

Open Enrollment 2013: Medicare Part D Benefits Improve but Premiums and Cost-Sharing Rise in Many Popular Plans

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While Medicare Part D prescription drug plan premiums are generally expected to remain steady in 2013, premiums for many popular plans will actually be considerably higher than they were in 2012. Many plans are also increasing cost-sharing and their reliance on utilization management tools for covered prescription drugs. Medicare beneficiaries should closely examine their 2013 prescription drug plan choices during open enrollment for Part D.

Medicare beneficiaries who are planning to enroll in Part D drug plans for 2013 will find more information, more savings on prescriptions filled in the coverage gap, and coverage for certain anti-anxiety medications for the first time since Part D began in 2006.¹ While these features increase the benefit's overall value, beneficiaries should continue to closely investigate plan options this year to help ensure that they receive the greatest value possible based on their own needs.

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 2013.² But this new AARP Public Policy Institute (PPI) analysis shows that premiums for many popular stand-alone plans will be considerably higher (appendix A). In addition, higher-income Part D enrollees³ will still be required to pay a larger share of their Medicare Part D plan premium, increasing their monthly costs by \$11.60 to \$66.60.⁴

PPI's analysis also shows that enrollees will face a wide range of out-of-pocket costs and/or utilization management tools for commonly used prescription drugs

(see appendixes B and C). This is a continuing trend since Part D's inception.

Many popular drug plans will not offer coverage in the gap—commonly known as the doughnut hole—beyond that required by the Affordable Care Act. This law phases out the coverage gap by 2020 through a series of escalating discounts.

Enrollees will have an average of 31 plans to choose from in 2013.⁵ Those who receive “Extra Help” through Part D's low-income subsidy (LIS) will have slightly more plans available to them than in 2012, although nearly one in three LIS beneficiaries are in plans that will not qualify as benchmark plans in 2013 (i.e., will not be available to LIS beneficiaries for no monthly premium). These beneficiaries will need to select a new plan in order to avoid paying a premium.⁶

Wide Variety of Plan Benefit Designs

PPI's review of 10 stand-alone Part D plans with the highest enrollment⁷ in 2012⁸ (appendix A) found that only one will have a monthly premium under \$30;

premiums for the other plans range from \$18.50 to \$81.00. Six will require the standard annual deductible of \$325.

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

- Half the Part D plans with the highest enrollment have five tiers.
- Four plans have cost-sharing that varies within each tier, depending on whether prescriptions are filled at preferred or nonpreferred pharmacies.
- Two plans will require coinsurance for branded drugs regardless of tier, but will charge low copayments for generics.
- One plan 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.⁹

Utilization management is employed for a majority of commonly prescribed brand-name prescription drugs and some generic prescription drugs (see appendixes B and C). Among all stand-alone prescription drug plans, the average share of covered drugs with any utilization management has increased substantially over the years.¹⁰

Cost-Sharing Can Vary Dramatically

Substantial cost-sharing for certain brand-name medications is a continuing trend under Medicare Part D. In 2013, some popular plans will require copayments of \$90 or more for "nonpreferred" brand-name medications. Other plans will require coinsurance of 23 percent to 50 percent. Such cost-sharing differences greatly influence enrollees' potential out-of-pocket costs, many of whom may be accustomed to

much lower cost-sharing through their employer or retiree coverage.

For example, PPI's analysis of commonly used brand-name drugs found that typical cost-sharing for Advair Diskis 250/50 (used to treat asthma and chronic obstructive pulmonary disease) could range from \$28 to more than \$103 monthly (see appendix B). Some popular plans do not cover all of the brand-name prescription drugs analyzed by PPI; enrollees in these plans will typically pay the full cost of the prescription.¹¹

Our analysis found similar variation in plan cost-sharing for commonly used generic drugs (see appendix C). An enrollee taking simvastatin 20 mg (high cholesterol) could pay from \$0 to \$7 per month, depending on the plan.

