

MEMO

DATE: April 7, 2011
TO: Clients & Friends
FROM: John Gorman and Jean LeMasurier
SUBJECT: Memo on Rate Announcement and Call Letter for 2012

On April 4, 2011, CMS issued the CY 2012 Medicare Advantage (MA) Capitation Rates, MA and Part D Payment Policies and 2012 Final Call Letter. A copy of the announcement can be found at: <http://www.gormanhealthgroup.com/docs/cms/Announcement2012.pdf>.

On average MA rates are estimated to increase 0.4 percent in 2012. The rates for 2012 will be determined by blending two rates:

- The “applicable” amount which uses the current payment methodology (greater of the county’s 2012 FFS rate or the prior year MA rate increased by the CY 2012 national per capita MA growth percentage) and
- The “specified” amount which phases in the new methodology from the Affordable Care Act (each county is assigned to a quartile ranging from 95-115 percent of FFS and plans receive a quality bonus based on their star score).

In addition, Indirect Medical Education (IME) costs will continue to be phased out. The actual rate will vary by county. The announcement assumes that the physician fee cut of 29.4 percent will take place January 1.

The Final Call Letter makes few changes from Draft Call Letter issued on February 18, 2011.

The most significant changes include:

- Modify the star demonstration to apply the quality bonus to the full blended rate without a cap
- Expand the SEP for 5 star plans to PDPs as well as MA-PDs and allow all eligible individuals to make a one- time election under the SEP
- Scrutinize all bids that that increase total beneficiary costs 10 percent or more for 2012
- Remove Dual Eligible SNPs from meaningful plan difference review
- Post a report evaluating the Risk Adjustment system
- Retain the current payment process for EGWPs
- Update risk adjustment models for ESRD and PACE
- Use the minimum PACE level of frailty to set frailty adjustor for Fully Integrated Dual SNPs
- Not include fill fees in coverage gap discount payments
- Modify the policy on prescriber identifiers
- Modify the policy on hospice drugs if information is not available at the point of sale
- Revise the RADV audit methodology in the future based on comments

2012 MA CAPITATION RATES AND PART C PAYMENT POLICIES

MA National Growth Rate – The final estimate of the National Per Capita MA growth rate is a - 0.16 percent which is lower than the preliminary announcement of a 0.7 percent increase. This reflects a 0.59 percent correction to prior years' estimates.

Coding Adjustment –The coding pattern adjustment is 3.41 percent, which is the same as proposed in the advance notice and in 2011.

Risk Adjustment Normalization Factor – The Part C normalization factor for the aged and disabled is 1.079. The ESRD factor is 1.012 for dialysis and 1.051 for functioning graft enrollees. The Part D normalization factor is 1.031 (rather than 1.032 as included in the advance notice).

ESRD Rates – CMS fully phases-in revised state capitation rates in 2012. The 2012 ESRD state rates are based on 2006-09 FFS spending by beneficiaries in dialysis status. CMS will continue to pay functioning graft enrollees based on the county rate and risk score that will include the ACA changes to the benchmarks and the quality bonus payment.

Hierarchical Condition Category (HCC) Risk Adjustment Model – CMS will not implement an updated version of the CMS HCC risk adjustment model for MA plans for 2012.

CMS will implement an updated version of the ESRD risk adjustment model in 2012 which recalibrates all components of the ESRD model. The new model will include 87 HCCs with changes that add, delete and revise condition categories. For 2012, the ESRD risk adjustment model was also recalibrated using ore recent data. CMS will also update the model for PACE plans to include 87 HCCs with changes that add, delete and revise condition categories.

CMS has posted a final report on the ACA mandated evaluation of its risk adjustment system. The report can be viewed at:

https://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf.

ACA Quality Bonus – CMS will modify the demonstration to further incent more rapid and larger year-to-year quality improvement. The bonus will be applied to the full blended rate for plans with 3-5 stars and will not cap the blended rates. The announcement confirms that the 2011 star rating will be used to determine the 2012 quality bonus percentage.

