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MEDICARE PART D

CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability

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CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability

Why GAO Did This Study

The Medicare prescription drug program, known as Medicare Part D, provides a voluntary outpatient prescription drug benefit for Medicare beneficiaries. Beneficiaries may choose Part D plans from among multiple plans offered by private companies—plan sponsors—that contract with CMS. Plans may differ in their premiums and cost-sharing arrangements, the drugs they cover, and the pharmacies they contract with to fill prescriptions. CMS developed the Medicare Plan Finder interactive website in 2005 as a tool to help beneficiaries compare Part D plans and identify plans that meet their needs. For Plan Finder to serve its intended purpose, beneficiaries and their advisers need to be able to obtain accurate drug cost information, understand plan options, and navigate the website effectively.

GAO was asked to review CMS's efforts to ensure that beneficiaries can use Plan Finder effectively. This report examines (1) how CMS oversees the accuracy of drug pricing information in Plan Finder; and (2) how CMS assesses the usability of Plan Finder and any steps CMS has taken to improve it. To conduct this work, GAO reviewed documentation detailing CMS's processes for overseeing Plan Finder pricing accuracy and obtained data on agency compliance actions. GAO also interviewed CMS officials and organizations that help Medicare beneficiaries navigate Plan Finder to learn about CMS's processes for obtaining feedback on Plan Finder's usability and steps the agency has taken to improve the website.

View GAO-14-143. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare, uses data checks and quality measures to oversee the accuracy of Part D plan pricing information on the Plan Finder interactive website. Part D sponsors may have multiple contracts with CMS to provide drug coverage, with each contract covering one or more distinct Part D plans, and CMS is responsible for overseeing plan sponsors' compliance with their Part D contracts. CMS requires Part D plan sponsors to submit drug pricing information for their plans, which Plan Finder uses to estimate beneficiaries' cost-sharing amounts and expected annual drug costs. To ensure the accuracy of this information,

- CMS performs computerized data checks on the pricing information for each plan to identify incomplete and potentially inaccurate data before information is displayed on Plan Finder. If CMS's data checks identify potentially inaccurate plan pricing information, CMS gives the plan's sponsor an opportunity to attest to the accuracy of the data, or correct it. If the plan's sponsor does not verify or correct potential inaccuracies identified by these checks, CMS will "suppress" the plan from Plan Finder, which means that the plan's pricing information is removed and that beneficiaries cannot enroll in the plan through the website. In the first seven months of 2013, 25 percent of Part D contracts had one or more plans suppressed from Plan Finder at least once. CMS has taken compliance actions against plan sponsors for repeated suppressions—between January 1, 2009, and July 31, 2013, CMS issued 89 notices of noncompliance and 67 warning letters.

- CMS uses quality measures to evaluate the accuracy of pricing information on Plan Finder. As part of its Part D Star Ratings, which provide beneficiaries with information on plan quality, CMS collects performance data on Part D plans covered under each individual contract. CMS assigns scores to each contract based on the extent to which beneficiaries' point-of-sale costs were higher than prices posted on Plan Finder. For the 2013 Star Ratings, 6 percent of contracts had point-of-sale prices that were greater than Plan Finder prices by an average of 4 percent or more.

CMS has assessed the usability of Plan Finder by obtaining feedback from a variety of sources, including beneficiary assistance organizations, user testing, a website survey, and website user data. CMS has used feedback on Plan Finder to update the website and improve usability. For example, CMS developed and added a "frequently asked questions" webpage to the website. Officials from the beneficiary organizations GAO spoke with generally said that Plan Finder helps beneficiaries compare Part D plans and that its usability has improved over time.

GAO provided a draft of this report to HHS and HHS agreed with GAO's findings.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
LIS	low-income subsidy
MA-PD	Medicare Advantage prescription drug plan
OIG	Office of Inspector General
PDP	stand-alone prescription drug plan
SHIP	State Health Insurance Assistance Program

January 10, 2014

The Honorable Bill Nelson
Chairman
The Honorable Susan Collins
Ranking Member
Special Committee on Aging
United States Senate

The Medicare prescription drug program, known as Medicare Part D, provides a voluntary outpatient prescription drug benefit for Medicare beneficiaries.[1] As of January 2013, nearly 34 million beneficiaries were enrolled in Part D. Beneficiaries may choose Part D plans from among multiple plans offered by private companies—Part D plan sponsors—that contract with the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare. Part D plan sponsors may have multiple contracts with CMS to provide drug coverage, with each contract covering one or more distinct Part D plans.[2] Plans may charge different monthly premiums and have different beneficiary cost-sharing arrangements— such as deductibles and copayments or coinsurance for covered drugs.[3] In addition, plans may differ in the drugs they cover and the pharmacies they contract with to fill prescriptions.

Beneficiaries' annual drug costs—the total amount beneficiaries pay in premiums, cost-sharing, and costs for non-covered drugs each year—

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[1]Medicare—a federal health insurance program—is for people age 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease. Medicare consists of four parts. Parts A and B are known as original Medicare or Medicare fee-for-service. Part A covers hospital and other inpatient stays. Part B covers hospital outpatient, physician, and other services. Part C is Medicare Advantage, under which beneficiaries receive health benefits through private health plans. Part D provides the outpatient prescription drug benefit.

[2]For example, a plan sponsor may have a contract that covers plans in one region of the country, and another contract that covers plans in another region. Plans covered under the same contract may differ in their benefit structure, such as the premiums they charge.

