unbiased advice.
- Help beneficiaries with their specific drugs in their Medicare.gov account, comparing different plans and pharmacy costs.
- If beneficial to switch plan for following year, enrollment through their Medicare.gov account.
- Medicare takes care of transferring accounts. Patients don't have to do anything but wait for a new Welcome packet with new card.

OPEN ENROLLMENT HOW TO HELP

- Ask patients if they have reviewed their Part D plan for next year.
- They will get a letter from their current plan in late September with plan changes. Help them review it, if they request.
- Refer them to SHICK, 316-660-0126. Set OE appointments starting August 1.
- An insurance broker can also help them during OE dates.

POST-TEST

1. Client asks, "How can I tell which part of Medicare is paying for this bill?"

   A. Part D covers all your drugs and vaccines.

   B. It will probably cost you less if you get your Prolia shot using your Part B and supplement plan.

   C. Skilled nursing is done in your doctor's office.

   D. Your Advantage Plan will work all over the country for any non-life-threatening injury at no cost to you.

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2. Which Coverage scenario is paid by Medicare Part B?
   A. All prescription drugs and some vaccines.
   B. All vaccines.
   C. No prescription drugs or Shingrix, RSV shots or TDAP vaccines.
   D. Prescription drugs and flu, pneumococcal, COVID 19, and Hepatitis.

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3. How are medications administered in a physician's office (such as injections) typically covered under Medicare?

A. Usually under Part B when administered in a clinical setting.

B. Always under Part B.

C. Always under Part D.

D. Not covered by Medicare.

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4. What features are included in Part B?

A. Mandatory annual out-of-pocket limit.

B. Healthcare providers included in your in-network HMO or PPO.

C. Dentists and eye doctors within the local area.

D. Your choice of doctors, specialists and hospitals that accept Medicare.

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B. Healthcare providers included in your in-network HMO or PPO.

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5. What is a key benefits of the Low-Income Subsidy (LIS/Extra Help) program?

A. It eliminates the need to enroll in a Part D plan.

B. It reduces premiums and lowers prescription drug co-payments.

C. It guarantees all drugs are free.

D. It automatically enrolls beneficiaries into Medicare Advantage plans.

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6. What is a key benefit of the Medicare Savings Program (MSP) for Medicare Beneficiaries?

A. It can pay for the monthly Medicare Part B premium of $202.90.

B. There are four levels of qualification.

C. The income and asset levels for qualification are higher than the federal Extra Help program.

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7. What is a qualification for the Medicare GLP-1 Bridge Program for weight loss and when does it start?

A. The program is for beneficiaries with a BMI over 35 and starts in October.

B. Medicare will pay for all weight loss drugs at $245 with a monthly $50 copay.

C. Program starts July 1, 2026 with a special authorization process through CMS Central Processor.

D. The weight loss drugs are purchased like any other prescription.

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8. Client asks, "What is Open Enrollment and do I have to do anything?

A. No, Medicare takes care of everything.

B. You should call your friend or relative and ask what they are doing.

C. You don't need a drug plan, you are only taking this generic drug.

D. Look at your current drugs and your current plan every year in your Medicare.gov account between October 15 and December 17.

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9. What can pharmacists and assistants do before and during Open Enrollment (Oct 15-Dec 7) to encourage beneficiaries to review and look at Part D or Advantage Plans for the following year?

A. Determine the plan the beneficiary has for the current year and if they have received notice from the plan as to changes for the next year including premium and/or copay changes along with drug coverage changes. Review information with them if they have brought the letter.

B. Urge beneficiaries to look at their Medicare.gov account and check their drug list accuracy. Print their current drug list for them.

9. Cont'd.

C. Put up a sign or urge them to call (316-660-0126) for an appointment with SHICK on August 1 and leave a message. An appointment will be reserved for them during Open Enrollment. Over 2,000 appointments were made last year in Wichita alone. There is also a state SHICK Hotline (800-860-5260) if they are outside Wichita to direct them to the nearest SHICK office.

D. All of the Above!

9. What can pharmacists and assistants do before and during Open Enrollment (Oct 15-Dec 7) to encourage beneficiaries to review and look at Part D or Advantage Plans for the following year?

D. All of the above options are helpful.

REFERENCES

MEDICARE INFORMATION:
www.kdads_medicare@ks.gov

GLP-1 INFORMATION :
https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-pharmacies

THANK YOU!

Questions?

You can reach me at SHICK

Name Linda Turley
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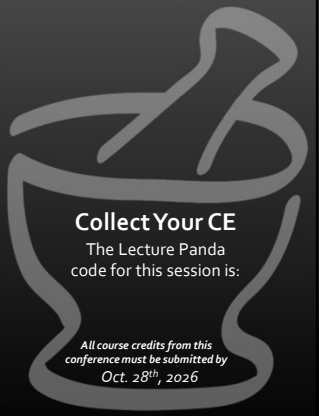

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The Lecture Panda code for this session is:

All course credits from this conference must be submitted by Oct. 28th, 2026