Star Rating	QBP Percent for 2012/13	QBP Percent for 2014
Less than 3 stars	0%	0%
3 stars	3%	3%
3.5 stars	3.5%	3.5%
4 stars	4%	5%
4.5 stars	4%	5%
5 stars	5%	5%

Qualifying County Quality Bonus – The ACA also provides that the quality bonus will be doubled in “qualifying” counties. These counties have an urban floor rate in 2004, a minimum of 25,000 enrollees, and an average FFS spending that is less than the national average FFS spending for 2012.

ACA Transitional Phase-In – Each county will be assigned to one of three transitions periods—two, four or six years based on the difference between the county’s projected 2010 Benchmark Amount and the 2010 Applicable Amount. If the difference is under \$30, the county rate will be blended over two years. If the difference is between \$30 and \$50, the blend will be four years. The blend will be six years if the difference is at least \$50.

The quartiles were determined based on the published 2009 FFS county rates. Details can be found in the *risk2012.csv* file at:

<http://www.cms.gov/MedicareAdvtgSpecRateStats/RSD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1246530&intNumPerPage=10>

Beneficiary Rebate - The ACA changes the beneficiary rebate calculation to link it to the quality bonus in 2012 and phases this change in over three years.

Star Rating	2012	2013	2014
4.5 +Stars	73.33%	71.67%	70%
3.5 – <4.5	71.67%	68.33%	65%
<3.5	66.67%	58.33%	60%

A low enrollment plan is treated as a 4.5 star rated plan and a new plan under a new parent organization is treated as a 3.5 star rated plan.

CMS will use the same policies in 2012 regarding the use of rebate dollars that currently apply, e.g. provision of extra benefits, reduction in cost sharing or buying down premiums including Part B premiums.

Determination of FFS Costs – CMS will rebase the FFS capitation rates for 2012. CMS is changing the AGA methodology it uses to determine FFS costs in a county to exclude hospice claims and cost plan data over a five year period. This will have a negligible impact on most counties. In addition, the FFS costs in Puerto Rico will be based on enrollees in both Part A and Part B, resulting in an average increase of .4% in the blended benchmark for 2012. CMS will use a 1,000 member threshold for the small county adjustment.

Medicare Secondary Payer (MSP) Adjustment – CMS has revised the MSP factor for ESRD for 2012 resulting in a lower adjustment of 0.189 for dialysis/transplant and 0.174 for post-graft.

IME Adjustment – For 2012, IME costs will be phased out under the MIPPA formula based on the amount of IME included in the FFS rate, up to a maximum of 1.8 percent in a given county. The final announcement identifies the amount of IME for each county.

Bonus and Incentive Payments – MA plans must pay qualifying non-contracted physicians PQRI and E-prescribing bonuses respectively of 2 percent of Medicare allowed charges under FFS. PFFS plans pay these bonuses to deemed providers.

Clinical Trials – Clinical trials will continue to be paid on a FFS basis.

DOD Adjustment – For 2012, CMS will adjust 138 county rates with at least 10 beneficiaries who are eligible for the Uniformed Services Family Health Plan (USFHP) by approximately \$1.85 (ranging from a decrease of \$0.10 to an increase of \$5.00). Details can be found in the *risk2012.csv* file at:

<http://www.cms.gov/MedicareAdvtgSpecRateStats/RSD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1246530&intNumPerPage=10>

Frailty Adjustor –The new frailty adjustor for PACE plans is fully transitioned in 2012. CMS is planning to implement a frailty adjustor for qualifying Fully Integrated Dual Eligible SNPs in 2012 and has decided to use the minimum score of the PACE range of frailty scores. These DE SNPs must have a capitated state Medicaid contract and a frailty level similar to PACE plans. To make a determination of eligibility, CMS is requiring these plans to field their Health of Senior (HOS) survey at the PBP level in 2011.

PFFS Network Areas – In 2012, non-employer PFFS plans that are offered in counties that have two or more network plans open to enrollment must have networks that meet CMS access standards. The counties for 2012 and 2013 are listed online at:
<http://www.cms.hhs.gov/PrivateFeeForServicePlans/>.

MSA Demonstration Program – CMS will end the demonstration project that allowed MSA plan designs that more closely resemble private sector high deductible plans. The maximum deductible for current law MSA plans for 2012 is \$10,600.

Employer Group Waiver Plan Bidding – CMS will not change the EGWP bidding for 2012. CMS is reviewing the comments from the Advance Notice in response to concerns that EGWP bids are higher than non-EGWP bids.