Many plans reserve a formulary 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 \$260 to \$484, depending on the plan.

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

The Part D benefit includes a coverage gap, where non-LIS enrollees are responsible for all of their prescription drug costs. About 3.8 million non-LIS enrollees fell into the coverage gap in 2011.¹²

As part of the Affordable Care Act, the coverage gap is slowly being eliminated through a series of escalating discounts. According to CMS, these changes, as well as a one-time \$250 rebate for enrollees who hit the coverage gap in

2010, have saved Medicare Part D enrollees more than \$4.1 billion on prescription drugs since the Affordable Care Act was enacted.¹³ In 2013, non-LIS Part D enrollees will receive a 52.5 percent discount on their brand-name and biologic prescription drugs and a 21 percent discount on their generic prescription drugs.

Meanwhile, the percentage of stand-alone prescription drug plans that offer coverage in the gap continues to increase (24 percent in 2012 vs. 30 percent in 2013).¹⁴ 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 2013.

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 allow plans to avoid passing along the full cost of brand-name drugs to enrollees.¹⁵

"Extra-Help" Enrollees Still Protected from High Prescription Drug Costs in 2013

Currently, more than 10 million Part D enrollees receive the low-income subsidy.¹⁶ The subsidy covers some or all of their monthly Part D premiums, plan deductible, copayments, and the cost of drugs in the coverage gap. In 2013, regardless of which Part D plan they select, these enrollees will still be protected from high levels of cost-sharing.

The number of plans serving them is slightly higher than in 2012; about one-third 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.¹⁷ If this policy were not in place, LIS enrollees in these plans would have to find a new plan or pay a premium.

However, the 332 prescription drug plans that will offer LIS coverage in 2013 are not distributed equally among the states; LIS plan availability will actually decrease in 19 out of 34 plan regions.¹⁸ 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 2013 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 and often end up paying a premium.¹⁹

Overall, in 2013, CMS will reassign approximately 930,000 people to a new prescription drug plan that enables them to avoid paying a premium.²⁰ This number is considerably higher than in 2012, when 500,000 LIS enrollees were reassigned.²¹

Improvements in 2013 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 2012 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 2013 ratings emphasize outcomes of care 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.²²

Further, Part D enrollees are now 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. However, five-star plans are very few in number, and no plan that is offered nationally has qualified for five stars.

Important Changes to Medication Therapy Management

Another clinically important Part D feature that can help enrollees get the most value from, and avoid problems with, their medicines is medication therapy management (MTM) programs. Plans must offer MTM services at no charge to enrollees who meet certain criteria, such as having annual covered drug costs of at least \$3,144. Other eligibility criteria, such as qualifying medical conditions or a minimum number of medications being utilized by the enrollee, are set by the drug plans.

Under Part D, MTM-eligible enrollees can receive, either in person or by telephone, a comprehensive review of all medications being used (prescription, nonprescription, and dietary supplements), a written summary of that discussion, and development of a personal medication list. All Part D plans will begin following a standardized format for these activities in 2013.

Also in 2013, Part D plans must offer comprehensive medication reviews to all eligible beneficiaries regardless of setting, including those in long-term care facilities.

Use Open Enrollment to Review Medication Usage, Plan Choices

Despite evidence that Part D plans change every year, only about 6 percent of Medicare Part D enrollees voluntarily switch plans.²³ Research has shown that this year-to-year consistency has undermined the robust competition that was expected in the Part D marketplace, allowing plan sponsors to price existing plans higher than comparable new plans.²⁴

More important, growing evidence suggests that a majority of Part D enrollees are overspending on their prescription drug coverage by not choosing the most cost-effective plan that meets their medication needs.²⁵

Beneficiaries should closely investigate plan benefits and choices every year to ensure that they are maximizing the value of the benefit. New enrollees may wish to enlist the help of a family member, friend, or their local pharmacist to evaluate plan options.

