

MEDICARE PART D: TIME FOR A CHECKUP

Authors: Jordan Battani and Harold Horton



As Medicare Part D plans enter the program's fourth year, the direction is clear:

1. Operational excellence in:

- Enrollment, eligibility and reconciliation processes
- Grievance and appeals resolution and reporting
- Claims processing and reconciliation

2. Cost transparency, efficiency and effectiveness

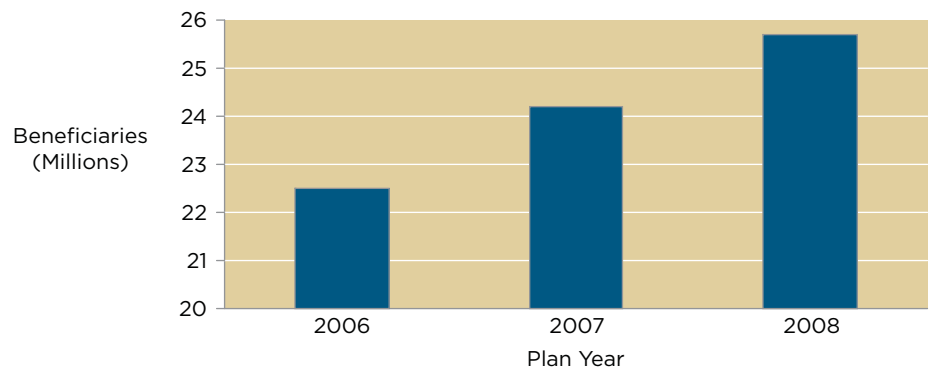
In 2003, sweeping Medicare legislation expanded the role of private health plans in providing coverage to Medicare beneficiaries, including for the first time addition of a drug benefit for Medicare recipients. The creation of Medicare Part D drug coverage was the single largest change to Medicare since the program's inception in 1965.

The 2009 plan year is the third anniversary of Medicare prescription drug coverage under Part D — a good time for health plans and Plan D sponsors to do a checkup on their programs and plans. The industry landscape and the emerging priorities from auditors and lawmakers provide clear direction in setting improvement targets and priorities for Part D plans. Operational excellence in enrollment processing and reconciliation continue to be high priority initiatives for Part D sponsors in order to optimize plan financial performance, and because they are an increasing area of CMS audit scrutiny. Beneficiary grievance handling, resolution and reporting capabilities are also emerging as significant areas of concern for legislators, regulators and auditors. Recent legislation mandated claims operations improvements and plans would be wise to take steps to ensure that their operations, and those of their pharmacy benefit managers, are in compliance. Finally, recent rate reductions and cost scrutiny for Medicare Advantage programs, combined with continuing macroeconomic events, make cost transparency, efficiency and effectiveness very high priorities for Part D plan sponsors.

Part D Plan Performance: The Market

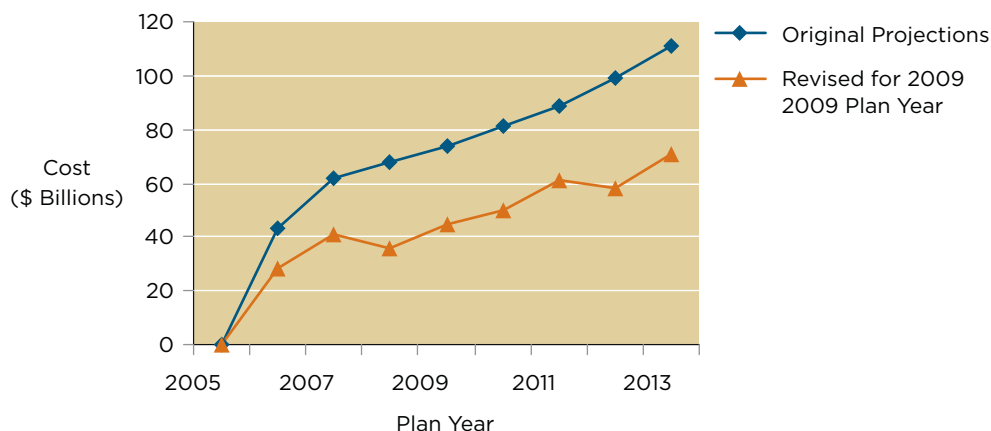
Part D plan growth exploded in 2006 — the first complete year of the program — when more than 22 million beneficiaries enrolled in the new plans. Over the last three years growth has continued at a steady rate, and there are now more than 25 million beneficiaries. Midway through the 2008 plan year, more than 51 percent of all Medicare eligible beneficiaries received coverage through a Part D program either through the Part D plan component of a Medicare Advantage product (MAPD) or through a stand-alone Part D plan (PDP). When the number of Medicare beneficiaries eligible for low income subsidies is included, the market penetration reaches 73 percent.

