

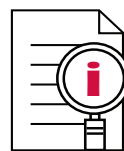
COSTS AND PRICES

This section covers:

- Beneficiary Cost-Sharing
- True Out-of-Pocket (TrOOP) Costs
- Late Enrollment Penalty

Beneficiaries enrolled in both types of Part D plans – PDPs and MA-PDs – will have costs associated with enrollment in those plans. The costs will differ from beneficiary to beneficiary and from plan to plan.

Those who qualify for the low-income subsidy (LIS) receive assistance from Medicare to help cover some or all of these costs that others pay out-of-pocket. Throughout this section, for the sake of simplicity, the costs and prices discussed will apply to those beneficiaries who do not qualify for LIS.



For more information about costs for low-income beneficiaries, see Help for Low-Income Beneficiaries on page 37.

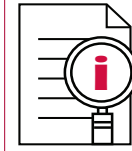
BENEFICIARY COST-SHARING

Beneficiaries enrolled in Part D plans almost always have cost-sharing responsibilities. These costs generally include the monthly premium, an annual deductible, and copayments or coinsurance for each prescription filled. Above a certain level of out-of-pocket spending, beneficiaries also will have costs in the coverage gap, also known as the “doughnut hole.” Once beneficiaries have spent to another set level, costs are minimal as there is a level of catastrophic coverage in the Part D plan design.

Monthly Premiums

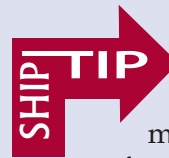
A premium is a set amount of money beneficiaries must pay each month to a Part D plan in order to be enrolled in a plan. Monthly premium amounts range widely. Depending on the region of the country, PDPs in 2010 have premiums anywhere from \$10 to \$120; the premiums for MA-PDs range from \$0 to several hundred dollars in 2010. Plans with higher premiums sometimes offer enhanced benefits, such as a broader formulary with more access to brand-name medications or coverage for some drugs in the coverage gap.

Stand-alone Prescription Drug Plans (PDPs) typically have higher monthly premiums than Medicare Advantage Plans with Prescription Drug Coverage (MA-PD) plans. Since MA-PD plans can offset the costs of the Part D premium from savings on Part A and Part B coverage, many MA-PD plans have a low or \$0 monthly Part D premium. As counselors, you may notice that beneficiaries sometimes gravitate to plans with low or \$0 premiums; to make a well-informed decision, beneficiaries should examine more than a plan's premium, or even a plan's total costs. Since the annual cost to those enrolled in Part D plans varies, the monthly premium is not the only cost consideration beneficiaries should weigh when comparing plans.



For more information about PDP and MA-PD plans, see Types of Drug Plans on page 5.

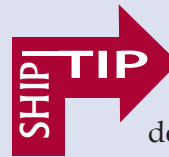
Beneficiaries have several options to pay the monthly premium to their plan. They can choose to pay the premium directly to the plan by check or money order. Another option is to have the premium deducted directly to the plan from a savings or checking account. Additionally, some plans allow beneficiaries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



Due to errors, some beneficiaries have had erroneous premium deductions taken from their Social Security checks. Many SHIPs have begun to advise beneficiaries to avoid having payments deducted from their Social Security checks because of this issue.

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 maximum annual deductible in 2010 is \$310. The allowed deductible amount increases each year. Plan deductibles range from \$0 to \$310 (2010), depending on the type of plan. Some plans have a structure in which certain tiers of their formularies are exempt from the deductible. For example, a plan could allow enrollees to pay reduced cost-sharing for generic drugs, but brand-name drugs are full price until the enrollee reaches the deductible.

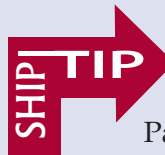


SHIP counselors should note that plans with no deductible are not necessarily more affordable than plans with a deductible. It is important for your clients to consider other cost and coverage factors as they make enrollment decisions.

Copayments and Coinsurance Amounts

After plan enrollees spend the full amount of a plan's deductible, they enter the period of coverage known as the "initial coverage period." During the initial coverage period, Part D plans charge either a copayment or coinsurance amount for each medication that enrollees fill at pharmacies. Each plan sponsor sets the copayment or coinsurance amount, and the amount differs according to the drug plan's design. Typically, beneficiaries pay this out-of-pocket cost at the time they receive each filled prescription.