Encounter Data – MA organizations will submit encounter data each time services are provided to enrollees for dates of service beginning January 1, 2012. CMS plans to release a manual providing detail on deadlines and frequency of submission this summer.

Risk Adjustment – CMS has updated the Acceptable Physician Specialty Types for the purpose of submitting risk adjustment data. Effective January 1, 2012 RAPS will be changed to accommodate the ICD-10 system which will use the 5010 transaction.

RADV Audits – Based on comments, CMS will be revising the sampling and payment error calculation methodology in the near future.

PART D PAYMENT METHODOLOGY

Coverage Gap Discount Program (CGDP) - CMS will determine monthly prospective CGDP payments based on the Part D bid estimates multiplied by the number of non-LIS enrollees. PACE and EGWPs will not receive these payments. CMS has decided not to adjust the payments to include fill fees (dispensing fees and vaccine administration fees) since they are small and will have little impact on prospective CGDP payments.

Gap Coverage – The 2012 coinsurance non-applicable drugs (i.e. generic drugs) will be equal to 86 percent or an actuarially equivalent amount. This is an increase in plan liability and a reduction in enrollee cost sharing. The 14 percent plan liability will not count towards TrOOP.

Rx-HCC Model – The model will be recalibrated to factor in the impact of the Part D benefit. CMS will use a new formula to calculate plan liability for non-LIS beneficiaries. The new denominator is \$1,107.82.

De Minimis Policy – Part D sponsors may not use the de minimis policy to waive Part D premiums for partial subsidy or non-LIS beneficiaries.

Payment Reconciliation – In 2012 CMS will continue to use the 2011 risk percentages and payment adjustments for Part D risk sharing.

Part D Benefit Parameters – The final rate announcement includes the updated Part D and RDS benefit parameters which will be increased by 3.34 percent for 2012 (4.67 annual percentage trend for 2011 adjusted by -1.27 percent for prior year revisions). Due to changes in cost sharing in the coverage gap, there is a different Total Covered Spending at the Out of Pocket Threshold for LIS and non-LIS beneficiaries.

Part D Benefit Parameters	2011	2012
<u>Defined Standard Benefit</u>		
Deductible	\$310	\$320
Initial Coverage Limit	\$2,840	\$2,930
Out-of-Pocket Threshold	\$4,550	\$4,700
Total Spending at Out of Pocket -LIS	\$6447.50	\$6657.50
Total Spending at Out of Pocket – non-LIS	\$6483.72	\$6730.39
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	\$2.50	\$2.60
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	\$6.30	\$6.50
Retiree Drug Subsidy		
Cost Threshold	\$310	\$320
Cost Limit	\$6,300	\$6,500

FINAL CALL LETTER FOR 2012

Calendar – The calendar includes the earlier Annual Election Period (October 15-December 7) and thus earlier dates in some instances than in the past. For example, the ANOC/EOC documents and LIS rider and formulary must be sent to current members by September 30, 2011. CMS declined to change these dates in response to comments expressing concern about the shorter timeframes.

Quality Improvement Projects and Chronic Care Improvement Programs – MA Organizations must submit QIPs and CCIPs on appropriate templates. The annual collection will begin with CY 2011 and must include plans deemed by an accrediting organization. Guidance will be sent out separately.

SNP plans – CMS will analyze comments on an initiative offering plan design flexibility to promote enrollment of duals in fully integrated (i.e. capitated for full array of Medicaid services), high quality SNPs for 2013.

Chronic care SNPs must disenroll all members who no longer qualify for the special needs requirements by January 1, 2012. The appendix to the Call Letter includes the process and deadlines for notifying and disenrolling ineligible members.

Starting in CY 2013, Dual Eligible SNPs must have contracted with the State Medicaid agency in areas where they operate. Existing Dual SNPs that are not expanding can continue to operate without a state contract through December 31, 2012. CMS will coordinate the submission of the contract with the MA contracting process and state budgetary and contracting timelines.

Plan Renewal – CMS has authority from the ACA to deny plan bids if there are significant increases in cost sharing or decreases in benefits. Renewal and Non-renewal guidance is included in the Call Letter.