[3]A deductible is a fixed dollar amount that beneficiaries must pay before coverage takes effect. A copayment is usually a fixed amount paid by beneficiaries for a drug, whereas coinsurance is a percentage of a drug's point-of-sale cost that the beneficiary is responsible for paying.

vary depending on which Part D plans they choose. Drug costs vary based on plans' benefit structures and drug coverage, the costs and amount of drugs needed, and the pharmacies the beneficiaries use. In addition, beneficiaries' drug costs can change from one year to the next as their drug needs change, and as plans modify their premiums, cost-sharing arrangements, and drugs they cover each year.[4]

Given the variation amongst plans and the numerous factors affecting beneficiaries' drug costs, beneficiaries may face challenges comparing plans and may not enroll in plans that best meet their needs. Several studies have found that most beneficiaries could have saved money had they enrolled in lower-cost plans available to them based on their prescription drug needs.[5] Other studies have also found that even though beneficiaries are eligible to switch plans each year as their needs change, relatively few beneficiaries reevaluate their plan options or switch plans.[6]

To help beneficiaries compare Part D plans and identify plans that meet their needs, CMS developed the Medicare Plan Finder interactive website.[7] Plan Finder uses coverage and prescription drug pricing information that Part D plan sponsors are required to submit, along with

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[4]Part D plan sponsors must make these types of changes in accordance with federal requirements. For example, plan sponsors must provide advance notice to CMS, affected beneficiaries, and other parties prior to removing a drug from a formulary or changing a drug's cost-sharing status.

[5]See Chao Zhou and Yuting Zhang, "The Vast Majority Of Medicare Part D Beneficiaries Still Don't Choose The Cheapest Plans That Meet Their Medication Needs," *Health Affairs*, vol. 31, no.10 (2012): 2259-2265, accessed May 23, 2013, http://content.healthaffairs.org/content/31/10/2259.full.html, and Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?," Henry J. Kaiser Family Foundation, accessed May 31, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7864.pdf.

[6]A 2012 Kaiser Family Foundation study found that about one quarter of beneficiaries rarely or never review and compare their coverage options, and the Medicare Payment Advisory Commission reported that 13 percent of beneficiaries not eligible for low-income subsidies voluntarily switched plans in 2010 and 2011. See Henry J. Kaiser Family Foundation, "Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors: Seniors' Knowledge and Experience with Medicare's Open Enrollment Period and Choosing a Plan," accessed May 30, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8374.pdf and Medicare Payment Advisory Commission, *March 2013 Report to the Congress: Medicare Payment Policy*, (Washington, D.C.: March 2013).

[7]See www.medicare.gov/find-a-plan.

information entered by beneficiaries on the prescription drugs they take and the pharmacies they use, to estimate beneficiaries' cost-sharing amounts and expected annual drug costs. Plan Finder also provides beneficiaries with information on CMS's ratings of the quality of each plan, based on their performance across a range of quality measures. For Plan Finder to serve its intended purpose effectively, beneficiaries and their advisers need to be able to obtain accurate drug coverage and cost information, understand available plan options, and navigate the website.

You asked us to review CMS's efforts to ensure that beneficiaries can use Plan Finder effectively. We examined (1) how CMS oversees the accuracy of drug pricing information in Plan Finder and (2) how CMS assesses the usability of Plan Finder and any steps that CMS has taken to improve it.

To examine how CMS oversees the accuracy of drug pricing information in Plan Finder, we interviewed officials from CMS on their processes for ensuring Plan Finder pricing accuracy and for taking compliance actions against Part D plan sponsors that do not provide accurate Plan Finder pricing information. We reviewed documentation describing the data checks performed by CMS to identify outlying and inaccurate pricing information submitted by Part D plan sponsors. We also obtained documentation related to CMS compliance activities, including documentation associated with an instance of noncompliance that was referred by CMS to the Department of Justice. We analyzed data on actions taken by CMS when plan sponsors did not submit accurate drug pricing information, including data from CMS's Compliance Activity Module—CMS's data repository for compliance actions taken against Part D plan sponsors— from January 1, 2009, through July 31, 2013.[8] CMS tracks compliance activities by the individual contract. We also reviewed CMS's Star Ratings performance data, which assigns scores to individual Part D contracts based on the performance of plans covered under the contracts across a range of quality measures, from 2011

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[8]To focus on plans available to eligible beneficiaries, our analysis of this data excluded Part D contracts that cover plans with restricted enrollment—employer-sponsored, Demonstration, Cost, and PACE plans.

through 2013.[9] We discussed these data with agency officials and reviewed them for reasonableness and consistency; we determined that the data were sufficiently reliable for our purposes.

To examine how CMS assesses the usability of Plan Finder and any steps that CMS has taken to improve it, we interviewed CMS officials regarding their processes for obtaining feedback on the usability of Plan Finder and addressing any identified issues. We obtained documentation describing changes made to the website from January 1, 2011, through July 31, 2013, along with documentation associated with beneficiary user testing and website surveys conducted by CMS. We also obtained agency data on the total number of beneficiary enrollments in Part D plans, and the number of beneficiary enrollments through the website from January 1, 2009, through July 31, 2013.[10] We discussed these data with agency officials and reviewed them for reasonableness and consistency; we determined that the data were sufficiently reliable for our purposes. We also interviewed officials from organizations that help Medicare beneficiaries navigate the Plan Finder website and use Plan Finder themselves when counseling beneficiaries. We discussed their experiences with the website, their observations of beneficiaries' experiences, and any feedback on the website that they have provided to CMS. While perspectives obtained from these interviews are not generalizable, they provided insights into users' perspectives on Plan Finder. We compared CMS's processes for obtaining feedback on Plan Finder's usability to leading practices for collecting feedback and

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[9]CMS's Star Ratings assign scores to individual Part D contracts and all of the plans under a given contract assume the same Star Ratings scores. To focus on plans available to eligible beneficiaries, our analysis of this data excluded Part D contracts that cover plans with restricted enrollment—employer-sponsored, Demonstration, Cost, and PACE plans.

