Fact Sheet

Medicare Part D Open Enrollment for 2012: Increasing Plan Complexity Highlights Need for Careful Evaluation

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Medicare beneficiaries should closely examine their 2012 prescription drug plan choices during open enrollment for Part D—which now begins on October 15 and ends on December 7. Many plans are increasing cost-sharing and their reliance on utilization management tools for covered prescription drugs. "Extra Help" beneficiaries continue to be protected from high cost-sharing.

To make the most of Medicare Part D, beneficiaries need to closely investigate changes in plan benefits and choices. As a result of the Affordable Care Act, open enrollment now begins on October 15 and ends on December 7.

The Centers for Medicare and Medicaid Services (CMS) said that premiums for stand-alone Medicare Part D plans will continue to average around $30 in 2012.[1] But this new AARP Public Policy Institute (PPI) analysis shows that premiums for many popular stand-alone plans will be considerably higher (appendix A).

The analysis also shows that enrollees will face a range of out-of-pocket costs and/or utilization management tools for commonly used prescription drugs (see appendixes B through E).

Many enrollees will face higher cost-sharing and higher premiums than in 2011. Popular drug plans will not offer gap coverage beyond that required by the Affordable Care Act, which phases out the coverage gap by 2020 through a series of escalating discounts. In addition, higher-income Part D enrollees[2] will continue to be required to pay a larger share of their Medicare Part D plan premium, increasing their monthly costs by $11.60 to $66.40.[3]

Enrollees will have an average of 31 plans to choose from in 2012.[4] Those who receive "Extra Help" through Part D's low-income subsidy (LIS) will have about the same number of plans available as in 2011, although nearly one in three LIS beneficiaries are in plans that will not qualify as benchmark plans in 2012 (i.e., will not be available to LIS beneficiaries for no monthly premium) and will need to shift plans in order to avoid paying a premium.[5]

Plan Benefit Designs Vary Greatly in 2012

PPI's review of 10 stand-alone Part D plans with the highest enrollment[6] in 20117 (appendix A) found that only one will have a monthly premium under $30; premiums for the other plans range from $34.10 to $46.80. Seven will require annual deductibles ranging from $250 to $320.

Substantial cost-sharing for certain brand-name medications is not uncommon. In 2012, some popular plans will require copayments of $90 or more for "nonpreferred" brand-name

medications. Other plans will require coinsurance of 20 percent to 46 percent. Such cost-sharing differences greatly influence enrollees' potential out-of-pocket costs.

For example, PPI's analysis of commonly used brand-name drugs found that an enrollee in a popular Part D plan could pay anywhere from $34 to more than $200 monthly for Nexium 40 mg (acid reflux), depending on the plan. Similarly, cost-sharing for Plavix 75 mg (blood clot inhibition) ranges from $38 to more than $90 per month (see appendix B), depending on the plan. Some popular plans do not cover all of the brand-name prescription drugs analyzed by PPI (e.g., Nexium); enrollees in these plans will typically pay the full cost of the prescription.[8]

Our analysis found similar variation in plan cost-sharing for commonly used generic drugs (see appendix D). An enrollee taking simvastatin 20 mg (high cholesterol) could pay from slightly more than $1 to almost $8 per month. Monthly costs for hydrocodone-acetaminophen 5–500 mg (pain) ranged from $2 to more than $12 (see appendix D).

Many plans typically reserve a tier for biologics and injectable drugs, with cost-sharing determined by coinsurance that represents a percentage of the drug's price, rather than a fixed copayment. Coinsurance can lead to markedly higher enrollee costs. For example, the monthly out-of-pocket cost of the biologic Enbrel 25 mg (rheumatoid arthritis) ranges from $231 to $329, depending on the plan.

Some Part D enrollees using brand-name prescription drugs could reduce their out-of-pocket costs by switching to lower-cost brand-name drugs or generics, if available; or to nonprescription (over-the-counter) medicines. For example, an enrollee using Fosamax (osteoporosis) could potentially save more than $800 in annual out-of-pocket costs by switching to the generic version (alendronate sodium).[9]

Continued Evolution of Plan Design

PPI found several notable benefit designs among popular stand-alone Part D plans (see appendix A):

- Two plans (Community CCRx and First Health) will require coinsurance for branded drugs regardless of tier, but will charge low copayments for generics.
- Cost-sharing varies within each tier for Humana's plans, depending on whether prescriptions are filled at preferred or nonpreferred pharmacies.
- Two plans (HealthSpring and BravoRx) will require 25 percent coinsurance for all drugs, regardless of tier.

