

## V. Costs and Prices

*This section covers:*

- *Beneficiary cost-sharing*
- *True Out-Of-Pocket costs (TrOOP)*
- *Coverage gap, also known as the “doughnut hole”*
- *Late Enrollment Penalty*

Both PDPs and MA-PDs have beneficiary cost-sharing features. But, keep in mind that those who qualify for the Extra Help program receive a low-income subsidy (LIS) to help cover some or all of these costs that others pay out-of-pocket. *Please refer to Chapter VI “Help for Low-Income Beneficiaries” for more in-depth information.*

### A. Beneficiary Cost-sharing

Beneficiaries enrolled in a Part D plan have cost-sharing responsibilities. These generally include the monthly premium, an annual deductible, and co-payments or co-insurance for each prescription filled. Beneficiaries may also have significant out-of-pocket costs while in the coverage gap or “doughnut hole.” Subsection B, “*True Out-Of-Pocket (TrOOP) Costs and the Coverage Gap,*” will discuss these costs in more detail.

#### *Monthly Premiums*

Monthly premium amounts range widely. Plans with higher premiums typically offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for generics in the coverage gap or “doughnut hole.” *Please refer to Section II “Types of Plans” for more information on enhanced plans.*

Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check or money order. Beneficiaries may also elect to have the premium deducted from their Social Security checks by informing the plan or selecting this option on the application. However, data transfers from the drug plans to CMS and then to SSA can take a few months to process, resulting in several months of premiums taken out of a beneficiary’s Social Security check at once. Additionally, some plans allow beneficiaries to make an electronic payment by phone or through the Internet by using credit cards.

**Counseling Tip:** Due to data match errors in 2006 and 2007, many beneficiaries had erroneous premium deductions taken from their Social Security checks. For 2008, it is recommended that beneficiaries make changes to their plans as close to November 15 as possible to avoid such errors.

#### *Annual Deductible*

A deductible is the amount a beneficiary owes out-of-pocket before the drug plan starts to pay for medications on its formulary. The MMA allows plans to charge an annual deductible of \$275.00 or less (2008). The allowed deductible amount increases each year. Plans with the defined standard benefit have a \$275.00 annual deductible, whereas basic alternative and

enhanced alternative plans have annual deductibles as low as \$0.00. SHIP counselors should note that the absence of a deductible does not mean that a drug plan is, on the whole, more affordable than plans with a deductible. It is important for your clients to consider other cost and coverage factors as they make enrollment decisions. *Please refer to Chapter III “Eligibility and Enrollment” for more detailed information on how to select a plan.*

### *Co-payments and Coinsurance Amounts*

The MMA allows the drug plans to charge either a co-payment (co-pay) or coinsurance amount for each medication that an enrollee fills at the pharmacy. Beneficiaries will find the lowest co-payments at preferred pharmacies in the drug plan’s pharmacy network. Each plan sponsor determines the co-pay or coinsurance amount, and the amount differs according to the drug plan’s design. Typically, the beneficiary pays this out-of-pocket cost at the time he receives the filled prescription.

Co-pays are a flat-rate amount, such as \$10 or \$25, for each prescription. Coinsurance charges are based on a percentage of the total cost of a prescription, such as 25 percent (as in the case of a basic standard plan).

**Counseling Tip:** A plan that uses the co-payment structure may be more “user-friendly” in calculating drug costs for budgeting purposes.

**For Example:** Aleisa had two prescriptions filled at her local pharmacy, one of her drug plan’s preferred pharmacies. The plan’s price for Furosemide is \$20 and \$100 for Fosamax, for a total of \$120. After meeting her annual deductible of \$275.00, she must pay a 25 percent coinsurance amount for each prescription she fills while in the plan’s initial coverage period. This means she pays \$5.00 (or 25% of \$20 for Furosemide) and \$25.00 (or 25% of \$100 for Fosamax) for a total of \$30 for both medications.

## B. True Out-Of-Pocket (TrOOP) Costs and the Coverage Gap

“True Out-Of-Pocket” (TrOOP) costs are those that a beneficiary incurs in the course of paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Note that the monthly premium does not count towards TrOOP costs.

It is important for SHIP counselors to understand the relationship between TrOOP costs and the initial coverage gap (doughnut hole) and the catastrophic coverage benefit in all Part D drug plans. As beneficiaries incur TrOOP costs, they move closer to the initial coverage gap. Using the standard design basic plan to illustrate, a beneficiary enters the coverage gap after incurring \$833.75 in TrOOP costs (2008). This includes the \$275.00 annual deductible and \$558.75 in coinsurance (2008). TrOOP costs only include payments for drugs that are on the plan’s formulary.

**Counseling Tip:** The monthly premium does not count towards the total true out-of-pocket costs (TrOOP) that a beneficiary must spend to get catastrophic coverage. Similarly, out-of-pocket payments for drugs that are not on the plan’s formulary do not count towards TrOOP.

