By JANE ZHANG and VANESSA FUHRMANS

Figuring out which Medicare drug-insurance plan is right for you is confusing enough. Now, complaints are mounting about an obscure drug-pricing system that can force many older Americans to pay stiff penalties when they opt for brand-name drugs instead of a generic.

The system, known as reference-based pricing, is used by dozens of plans offering coverage through Medicare's Part D drug-insurance program. Under reference-based pricing, patients who insist on certain brand-name drugs when a cheaper generic version is available are charged a much higher price – typically representing the difference between the cost of the two drugs, plus a copayment. By contrast, people buying a brand-name drug when there is no generic equivalent are charged just a copayment.

Avoiding the Penalty Box

Finding out if a Medicare drug plan requires more than copays for certain brand-name drugs takes detective work. Here's how to avoid unexpected charges:

If you're comparing drugs on Medicare's Plan Finder (at www.medicare.gov) follow the steps and enter your information, including the drugs you currently take. A list of plans in your zip code will come up. Click on three to compare in more detail. The last section lists the plan's full negotiated price for a drug and will include a footnote (labeled as 8) if the drug is subject "to supplemental costsharing in addition to the price displayed."

To double check, look at the drug plan's formulary and summary of benefits and call the customer-service line. Some, but not all, plans that use reference-based pricing will include a list, or mark which drugs may be subject to the additional costs.

To avoid unexpected and unnecessary costs, make sure your pharmacy fills your prescriptions with generics. Consult your doctor, too – there may be other opportunities to save on your medications.

If you or your doctor feels you must take the brand-name equivalent, consult your plan on how to get an exception.

Patients in some cases might be responsible for paying nearly the full cost of their brand-name medications under reference-based pricing. But sorting out which drugs are subject to the extra charges and calculating how big the penalties might be are difficult because the information isn't clearly spelled out by Medicare or many of the insurers, say lawmakers and consumer advocates, who are stepping up demands for greater transparency from insurers. That's especially important as many Medicare beneficiaries are currently shopping around for a drug plan for 2009 during the so-called open-enrollment period that runs through Dec. 31.

For next year, 30 insurers will use reference-based pricing in 63 separate drug plans, which represent nearly 10% of all Part D plans, according to the Centers for Medicare and Medicaid Services, the agency that manages the government insurance program for the elderly and disabled. About three million people are enrolled with companies that use the pricing system in some instances, or about 12% of all Part D participants, says consulting firm Avalere Health LLC.

Reference-based pricing is one of a number of tactics the industry has adopted in recent years to steer consumers away from expensive brand-name drugs and encourage them to use generics. The measures help to keep overall health-care costs down, insurers say. In just about every case, drug-plan beneficiaries could avoid extra charges by asking their doctors and pharmacists for generics.

But critics complain reference-based pricing can result in hidden charges. "I am concerned that beneficiaries could find themselves paying far more out-of-pocket than they expected," Rep. Pete Stark, chairman of the House Ways and Means health subcommittee, recently wrote in a letter to the Centers for Medicare and Medicaid Services. "CMS needs to make sure that beneficiaries are aware of these penalties before they choose their plans."

AARP Issues Warning

AARP, the advocacy group for older Americans, plans Tuesday to issue a warning to seniors and send a letter to CMS to complain about the lack of disclosure of reference-based pricing. Other groups, including the National Senior Citizens Law Center, also have written recently asking CMS to require that plans more clearly disclose the true cost consumers will have to pay for drugs. CMS says it is currently considering ways to ensure that disclosures about reference-based pricing are as transparent as possible to consumers.

Consider, for example, the brand-name drug Norpace, used to treat an abnormally fast heartbeat, or arrhythmia. Under Health Net Inc.'s Orange Option 1 plan, a patient in Tampa, Fla., could pay about $152.11 for a one-month supply of 150 mg of the drug, according to price data on Medicare's Web site. That cost includes a co-payment of $43. It also includes $109.11, which represents the difference between Health Net's $161.51 negotiated price for Norpace and the $52.40 cost of the generic equivalent, disopyramide phosphate. (Prices can vary by pharmacy.)