[10]The Part D enrollment data we obtained excluded Demonstration, Cost, and PACE plans, though it included employer-sponsored plans. The Plan Finder enrollment data we obtained included enrollment in all Medicare Advantage plans, not just Medicare Advantage prescription drug plans, and included employer-sponsored plans.

performance data on website usability provided on HowTo.gov, a source of information for federal website development and management.[11]

We conducted this performance audit from July 2013 to January 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Part D was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[12] Since January 1, 2006, beneficiaries have been able to obtain prescription drug coverage through prescription drug plans offered by Part D plan sponsors that contract with CMS. Plan sponsors offer prescription drug coverage through stand-alone prescription drug plans (PDP) or through Medicare Advantage prescription drug plans (MA-PD), which combine medical and prescription drug benefits. In 2013, CMS had 75 PDP and 555 MA-PD contracts with Part D plan sponsors that together offered 2,660 plans. About 64 percent of beneficiaries with a Part D plan enrolled in PDPs and 36 percent enrolled in MA-PDs.

[11]Howto.gov is a website managed by the General Services Administration that serves as a resource to federal agencies to improve how they communicate and interact with users and provide services and information. The website makes available a list of the "Top 10 Best Practices" for federal websites and provides detailed information on how to implement each practice; accessed November 5, 2013, http://www.howto.gov/web-content/requirements-and-best-practices/top-10-best-practices. We summarized the implementation guidance associated with these practices in a prior GAO report. See GAO, *Managing for Results: Leading Practices Should Guide the Continued Development of Performance.gov*, GAO-13-517 (Washington, D.C.: June 6, 2013).

[12]Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071 (2003) (codified, as amended, at 42 U.S.C. §§ 1395w-101, et seq.).

Part D Benefits and Costs

Part D plan sponsors are required to offer plans that provide a minimum set of benefits to beneficiaries—the standard benefit—or an actuarially equivalent benefit.[13] Under the standard benefit, beneficiaries pay monthly premiums and cost-sharing for drug purchases. Cost-sharing varies over the course of the year as beneficiaries move through the phases of the benefit. The standard benefit features a deductible and an initial coverage period during which beneficiaries pay coinsurance for prescription drugs until they reach the initial coverage limit. After the initial coverage period, beneficiaries enter the coverage gap, which is followed by the catastrophic coverage period in which beneficiaries pay a small share of total drug costs (see fig. 1).

Figure 1: Medicare Part D Cost-Sharing Structure under the Standard Benefit, 2013
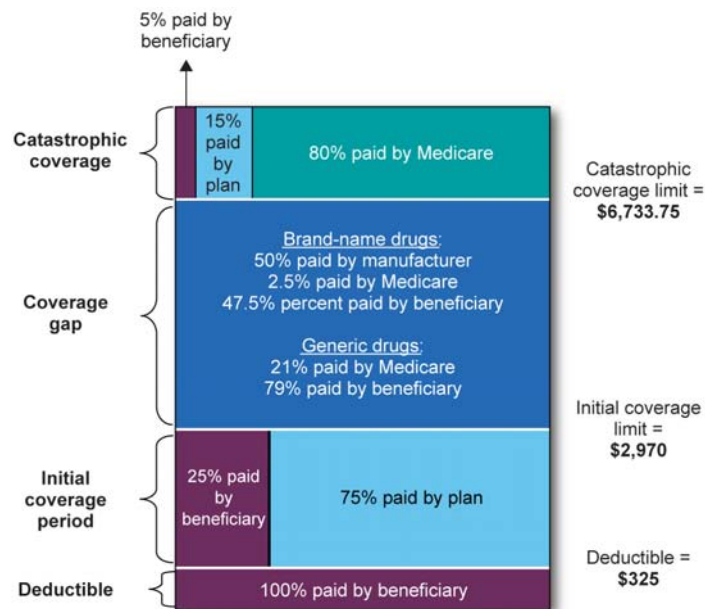
Source: GAO analysis of CMS information.

Note: Part D plan sponsors are required to offer plans that provide a minimum set of benefits to beneficiaries—the standard benefit—or an actuarially equivalent benefit. The cost-sharing structure under the standard benefit does not apply to beneficiaries that receive the Part D low-income subsidy, who generally have zero or nominal cost-sharing.

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[13]To provide an actuarially equivalent benefit, plan sponsors must meet certain requirements, including obtaining the approval of CMS.

In addition to the standard Part D benefit, plan sponsors can offer a range of plans with different benefit structures that are actuarially equivalent to, or exceed the standard benefit.[14] Under these plans, monthly premiums and cost-sharing arrangements can vary. For example, plans with enhanced benefits may charge higher monthly premiums than standard benefit plans, but may offer lower cost-sharing arrangements, such as a reduction or elimination of a deductible. Under Part D, certain individuals are also entitled to a low-income subsidy (LIS), through which they get reduced premiums and generally have zero or nominal cost-sharing.[15]

Subject to certain rules, the prescription drugs covered by Part D plans and the cost-sharing arrangements for covered drugs may differ between plans. Each Part D plan has a formulary—a list of the prescription drugs that it covers and the terms under which they are covered. While each plan may vary in the specific drugs it covers, plans must adhere to a minimum set of formulary requirements established in statute and regulation.[16] In addition, a plan's formulary may assign drugs to tiers that correspond to different levels of cost-sharing. For example, plans often assign generic drugs to the tier that requires the lowest cost-sharing level. Plans have flexibility in how they structure tiers, and different plans may place the same drug in different tiers. Plans may also subject drugs to utilization management practices, such as a limit on the amount of a drug that is covered.[17]

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[14]In 2012, over 95 percent of beneficiaries were enrolled in actuarially equivalent or enhanced Part D plans. See Medicare Payment Advisory Commission, *March 2013 Report to the Congress: Medicare Payment Policy*.