All of the popular Part D plans rely on utilization management tools such as quantity limits, prior authorization, and step therapy to manage enrollees' use of formulary prescription drugs.[10] Utilization management is employed for a majority of commonly prescribed brand-name prescription drugs and some generic prescription drugs (see appendixes C and E). Among all stand-alone prescription drug plans, the average share of covered drugs with any utilization management has increased substantially over the years (18 percent in 2007 vs. 32 percent in 2011).[11]

Gap Coverage Mostly for Generics; Many Popular Plans Skip Gap Coverage Entirely

The Part D benefit includes a coverage gap, also known as the "doughnut hole," where enrollees are responsible for all of their prescription drug costs. In 2012, the gap begins after enrollees'

total prescription drug spending reaches $2,930 and continues until out-of-pocket costs exceed $4,700.

The percentage of stand-alone prescription drug plans that offer coverage in the gap has increased slightly (24 percent in 2011 vs. 27 percent in 2012).[12] Almost all plans limit such coverage to generic drugs. However, none of the 10 popular Part D plans reviewed by PPI offers any coverage in the gap in 2012.

The recent increase in the number of plans offering gap coverage has been linked to CMS's new "meaningful differences" regulations, which allow plan sponsors to offer two enhanced plans in a given region, provided that one enhanced plan has a higher value and at least some gap coverage of brand-name drugs. Another factor is the Affordable Care Act coverage gap discounts that save plans from passing along to enrollees the full cost for brand-name drugs.[13]

Protection for "Extra-Help" Enrollees Continues; Similar Plan Selection in 2012

Currently, about 10 million Part D enrollees receive the low-income subsidy[14] that covers some or all of their monthly Part D premiums, plan deductible, copayments, and the cost of drugs in the coverage gap.

In 2012, regardless of which Part D plan they select, these enrollees will still be protected from additional cost-sharing. The number of plans serving them is relatively unchanged from 2011; more than one-fifth of the available plans qualified under CMS's new "de minimis" policy that allows plans to waive a premium of up to $2 in order to retain their LIS enrollees.[15]

However, the 327 prescription drug plans that will offer LIS coverage in 2012 are not distributed equally among the states; LIS plan availability will actually decrease in 15 out of 34 plan regions.[16] These changes could push some low-income beneficiaries into Part D plans that offer reduced coverage for their medical needs.

In addition, many of the LIS beneficiaries in plans that will not qualify as benchmark plans in 2012 (i.e., will not be available to LIS beneficiaries for no monthly premium) must switch plans on their own to avoid paying a premium. These beneficiaries, known as "choosers" due to their having selected a plan on their own in the past, are no longer reassigned by CMS. This population typically does not switch to a new LIS-eligible plan in order to avoid paying a premium: In 2010, more than two-thirds of choosers were paying premiums that ranged from 10 cents to more than $80 per month.[17]

Overall, in 2012, CMS will reassign approximately 500,000 people to a new prescription drug plan that enables them to avoid paying a premium.[18] These reassignments are lower than in prior years, when numbers ranged from 600,000 in 2011 to 2.1 million in 2008.[19]

Points of Light in 2012 Plan Options

Similar to CMS comparisons of nursing homes and hospitals, Medicare Part D plans feature CMS-determined ratings ranging from one to five stars. The ratings reflect a plan's performance in 2011 in both administrative (e.g., complaints, ease of accessing services) and clinical components (e.g., patient safety, appropriate prescribing, adherence to recommended drug regimen).

The 2012 ratings increase the emphasis on outcomes of care, weight clinical outcome measures and patient experience measures more heavily than process measures, and incorporate additional measures that are expected to

improve the overall health of Medicare beneficiaries. Previously, all measures were weighted equally, suggesting equal importance. The new weighting is intended to increase the focus on beneficiary outcomes, beneficiary satisfaction, population health, and efficiency of health care delivery.[20]

Further, effective in 2012, Part D enrollees are permitted to switch at any time during the year to a plan that has a five-star rating from a plan with a lower rating.

Another clinically important Part D feature that can help enrollees use and manage their prescription medicines safely is medication therapy management (MTM) services, which plans must offer at no charge to enrollees who meet certain criteria. Enrollees with annual covered drug costs of at least $3,100 qualify for MTM, provided they also meet plans' self-determined flexible criteria. MTM includes an in-person or telephonic comprehensive review of all medications being used, a written summary of that discussion (usually with a pharmacist or other health care professional), and development of a personal medication list.