A patient insured by CVS Caremark Corp.'s SilverScript Value plan would be charged $119.88 for Norpace. The company says this represents the price difference of $111.88, plus the copayment for the generic equivalent, or $8.

The extra charge isn't necessarily clear to consumers who use the popular Plan Finder tool, which

Medicare set up on its Web site to help people compare how much they would pay for a drug under different plans. CMS did add a footnote to the site last summer that warns consumers: "This drug may be subject to supplemental cost-sharing in addition to the price displayed. Please contact the plan for details." A CMS spokesman says the agency "will continue to work to make that material transparent on our Plan Finder tool."

Formulary Footnotes

CMS also recently began requiring drug-plan sponsors to ensure its members are aware of which drugs are subject to reference-based pricing. HealthNet, for example, includes in its drug-formulary list a footnote next to each medication subject to the pricing system. CVS Caremark's SilverScript formulary has a link to "drug cost exceptions" where consumers can view a complete list of drugs that are subject to the insurer's "maximum allowable cost" program. But neither insurer tallies the drugs' approximate cost to the consumer.

Vivian O'Connor of Deerfield, Wis., says she has been shopping for a 2009 Medicare drug plan to help pay for Prilosec, which she takes to treat acid reflux. Under one plan she was considering, the drug would have cost her $42, plus a copayment of $98, for a total of $140 a month. The 55-year-old, who is disabled, says she learned about the extra charge, representing the price difference between the brand-name and generic versions, only after talking with an advocate at Disability Rights Wisconsin.

"That's terrible. [Insurers] should be upfront," says Ms. O'Connor, who says she is continuing to shop for a drug plan for next year.

John Sivori, president of Health Net's Pharmaceutical Services, says members who need a brand-name drug because they can't tolerate the generic version or find it isn't effective would be charged only the copayment. Depending on the plan, these members and their doctors might need to establish in advance their need for a brand-name drug, the company says.

Reference-based pricing has been used elsewhere to encourage generics, including some group plans sponsored by private employers, state Medicaid programs and in foreign countries.

In its letter to CMS, AARP will ask the agency to revise Plan Finder so consumers using the online tool will see the total cost of drugs, including any reference-based pricing, an AARP spokesman said. The group also will request a special Part D enrollment period for members who signed up for plans that use the pricing system "based on misleading information." AARP is also expected to urge CMS to ban the use of reference-based pricing in Part D plans.

Most plans don't use reference-based pricing to manage drug costs. "It's a very blunt tool," says Jackie Kosecoff, chief executive of the Prescriptions Solutions unit at UnitedHealth Group Inc., which sets up drug lists. "I can get to the same place with other approaches," she says. Other ways plans encourage generics include setting higher copayments for brand-name drugs, requiring prior authorization for expensive medications or insisting that consumers try cheaper drugs first.

Higher Charges

Members of some Medicare drug plans could pay a lot more for the following branded drugs than the listed copay. Here's how the pricing would work out for a consumer living in Tampa, Fla.:

Plan: Health Net Orange 1		Copay tier	Full price	Price under reference-based pricing*
Brand	Norpace, 150 mg, anti-arrhythmia pill	$43	$161.51	$152.11
Generic	dysopyramide phosphate	$2	$52.40	
Brand	Mevacor, 40 mg	$43	$113.98	$113.98 **
Generic	lovastatin	$2	$20.22	
Plan: SilverScript Value				
Brand	Norpace, 150 mg, anti-arrhythmia pill	$98	$170.63	$119.88 ***
Generic	dysopyramide phosphate	$8	$58.75	
Brand	Mevacor, 40 mg	$98	$120.39	$89.29 ***
Generic	lovastatin	$8	$39.10	

* Reference-based pricing cost = brand copay + cost difference between the generic and brand-name drugs

** Since the amount can never be more than the plan's price for the brand-name drug, the consumer in this case pays the brand-name drug price since it's the lower amount

*** Unlike most plans, SilverScript's reference-based pricing formula adds in the generic copay, not the brand-name copay

Source: Medicare, the companies

Write to Jane Zhang at Jane.Zhang@wsj.com and Vanessa Fuhrmans at vanessa.fuhrmans@wsj.com