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## 2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries- The Twelfth in the Medlearn Matters Series on Drug Plans

### Provider Types Affected

Physicians, providers, and suppliers, and their staff who provide service to people with Medicare

### Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- Beneficiaries can join a Medicare Prescription Drug Plan that covers prescription drugs only and keep their Original Medicare coverage. Or, they can join a Medicare Advantage Plan or other Medicare Health Plan that covers doctor and hospital care as well as prescriptions.
- Medicare prescription drug coverage is NOT automatic - people must join a plan to get coverage
- Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.
- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

This penalty consists of an additional 1% of the base premium for every month the person went without coverage, and is levied as long as the person is enrolled in a Medicare drug plan.

- People who do not join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006 for their next opportunity to join.

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If your Medicare patients ask you questions about the new coverage, you can refer them to <http://www.medicare.gov> and 1-800-MEDICARE for additional information and assistance.

## General Information

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One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan.

Actual costs of the specific Medicare Prescription Drug Plans and the Medicare Advantage Plans or other Medicare Health Plans in each area are available in the "Medicare & You 2006" handbook and at <http://www.medicare.gov> on the web.

### *Costs Covered by a Standard Plan*

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below.

Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums.

Patient costs under standard Medicare drug coverage as defined by the MMA for 2006 will include the following:

- A monthly premium (average of \$32 in 2006);
- A \$250 deductible;
- Person pays, on average, 25% of allowable drug expenses up to a coverage limit of \$2,250 (plan pays the other 75%);
- After \$2,250 in covered drug costs, person pays 100% of covered drug costs until \$3,600 limit in true out-of-pocket spending is reached;
- About 5% coinsurance for covered drug costs after \$3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between \$2,250 and up to their true out-of-pocket limit of \$3,600. However, plan enrollees will still be able to obtain their plan's discounted price for prescription drugs in this coverage gap.

### *Alternate Coverage*

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than \$250, or use tiered copayments rather than

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coinsurance – provided that the alternative coverage structure meets certain tests of actuarial equivalence.

Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do not subsidize such supplemental coverage.

### ***Costs for Patients With Medicare and Full Medicaid Benefits***

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100% of the federal poverty level will have Medicare prescription drug coverage with no deductibles, no premiums, nominal copays, and no coverage gap.

Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost-sharing and no coverage gap.

## **Specific Information on Out-of-Pocket Expenses**

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### ***Medicare Drug Plan Premiums***

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below \$30.
- There will be at least one prescription drug plan with a premium below \$20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is \$32.20, about \$384 per year.

### ***True Out-Of-Pocket Costs***

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as “true out-of-pocket expenses” or TrOOP.

The TrOOP represents the amount a beneficiary must spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary's out-of-pocket expenses reach \$3,600 in a year.

In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount (\$250) and coinsurance (25% of covered drug costs during the plan payment + coinsurance stage);

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- All costs during the coverage gap stage; and
- Five percent of covered drug costs during the catastrophic coverage stage.

These additional TrOOP expenses are explained as follows:

**Deductible (From \$0 to \$250: A net value of \$250)**

Under standard coverage, plan enrollees pay a \$250 deductible each calendar year out of their own pockets for Part D covered drugs.

**Plan Payments + Coinsurance (From \$251 to \$2250)**

Once the annual (\$250) deductible is met, standard coverage pays for 75% of the next \$2,000 (or up to \$1,500) for covered (allowable) drugs and biologicals. The remaining 25% (a maximum of \$500) of the cost is covered by the beneficiary via coinsurance/copayments.

**Coverage Gap (From \$2,251 to \$3,600 TROOP limit)**

Once covered drug costs have reached the plan payment + coinsurance + deductible limit of \$2,250, the plan does not pay again until the plan enrollee has reached the \$3,600 limit in out-of-pocket spending. The beneficiary pays all covered drug costs incurred in this "gap." The total out of pocket cost (not including premiums) to this point (deductible + plan payments + coinsurance + coverage gap) is \$3,600 for coverage through the full "gap" (see TrOOP discussion below.)

**Catastrophic Coverage (Costs over \$3,600 TROOP limit)**

Once the individual's true out-of-pocket spending reaches \$3,600, costs for necessary covered drugs are covered as follows:

- Reinsurance – 80% of covered drug-related costs are covered by Medicare;
- Plan payments – 15% of covered drug-related costs are covered by the drug plan;
- Coinsurance – 5% of covered drug-related costs are covered by the individual.

***What Counts Toward True Out-of-Pocket (TrOOP) Costs?***

Beneficiaries must adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the \$3,600 limit.

The following types of spending count toward the \$3,600 threshold:

- The beneficiary's own out-of-pocket spending;
- Spending by a family member or official charity, on behalf of the beneficiary;
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare's extra help; and

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- Under the Centers for Medicare & Medicaid Services' (CMS') demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

In summary, the amount that a beneficiary must spend on part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

	\$250	deductible
+	\$500	plan enrollee coinsurance during initial coverage
+	\$2,850	coverage gap
=	\$3,600	(plus the monthly premium, which averages \$384/year)

Once this cost has been reached for covered drugs, catastrophic coverage begins.

## Related Links

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HHS Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit:

<http://www.hhs.gov/medicare2final.pdf> on the web.

For more information about *Medicare Prescription Drug Coverage for Providers*, visit [http://www.cms.hhs.gov/MedlearnProducts/23\\_DrugCoverage.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage) on the CMS web site.

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