[15]If beneficiaries who qualify for LIS fail to enroll in a Part D plan, CMS enrolls those beneficiaries in a plan, subject to certain exceptions. This group includes beneficiaries who are dually eligible for both Medicare and Medicaid, know as full-benefit dual-eligible beneficiaries.

[16]The formularies generally must include within each therapeutic category and class of covered Part D drugs at least two drugs that are not therapeutically equivalent and bioequivalent. Exceptions are allowed, for example, when there is only one drug in a particular category or class. CMS has also designated categories and classes for which formularies must include every Part D drug, subject to certain exceptions. See 42 U.S.C. § 1395w-104(b)(3)(C)(i); 42 C.F.R. § 423.120(b)(2)(2011).

[17]These utilization management practices can include (1) step therapy, which requires that beneficiaries try lower-cost drugs before plans will cover more costly drugs; (2) prior authorization, which requires individual beneficiaries to obtain the plan's approval before a drug is covered; and (3) quantity limits, which restrict the dosage or number of units of a drug provided within a certain period of time.

Part D cost-sharing for beneficiaries may also vary based on the pharmacies they use. Plan sponsors contract with retail and mail order pharmacies to dispense the drugs that plans cover. Plan sponsors negotiate the prices for covered drugs with pharmacies, and may negotiate different rates with different pharmacies. Some plans have "preferred" pharmacies within their pharmacy network that have agreed to offer drugs at lower cost-sharing levels.

The Medicare Plan Finder

Since the beginning of the Part D program, CMS has administered the Plan Finder website to assist beneficiaries and their advisers in assessing Part D plan options by providing them with information on plan coverage and quality, and by estimating their annual drug costs.[18] Beneficiaries can use Plan Finder to evaluate their plan options when they first become eligible for Part D or to reevaluate their options during the open enrollment period each year, and they can enroll in a plan through the website.[19] To compare plans in Plan Finder, beneficiaries work their way through the website by entering information on where they live, the drugs they take, and the pharmacies they use. Plan Finder then identifies Part D plan options available to them and estimates their annual drug costs for each plan at their selected retail and mail order pharmacies (see fig. 2). It also provides information on how beneficiaries' monthly drug costs change as they move through the Part D benefit over the course of the year. In addition to the website, customer service representatives for 1-800-MEDICARE—a nationwide toll-free telephone help line that beneficiaries and their advisers can call to ask questions about Medicare—also use a version of Plan Finder to provide information on Part D plan options and to enroll beneficiaries over the phone.

[18]CMS implemented the Part D Plan Finder tool in 2005 to help beneficiaries compare plans for the 2006 open enrollment period. Beneficiaries can also use Plan Finder to obtain information on Medicare Advantage plans and Medigap plans—supplemental health care plans that cover beneficiaries' out-of-pocket expenditures, including copayments, coinsurance, deductibles, and services not covered by Medicare.

[19]During the Part D open enrollment period—typically October 15 to December 7—beneficiaries can change their Medicare prescription drug plan for the following calendar year. Under certain circumstances, beneficiaries may be eligible to change or enroll in plans outside of the open enrollment period.

Figure 2: Example of Plan Finder's Plan Results Webpage

Source: CMS.

CMS Oversight of the Part D Program

CMS is responsible for overseeing plan sponsors' compliance with their Part D contracts. CMS imposes program requirements on Part D plan sponsors—including a requirement that they submit accurate drug price, formulary, and pharmacy network information for Plan Finder[20]—and sponsors are subject to possible compliance and enforcement actions for failure to meet those requirements. In addition, compliance and enforcement actions are included in the plan sponsor's record of past performance, which CMS considers when reviewing applications for new or expanded Medicare contracts submitted by that plan sponsor.

CMS can impose a range of compliance and enforcement actions to ensure compliance with program requirements, including requirements related to Plan Finder. The lowest-level compliance action is a notice of noncompliance, which notifies the Part D plan sponsor that it is in violation of program requirements under the terms of one or more of its contracts. The notice of noncompliance requests that the plan sponsor address the problem. If the noncompliance continues, CMS may issue a warning letter.[21] If CMS determines that the noncompliance affects a significant number of beneficiaries, represents an ongoing or systemic inability to adhere to program requirements, or is particularly egregious, CMS may require the plan sponsor to develop and implement a corrective action plan. The corrective action plan must address the deficiencies identified by CMS, provide an attainable time frame for implementing corrective actions, and include a process for validating and monitoring that the corrective actions were taken and remain effective. CMS can also take enforcement actions for persistent noncompliance or to address more significant violations. Enforcement actions include civil money penalties; marketing, enrollment, and payment suspensions; and contract terminations. The nature of each instance of noncompliance is considered when determining the appropriate compliance or enforcement actions, and the actions generally proceed through the process in a step-by-step manner. However, for more serious violations, CMS may choose to immediately proceed to later-stage compliance or enforcement actions.