People who expect to incur annual drug costs above the threshold should contact plan sponsors directly to inquire about what their MTM program entails, what entity provides the services, and how recommended therapy changes are communicated to prescribers. Effective with the current open enrollment period, plans are detailing their MTM programs and eligibility criteria on their websites, as well as on the Plan Finder website.

Use Open Enrollment to Review Medication Usage, Plan Choices

Returning Part D enrollees, who can best predict prescription drug usage in the coming year, are best equipped to consider their plan choices for 2012. New enrollees may wish to enlist the help of a family member or friend to evaluate plan options. The multitude of plan options in 2012, featuring a variety of benefit designs and out-of-pocket costs, requires examining all Part D-related prescription drug costs—not just premiums—when choosing a plan. Enrollees should also consider plan ratings in their assessment, which could be a decisive factor when evaluating plans that may otherwise appear very similar.

Beneficiaries should talk with doctors, pharmacists, and other clinicians about their medication options, and should review Part D plan choices before open enrollment ends on December 7.

Appendix A

Characteristics of National Medicare Part D Plans with Highest Enrollment, 2012[1]

Prescription Drug Plan	Monthly Premium	Annual Deductible	Coverage in Gap	Copays ($) or Coinsurance (%) Preferred pharmacy/nonpreferred pharmacy				
				Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
AARP MedicareRx Preferred	$40.30	$0	No	$4.00	$8.00	$42.00	$91.00	33%
CIGNA Medicare Rx Plan One	$34.10	$320	No	$3.00	$20.00	$34.00	$85.00	25%
Community CCRx Basic	$37.10	$320	No	$2.00	25%	46%	25%	
CVS Caremark Value	$35.90	$320	No	$8.00	$45.00	$95.00	25%	
First Health Part D-Premier	$46.80	$250	No	$6.00	20%	35%	26%	
Humana-Walmart Preferred	$15.10	$320	No	$1.00/$10.00	$5.00/$12.00	20%/37%	35%/40%	
Humana Enhanced	$44.50	$0	No	$7.00/$12.00	$40.00/$45.00	$74.00/$79.00	33%	
WellCare Classic	$39.40	$0	No	$6.00	$44.00	$95.00	33%	
				All Drugs				
BravoRx PDP	$40.80	$320	No	25%				
HealthSpring PDP	$39.90	$320	No	25%				

Note: All data are for 2012. New York (ZIP code 12144) was used as a constant.

[1]Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

Source: AARP Public Policy Institute analysis of Part D plan offerings for 2012. Accessed from plan websites and the Medicare Plan Finder, October 13, 2011.

Appendix B

2012 Plan Coverage and Out-of-Pocket Costs for Five Popular Brand-Name Drugs and One Popular Specialty Drug among Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Out-of-Pocket Costs per Monthly Prescription					
	Actonel 35 mg	Diovan 80 mg	Nexium 40 mg	Plavix 75 mg	Vytorin 10–20 mg	Enbrel 25 mg
AARP MedicareRx Preferred	$42.00	$42.00	$42.00	$42.00	$91.00	$308.35
BravoRx PDP	$29.33	$98.44[2]	$45.60	$48.26	$149.68[2]	$237.92
CIGNA Medicare Rx Plan One	$133.87[2]	$34.00	$34.00	$85.00	$34.00	$233.16
Community CCRx Basic	$135.62[2]	$22.25	$46.52	$90.54	$151.43[2]	$240.87
CVS Caremark Value	$133.62[2]	$45.00	$45.00	$45.00	$149.43[2]	$231.06
First Health Part D-Premier	$40.35	$29.66	$35.90	$38.00	$25.78	$244.02
HealthSpring PDP	$28.92	$21.27	$45.00	$47.63	$129.34[2]	$235.02
Humana Enhanced[3]	$74.00	$40.00	$40.00	$74.00	$74.00	$310.20
Humana-Walmart[3]	$37.30	$17.03	$208.05[2]	$66.70	$149.48[2]	$329.04
WellCare Classic	$134.12[2]	$87.09	$208.50[2]	$44.00	$149.93[2]	$315.91

Note: All data are for 2012. New York (ZIP code 12144) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period.

