



CMA Weekly Alert – March 23, 2006

## CALCULATING THE MEDICARE PART D DONUT HOLE

### Introduction

The focus for the first few months of the new Medicare Part D prescription drug program has been on problems experienced by Medicare beneficiaries with getting their medicines. Most discussions have omitted one of the biggest problems with the design of the new drug program: the “Donut Hole”, or gap in coverage.

The standard statutory Part D drug benefit provides for drug coverage for formulary drugs up to an initial coverage limit of \$2250. Upon reaching this coverage limit, beneficiaries fall into the Donut Hole; that is, they become responsible for the full cost of their formulary medicines. They do not get out of this coverage gap unless and until they incur \$3600 in out-of-pocket costs for drugs **on their Part D formulary** – for a total of \$5100 in costs for formulary drugs - in the same calendar year. They are, of course, also responsible for the full costs of non-formulary and non-covered drugs. Beneficiaries who reach \$3600 in qualifying out-of-pocket expenses are eligible for catastrophic drug coverage in the form of reduced cost sharing.

Now, three months after implementation of Medicare Part D, some beneficiaries are surprised to realize how quickly they reach the Donut Hole. They are further surprised to learn that they may not be able to get out of this coverage gap. This *Weekly Alert* will consider how the initial coverage limit and out-of-pocket limit are calculated and the impact of different benefit structures on how quickly the two limits are reached.

### Plan Benefit Structures

The Medicare Part D statute describes a standard benefit structure:

- \$250 deductible;
- 25% co-insurance on formulary drugs between the deductible and initial coverage limit;
- \$2250 initial coverage limit on total drug expenses;
- \$3600 out-of-pocket threshold, reached after total drug costs equal \$5100;
- Catastrophic coverage of no more than 5% co-insurance for formulary drugs.

The deductible, initial coverage limit and out-of-pocket threshold can increase each year based on increases in expenditures for Part D drugs. Thus, these figures are likely to be higher in 2007.

The statute also allows plans to provide actuarially equivalent benefits, that is, a benefit having the same value as the standard benefit. According to the Medicare Payment Advisory Committee (MedPAC), the standard benefit structure is offered by only 9% of stand-alone prescription drug

plans (PDPs) and by only 15% of Medicare Advantage plans with prescription drug coverage (MA-PDs).

Drug plans that offer an **actuarially equivalent benefit** change the cost-sharing requirements in different ways. For example, instead of requiring a 25% co-insurance amount for all drugs on their formularies, plans may have tiered co-payments whereby enrollees pay set and varying amounts depending on whether a drug is a generic drug, a preferred brand name drug, a brand name drug, or a specialty drug. Some plans may not require any deductible; other plans have a deductible that is less than \$250. Regardless of their specific benefit structure, plans that offer an actuarially equivalent benefit in 2006 cannot require beneficiaries to pay more than a \$250 deductible or to incur more than \$3600 in out-of-pocket costs to get catastrophic coverage.

Drug plans can also offer **enhanced benefit** packages that include more than the standard benefit for a higher premium. MedPAC notes that 42% of PDPs and 55% of MA-PDs offer enhanced benefits. Such plans may provide coverage for generic or brand name drugs in the Donut Hole or they may cover drugs that are excluded from coverage under Part D.

### **What are “total drug expenses” and “out-of-pocket expenses”?**

Beneficiaries often confuse the two different concepts used to calculate their cost-sharing. The concept of “total drug expenses” refers to the negotiated price for the drug at the pharmacy counter, and includes the amount the beneficiary pays and the insurance payment. This concept is used to calculate whether the deductible (if the plan has one) and the \$2250 initial coverage limit have been reached. The concept of “out-of-pocket expenses” includes only the payments made by the beneficiary, such as the deductible and the 25% co-insurance or the flat co-payments.

### **What counts toward the \$2250 initial coverage limit?**

Regardless of the benefit structure of the plan in which someone is enrolled, he or she will reach the initial coverage limit, and enter the Donut Hole, when total drug costs (not counting premiums) equal \$2250. Total drug costs are calculated by looking at the price of the drugs and include the beneficiary cost-sharing as well as the amount paid for by Medicare.

**For example**, two beneficiaries take three drugs with retail prices that total \$450 each month. **Beneficiary A** is in the standard drug plan and must pay the \$250 deductible and 25% co-insurance for his medicine. **Beneficiary B** is in an actuarially equivalent drug plan, has no deductible, and pays co-payments of \$10, \$20, or \$30 for her medicine. Although their cost sharing is different, both of them reach the Donut Hole after 5 months ( $5 \times \$450 = \$2250$ ) because their total monthly drug costs are the same.

**Beneficiary C** is enrolled in a different drug plan in which the three drugs have a total retail cost of \$350 each month. Beneficiary C would reach the Donut Hole in slightly more than six months because the total cost of the same drugs in her plan is less than the total cost of the drugs in the other plans.