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[20]In accordance with federal requirements, Part D plan sponsors must submit information that enables CMS to provide current and potential beneficiaries with the information they need to make an informed choice among Part D plans.

[21]In some instances, CMS may request in the warning letter that the sponsor submit a business plan for resolving issues related to the noncompliance.

CMS also oversees the Part D program through its Star Ratings, which assigns scores to Part D contracts every year across a range of quality measures. CMS collects performance data on Part D plans covered under each individual contract for 18 quality measures—including a measure for Plan Finder drug pricing accuracy. CMS aggregates these quality measure scores and assigns an overall quality score between one and five stars, with five being the highest, to each contract. Each contract's overall score and individual quality measure scores are applied to all plans covered under the contract, and CMS posts plans' scores on the Plan Finder website to help beneficiaries choose high-quality plans.[22] CMS also considers Star Ratings performance when reviewing sponsors' applications for new or expanded Medicare contracts.

CMS Uses Data Checks and Quality Measures to Oversee Plan Finder's Drug Pricing Accuracy and Has Taken Compliance Actions against Plan Sponsors

To assess the accuracy of pricing information on Plan Finder, CMS performs computerized data checks on pricing information before it is displayed on Plan Finder and has taken compliance actions against certain Part D plan sponsors for submitting inaccurate and incomplete pricing information. In addition, CMS uses quality measures to retrospectively evaluate the accuracy of pricing information on Plan Finder.

CMS Uses Data Checks and Compliance Actions to Oversee Drug Pricing Accuracy

CMS performs computerized data checks to identify incomplete and potentially inaccurate pricing information before it is posted to Plan Finder. CMS requires Part D plan sponsors to submit drug pricing information for their plans on a biweekly basis—which Plan Finder uses to estimate beneficiaries' cost-sharing amounts and expected drug costs. In 2013, CMS performed a set of over 25 data checks on the biweekly

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[22]CMS first posted plans' Star Ratings on Plan Finder in the fall of 2006 for the 2007 open enrollment period. For the 2011 open enrollment period, CMS implemented an icon that identifies low performing plans—plans that received a Star Rating of 3 stars or less for at least 3 consecutive years—and for the 2012 open enrollment period, CMS implemented an icon that highlights plans that achieved a 5 star rating.

submission for each plan, including checks to identify outlying drug prices significantly higher or lower relative to the prices submitted by other plans and checks to identify missing data.

If CMS's data checks identify potentially inaccurate plan pricing information, CMS notifies the sponsor of the plan and gives the sponsor an opportunity to attest to the accuracy of the data, or correct it. If the sponsor does not verify or correct the pricing information, CMS will "suppress" the plan from Plan Finder for two weeks, or longer if the sponsor does not provide accurate pricing information for the next biweekly data update.[23,24] When a Part D plan is suppressed from Plan Finder, its pricing information is removed and beneficiaries cannot enroll in the plan through the website. Plan Finder displays a warning notice alerting beneficiaries that the plan's pricing information is unavailable and that they must contact the plan directly for cost information as well as to enroll. In 2012, 18 percent of Part D contracts had one or more plans that were suppressed from Plan Finder at least once, and, from January 1, 2013, through July 31, 2013, 25 percent of contracts had one or more plans that were suppressed at least once (see table 1).

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[23]Because Part D plan sponsors submit formulary information every four weeks, CMS officials noted that a plan is suppressed from Plan Finder for four weeks when sponsors do not submit accurate formulary information for that plan. According to CMS officials, CMS may also suppress plans from Plan Finder as a penalty for instances of noncompliance unrelated to Plan Finder.

[24]According to CMS officials, there are certain circumstances in which Plan Finder prices may be expected to differ from beneficiaries' point-of-sale prices. For example, officials stated that Plan Finder may display inaccurate prices when there is a lag between a change in the manufacturer's price for a particular drug and the bi-weekly Plan Finder pricing information update. In certain instances—such as when beneficiaries enter drugs that are not covered by particular plans, or when pharmacies that beneficiaries select are out of plans' networks—Plan Finder will display estimated prices for those drugs.

Table 1: Part D Plan Finder Suppressions due to Inaccurate Pricing Information, January 1, 2012, through July 31, 2013

Number of times contracts had plans that were suppressed from Plan Finder	2012		2013[a]	
	Number of contracts (n=620)	Percentage of contracts	Number of contracts (n=630)	Percentage of contracts
1	85	14%	112	18%
2	19	3%	40	6%
3 or more	7	1%	8	1%
Contracts that had plans suppressed	**111**	**18%**	**160**	**25%**

Source: GAO analysis of CMS data.

Notes: CMS tracks compliance activities by the individual contract. In tracking suppressions, CMS tracks the number of times each contract has one or more plans suppressed from Plan Finder. When a plan is suppressed from Plan Finder, its pricing information is removed and beneficiaries cannot enroll in the plan through the website.

[a]Through July 31, 2013.

In addition to these quality assurance checks, CMS officials noted that they may identify Plan Finder pricing inaccuracies based on feedback provided by beneficiaries and organizations that provide assistance to beneficiaries, such as the State Health Insurance Assistance Programs (SHIP).[25] According to CMS officials, SHIPs and other stakeholders can report inaccurate prices or other concerns through a Plan Finder email inbox maintained by CMS, and beneficiaries can report inaccuracies through 1-800-MEDICARE.