The multitude of plan options in 2013, featuring a variety of benefit designs and out-of-pocket costs, requires examining all Part D-related prescription drug costs—not just monthly premiums—when choosing a plan. Enrollees should also consider “star” ratings in their assessment, which could be a decisive factor when evaluating plans that may otherwise appear very similar.

Beneficiaries should regularly talk with doctors, pharmacists, and other clinicians about their medication needs, 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, 2013¹

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 Preferred²	\$41.40	\$0	No	\$3/\$6	\$5/\$10	\$40/\$45	\$85/\$95	33%
CIGNA Medicare Rx Plan One	\$45.80	\$325	No	\$0	\$8	\$28	\$72	25%
Express Scripts Medicare-Value	\$54.20	\$325	No	\$4	\$6	25%	50%	25%
Humana Enhanced	\$45.70	\$0	No	\$2/\$5	\$5/\$7	\$41	\$90	33%
Humana-Walmart	\$18.50	\$325	No	\$1/\$7	\$4/\$16	20%/25%	32%/35%	25%

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
First Health Part D-Value Plus	\$33.90	\$0	No	\$0/\$7	\$35/\$45	\$70/\$95	33%
SilverScript Basic	\$27.60	\$325	No	\$2	23%	43%	25%
WellCare Classic	\$28.50	\$0	No	\$6	\$45	\$95	33%

Prescription Drug Plan	Monthly Premium	Annual Deductible	Coverage in Gap	Copays (\$) or Coinsurance (%) Preferred pharmacy/nonpreferred pharmacy		
				Tier 1	Tier 2	Tier 3
First Health Part D-Premier	\$47.40	\$325	No	\$1	25%	45%

Prescription Drug Plan	Monthly Premium	Annual Deductible	Coverage in Gap	Copays (\$) or Coinsurance (%) Preferred pharmacy/nonpreferred pharmacy
				All Drugs
HealthSpring	\$81.00	\$325	No	25%

Note: All data are for 2013. Florida (ZIP code 33301) was used as a constant.

¹ Avalere Health, "Avalere Analysis Reveals Significant Fluctuations in Medicare Prescription Drug Plan Premiums for 2013," Press Release, September 24, 2012.

² Insured through UnitedHealthcare.

Source: AARP Public Policy Institute analysis of Part D plan offerings for 2013. Accessed from plan websites and the Medicare Plan Finder, October 15, 2012.

Appendix B
2013 Plan Coverage, Out-of-Pocket Costs, and Utilization Management Tools for Five Popular Brand-Name Drugs and One Popular Specialty Drug among Medicare Part D Plans with Highest Enrollment¹

Prescription Drug Plan	Monthly Out-of-Pocket Costs and Utilization Management (UM)											
	Advair Diskus 250/50		Crestor 10 mg		Cymbalta 60 mg		Diovan 80 mg		Namenda 10 mg		Enbrel 25 mg	
	\$	UM	\$	UM	\$	UM	\$	UM	\$	UM	\$	UM
AARP MedicareRx Preferred^{3,4}	\$45.00		\$45.00		\$45.00		\$45.00		\$45.00		\$350.45	√
CIGNA Medicare Rx Plan One	\$28.00		\$28.00	√	\$28.00	√	\$72.00	√	\$28.00	√	\$260.12	√
Express Scripts Medicare-Value	\$62.34	√	\$41.10	√	\$48.62	√	\$116.712		\$60.02	√	\$298.42	√
First Health Part D-Premier	\$62.34	√	\$41.10	√	\$87.52	√	\$116.712		\$60.02	√	\$484.16	√
First Health Part D-Value Plus³	\$95.00	√	\$45.00	√	\$95.00	√	\$95.00	√	\$45.00	√	\$355.05	√
HealthSpring PDP	\$60.16	√	\$39.39	√	\$44.89	√	\$25.30		\$57.88	√	\$265.29	√
Humana Enhanced³	\$41.00	√	\$41.00	√	\$41.00	√	\$41.00	√	\$41.00	√	\$349.94	√
Humana-Walmart³	\$59.97	√	\$39.20	√	\$46.56	√	\$23.92	√	\$57.69	√	\$265.11	√
SilverScript Basic	\$103.18	√	\$177.112		\$80.23	√	\$41.48	√	\$53.11	√	\$264.13	√
WellCare Classic	\$45.00	√	\$176.862		\$95.00	√	\$95.00	√	\$45.00	√	\$352.66	√