Parent Organization – CMS is increasingly focused on the relationship with Parent Organizations and plans must accurately report their “ultimate” parent which is the top entity in a hierarchy. All changes in parental organizations must be reported to CMS within 30 days.

EGWP Plans – CMS will develop an information collection effort to require EGWPs to submit supplemental benefits negotiated between employers and EGWPs to CMS to assure that plans properly apply the manufacturer coverage discount after the supplemental benefits are applied. Beginning in 2012 Direct EGWPs will be required to report HEDIS, HOS and CAHPS data.

Plan Ratings – The Call Letter outlines CMS principles for improving plan ratings.

For 2012, CMS proposes to add the following measures:

- All-Cause Readmission rates
- Advising Smoker and Tobacco Users to Quit
- Body Mass Index
- SNP specific measures including three rates included as part of the Care for Older Adults measure
- Voluntary disenrollment rates
- One or more measures from the Hospital Inpatient Quality Reporting program
- Appropriate Part D transition processes to ensure continuity of care
- Part D Medication Adherence

For 2012, CMS will set 4 star thresholds for measures with at least a two year data history. CMS is also considering the following enhancements for 2012:

- Giving greater weight to clinical outcomes measures and less weight to process measures
- Controlling for concentration of providers in an area
- Rewarding contracts for quality improvement
- Reducing ratings for plans with serious compliance issues

For 2013, CMS is considering adding the following measures:

- Adding survey measures of care coordination, care transitions and patient activation to CAHPS
- Case mix adjusted mortality rates
- Preventable hospitalizations
- Serious Reportable Adverse Events including Hospital Acquired Conditions
- Grievances
- Use of highly rated hospitals by plan members
- MTM measures related to comprehensive medication reviews
- Evaluation of CCIP and QIP

Plans with Less than 3 Star Ratings – CMS is strengthening its position that plans with less than a 3 star average summary rating on either Part C or Part D are substantially out of compliance and are on notice that they are to take corrective action to come into compliance. CMS plans to initiate action to terminate their contracts after publicizing the third consecutive summary rating of less than 3 stars and confirming that the data used to calculate the 3 star rating reflects substantial non-compliance.

SEP for Enrollment in a 5 Star Plan – The SEP to enroll in a plan with an overall 5 star rating any time during the year will begin December 8, 2011. Enrollment will be effective the first of the month following the request between January 1 and December 1. An individual has a onetime election under this SEP. In the final Call Letter, CMS expands the SEP to eligible PDPs as well as eligible MA and MA-PD plans and expands the SEP to all eligible individuals including those who are enrolled in another 5 star plan.

Part C Plans with Low Enrollment and Meaningful Plan Differences – During April or May 2011 CMS will notify plans with fewer than 500 enrollees (100 enrollees for SNPs) after operating for 3 years and request justification or confirm that the plan will be eliminated or consolidated. CMS will non-renew the plan if there is not a compelling reason for maintaining the low enrollment plan. CMS will recognize legitimate reasons for low enrollment, e.g. service areas without sufficient competing plans of the same type, specific populations or geographic area served.

For 2012, CMS will use plan specific out of pocket cost (OOPC) estimates that combine Part C and Part D to identify meaningful differences among similar plan types. The plan OOPC will be compared to data from the Medicare Current Beneficiary Survey information and will exclude premiums. CMS will evaluate differences among non-employer plan types offered by the same organization in the same county. There must be a total OOPC difference of at least \$20 per member per month between each plan to be considered meaningfully different. This is the same threshold used in CY 2011. The final Call Letter clarifies that the meaningful difference policy will not apply to Dual SNPs

Part C MOOP for 2012 – All plans must include a MOOP (maximum out of pocket) limit in their bid. This includes D-SNPs where states usually pay cost sharing to cover situations where a beneficiary’s eligibility may change mid-year. D-SNPs must track only the beneficiary’s out of pocket costs. The final rule provides that RPPO limits may not exceed the amounts set by CMS.