CMS has taken compliance actions against Part D plan sponsors for repeated instances of submitting inaccurate or incomplete Plan Finder pricing information.[26] These compliance actions, including notices of noncompliance and warning letters, notify the sponsor that one or more of its contracts is out of compliance with Part D requirements. Between January 1, 2009, and July 31, 2013, CMS issued 89 notices of

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[25]SHIPs are state agencies that provide counseling and assistance to Medicare beneficiaries.

[26]For the first 7 months of 2013, CMS issued notices of non-compliance to plan sponsors when one of their contracts had two instances of a plan being suppressed and a warning letter after three or four instances.

noncompliance and 67 warning letters for inaccurate or incomplete drug pricing information.[27,28]

According to CMS documents, there has only been one instance in which CMS required a Part D plan sponsor to develop and implement a corrective action plan for compliance concerns related to Plan Finder pricing accuracy. CMS required this corrective action plan in 2008 after it found ongoing discrepancies between a plan's drug prices submitted to Plan Finder and the prices beneficiaries paid at the point-of-sale. CMS found the discrepancies so egregious that the agency referred the issue to the Department of Justice. In 2012, the plan sponsor entered into a civil settlement agreement with the federal government to resolve allegations that the plan sponsor submitted false pricing information in 2007 and 2008.[29]

CMS's processes for overseeing the accuracy of drug pricing information in Plan Finder are consistent with internal control standards for the federal government. These standards specify that agencies should have processes in place to oversee the accuracy of data and that they should design and implement controls and processes to ensure that ongoing monitoring occurs in the course of normal operations.[30]

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[27]In some instances, CMS may take compliance actions against plan sponsors for instances of noncompliance that occurred the previous year.

[28]When CMS issues a notice of noncompliance or warning letter to a Part D sponsor, it may reference instances of noncompliance for more than one contract. Since CMS tracks compliance actions by individual contract, an issued notice of noncompliance or warning letter that references more than one contract is counted as multiple notices or letters. For example, an issued warning letter that references noncompliance for three different contracts is counted as three letters.

[29]This settlement resolved allegations made in two separate complaints against RxAmerica, *U.S. ex rel. Doe v. RxAmerica* (E.D.N.Y. 2008) and *U.S. ex rel. Hauser v. CVS Caremark Corp. and RxAmerica* (W.D.N.C. 2011). The two cases were consolidated in November 2011.

[30]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, DC: Nov. 1, 1999).

CMS Uses Quality Measures to Evaluate Pricing Accuracy

CMS's Star Ratings, which provide beneficiaries with information on plan quality, assigns scores to each Part D contract on the accuracy of pricing information on Plan Finder. To determine the annual quality ratings for drug pricing accuracy, CMS compares Plan Finder drug prices with beneficiaries' point-of-sale drug costs and assigns scores based on the extent to which the point-of-sale costs were higher than prices posted on Plan Finder.[31] For the 2013 Star Ratings, 6 percent of contracts had point-of-sale prices that were greater than Plan Finder prices by an average of 4 percent or more. This is a decrease from 13 percent of contracts in 2011 (see table 2).[32]

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[31]By comparing Plan Finder pricing information to point-of-sale costs, CMS addressed a recommendation from a July 2009 report by the HHS Office of Inspector General (OIG). The OIG recommended that CMS ensure that drug prices displayed on Plan Finder accurately reflect point-of-sale drug costs on Part D claims and suggested that CMS use claims information with point-of-sale costs to monitor the accuracy of Plan Finder drug prices at regular intervals. See HHS-OIG, *Accuracy of Part D Plans' Drug Prices on the Medicare Prescription Drug Plan Finder*, Report No. OEI-03-07-00600 (Washington, D.C.: July 2009).

[32]CMS posts Part D Star Ratings prior to open enrollment periods. For example, 2013 Star Ratings were posted to Plan Finder in October 2012, and were based on pricing data displayed on Plan Finder between January 1 and September 30, 2011.

Table 2: Part D Contracts Pricing Accuracy, 2011 through 2013 Star Ratings

Average percentage by which point-of-sale costs were higher than Plan Finder prices	Percent of Contracts		
	2011[a] (n=506)	2012[b] (n=553)	2013[c] (n=531)
0%	1%	1%	0%
1%	30%	54%	55%
2%	41%	22%	26%
3%	15%	16%	13%
4%	6%	3%	3%
5% or more	7%	4%	3%

Source: GAO analysis of CMS data.

Notes: The Star Ratings assign scores to each Part D contract on the accuracy of pricing information on Plan Finder. Data excludes Part D contracts that were new or did not have enough data to calculate the extent to which point-of-sale costs were higher than Plan Finder prices.

[a]The 2011 measure of pricing accuracy is based on pricing data displayed on Plan Finder between January 1 and December 31, 2009.

[b]The 2012 measure of pricing accuracy is based on pricing data displayed on Plan Finder between January 1 and December 31, 2010.

[c]The 2013 measure of pricing accuracy is based on pricing data displayed on Plan Finder between January 1 and September 30, 2011.

CMS officials stated that the Star Ratings drug pricing accuracy measure evaluates point-of-sale costs that are higher than Plan Finder prices because CMS particularly wants to discourage plan sponsors from using "bait and switch" tactics that would encourage beneficiaries to enroll in plans based on inaccurately low prices. The extent to which point-of-sale prices are lower than prices posted on Plan Finder are not reflected in the drug pricing accuracy measure. However, although not part of the Star Ratings, for 2014 CMS developed an additional "display" quality measure to track the extent to which point-of-sale costs were lower than prices posted on Plan Finder.[33] According to CMS, this display measure is intended to discourage plan sponsors from potentially submitting inaccurate high prices for select drugs or drug classes to discourage enrollment by certain beneficiaries.