Copayments are a flat-rate amount, such as \$5 or \$25, charged to beneficiaries for each prescription. Coinsurance charges are based on a percentage of the total negotiated price of a prescription, such as 25 percent (as in the case of a basic standard plan). Negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer. In effect, the negotiated price is the amount paid by Part D plans to pharmacies for each prescription drug filled by a plan enrollee.



For budgeting purposes, beneficiaries may find that Part D plans that use a copayment structure may be more "user-friendly" for calculating expected yearly drug costs.

TRUE OUT-OF-POCKET (TRROOP) COSTS

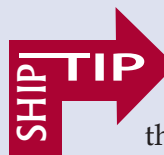
True Out-of-Pocket (TrOOP) costs are those that a beneficiary incurs in the course of paying the cost-sharing amounts for covered drugs under a Medicare Part D drug plan. Plans calculate these costs for each enrollee in order to determine which level of coverage to provide (i.e., deductible, initial coverage period, coverage gap, or catastrophic coverage). TrOOP includes the total amount of any annual deductible paid plus the price paid for each formulary prescription filled. 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 limit and catastrophic coverage. As beneficiaries incur costs under their Part D plans, they move closer to the initial coverage limit.

Using the standard design basic plan to illustrate, a beneficiary enters the coverage gap after incurring \$2,830 in total drug spending. (\$2,830 is the initial coverage limit in 2010.) The total drug spending amount includes the \$940 (in 2010) in TrOOP costs paid by the beneficiary plus about \$1,890 in plan spending. The TrOOP costs of \$940 include the \$310 annual deductible and \$630 spent in coinsurance (in 2010).

Note:

Plans may not use the term TrOOP but may call it "Your Costs" or "Your Spending."



The monthly premium does not count towards the TrOOP costs that beneficiaries must spend to get catastrophic coverage from their Part D plans. Similarly, out-of-pocket payments for drugs that are not on a plan's formulary do not count towards TrOOP.

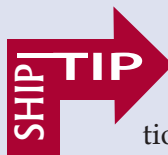
After plan enrollees reach the initial coverage limit of \$2,830 (in 2010) measured by total drug spending, they enter the coverage level known as the coverage gap. During the coverage gap, beneficiaries must pay the entire negotiated price for covered drugs. All formulary drug expenses in the coverage gap count as TrOOP. When beneficiaries have incurred \$4,550 in TrOOP costs (2010), they reach the catastrophic coverage threshold. Beneficiaries with catastrophic coverage pay the greater of five percent of the plans' negotiated drug costs or copayments of \$2.50 for generics and preferred brand-name drugs and \$6.30 for other brand-name drugs for the remainder of the calendar year. The Part D plan covers 95 percent or the balance of the cost.

Beneficiaries with LIS also incur TrOOP costs. Their TrOOP includes the amount Medicare pays for formulary drugs for LIS beneficiaries in Part D plans. For those with LIS, Part D plans use TrOOP to determine the point when beneficiaries enter catastrophic coverage. The catastrophic limit is the same for all enrollees in Part D plans.

A plan must send a statement, called an "Explanation of Benefits," to every enrollee at the end of each month showing how much the plan and the enrollee have paid in TrOOP costs. Part D plans are responsible for calculating and reporting TrOOP costs. (See Appendix A for CMS's *Model Explanation of Benefits*.)

TrOOP costs for each Part D enrollee follow enrollees throughout the plan year. If a beneficiary switches Part D plans, his TrOOP costs are transferred to the new Part D plan. For this reason, beneficiaries cannot switch Part D plans to "reset" their TrOOP costs and avoid the coverage gap. Because TrOOP follows Part D enrollees from plan to plan, there is no way to "game the system."

Certain out-of-pocket expenses count towards TrOOP costs, and other out-of-pocket spending does not count. See the chart on page 33 for a detailed list of costs.



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. Your clients need to understand that they may not reach the catastrophic coverage benefit during the year if they do not use their plans.

Enrollees who switch plans during a calendar year may want to refer to their monthly statements from their old Part D plan and their new Part D plan to check their TrOOP spending. It's important to make sure the plan is accurately calculating spending through the enrollment switch. When the new plan has a different cost structure than the old plan, the plan must calculate how TrOOP spending in the old plan will work in the new plan.

For example, an enrollee in a plan with a \$310 deductible changes plan in January. She has already spent \$100 to her plan's deductible in January. Her new plan has a \$0 deductible. The new plan must calculate how her \$100 affects her level of benefit.