Note: All data are for 2013. Florida (ZIP code 33301) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period. Common utilization management tools include: quantity limits (plan limits the quantity of drugs that are covered over a certain period of time); prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage); and step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

¹ Avalere Health, "Avalere Analysis Reveals Significant Fluctuations in Medicare Prescription Drug Plan Premiums for 2013," Press Release, September 24, 2012.

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.

⁴ Insured through UnitedHealthcare.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 15, 2012. Popular prescription drugs were drawn from CMS data file, 2010 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, February 2012, available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html>.

Drug indications: Advair Diskus 250/50 (asthma/chronic obstructive pulmonary disease); Crestor 10 mg tablets (high cholesterol); Cymbalta 60 mg capsules (anxiety/depression); Diovan 80 mg tablets (high blood pressure); Namenda 10 mg tablets (dementia); Enbrel 25 mg inj (rheumatoid arthritis/psoriasis).

Appendix C
2013 Plan Coverage, Out-of-Pocket Costs, and Utilization Management Tools for Five Popular Generic Drugs among Medicare Part D Plans with Highest Enrollment¹

Prescription Drug Plan	Monthly Out-of-Pocket Costs and Utilization Management (UM)									
	amlodipine besylate 2.5 mg		levothyroxine sodium 100 mcg		lisinopril 10 mg		omeprazole 20 mg		simvastatin 20 mg	
	\$	UM	\$	UM	\$	UM	\$	UM	\$	UM
AARP MedicareRx Preferred^{2,3}	\$5.65		\$6.75		\$2.99		\$5.44		\$6.00	
CIGNA Medicare Rx Plan One	\$5.43	√	\$8.00		\$0.00		\$8.00	√	\$0.00	√
Express Scripts Medicare-Value	\$6.00		\$4.00		\$4.00		\$6.00	√	\$6.00	√
First Health Part D-Premier	\$1.00		\$1.00		\$1.00		\$1.00		\$1.00	
First Health Part D-Value Plus²	\$7.00		\$7.00		\$7.00		\$7.00		\$7.00	
HealthSpring PDP	\$0.84		\$1.65		\$1.02		\$1.10	√	\$1.00	√
Humana Enhanced²	\$5.00		\$5.00		\$5.00		\$7.00	√	\$5.00	√
Humana-Walmart²	\$5.00		\$5.00		\$5.00		\$11.64	√	\$5.00	√
SilverScript Basic	\$2.00	√	\$2.00		\$2.00		\$2.00	√	\$2.00	√
WellCare Classic	\$6.00		\$5.93		\$3.08		\$5.65		\$6.00	√

Note: All data are for 2013. Florida (ZIP code 33301) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period. Common utilization management tools include: quantity limits (plan limits the quantity of drugs that are covered over a certain period of time); prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage); and step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

¹ Avalere Health, "Avalere Analysis Reveals Significant Fluctuations in Medicare Prescription Drug Plan Premiums for 2013," Press Release, September 24, 2012.

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

³ Insured through UnitedHealthcare.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 15, 2012. Popular prescription drugs were drawn from CMS data file, 2010 Part D Top 100 Drugs By Total Fills for Non-LIS Beneficiaries, February 2012, available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html>.

Drug indications: amlodipine besylate 2.5 mg tablets (high blood pressure/angina); levothyroxine sodium 100 mcg tablets (hypothyroidism); lisinopril 10 mg tablets (high blood pressure); omeprazole 20 mg capsules (acid reflux); simvastatin 20 mg tablets (high cholesterol).

