CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

50% Discount on Part D Brand Name Drugs Starts January 1st

PUBLISHED: OCT. 26, 2010

Positive changes are happening to Medicare Part D next year as a result of the Affordable Care Act passed last March. Starting January 1, 2011, the ominous Part D donut hole, or coverage gap, will begin to close and gradually phase out by 2020. The first step of this 'phase-out' started this year with the $250 rebate checks. All beneficiaries who have 'fallen' into the donut hole in 2010 will have received a $250 tax-free rebate check from Medicare, mailed to them within 45 days of the end of the quarter in which they entered the donut hole. (Those with the low-income subsidy and/or drug coverage through their retiree plan are not eligible for the rebate.) The second step of the phase-out starts next year and will provide substantially more savings to beneficiaries. As of January 1, 2011, beneficiaries in the coverage gap will receive a 50% discount on all Part D covered brand name drugs and a 7% discount on generic drugs. This discount will gradually increase until beneficiaries pay just 25% of their drug costs in 2020.

How Will the Donut Hole Discount Work?

Part D plan members who reach the donut hole (after incurring $2,840 in drug costs in 2011) will receive their discount immediately when paying for their drugs at the pharmacy. There will be no delays or forms to fill out. The 50% brand-name drug discount applies to all "applicable" Part D covered drugs on the plan's formulary and/or a drug granted by an exception. Beneficiaries will pay 50% of the brand name drug's cost, plus a small dispensing fee (usually $2 - $5) charged by the pharmacy which will not be discounted.

"Applicable drugs" refer to brand name drugs provided by manufacturers who have signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the discount program. Drugs sold by manufacturers who do not sign an agreement will not be covered under Part D and cannot be requested by exception. CMS expects that most, if not all, manufacturers will sign agreements. Beneficiaries with non-applicable drugs will automatically receive the 7% generic drug discount.

What Costs Count Toward TrOOP — True Out-Of-Pocket Costs?

For brand name drugs, the total cost of the drug will be counted toward one's TrOOP, not just the 50% the beneficiary pays. For generics, however, only the amount the beneficiary pays, which in this case includes the dispensing fee, will count toward their TrOOP. This is because the 7% discount is provided through an additional subsidy from Medicare, rather than through rebates from the drug manufacturers.

For example, Anne just entered the donut hole and her brand-name prescription drug costs $70, plus a $2 dispensing fee. She'll pay $37 ($35 for 50% of the drug's cost + $2 dispensing fee), but $70 will be counted toward her TrOOP.

Anne also takes a generic drug which costs $10 plus a $2 dispensing fee. The 7% subsidy applies to both her drug cost and the dispensing fee, so she'll pay a total of $11.16, all of which will count toward her TrOOP.

Are There Exceptions?

Yes, there are exceptions.

1. The brand name and generic drug donut hole discounts do not apply to people with the low-income subsidy (LIS) and/or people in a retiree drug subsidy program.
2. As mentioned, the discount is only available if the drug's manufacturer has signed an agreement to participate in the discount program. Drugs sold by manufacturers who do not sign an agreement will not be covered under Part D and cannot be requested by exception.
3. The discount is only available if Medicare Part D is the primary payer. If there is secondary insurance, it will pay after the Part D discount has been applied.

In addition, if a beneficiary fills a prescription that crosses Part D stages of coverage, also referred to as a "straddle claim," the discount will only apply to the portion of the prescription that falls under the donut hole.

Additional Part D Plan Changes and Updates

There are fewer Part D plan offerings because CMS has required plan sponsors to consolidate under-enrolled and duplicative plans in 2011. In general, companies can now only offer one basic plan and one enhanced plan, which will make comparing plans easier for beneficiaries.

In California we currently have 47 prescription drug plans (PDPs) available; in 2011, there will be 33 plans. This reduction trend is seen nationwide. The 2011, national average premium for Part D plans is $32.34, up less than $1 from $31.94 in 2010. In California, 2011 PDP premiums will range from $14.80 to $114.80.

In addition, next year California will have 5 benchmark plans (plans with premiums below the average in California), which is down from 7 in 2010. The regional benchmark figure, however, will be higher at $32.35, up from $28.99.

Two provisions in the Affordable Care Act (Sections 3302 and 3303) also bring some good news for people with the Part D low-income subsidy (LIS). The number of beneficiaries with LIS that will be reassigned this year to a different Part D plan is down from 2.1 million to as few as 500,000 nationwide.

Section 3302 of the Affordable Care Act modifies the LIS regional benchmarks by requiring the use of basic Part D premiums before the application of Part C rebates for Medicare Advantage Part D plans (MA-PDs). The change in the benchmark calculation reduced the number of reassignments by about 1 million.

Section 3303 of the Affordable Care Act codifies the 'de minimis' policy, under which Part D plans may charge LIS beneficiaries a Part D premium equal to the low-income subsidy amount, even if the plan's basic premium exceeds the LIS benchmark by a "de minimis" amount. This amount is $2 in 2011. The law prohibits CMS from reassigning LIS members from plans who volunteer to waive the de minimis amount. In other words, if all plans with premiums within $2 of the LIS benchmark exercise their option to retain their LIS beneficiaries, nearly 600,000 LIS beneficiaries who would have otherwise been reassigned will remain in the current plans.

2011 Part D Standard Plan Costs

The chart below describes the required basic coverage under Part D. Part D plans must offer coverage that is at least as good as this standard plan. Most of the costs for 2011 are the same as they were for 2010 except that the initial coverage limit is $10 higher. This means it will take beneficiaries slightly longer to reach the donut hole. Even though the costs are similar to 2010, out-of-pocket expenses for beneficiaries who reach the donut hole will be substantially less due to the brand name and generic drug discount.

	Drug costs	Beneficiary pays (TrOOP)	Plan pays
Before meeting deductible	0-$310	100% = $310	0%
Initial coverage	>$310-$2,840	25% = $632.50	75%
Coverage gap (doughnut hole)	>$2,840-$6,447.50	100% = $3,607.50, minus discounts	0%
Catastrophic coverage	>$6,447.50	5% or $2.50/$6.30, whichever is greater	95%

Shopping for Coverage

With the Annual Election Period (AEP) about to start (Nov 15 – Dec 31), it's time for beneficiaries to review their current plan and its changes for 2011 and to see if it will still meet their prescription drug needs at a reasonable cost. If not, it's time to shop.

When comparing drug plans, beneficiaries should look at each plan's total annual costs, including the premium and cost-sharing (the deductible, copays and coinsurance), and carefully review plan formularies. They should make sure the drugs they take are available with as few restrictions (such as prior authorization requirements) as possible. To view and compare the premiums, deductibles, copays, formularies and restrictions of the plans in one's area, visit Medicare.gov.

Share Like

Copyright 2011 California Health Advocates

California Health Advocates: *the* best source of unbiased Medicare information for California beneficiaries.