Part D Plan Enrollment¹



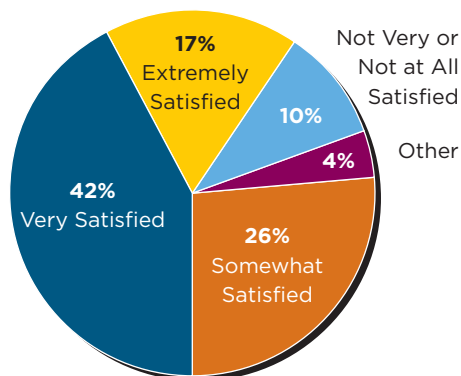
The Part D Program is beating the original Centers for Medicare and Medicaid Services (CMS) cost estimates as well. Recent updates to the ten year Part D program cost projections show a savings of 38 percent over original expectations.²

Part D Projected Spending



Source: Testimony of Kerry Weems, “The Medicare Drug Benefit: Are Private Insurers Getting Good Discounts for the Taxpayer?” Hearing of the U.S. House of Representatives Committee on Oversight and Government Reform, July 24, 2008.

Age 65+ Medicare Beneficiary Satisfaction with Part D Plan



Source: Keenan, Teresa A. *Prescription Drugs and Medicare Part D: A Report on Access, Satisfaction, and Cost*, AARP, November 2007.

In July 2008, Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) addressing a variety of lawmakers’ concerns about Medicare programs. This package of reforms and revisions included modest changes to Medicare Part D plans and requirements. The major impact of the MIPAA package is on Medicare Advantage plans and sponsors; the growth and profitability of these private sector plans made them the legislative focus for cost containment reforms.³

There are lessons in that experience for Part D plans. A new administration in 2009, continuing cost pressures facing the entire Medicare program and a significant downturn in the international and domestic economic outlook make it almost certain that new requirements and regulations are forthcoming. A review of the current state of the program and the content of emerging and proposed reforms provide important insights for planning and execution of program and operational enhancements.

Part D Plan Performance: Beneficiary Satisfaction

Surveys conducted near the reenrollment period of plan year 2008 have found that Part D beneficiaries are generally satisfied with their experiences with plans. An AARP survey of 400 beneficiaries in late 2007 found consistent satisfaction with Part D coverage in terms of premium cost, ease of use and cost of prescriptions under the program. More than 80 percent planned to enroll in a Part D plan the following year, and the overwhelming majority intended to reenroll with the same plan.⁴ A Kaiser Family Foundation assessment, conducted at the end of the 2008 open enrollment period, also found that Part D beneficiaries were generally satisfied with plans, coverage and their costs.⁵

On the other hand, beneficiaries who had reached the coverage limit on their plans were much less satisfied with plan design, benefits and cost. The Kaiser study also uncovered several areas of concern to beneficiaries, particularly in deciding between reenrolling in their current plan or selecting a new one. Many beneficiaries expressed concern about their ability to make good enrollment selections, noting that the complexity of the information made it hard to compare plans and benefit offerings. Beneficiaries who had not reached their plan’s coverage limit nevertheless expressed concern about the cost and quality implications of doing so in the future.

Part D Plan Performance: CMS Audits

One of the provisions of the Medicare Advantage and Part D programs is the requirement that CMS conduct periodic audits of plan performance. Audits are conducted under a variety of circumstances: both routine and on an ad hoc basis when the agency has reason to believe a plan is out of compliance with program regulations. In late 2007 the agency began publishing the results of these audits on the publicly available Health and Human Services website. When a violation is uncovered, the agency requests a corrective action plan (CAP) in which the plan sponsor must identify the steps taken to correct the violation as well as the actions taken to prevent its recurrence.