Endnotes

¹ Starting in 2013, Part D will begin covering anti-anxiety medications known as benzodiazepines and barbiturates. Both drug types were originally excluded from Part D coverage due to concerns about their potential for causing serious adverse drug events in older adults. While the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mostly reversed this decision, ACA expanded coverage further by preventing states from excluding barbiturates and benzodiazepines from Medicaid coverage starting in 2014. Since Part D–covered drugs are defined generally as drugs covered under Medicaid, this provision will effectively eliminate the remaining coverage limitations for barbiturates set forth in MIPPA.

² U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), “Medicare prescription drug premiums to remain steady for third straight year,” Press Release, August 6, 2012, http://www.cms.hhs.gov/apps/media/press_releases.asp.

³ 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.

⁴ CMS, Office of the Actuary, “Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information,” August 6, 2012.

⁵ AARP PPI calculation based on 2013 prescription drug plan data released by CMS on September 17, 2012.

⁶ J. Hoadley, J. Cubanski, E. Hargrave, L. Summer, and J. Huang, *Data Spotlight: Medicare Part D: A First Look at Plan Offerings in 2013* (Menlo Park, CA: Kaiser Family Foundation, October 2012).

⁷ Avalere Health, “Avalere Analysis Reveals Significant Fluctuations in Medicare Prescription Drug Plan Premiums for 2013,” Press Release, September 24, 2012.

⁸ 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), Florida (ZIP code 33301) was used as a constant.

⁹ 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.

¹⁰ J. Hoadley, E. Hargrave, and K. Merrell, *Medicare Part D Formularies: 2006–2011: Update to Chartbook* (Washington, DC: MedPAC, August 2011).

¹¹ 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.

¹² CMS, “Part D Gap Discounts through June 30, 2012 for Benefit Year 2011,” June 2012.

¹³ CMS, “People with Medicare save over \$4.1 billion on prescription drugs thanks to the health care law,” Press Release, August 20, 2012, http://www.cms.hhs.gov/apps/media/press_releases.asp.

¹⁴ Hoadley et al., *Data Spotlight: Medicare Part D*.

¹⁵ Avalere Health, “Medicare Program Improves Gap Coverage, Access to Brand-Name Drugs for Millions of Beneficiaries in 2011,” Press Release, September 29, 2010.

¹⁶ MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13: Status Report on Part D* (Washington, DC: MedPAC, March 2012).

¹⁷ Hoadley et al., *Data Spotlight: Medicare Part D*.

¹⁸ Avalere Health, “Analysis of 2013 Prescription Drug Plan (PDP) Offerings and Benefit Designs,” September 2012.

¹⁹ MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13*.

Continued Changes for Medicare Part D in 2013

²⁰ Hoadley et al., *Data Spotlight: Medicare Part D*.

²¹ MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13*; 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>.

²² CMS, “2012 Part C and D Plan Ratings: Fact Sheet,” October 2011.

²³ MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13*.

²⁴ K. M. Marzilli Ericson, *Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange*, National Bureau of Economic Research Working Paper Series (Cambridge, MA: National Bureau of Economic Research, September 2012).

²⁵ C. Zhou and Y. Zhang, “The Vast Majority Of Medicare Part D Beneficiaries Still Don’t Choose The Cheapest Plans That Meet Their Medication Needs,” *Health Affairs* 31, no. 10: 2266–75; F. Heiss, A. Leive, D. McFadden, and J. Winter, *Plan Selection in Medicare Part D: Evidence from Administrative Data*, National Bureau of Economic Research Working Paper Series (Cambridge, MA: National Bureau of Economic Research, June 2012); R.A. Patel et al., “Cost Minimization of Medicare Part D Prescription Drug Plan Expenditures,” *The American Journal of Managed Care* 15, no. 8: 545–53; J. Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* (Menlo Park, CA: Kaiser Family Foundation, March 2009).

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