During the coverage gap, the beneficiary’s coinsurance is 100 percent of the cost for covered drugs. These expenses also count as TrOOP costs. When a beneficiary has incurred \$4,050 in TrOOP costs (2008), he leaves the doughnut hole and reaches the threshold for the Part D catastrophic benefit. For the remainder of the calendar year, the beneficiary pays the greater of five percent of costs, or co-pays of \$2.25 for generics and preferred drugs and \$5.60 for other brand name drugs. The drug plan covers 95 percent or the balance of the cost.

**For Example:** Corey is enrolled in a standard PDP for 2008. By filling many medications, Corey has met his \$275.00 deductible for 2008 and reached the initial coverage limit of \$2,235. The Part D plan had paid 75 percent of the costs, or \$1,676.25, and he has paid 25 percent or \$558.75. He is now entering the coverage gap, during which he pays out-of-pocket 100 percent of the cost for all of his medications. Before Corey can use his drug plan’s catastrophic benefit during this calendar year, he will have to spend an additional \$3,216.25 on drugs that his plan covers through its formulary.

This example illustrates that a person passes through the doughnut hole and reaches the catastrophic benefit through the accumulation of TrOOP costs. Note that if Corey had purchased medications from a pharmacy that does not have a contract with his plan after he entered the doughnut hole, those payments would not count toward TrOOP costs, and he may never reach the catastrophic benefit.

The drug plans are responsible for calculating and reporting TrOOP costs. A plan must send a statement to every enrollee at the end of each month showing how much the plan and enrollee have paid in TrOOP costs. Pharmacies should also be able to tell enrollees how close they are to meeting a plan’s annual deductible or to reaching the coverage gap. Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket costs do not count. Please see the chart below for a detailed list.

### What is TrOOP?

TrOOP Includes	TrOOP Does NOT Include
Beneficiaries' out-of-pocket expenses including the annual deductible and any coinsurance or co-payment amounts	Monthly premiums paid to the plan
Beneficiary spending using health savings accounts (HSAs), flexible spending accounts (FSAs) and medical savings accounts (MSAs)	Amount paid by other insurance plans in addition to the beneficiary's Part D coverage (for example, an employer or retiree group plan's drug benefit)
Contributions or payments at the pharmacy by friends or relatives on a beneficiary's behalf	Amount paid by state programs that receive federal or public funds, such as AIDS Drug Assistance Program (ADAP) that help cover the beneficiary's costs
Contributions or payments at the pharmacy from certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are not on the plan's formulary
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to the beneficiary's inability to pay	Amount spent for prescription drugs that are purchased from a pharmacy that is not in the pharmacy network of the plan (except for emergency care)
Payments by Qualified State Pharmaceutical Assistance Programs (SPAPs) <sup>1</sup>	The total cost of a drug that a private Patient Assistance Program (PAP) provides to a beneficiary
Co-payments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are on their plan's formulary	Co-payments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are not on their plan's formulary

**For Example:** Hindy has a coinsurance cost of \$43.50 for one of her medications. When she pays it at the pharmacy counter every month, the pharmacist records her payment with the plan, and the plan counts it toward her TrOOP costs.

<sup>1</sup> As of July 1, 2007, the Virgin Islands and 25 states (Alaska, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Massachusetts, Maine, Maryland, Missouri, Montana, North Carolina, New Jersey, Nevada, New York, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, and Wisconsin) offer qualified SPAPs. Some states offer more than one qualified SPAP. More information is available from CMS at: <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAP7-5.pdf>

**For Example:** Alma is in the coverage gap of her basic benefit plan. She's paying approximately \$500 per month for all of her prescriptions. Her sister contributes \$100 for two of her medications, and she receives a discounted formulary medication through a private Patient Assistance Program (PAP) for which she has a \$5 co-pay that she owes when she picks up the prescription at her doctor's office once a month. Both her sister's contribution and her PAP co-pays apply towards her TrOOP costs. After approximately six months and two weeks (\$500 per month x 6 months and 2 weeks = \$3,250), she will have spent more than \$3,216.25 in the doughnut hole and reached the catastrophic coverage portion of the benefit for 2008. For the remainder of 2008, she will pay 5% of the cost of her prescribed drugs.

*For more information about how TrOOP relates to those receiving the Low-Income Subsidy, please see Section VI "Help for Low-Income Beneficiaries" for more details.*

**Counseling Tip:** The most important thing is for your clients to receive their medications. If they can do so less expensively outside of the plan benefit, and their expenses do not count towards TrOOP costs, this is perfectly acceptable as long as they understand that they won't reach the catastrophic coverage benefit (or get out of the coverage gap) during the year.

Please refer to the cost-sharing chart at the end of this section, "*Medicare Drug Coverage: Beneficiary Cost-Sharing (2008)*," which details the cost-sharing structure for the MMA's Standard Plan with its basic benefit.

### **C. Late Enrollment Penalty**

The Part D late enrollment penalty affects those without creditable coverage who delay enrolling in a Medicare drug plan. Creditable coverage is insurance coverage that is at least equal to or better than the coverage in the Part D basic benefit. Employer and union sponsored group health plans may offer creditable coverage to their retirees. *Please refer to Section III "Eligibility and Enrollment" for more information on creditable coverage.* When beneficiaries lose creditable coverage, as when a bankrupt employer terminates its group health plan, they have 63 days to enroll in a Part D plan. If they do not enroll in a Part D plan within 63 days of losing their coverage, they will face a late enrollment penalty if they decide to enroll in a Part D plan at a later date.