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[33]CMS uses a variety of display measures to track contracts' performance, though they are not factored into the annual Star Ratings. Although not included on Plan Finder, CMS publishes display measure data on the agency's website. See http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

CMS Has Obtained Feedback on Plan Finder from a Variety of Sources and Has Taken Steps to Improve Usability

CMS has assessed the usability of Plan Finder by obtaining feedback from a variety of sources and has implemented updates to the website to improve usability. The practices employed by CMS to obtain feedback on Plan Finder's usability are consistent with leading practices identified by HowTo.gov, which recommends engaging users through surveys, user testing, and other outreach to collect feedback on usability. Howto.gov also recommends that agencies collect and analyze performance and other measures to identify potential improvements to the website's organization and content. CMS officials told us that they have obtained user feedback and web performance data on Plan Finder from the following sources:

- *Beneficiary assistance organizations*. CMS has obtained feedback on Plan Finder from SHIPs and other organizations that provide assistance to Medicare beneficiaries. These organizations help beneficiaries navigate the website, and their staff often use Plan Finder when counseling beneficiaries. CMS officials told us that they hold regular meetings with these organizations and that they maintain a specific email inbox for SHIP officials and beneficiary advocacy groups to submit feedback on issues related to Plan Finder. A number of organizations that we spoke with have provided CMS with documents detailing suggestions for improving the website. In addition, several of these organizations noted that CMS has reached out to them to obtain feedback on planned changes and updates to the website.

- *Beneficiary user testing*. CMS has conducted user tests on the usability of Plan Finder with beneficiaries, beneficiary advisers, and SHIP counselors. The user tests involved interviewing beneficiaries as they worked their way through Plan Finder to gain insight into their experiences and any challenges that they faced. For example, the user tests have analyzed the ease with which beneficiaries can enter information about the prescription drugs they take and their ability to use Plan Finder to compare plans. CMS has also conducted user tests with certain Medicare beneficiary subpopulations. For example, CMS conducted user tests with LIS beneficiaries to obtain feedback on their ability to understand LIS-specific information on the website.

- *A website survey*. CMS employs a website customer satisfaction survey that measures and collects performance data on users' experiences.[34] For example, the survey asks users to rate the layout of Plan Finder and the extent to which the website's design allows them to find plan information easily. It also asks about the usefulness of the resources that are available on the website to help users understand how to use Plan Finder to compare Part D plans. CMS has tracked several measures that are rated through these surveys, including measures related to how content is organized and the extent to which the website streamlines the plan comparison process.

- *Website user data*. CMS tracks Plan Finder website user data, such as the number of visitors to the website and the amount of time that users spend on specific webpages, to gain insight into users' experiences and website navigation patterns.[35] For example, if users are spending a long time on a specific Plan Finder webpage, it may indicate that they are having a hard time understanding the information that is being presented on the page, according to a CMS official. In addition, CMS officials said that they can also use this data to measure the number of users that work their way through Plan Finder to obtain information on Part D plan options available to them. For those that do not fully work their way through Plan Finder to obtain information on available plans, CMS tracks user data on when they exited the website.

CMS has implemented updates to the website on a quarterly basis and, according to CMS officials, has used feedback on Plan Finder to address identified issues and improve the website's usability. For example, CMS developed and added a "frequently asked questions" webpage to the website in 2013 to help beneficiaries with frequently encountered issues. Several of the questions explain how and why cost-sharing can vary under different circumstances. To help beneficiaries better understand plans' pharmacy networks, CMS added an indicator that identifies whether the pharmacies they entered into Plan Finder are in-network, in-network preferred, or out-of-network in the plans that are available to them. In addition, CMS has added filters to help beneficiaries compare Part D plans and select plans that meet their needs. For example, the

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[34]CMS contracts with a private firm, Foresee, to conduct the website survey and analyze survey data.

[35]CMS uses Google Analytics to track website user data.

filters allow beneficiaries to look only at plans that cover all of the drugs they take, or plans that have limited premiums or deductibles.

Although CMS has obtained feedback on Plan Finder, incorporating such feedback and addressing usability issues can present challenges. One CMS official we spoke with said that incorporating the feedback that CMS receives can sometimes be difficult since they try to balance the need to explain complex elements of the Part D benefit, while also keeping the website streamlined. For example, the official noted that providing too much information on the website can make it more difficult for beneficiaries to identify needed information.

Officials from the beneficiary assistance organizations we spoke with generally told us that Plan Finder helps beneficiaries compare Part D plans and that the website's usability has improved over time. However, certain beneficiaries may face barriers to using Plan Finder, regardless of the usability of the website. Most of the organizations we spoke with explained that some beneficiaries have a hard time using the information provided by Plan Finder to compare plans and identify plans that meet their needs because of the complexity of the Part D benefit and the variety of factors that influence cost-sharing. For example, a number of the beneficiary advocacy groups that we spoke with told us that some beneficiaries face difficulties understanding why cost-sharing varies between pharmacies under plans with preferred pharmacy networks. In addition, certain beneficiaries lack Internet access or do not have adequate levels of computer literacy to be able to use Plan Finder independently. Several officials noted, however, that beneficiaries aging into Medicare eligibility are increasingly experienced in using computers.

Officials from the beneficiary assistance organizations also told us that beneficiaries enrolling in MA-PDs may have a harder time using Plan Finder and our analysis of CMS enrollment data found that beneficiaries enrolling in MA-PDs are less likely to use the Plan Finder website to enroll than beneficiaries enrolling in PDPs (see table 3). These officials noted that, in addition to comparing prescription drug benefits, beneficiaries enrolling in MA-PDs have to identify plans that provide medical coverage that meet their needs as well. For example, one official we spoke with said that beneficiaries may not be inclined to enroll in MA-PDs that offer low cost prescription drug coverage if the beneficiaries' health care providers are not in-network.