A review of the first ten months of 2008 CAP activity provides some guidance for Part D plan sponsor operational planning and priority setting:⁶

- 61 percent of all CMS corrective action plans involved plans with a Part D program or component and a violation involving Part D compliance
- 57 percent of MAPD and PDP corrective action plans addressed compliance gaps in enrollment/disenrollment, grievance and appeals violations, or both

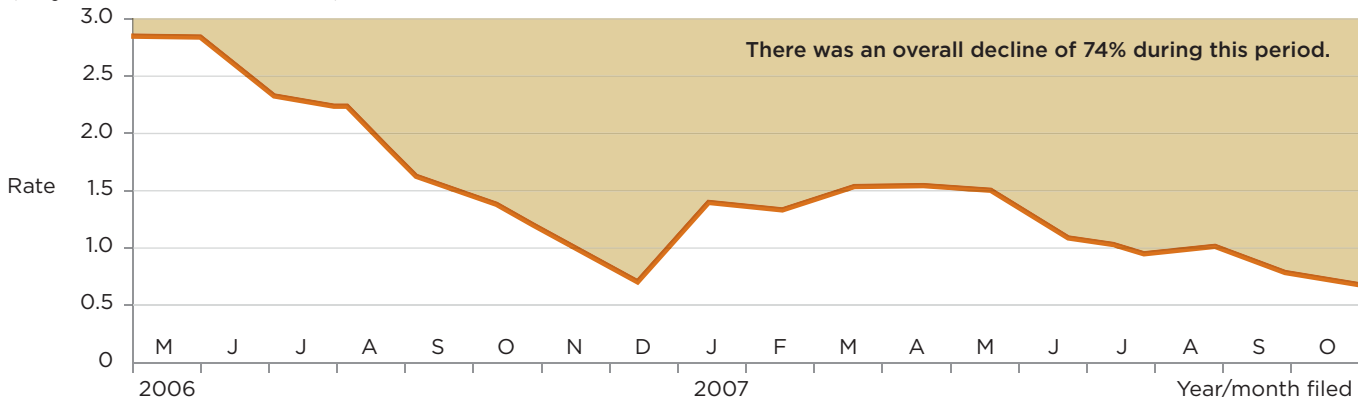
So far, the volume of compliance audits has been relatively low. However, when audits occur, they are time-consuming and costly. The level of effort required to respond to corrective action plans is arguably greater than the effort to attain compliance, and audits are compounded by the notoriety that accompanies the public reporting of compliance violations. Proactive plan sponsors will take steps to prepare for audits and prevent compliance gaps by focusing on improving operations in the key functional areas that support enrollment reconciliation and grievance handling and resolution.

Part D Plan Performance: Grievances and Complaint Resolution

At the end of June 2008, the General Accountability Office (GAO) reported on its investigation of the extent to which beneficiaries experienced problems obtaining and using their benefits under Part D. Using data from complaints filed with CMS directly, GAO determined the following about the 18-month period from May 2006 through October 2007:⁷

- Complaint rates declined by 74 percent — largely a reflection of the resolution of early program implementation issues and “bugs”
- Average time for complaint resolution declined from 33 days to nine days
- The majority of complaints filed continued to be issues with errors in processing enrollment and disenrollment information (63 percent)
- The next largest categories were complaints about errors in the calculation, assessment and delivery of pricing and coinsurance information (21 percent), including errors in premium calculations, deductions from social security payments and delivery to Part D plans

Medicare Part D Complaint Rates per 1,000 Beneficiaries
(May 2006 - October 2007)



Source: GAO analysis of CTM data. From “MEDICARE PART D: Complaint Rates Are Declining, but Operational and Oversight Challenges Remain,” June 2008, United States Government Accountability Office, GAO-08-719.

The GAO was unable to use plan sponsor-reported grievance data for the investigation. A review of the reported data revealed significant gaps in reporting across plan sponsors, indicating considerable variation in practices and processes, and lack of oversight from CMS in the early stages of Part D implementation.

GAO's recommendations to CMS were limited to the need to create enhanced guidance and oversight processes for plan handling of beneficiary grievances. Prudent Part D sponsors will pay attention to their grievance handling processes and reporting mechanisms — using other Medicare program guidelines from CMS as a model for what is likely to be required.