CY 2012 MOOP Amounts	Voluntary	Mandatory
HMO	\$3,400	\$6,700
HMO POS	\$3,400 In-network	\$6,700 In-network
Local PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
Regional PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
PFFS (full network)	\$3,400 In- and out-of-network	\$6,700 In- and out-of-network
PFFS (partial network)	\$3,400 In- and out-of-network	\$6,700 In- and out-of-network
PFFS (non-network)	\$3,400	\$6,700

**Catastrophic MOOP is inclusive of in- and out-of-network Parts A and B services.*

For 2012, CMS is modifying the Summary of Benefits to properly display cost sharing amounts for Dual Eligible SNPs.

Part C Total Beneficiary Cost (TBC) – CMS will further scrutinize bids (rather than deny bids as included in the draft call letter) if the TBC (premium plus other cost sharing) shows significant cost increases from year to year. For 2012, CMS will include a factor to account for Part B premium buy down as an additional benefit. Based on comments, in the final Call Letter CMS chose a different method from the outlier method used to set TBC in the past. For 2012 CMS will establish a TBC change amount of \$36 PMPM or a 10% increase in TBC from 2011 to 2012. CMS will provide a plan specific adjustment factor to account for geographic and quality bonus payment changes in 2012. Each plan specific amount will be an effective TBC limit for that plan. The TBC policy applies to non-employer plans (excluding D-SNPs).

Discriminatory Cost Sharing – CMS is establishing 3 benefit discrimination assessments for 2012 for all MA plans including employer and non-employer plans:

- PMPM Actuarially Equivalent Cost Sharing Maximums – amounts may not exceed FFS on an actuarially equivalent basis. Also CMS will apply this separately in 2012 for inpatient facility, SNF, home health, DME and Part B drugs.
- Service Category Cost Sharing Standards – the Call Letter includes cost sharing limits for services that may vary based on whether the plan chooses the mandatory MOOP or a lower voluntary MOOP.
- Discriminatory Pattern Analysis – this analysis will consider cost sharing amounts that discriminate against sicker patients, or certain disease states.

Multi-Year Benefits – CMS finds that multi-year benefits are confusing to beneficiaries and encourages plans to limit benefits to one contract year.

Copayment and Coinsurance for the Same Service – CMS is discouraging plans from entering both types of cost sharing for the same service, but will not disallow the practice since CMS recognizes a plan's network may require varying cost sharing arrangements. Plans must make these differences transparent to beneficiaries in their marketing materials.

PART D

SEP for Enrollment in a 5-Star Plan – The final Call Letter extends the SEP for 5 star plans to PDPs. The SEP to enroll in a PDP with an overall 5 star rating any time during the year will begin December 8, 2011. Enrollment will be effective the first of the month following the request between January 1 and December 1. An individual has a onetime election under this SEP. The SEP is available to all beneficiaries eligible to enroll in the 5 star PDP.

Bids – Part D bids for a plan in the Commonwealth of Puerto Rico as part of the Platino program must reflect only basic benefits (i.e., defined standard, actuarial equivalent standard or basic alternative design). For 2012, the HPMS benefit package will be revised and plan sponsors may not validate bids for enhanced plans that apply to Platino programs.

ESRD Drugs – CMS reminds plans to exclude drug costs related to oral drugs from the Part D bids since these are now included in the bundled PPS system for renal dialysis services.

Prescriber Identifiers – For prescriptions written by foreign prescribers, sponsors should use the license number assigned by the appropriate licensing board in the foreign jurisdiction on the claim with the state license qualifier.

For 2012, Part D sponsors must verify and report valid prescriber IDs, including for non-standard claims formats. Sponsors can use the current four prescriber identifiers on claims and PDE records – NPI, DEA, UPIN or state license number. CMS will exclude PDEs with invalid NPIs. Effective January 1, 2012 Part D sponsors must confirm the validity of DEA numbers for all controlled substances and must confirm that the controlled substance is within the prescriber's scope of practice.

Supplemental Formulary Files – These must be submitted by June 13, 2011.

Hospice Drugs – Part D plan sponsors must ensure that drugs for beneficiaries who elect hospice as identified on the TRR are not submitted under Part D since these are covered under Part A. Additional guidance will be issued. If there is a question at the point of sale, sponsors should furnish drugs to members enrolled in a hospice program and retrospectively determine payment responsibility.

EGWPs and the Manufacturer Discount- The value of supplemental benefits must be calculated prior to the application of the manufacturer coverage gap discount. CMS will be issuing future guidance on an upcoming information collection process that will require EGQP plans sponsors to submit supplemental benefit information. In the meantime, plan sponsors must attest to the accuracy of the discount amounts.