It would seem, therefore, that beneficiaries can extend the time before they enter the Donut Hole by enrolling in the plan with the lowest prices for the medicines they take. Such a calculation is difficult to make, however. The negotiated price paid at the pharmacy (beneficiary cost sharing plus insurance payment) is not readily available on CMS or drug plan web sites. Even more important, drug plans can change the prices they charge for formulary drugs on a weekly basis. The plan that offers the lowest cost drugs one month may not offer the lowest cost drugs the following month. Because drug prices can change so frequently, beneficiaries may not be able to calculate with certainty when they will reach the Donut Hole. And, of course, the calculations may be meaningless if a beneficiary's prescriptions change.

### **What counts toward the \$3600 out of pocket limit?**

Benefit structure plays an important role in determining if and when a beneficiary will reach the catastrophic coverage. A beneficiary who pays less out-of-pocket at the beginning of the year may have more difficulty in exiting the Donut Hole. In order to understand why, one must look at how the \$3600 out-of-pocket limit is calculated.

The following payments **for drugs on the plan formulary** count toward the \$3600 out-of-pocket limit:

- The deductible, if the plan requires any;
- Co-payments for drugs on the plan's formulary, or list of covered drugs;
- Payments made by a state pharmacy assistance program (SPAP);
- Payments by family members or charities;
- Payments made by the low-income subsidy known as extra help

The following payments do not count toward the \$3600:

- Monthly premiums;
- Costs for non-formulary drugs;
- Payments by retiree health plans or other insurance;
- Payments by AIDS Drug Assistance Programs (ADAPs).

### **Examples**

**Beneficiary A** in the above example, who has total monthly drug expenses of \$450, would enter the Donut Hole in month five. He would have incurred \$750 toward his \$3600 out-of-pocket limit when he reaches the initial coverage limit, because he will have paid a \$250 deductible and \$500 co-insurance. (The co-insurance is calculated by multiplying 25% times \$2000, the difference between the deductible and the initial coverage limit.) That means he must pay \$2850 (\$3600-\$750) more out-of-pocket before he is eligible for catastrophic coverage. By paying the full \$450 each month for his drugs, Beneficiary A may reach the Donut Hole after 6½ months – meaning that he could get a reduced cost sharing for a few weeks at the end of the year.

Suppose, in addition to the \$450 in total monthly costs for covered drugs, Beneficiary A pays \$100 out-of-pocket for a non-formulary drug. The additional \$100 expense has no bearing on

whether or when Beneficiary A will get out of the Donut Hole and reach catastrophic coverage; costs for non-formulary drugs are not included in the calculation.

Suppose further that Beneficiary A also has a retiree health plan that pays for his co-payments. He will still reach the initial coverage limit in 5 months because the calculation is based on total drug costs. However, he will never get out of the Donut Hole, since payments made by a retiree health plan do not count toward the \$3600 out-of-pocket limit.

**Beneficiary B**, who has the same monthly drug expenses and who enters the Donut Hole at the same time as Beneficiary A, will never get out of the Donut Hole. Her total monthly out-of-pocket drug costs are \$60 ( $\$10 + \$20 + \$30 = \$60$ ). When she reaches the initial coverage limit after 5 months, she will only have incurred \$300 toward her \$3600 out-of-pocket limit. She will have to incur \$3300 more in prescription drug costs before catastrophic coverage begins. Since her drug costs are \$450 per month, she will not incur \$3300 in additional costs by the end of the year.

Suppose that Beneficiary B is in an enhanced plan that also provides supplemental coverage of generic drugs while in the Donut Hole. She will continue paying only \$10 for her lowest cost generic drug but she will pay the full cost of her more costly brand name drugs while in the coverage gap. The co-payment, not the full cost, of the generic drug will count toward the \$3600. Coverage of generic drugs in the Donut Hole constitutes supplemental coverage, and supplement coverage does not count toward the out-of-pocket limit. Since the co-payment presumably is less than the cost of the generic drug, she will have even lower out-of-pocket expenses and be even less likely to reach the \$3600.

It is unlikely that **Beneficiary C** will get out of the Donut Hole, either. She has monthly expenses of \$350 and enters the Donut Hole sometime in month 6. If she is in a plan that offers the standard benefit, she also will have paid \$750 out-of-pocket when she reaches the Donut Hole. Because she will pay \$350 out-of-pocket each month while in the coverage gap, she will need more than 8 months to incur the additional \$2850 in out-of-pocket spending. The calendar year will conclude before she reaches that amount. If she is in an actuarially equivalent plan with set, tiered co-payments, her out-of-pocket expenses also will not total \$3600.

## **Conclusion**

Calculating the Donut Hole is complicated. Beneficiaries cannot be assured that they will reach the other side and so cannot really calculate their Part D savings, if any, until the end of the year. Medicare beneficiaries would understand and be able to plan better for their prescription drug costs if there was a single, uniform drug benefit included as part of the traditional Medicare program.

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