

**Testimony of  
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Before the  
Senate Finance Committee  
On  
The Medicare Prescription Drug Benefit: Review and Oversight  
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Good afternoon Chairman Baucus, Senator Grassley and distinguished members of the Committee. I am pleased to be here today to discuss the Medicare prescription drug benefit (Part D) and in particular, plan oversight. Following the enactment of Part D with the Medicare Prescription Drug, Improvement and Modernization act of 2003 (MMA), CMS undertook an unprecedented outreach campaign, resulting in more than 90 percent of eligible beneficiaries having creditable coverage for prescription drugs through Part D or other sources by the end of the initial enrollment period (May 15, 2006). CMS has worked equally hard to ensure that once enrolled, people with Medicare are able to take advantage of their prescription drug coverage without difficulty.

**Part D in 2007: Lower Costs and Improved Satisfaction**

In many respects, Part D is the single most important benefit addition in the history of the Medicare program. Nearly 24 million beneficiaries are enrolled in Part D. More importantly, according to recent surveys, over 80 percent of Medicare beneficiaries are satisfied with their current coverage and drug plans, including beneficiaries eligible for both Medicare and Medicaid, who receive the low income subsidy (LIS).<sup>1</sup> Additionally,

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<sup>1</sup> Results are based on a telephone survey of 802 seniors ages 65+ enrolled in Medicare, conducted September 1-7, 2006, by KRC Research for the Medicare Rx Education Network. Of those surveyed, 82

the recent surveys report that 87 percent of dual-eligibles feel “peace of mind” now that they are enrolled in Part D and more than 9 out of 10 dual-eligibles are satisfied. Almost half of the people who reported skipping or splitting dosages of medication prior to Medicare’s prescription drug coverage say they no longer have to under Part D.<sup>2</sup>

In addition to beneficiary participation and satisfaction, the program also has resulted in significant savings for beneficiaries and lower-than-projected costs for taxpayers.

Beneficiaries are saving an average of \$1,200 a year, with estimated premiums for 2007 expected to average \$22 a month, down from an average of \$23 a month in 2006 and 42 percent lower than the original estimates of \$37 a month.

The latest cost projections for Part D through 2015, released on April 23 with the 2007 Medicare Trustees Report, are 13 percent lower than estimated in the 2006 Trustees Report (and substantially lower than the original estimates from 2003). Plan bids for 2007 were 10 percent lower than in 2006, as a result of intense competition among plans to attract and retain enrollees and plans’ expectations to further increase use of inexpensive generic drugs, rather than more costly brand-name equivalents. In addition, overall prescription drug costs have increased much more slowly during 2004-2006 than in prior years. Together, these developments reduce projected Part D costs significantly compared to the estimates in the 2006 Trustees Report.

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percent are somewhat (29 percent) or very (53 percent) satisfied with their coverage. The margin of error for the full sample is  $\pm 3.5$  percentage points.

<sup>2</sup> KRC Research survey for the Medicare Rx Education Network, conducted September 1-7, 2006.

## **What a Difference a Year Makes: Lessons Learned**

One year ago, CMS was resolving a number of systems and process issues that impacted some Part D enrollees' ability to access covered drugs. CMS worked hard to find and fix the problems, and took significant steps early to avoid similar issues in 2007. We worked with plans, pharmacists and States to improve data systems impacting beneficiary access. For example, we facilitated better communication between plans and pharmacies, which resulted in upgrades to pharmacy software systems that will improve messaging between pharmacies and plans for better customer service. Also, throughout the year, CMS made a series of systems and process changes and enhancements to improve our file and data exchanges with plans, SSA and the states to improve performance and accuracy in beneficiary enrollment and benefits processing.

In September 2006, CMS published a "Readiness Checklist" for all prescription drug plans, reminding them of their obligations, key dates, and vital tasks to ensure a smooth annual enrollment season and transition to the 2007 benefit year. The Readiness Checklist included elements related to call center requirements, complaint resolution, systems testing and connectivity, data submission and file processing, enrollment procedures, beneficiary marketing and communication strategies, beneficiary and pharmacy customer service, and timely payment to pharmacies.

In early November 2006, CMS asked all plans to report back to CMS on their successes and any problems encountered in accomplishing the tasks on the Readiness Checklist. The results from this exercise served two important functions: First, it reassured CMS

that the vast majority of plans were fully prepared for annual enrollment and the new benefit year, and that they had successfully implemented our guidance and requirements. Second, it identified areas where some plans indeed were having problems – for example, some plans reported that they were not able to issue the Annual Notices of Change (ANOCs) within the timeframe specified by CMS. Using this information from the Readiness Checklist, CMS was able to quickly implement a strategy to ensure that beneficiaries who did not receive an ANOC in a timely manner would be granted a special election period to extend the period of time they had to make a decision about their 2007 plan choice.

### **CMS Oversight of Part D Plans**

Building upon lessons learned and information gathered during 2006, CMS has strengthened its oversight of Part D plans. For example, CMS has improved its method for identifying companies for compliance audits, making more efficient use of the resources available for ensuring compliance, and developing a closer relationship with State regulators.