[1]Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

[2]Drug is not on the plan's formulary. Payments for off-formulary drugs do not count toward the deductible, initial coverage limit, or out-of-pocket costs unless the plan approves a formulary exception.

[3]Costs are based on purchase at a preferred pharmacy. Costs at a nonpreferred pharmacy would be higher.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 13, 2011. Popular prescription drugs were drawn from CMS data file, 2008 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, June 2010, available at http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp.

Drug indications: Actonel 35 mg tablets (osteoporosis); Diovan 80 mg tablets (high blood pressure); Nexium 40 mg capsules (acid reflux); Plavix 75 mg tablets (blood clot inhibition); Vytorin 10–20 mg tablets (high cholesterol); Enbrel 25 mg inj (rheumatoid arthritis/psoriasis).

Appendix C

2012 Utilization Management Tools for Five Popular Brand-Name Drugs and One Popular Specialty Drugamong Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Utilization Management Tools					
	Actonel 35 mg	Diovan 80 mg	Nexium 40 mg	Plavix 75 mg	Vytorin 10–20 mg	Enbrel 25 mg
AARP MedicareRx Preferred	QL	QL	QL	QL	QL	PA/QL
BravoRx PDP	QL	*	QL	QL	*	PA/QL
CIGNA Medicare Rx Plan One	*	QL	QL		QL	PA
Community CCRx Basic	*	QL	QL	QL	*	PA/QL
CVS Caremark Value	*		QL		*	PA
First Health Part D-Premier	QL/ST	QL/ST	QL	QL	QL	PA/QL
HealthSpring PDP	QL		QL	QL	*	PA/QL
Humana Enhanced	QL	QL	QL	QL	QL	PA/QL
Humana-Walmart	QL	QL	*	QL	*	PA/QL
WellCare Classic	*	QL	*	QL	*	PA

*Drug is not on the plan's formulary.

Note: All data are for 2012. New York (ZIP code 12144) was used as a constant. QL: quantity limit (plan limits the quantity of drugs that are covered over a certain period of time). PA: prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage). ST: step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

[1]Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 13, 2011. Popular prescription drugs were drawn from CMS data file, 2008 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, June 2010, available at http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp.

Drug indications: Actonel 35 mg tablets (osteoporosis); Diovan 80 mg tablets (high blood pressure); Nexium 40 mg capsules (acid reflux); Plavix 75 mg tablets (blood clot inhibition); Vytorin 10–20 mg tablets (high cholesterol); Enbrel 25 mg inj (rheumatoid arthritis/psoriasis).

Appendix D

2011 Plan Coverage and Out-of-Pocket Costs for Five Popular Generic Drugs among Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Out-of-Pocket Costs per Monthly Prescription				
	furosemide 40 mg	hydrocodone-acetaminophen 5–500 mg	levothyroxine sodium 100 mcg	lisinopril 10 mg	simvastatin 20 mg
AARP MedicareRx Preferred	$3.14	$8.00	$7.00	$4.00	$4.00
BravoRx PDP	$0.89	$8.34	$2.07	$1.27	$1.51
CIGNA Medicare Rx Plan One	$3.00	$3.00	$3.00	$3.00	$3.00
Community CCRx Basic	$2.00	$2.00	$2.00	$2.00	$2.00
CVS Caremark Value	$2.45	$8.00	$5.42	$4.88	$7.71
First Health Part D-Premier	$4.33	$6.00	$6.00	$6.00	$6.00
HealthSpring PDP	$0.72	$4.33	$1.65	$1.01	$1.44
Humana Enhanced[2]	$2.64	$12.08	$5.05	$3.84	$7.00
Humana-Walmart[2]	$1.00	$2.51	$1.00	$1.00	$5.00
WellCare Classic	$3.39	$6.00	$6.00	$6.00	$6.00

Note: All data are for 2012. New York (ZIP code 12144) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period.

[1]Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

[2]Costs are based on purchase at a preferred pharmacy. Costs at a nonpreferred pharmacy would be higher.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 13, 2011. Popular prescription drugs were drawn from CMS data file, 2008 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, June 2010, available at http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp.

Drug indications: furosemide 40 mg tablets (fluid retention); hydrocodone-acetaminophen 5–500 mg tablets (pain); levothyroxine sodium 100 mcg tablets (hypothyroidism); lisinopril 10 mg tablets (high blood pressure); simvastatin 20 mg tablets (high cholesterol).