TrOOP Includes	TrOOP Does NOT Include
Out-of-pocket expenses including the annual deductible and all coinsurance and copayment amounts for drugs on the plan's formulary	Monthly premiums paid to the plan
Spending from 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 (e.g., an employer or retiree group plan's drug benefit, VA, or TRICARE)
Contributions or payments for drugs on the plan's formulary paid by friends or relatives on a beneficiary's behalf	Amount paid by Medicaid or by state programs that receive federal or public funds, such as AIDS Drug Assistance Programs (ADAPs) that help cover the beneficiary's costs
Contributions or payments for drugs on the plan's formulary paid by certain charitable foundations on a beneficiary's behalf	Amount spent for prescription drugs that are non-Part D drugs or that are not on the plan's formulary (unless the enrollee received a formulary exception for a drug)
Unadvertised, individualized waivers or reductions of plan cost-sharing amounts by pharmacies due to a 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 drugs received due to a plan's out-of-network policy)
Payments by Qualified State Pharmaceutical Assistance Programs (SPAPs)*	Total cost of a drug that a private Patient Assistance Program (PAP) provides to a beneficiary
Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are on their plan's formulary	Copayments paid by beneficiaries who use private Patient Assistance Programs (PAPs) to cover Part D drugs that are not on their plan's formulary

* As of February, 2009, 24 states and territories offer qualified SPAPs. More information is available from CMS at <http://www.cms.hhs.gov/States/Downloads/QualifiedSPAP2.17.09.pdf>.

EXAMPLE *Alma is in the coverage gap of her basic benefit plan. She's paying approximately \$600 per month for all of her prescriptions. After approximately eight months in the coverage gap (\$600 per month x 8 months = \$4,800), she will have spent enough to reach the catastrophic coverage portion of the benefit for 2010. For the remainder of 2010, she will pay no more than 5% of the cost of her prescribed drugs.*

See Appendix B for the chart, *Medicare Drug Coverage: Beneficiary Cost-Sharing (2010)*, which details the cost-sharing structure for the MMA's standard plan with a basic benefit.

LATE ENROLLMENT PENALTY

The late enrollment penalty (LEP) affects those without Part D or 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. Generally all beneficiaries without creditable coverage for more than 63 days will face an LEP if they decide to enroll in a Part D plan at a later date.

Most beneficiaries who do not have creditable coverage and delay enrolling in a Part D plan will owe an

LEP. The penalty is added to their plan's monthly premium. The penalty will continue as long as they are enrolled in a Part D plan and, for many, this means that they will pay the penalty for the rest of their lives. Plans are not permitted to charge an LEP to beneficiaries with LIS.



For more information about creditable coverage, see Eligibility and Enrollment on page 11.

The penalty is calculated as 1 percent of the Part D base beneficiary premium (\$31.94 for 2010) for each month the beneficiary does not have creditable coverage and is not enrolled in Part D plan.

Another category of beneficiaries will not face an LEP, in one specific situation. The under-65 Medicare population, like all Medicare beneficiaries, who are not enrolled either in Part D or in creditable coverage for more than 63 days have an LEP if they later choose to enroll in Part D. These beneficiaries receive a new Initial Enrollment Period (IEP) upon turning 65. With the new IEP comes an exemption from past or current LEP. The exemption is in effect for beneficiaries who were paying an LEP as well as those who never enrolled in Part D and otherwise would have an LEP. The subsequent IEP, in effect, erases any previous record of months without creditable coverage.

Penalty Calculation

The LEP is not calculated as a percentage of the premium of the enrollee's chosen drug plan. 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. This amount is added onto the premium of the plan that the beneficiary selects. See the chart below for information on calculating the LEP.

(18%)	x	\$31.94	=	\$5.75	+	\$20.80	=	\$26.55
1% x 18 months (the number of months without creditable coverage)		Base Beneficiary premium		Penalty amount		Monthly premium		Total Monthly premium including the penalty

EXAMPLE *Ivan did not want to sign up for Part D when he was first eligible. Ivan decided to enroll in a PDP during the most recent Annual Enrollment Period. He chose Complete Choice PDP, and his Part D coverage began on January 1, 2010. His penalty is equal to one percent of the Part D base beneficiary premium (\$31.94) for 2009 multiplied by the 18 months he was without creditable coverage. His plan will collect a penalty of \$5.75 plus the \$20.80 monthly premium, making his total premium amount \$26.55 for 2010.*