Beneficiaries who do not have creditable coverage and delay enrolling in a Part D plan beyond their first opportunity to enroll in a plan, will owe a late enrollment penalty. The penalty is added to their plan's monthly premium. The penalty will continue as long as they are enrolled in a Part D drug plan and, for many, this means that they will pay the penalty for the rest of their lives. The penalty is calculated as one percent of the Part D base beneficiary premium (\$27.93 for 2008) for each month that the beneficiary does not have creditable coverage and is not enrolled

in Part D plan. Please note that it is not calculated as a percentage of the premium for the drug plan in which a person eventually decides to enroll. The penalty amount will change each year because CMS calculates the penalty based on the Part D base beneficiary premium for a current calendar year.

**Counseling Tip:** The penalty is not 1% of the premium for the beneficiary’s chosen plan. It is equal to 1% of the Part D base beneficiary premium for the year multiplied by the number of months that the beneficiary does not have Part D or creditable coverage. This amount is added onto the premium of the plan that the beneficiary has selected.

**For Example:** Isidor did not want to sign up for Part D in 2006. He was confused about which plan to choose, and has had a Medigap policy “H” with Maroon Health for 12 years. It pays a percentage of his drug costs with an annual cap on its coverage. Because it lacks a catastrophic benefit, it is not “creditable coverage.” For 2008, Isidor has decided to enroll in a PDP. In December 2007, he enrolls in a PDP, Plan Complete, and will drop his Medigap policy when his Part D coverage starts on January 1, 2008. Since the drug coverage offered by his Medigap policy is not “creditable coverage,” Isidor will have to pay a late enrollment penalty when his Part D coverage takes effect in January. His penalty will be equal to one percent of the Part D base beneficiary premium (\$27.93) for 2008 multiplied by the 19 months he was without creditable coverage (19 is the number of months since the Initial Enrollment Period for Part D ended in May 2006). His plan will collect a penalty of \$5.31 plus a \$10.80 monthly premium, making his total premium amount \$16.11 for 2008.

**Penalty Example:** A plan’s premium is \$10.80 per month. The Part D base beneficiary premium is \$27.93 per month for 2008. The penalty is one percent of the Part D base beneficiary premium for every month without Part D and creditable coverage. Please see the table below.

.19 (19%)	x	\$27.93	=	\$5.31	+	\$10.80	=	\$16.11
1% x 19 months (the number of months without creditable coverage)		The base premium, national average for		Penalty amount		Monthly premium		Total monthly premium including the penalty

Beneficiaries who qualified for the Low-Income Subsidy (LIS) in 2006 or 2007 are exempt from the late enrollment penalty. According to CMS, those who qualify for the LIS in 2008 will also be exempt from the penalty through December 2008. For more information, please see the CMS press release available at: <http://www.hapnetwork.org/assets/pdfs/2008-lep-9-24-2007.pdf>.

### Medicare Drug Coverage: Beneficiary Cost-Sharing (2008)

	Annual Deductible	Initial Coverage Period*	Coverage Gap (Doughnut Hole)**	TOTAL	Catastrophic Benefit (After \$4,050 in TrOOP)
<b>Beneficiary Costs (TrOOP)</b>	\$275	25% of drug costs up to \$558.75	100% of drug costs up to \$3,216.25	\$4,050	Greater of 5% of drug cost or \$2.25/\$5.60 co-pay
<b>Plan Costs</b>	\$0	75% of drug costs up to \$1,676.25	\$0	\$1,676.25	Balance of drug cost
<b>TOTAL</b>	<b>\$275</b>	<b>\$2,235**</b>	<b>\$3,216.25</b>	<b>Out-of-Pocket + Plan: \$5,726.25</b>	

**Note:** A chart detailing the cost-sharing amounts for beneficiaries receiving the low-income subsidy is available on the HAP website. Beneficiaries reach the catastrophic benefit once they have spent \$4,050 out-of-pocket (in 2008) with approximate total drug spending at \$5,726.25 in prescription drug costs. (Total out-of-pocket spending does not include the monthly premium.)

\* During the Initial Coverage Period the beneficiary pays 25% (and the plan pays 75%) of prescription drug costs between \$275 and \$2,510. The plan pays up to \$1,601.25 of these drug costs, and the beneficiary pays up to \$533.75 out-of-pocket. *Only beneficiary's "true" out-of-pocket (TrOOP) expenditures- contributions from friends, relatives, and certain charitable foundations and state pharmacy assistance program payments- count towards TrOOP. Any amount paid by other insurance may not be counted towards TrOOP. Likewise, any payments for prescription drugs not on the plan's formulary will not count.*

\*\* Beneficiaries enter the coverage gap when total drug costs reach \$2,510.

Source: <http://www.cms.hhs.gov/MedicareAdvTgSpecRateStats/downloads/PartDAnnouncement2008.pdf>