Generic Drug Samples – Expenses related to the provision of generic samples in a physician's office may be counted as Part D administrative costs if consistent with a cost effective drug utilization management program. However, these drugs may not be incorporated into step-therapy protocols.

BAE for Home and Community Based Waiver Services - Cost sharing is eliminated for full benefit dual eligible beneficiaries who receive home and community based waiver services. Plan sponsors must follow the best available evidence policies that require a copy of a state document confirming receipt of waiver services.

Transition Policy – Audit findings show that plans have not been following transition policy requirements. CMS will require that plan sponsors provide documentation that their transition policy is properly implemented in their claims system and that beneficiaries are receiving required transition supplies. CMS may require submission of: up to one quarter's worth of denied claims for 2012; test claims for new beneficiaries; documentation of paid claims for transition supplies; or evidence of transition supplies provided across contract years.

MTM and Racial Disparities – CMS is replicating a study that found that found Hispanic and African American enrollees could have a lower likelihood of meeting MTM eligibility criteria and that there was disparity among beneficiaries with severe health problems. CMS is asking plan sponsors to review their eligibility criteria and implement any necessary changes.

LIS Reassignment – CMS will reassign auto-enrolled beneficiaries when their plan is above the LIS benchmark. Plans that waive the de minimis amount of the premium will no longer lose LIS beneficiaries. Organizations under sanction will not receive reassignments.

Low Enrollment PDPs – CMS will review the lowest quintile (20%) of 2011 non-employer plans ranked by enrollment. CMS encourages plan sponsors to withdraw or consolidate plans with less than 1,000 enrollees. Before non-renewing a plan, CMS will consider whether the plan has less than 3 years in the program, whether it is a basic plan necessary to offer an enhanced plan; the total number of plans in an area; whether the premium is below the LIS benchmark; and whether it is a national plan.

Meaningful Plan Differences for PDPs – CMS will continue to use the cost sharing out of pocket amounts (OOPC) to establish meaningful differences between basic and enhanced plans and between low and high value enhanced plans. The 2012 minimum monthly

threshold between basic and enhanced plans will remain at \$22. CMS will also use the median monthly cost sharing OOPC difference of \$16 between 2 enhanced plans in the same service area. CMS will provide the OOPC model on their website and encourages plans to run their plan benefit structures through the model before submission. Plan sponsors can only submit 1 basic offering and at most 2 enhanced plans. The second enhanced plan will have a higher value and at least some brand name coverage (10-65% of formulary drugs labeled as brand) in the gap.

COB User Fee – The Part D COB user fee will be increased to \$1.62 per enrollee per year for 2012.

Part D Benefit Design - Co-Pay Thresholds – CMS will use the 95th percentile across all bids consisting of 3 or more tiers to identify outliers for 2012. The following thresholds were used in the 2011 discrimination review; tier 1 over \$10; tier 2 over \$45; and tier 3 over \$95. CMS will also increase scrutiny of coinsurance tiers. If a sponsor submits coinsurance values for its non-specialty formulary tiers that are greater than the standard benefit of 25%, CMS may request documentation of expected prices of medications.

Tier Labeling and Hierarchy – For 2012 there will continue to be a maximum of 6 drug tiers however a 6th tier will be accepted only if it is an excluded drug only tier or a tier that provides a meaningful benefit such as a \$0 vaccine-only tier, a low or \$0 cost sharing tier for SNP plans targeting specific conditions or an injectable drug tier with cost sharing that is at or below cost sharing in the other tiers.

CMS is adopting tier labels and hierarchy consistent with industry standards. The tier hierarchy is included in the Call Letter.

Gap Coverage – The basic package includes 14% generic drug coverage in the gap for 2012. CMS will evaluate plans that provide gap coverage at or below 30% of the cost of generic drugs or coinsurance higher than 70% to ensure substantial differences.

Specialty Tier Threshold – For 2012, the Part D specialty tier threshold will remain at \$600. Plans should have claims data that demonstrates that the majority of fills exceed the specialty tier cost criteria.

If you have specific questions regarding the content of this memo, please contact us at ghg@gormanhealthgroup.com.