Table 3: Beneficiary Enrollments in Part D Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PD) through Plan Finder, 2009-2013

	PDP			MA-PD		
Plan Year[a]	Number of enrollments through Plan Finder[b]	Total number of enrollments[b]	Percentage of enrollments through Plan Finder	Number of enrollments through Plan Finder[c]	Total number of enrollments[d]	Percentage of enrollments through Plan Finder
2009	783,900	3,347,334	23%	101,036	3,164,323	3%
2010	671,868	3,563,408	19%	139,903	3,988,435	4%
2011	673,879	3,707,783	18%	67,071	3,874,984	2%
2012	759,001	3,877,069	20%	81,322	3,677,873	2%
2013[e]	698,735	5,083,203	14%	73,824	3,370,626	2%

Source: GAO analysis of CMS data.

[a]Plan year refers to the first day of open enrollment to the last date plans can accept enrollments for a given year. Plan years typically begin on October 15 and end on November 30 of the following year.

[b]Includes new beneficiaries who enrolled in PDPs and beneficiaries that switched plans; excludes low income subsidy beneficiaries who were enrolled in plans by CMS.

[c]Includes new beneficiaries who enrolled in Medicare Advantage plans and beneficiaries who switched plans; excludes low income subsidy beneficiaries who were enrolled in plans by CMS. The vast majority of beneficiaries who enroll in Medicare Advantage plans through Plan Finder enroll in MA-PDs. During the open enrollment period for the 2013 plan year, 95 percent of beneficiaries who enrolled in Medicare Advantage plans through Plan Finder enrolled in MA-PDs.

[d]Includes new beneficiaries who enrolled in MA-PDs and beneficiaries who switched plans; excludes low income subsidy beneficiaries who were enrolled in plans by CMS.
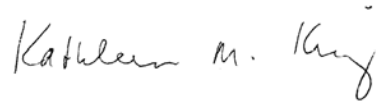
[e]Through July 31, 2013.

Agency Comments

GAO provided a draft of this report to HHS. HHS agreed with GAO's findings and provided a technical comment, which GAO incorporated. HHS's written comments are reprinted in appendix I.

We are sending copies of this report to the Administrator of CMS. We will also make copies available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or KingK@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Kathleen King
Director, Health Care

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 16 2013

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare Part D: CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability" (GAO-14-143).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' (HHS) GENERAL
COMMENTS TO GAO'S DRAFT REPORT "MEDICARE PART D: CMS HAS
IMPLEMENTED PROCESSES TO OVERSEE PLAN FINDER PRICING ACCURACY AND
IMPROVED WEBSITE USABILITY" (GAO-14-143)

The Department appreciates the opportunity to review and comment on the above titled report.

The Medicare prescription drug program, Medicare Part D, provides a prescription drug benefit
to Medicare beneficiaries. Medicare beneficiaries have the ability to choose the prescription
drug benefit that is the most beneficial to their individual needs. In order to assist beneficiaries,
beneficiaries' caregivers, and other stakeholders with the considerable number of choices
available, CMS developed and maintains the Medicare Plan Finder (MPF) tool. CMS provides
oversight of the accuracy of drug pricing information submitted by Part D sponsors for display
on the MPF and continuously reviews the MPF's usability for this complex Medicare Part D
benefit.

The CMS performs several activities to oversee the accuracy of drug pricing information
displayed on the MPF. CMS has implemented numerous computerized data checks, issued non-
compliance letters, warning letters, corrective action plans, enforcement actions, and contract
terminations, as well as developed a Part D Star Ratings measure which evaluates the accuracy
of drug pricing information displayed on the MPF. All of the above actions play a pivotal part in
overseeing drug pricing accuracy displayed on the MPF.

In addition to overseeing the dissemination of accurate Part D drug pricing data via the MPF,
CMS has and continues to assess the usability of the MPF by obtaining feedback from a variety
of sources, including, but not limited to beneficiary assistance organizations, user testing,
website surveys, and website user data. GAO found that the practices employed by CMS to
obtain feedback on the MPF's usability are consistent with leading practices identified by
HowTo.gov. CMS constantly evaluates the MPF's usability and implements modifications as
necessary.

HHS appreciates GAO's review and acknowledgement of CMS' efforts to oversee the accuracy
of drug pricing information in Plan Finder and the assessment of its usability. We concur with
GAO's finding that the practices employed by CMS to obtain feedback on the Plan Finder's
usability are consistent with leading practices identified by HowTo.gov.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact	Kathleen King, (202) 512-7114, kingk@gao.gov.
Staff Acknowledgments	In addition to the contact named above, Martin T. Gahart, Assistant Director; Lori Achman; Michael Erhardt; Cathleen Hamann; Sara Rudow; and Hemi Tewarson made key contributions to this report.

Related GAO Products

Managing for Results: Leading Practices Should Guide the Continued Development of Performance.gov. GAO-13-517. Washington, D.C.: June 6, 2013.

Consumer Product Safety Commission: Awareness, Use, and Usefulness of SaferProducts.gov. GAO-13-306. Washington, D.C.: March 11, 2013.

Medicare: Quality of CMS Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved. GAO-06-715T. Washington, D.C.: May 4, 2006.

Medicare: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved. GAO-06-654. Washington, D.C.: May 3, 2006.