The more important insight for plan sponsors, however, is the magnitude of the ongoing problem with enrollment, disenrollment and premium billing/reconciliation processes. The proactive Part D sponsor will use this information as a guide to building robust processes and reconciliation procedures that will limit the impact of externally-created enrollment, disenrollment and premium errors on plan profitability and operations. A plan without automated tools and integrated operational procedures for enrollment, eligibility and premium reconciliation will be at a significant and growing disadvantage, both financially and from a compliance perspective.

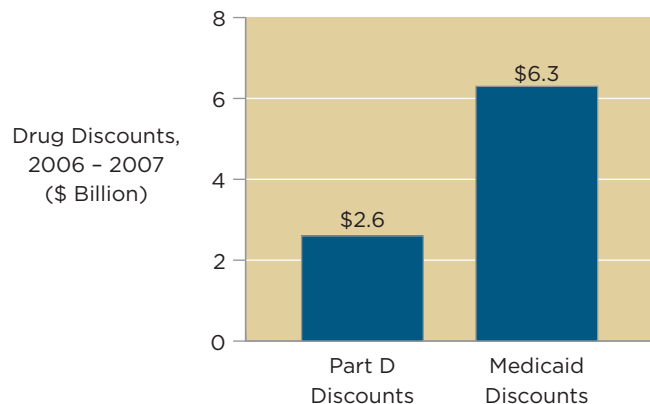
Part D Plan Performance: Pharmacy Reimbursement and Contracting

Early in the program, Congress commissioned several studies of Part D performance, including an Office of the Inspector General (OIG) examination of pharmaceutical costs and reimbursement levels, as well as Part D plan sponsor contracting activities. The detailed studies and their recommendations provide important clues for Part D sponsors as they plan service and operational changes for 2009 and beyond.

In response to Congressional concerns about the effect of contracting activities on pharmacies, and therefore on the availability of prescriptions for beneficiaries, OIG conducted an assessment of the contracting activities of Part D plans in 2006 — the first full year of operations. The recommendations proposed by OIG, and subsequently accepted by CMS, include the need for Part D plan sponsors to increase transparency about contracts and contracting processes, and for CMS to ensure compliance with “any willing pharmacy” requirements. OIG recommendations were considerably diluted during the revisions to the study — largely based on feedback from CMS. The original recommendations were much more aggressive in terms of changes to pricing strategies and on the actual conduct of negotiations. CMS objected that these recommendations were “contrary to the competitive market principles that are fundamental to the Part D program.”

Looking into the reimbursement practices of Part D sponsors, OIG uncovered results that were closely aligned with CMS expectations. Reimbursements to pharmacies exceeded their acquisition costs, and the excess reimbursement was almost nine times higher for generics than for brand name pharmaceuticals.⁸

Discounts Obtained by Part D Insurers



Source: “Medicare PART D: Drug Pricing and Manufacturer Windfalls,” United States House of Representatives Committee on Oversight and Government Reform Majority Staff, July 2008.

CMS views these findings favorably, noting that excess reimbursement acts as a subsidy for pharmacy dispensing costs, and high reimbursement for generics acts as an incentive for generic substitutions. Where CMS expressed concern about the findings was in the lack of transparent and consistent information regarding the impact of manufacturers' rebates on the reported acquisition costs.

Part D Plan Performance: Global Pharmacy Costs

Other observers have been more critical of Part D cost performance, examining it from the perspective of the underlying cost of pharmaceuticals provided to beneficiaries and thus the profit potential for pharmaceutical manufacturers. A recent report to the House Committee on Oversight and Government Reform called for extensive review of "windfall profits" that pharmaceutical companies are earning from the Part D program. The report examined costs paid for the top 100 drugs delivered to dual eligibles (those who are eligible for both Medicare and Medicaid) under Medicare Part D, in which drug prices are negotiated by private plan sponsors. These costs were found to be higher than the costs of providing the drugs under the Medicaid benefit, in which the federal government negotiates drug costs directly. Researchers determined that the higher prices under Medicare Part D increased the pharmacy costs to the taxpayer for these drugs by 30 percent.⁹

The new federal administration has sent clear signals that change is coming in the form of a more active role for CMS in the negotiation of pharmaceutical costs. The impact and interaction of pricing, dispensing reimbursement, and manufacturers' rebates are not well-understood by those outside the industry. This makes them likely targets for reform and new regulation. Part D plan sponsors should take steps now to improve transparency and communication in these areas.