Appendix E

2012 Utilization Management Tools for Five Popular Generic Drugs among Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Utilization Management Tools				
	furosemide 40 mg	hydrocodone-acetaminophen 5-500 mg	levothyroxine sodium 100 mcg	lisinopril 10 mg	simvastatin 20 mg
AARP MedicareRx Preferred		QL			
BravoRx PDP		QL			QL
CIGNA Medicare Rx Plan One					QL
Community CCRx Basic		QL			QL
CVS Caremark Value		QL		QL	QL
First Health Part D-Premier		QL			
HealthSpring PDP		QL			QL
Humana Enhanced[3]		QL			QL
Humana-Walmart[3]		QL			QL
WellCare Classic		QL			

Note: All data are for 2012. New York (ZIP code 12144) was used as a constant. QL: quantity limit (plan limits the quantity of drugs that are covered over a certain period of time). PA: prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage). ST: step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

[1]Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 13, 2011. Popular prescription drugs were drawn from CMS data file, 2008 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, June 2010, available at http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp.

Drug indications: furosemide 40 mg tablets (fluid retention); hydrocodone-acetaminophen 5–500 mg tablets (pain); levothyroxine sodium 100 mcg tablets (hypothyroidism); lisinopril 10 mg tablets (high blood pressure); simvastatin 20 mg tablets (high cholesterol).

Endnotes

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), "Medicare prescription drug premiums will not increase, more seniors receiving free preventive care, discounts in the donut hole," Press Release, August 4, 2011, http://www.cms.hhs.gov/apps/media/press_releases.asp.

[2] Similar to Medicare Part B, "higher-income" is defined as enrollees with incomes of more than $85,000 for an individual and $170,000 for a married couple. These income limits will be frozen until 2020, meaning a larger percentage of Medicare beneficiaries will be paying higher premiums over time.

[3] CMS, Office of the Actuary, "Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information," August 3, 2011.

[4] AARP PPI calculation based on 2012 prescription drug plan data released by CMS on September 8, 2011.

[5] J. Hoadley, J. Cubanski, E. Hargrave, L. Summer, and J. Huang, *Data Spotlight: Medicare Part D: A First Look at Plan Offerings in 2012*, (Menlo Park, CA: Kaiser Family Foundation, October 2011).

[6] Avalere Health, "New Avalere Analysis of Medicare Prescription Drug Data Shows Commercial Plans Aggressively Positioning for Membership in 2012," Press Release, September 19, 2011.

[7] Each plan's (1) monthly premium, (2) annual deductible (if applicable), (3) offering of any coverage in the doughnut hole, and (4) associated copayment or coinsurance level was determined using information provided on each organization's website. Since premiums vary by state (even among national plans), New York (ZIP code 12144) was used as a constant.

[8] Spending on nonformulary drugs is not counted toward the deductible, initial coverage limit, or out-of-pocket costs unless the plan approves a formulary exception. Thus, taking a nonformulary drug increases enrollees' out-of-pocket costs substantially.

[9] AARP PPI calculation based on cost-sharing data from the Medicare Plan Finder, October 13, 2011.

[10] Quantity limits refer to a plan limiting the quantity of drugs that are covered over a certain period. Prior authorization requires prescribers to verify that the prescribed drug is medically necessary before the plan will provide coverage. Step therapy is when a patient must first try one or more drugs before the originally prescribed drug will be covered.

[11] J. Hoadley, E. Hargrave, and K. Merrell, *Medicare Part D Formularies: 2006–2011: Update to Chartbook*, (Washington, DC: MedPAC, August 2011).

[12] Hoadley et al., "Medicare Part D Spotlight.

[13] Avalere Health, "Medicare Program Improves Gap Coverage, Access to Brand-Name Drugs for Millions of Beneficiaries in 2011," Press Release, September 29, 2010.

[14] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13: Status Report on Part D*, (Washington, DC: MedPAC, March 2011).

[15] Hoadley et al., "Medicare Part D Spotlight."

[16] Hoadley et al., "Medicare Part D Spotlight."

[17] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13*.

[18] Hoadley et al., "Medicare Part D Spotlight."

[19] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13*, and L. Summer et al., "Medicare Part D 2009 Data Spotlight: Low-Income Subsidy Plan Availability," (Menlo Park, CA: Kaiser Family Foundation, November 2008), http://www.kff.org/medicare/7836.cfm.

[20] CMS, "2012 Part C and D Plan Ratings: Fact Sheet," October 2011.

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