CMS has developed a contractor risk assessment methodology that identifies organizations and program areas representing the greatest compliance risks to Medicare beneficiaries and the government. CMS will direct its resources to those high risk contracts. We envision that this approach to oversight will include a mostly centralized data-driven program, fueled by data provided by contractors and beneficiaries. While receipt and analysis of data is central to this oversight strategy, regularly scheduled and

focused/targeted program compliance and program integrity audits will be necessary to ensure program compliance and document the Agency's program oversight responsibilities. CMS anticipates the risk assessment tool to be ready for implementation and use in January 2008.

Further, CMS is now working with a contractor to augment the internal agency resources available for Part D compliance audits. Among other things, the contractor is conducting "secret shopping" of sales events across the country; such information enables CMS to learn firsthand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements.

CMS also has strengthened relationships with State regulators that oversee the market conduct of health insurers. Specifically, CMS worked cooperatively with the National Association of Insurance Commissioners (NAIC) and State Departments of Insurance to develop a model Compliance and Enforcement memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of companies we jointly regulate and to facilitate the sharing of specific information about marketing agent conduct.

More fundamentally, before a plan sponsor is allowed to even participate in the Part D program, it must submit an application and secure CMS approval. CMS performs a

comprehensive review of the application to determine if the plan meets CMS requirements. Annually, plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each plan sponsor, CMS establishes a single point of contact (Account Manager) for all communications with the plan. The Account Managers work with plans to resolve any plan problems, including compliance issues.

CMS continually collects and analyzes performance data submitted by Part D plans, internal systems, and beneficiaries. CMS has established baseline measures for the performance data and has been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are initiated. Actions range from warning letters all the way through civil monetary penalties and removal from the program depending on the extent to which plans have violated Part D program requirements. All violations are taken very seriously by CMS, with beneficiary protection the foremost concern.

### **Looking Ahead: The 2008 Plan Call Letter**

The recently-released 2008 Call Letter to plans serves as a central guidance document to help plans implement new CMS policies and procedures and improve compliance with critical program requirements. Highlights from the Call Letter include:

***Ensuring Accountability.*** CMS strives to provide organizations with the guidance and information they need to meet the requirements of our programs and, in most cases,

organizations are meeting or exceeding those standards. Complying with the Part D program requirements is critical to meeting the needs of people with Medicare; consequently, we may take actions, including sanctions and civil money penalties, when organizations do not comply. If an organization thinks it will be unable to meet a requirement, it must notify CMS immediately. Often we can work with an organization to resolve issues and avoid delays. However, CMS *will* take action against organizations that do not meet critical deadlines or exhibit a pattern of missed deadlines. In order to help organizations meet the requirements of the Part D programs, a calendar of key dates and deadlines that organizations must meet was included with the Call Letter.

CMS also is improving ways of collecting performance data and refining our performance measures for the development of comparative materials such as plan report cards, so that people with Medicare can better evaluate their health care options. As CMS expands web-based and other resources, we expect organizations to provide comparative, in-depth plan information so people can choose the prescription drug benefits that best meet their needs. Looking forward, new areas for measurement may include, but are not limited to: medication therapy management (MTM) services, prescription drug utilization, patient safety, disenrollment, and member satisfaction. The measures to be included as part of the report card will come from multiple data sources, most of which are already currently collected by CMS.

***Fostering Transparency.*** The Health Plan Management System (HPMS) facilitates data exchanges between CMS and Part D plan sponsors. HPMS plays an important role in our

efforts to provide people with Medicare with the information they need to make confident and informed decisions about their health care needs. Data submitted by organizations via HPMS is integral to the Medicare Prescription Drug Plan Finder and the Medicare Options Compare website tools, the plan-specific portion of Medicare and You, and the standardized Summary of Benefits. CMS continually strives to enhance HPMS system and software functionality in support of our outreach efforts and to further streamline the bid and formulary submission processes. While streamlining, we want to make sure we are conveying accurate information. Prior to the publication of plan data, CMS provides organizations ample opportunity to preview the data, and expect them to ensure that all plan data is accurate. As has been done in the past, in cases where the data of a particular plan is inaccurate, CMS will suppress the data to avoid misleading people with Medicare.

***Protecting Beneficiaries.*** To ensure a non-discriminatory benefit, CMS expects that sponsors must assign preferred cost-sharing amounts in alignment with preferred formulary tiers. To this point, cost-sharing amounts for a preferred tier must be lower than cost-sharing amounts for a non-preferred tier. In addition, plans whose cost-sharing amounts fall above the mean will be rigorously examined under the discrimination review.

***Requiring Reporting.*** To ensure that Part D sponsors continue to provide beneficiaries high value health care, sponsors are required to submit data according to our reporting requirements document. They are also expected to comply with any other requests by

CMS for additional data necessary to support payment, program integrity, program management, and quality improvement activities under Part D.

***Focusing on Marketing.*** CMS uses several mechanisms to ensure that MA organizations conduct marketing activities that are compliant with the regulations and marketing guidelines. Organizations are responsible for the actions of sales agents/brokers whether they are employed or contracted. They must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Part D sponsors must provide strong oversight and training for all marketing activities. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Employees, brokers and independent agents must first ask for a beneficiary's permission before providing assistance in the beneficiary's residence, prior to conducting any sales presentations or accepting an enrollment form in person.

## **Conclusion**

CMS continues to make significant progress in overseeing and promoting quality Part D prescription drug coverage. With ongoing effort and vigilance, I am confident we will see continued high levels of plan compliance with program requirements, along with significant improvements where necessary on this critical front. Thank you again for the opportunity to speak with you today. I look forward to answering your questions.