New Regulation for Part D Plans: MIPPA

Fortunately for plan sponsors, relatively little of the new regulation included in the July 2008 MIPPA package is directed at Part D. Although Part D plans are included in the new restrictions on direct marketing and sales activities, these regulations focus primarily in the Medicare Advantage sales arena.

Part D plans will face new administrative requirements for prompt payment and interest penalties for late payments effective in 2010. These requirements are typical of medical claims operations. Plans should develop approaches for adding or extending those processes to their Part D business, and ensure that their subcontractors do so as well.

More immediately, Part D plans have until January 1, 2009 to implement processes for timely updates to prescription reimbursement pricing standards — narrowing the update window to seven days for plans that reimburse on the basis of pharmaceutical cost. This new requirement reinforces the need for plans to improve transparency around costs, pricing and reimbursement.

Some Direction for Plan Sponsors

Continuing cost pressure on the Medicare program, a new administration, and large scale economic uncertainty are likely to combine in unexpected ways for programs and plan sponsors. Private sector participants in Medicare programs are well-advised to plan ahead for emerging opportunities, regulation and rule setting.

There's no lack of incentive for Part D plans to improve enrollment processing and reconciliation. The lags, delays and retroactivity that characterize Part D enrollment processing have significant operational and financial impact on performance. Addressing these gaps proactively will produce better service levels to beneficiaries and improved financial performance. Moreover, industry experience with CMS audits suggests that enrollment processing and reconciliation are areas likely to receive enhanced scrutiny — and possibly sanctions and penalties. Part D plans should ensure that their enrollment reconciliation tools, processes and workflows are as rigorous, timely and automated as possible.

Key Part D Related Provisions of MIPAA

- Benzodiazepines and barbiturates will be covered under Part D for certain conditions
- Permanently waives Part D late enrollment penalty for individuals eligible for the low-income subsidy under Part D
- Prohibits co-branding
- Requires state appointed agents/brokers
- Defines agent/broker training and testing
- Defines agent/broker compensation
- Requires plan reporting of terminated agents

Source: Nguyen, Kathy. "Medicare Improvement for Patients and Providers Act of 2008 (MIPAA)," PowerPoint presentation, October 23, 2008.

Grievance handling and resolution are also emerging as critical areas for compliance and potential sanctions. Although optimizing operational support for grievance handling and resolution doesn't have the same immediate financial impact for Part D plans, it's clear from industry experience with the CMS audit process, and from investigations commissioned by Congressional Committees, that these are key areas of scrutiny and concern to regulators. Part D plans should take steps now to ensure that their processes and performance in these areas are world-class.

New regulation of claims processing this year provides a clear signal that operational excellence should continue to be a high priority for financial and compliance reasons. The world-class Part D plan must demonstrate continued improvements in transaction processing metrics to remain competitive and withstand compliance scrutiny.

Finally, as the new administration addresses the issue of underlying pharmacy costs, Part D plans must anticipate heightened scrutiny and the requirement to enable transparency in pharmaceutical acquisition, pharmacy contracting, and pharmacy reimbursement strategy.

About the Authors

Jordan Battani is a Principal Researcher in CSC's Emerging Practices Group. Emerging Practices is the applied research arm of CSC's Global Healthcare Sector. Harold J. Horton is a Senior Consultant with CSC and serves as the lead for Medicare solutions in CSC's Health Plan practice. For more information contact us at healthcaresector@csc.com or 1.800.272.0018.

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CSC

266 Second Avenue
Waltham, Massachusetts 02451
United States
+1.800.272.0018

Worldwide CSC Headquarters

The Americas

3170 Fairview Park Drive
Falls Church, Virginia 22042
United States
+1.703.876.1000

Europe, Middle East, Africa

Royal Pavilion
Wellesley Road
Aldershot, Hampshire GU11 1PZ
United Kingdom
+44(0)1252.534000

Australia

26 Talavera Road
Macquarie Park, NSW 2113
Australia
+61(0)29034.3000

Asia

139 Cecil Street
#08-00 Cecil House
Singapore 069539
Republic of Singapore
+65.6221.9095

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