

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HMO PRESCRIPTION
DRUG BENEFITS**

**Information Available to Beneficiaries on
Dollar Limits**



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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

This report describes (1) elements that can help Medicare beneficiaries assess the value of a health maintenance organization's (HMO's) prescription drug benefit, and (2) how HMOs convey information about dollar limits on drug benefits to beneficiaries.

BACKGROUND

The 1997 Balanced Budget Act established the Medicare+Choice program. Under this program, the Centers for Medicare & Medicaid Services (CMS) contracts with a greater variety of health plans, which increases health plan options for Medicare beneficiaries. This report focuses on HMO plans under contract with CMS. In addition to providing benefits covered by the Medicare fee-for-service program, the HMO plans may provide extra benefits such as a drug benefit that covers outpatient prescription drugs. The HMO plans can limit their drug benefit in various ways. One way is to limit coverage to a certain dollar amount. Of the HMO plans that offered an extra drug benefit in 2001, 87 percent limited the dollar amount of coverage. Plans can also limit the drug benefit by charging beneficiaries coinsurance or copayments, by only covering certain types of drugs (i.e., brand name or generic drugs), or only covering drugs on a formulary.

Beneficiaries can receive information about plans' drug benefits from a number of sources. One tool a beneficiary can use to compare drug benefits is the *Summary of Benefits*. The CMS, which administers the Medicare+Choice program, mandates that each plan have a *Summary of Benefits* so that beneficiaries can use them to make informed choices. In addition to reading the *Summary of Benefits*, beneficiaries can phone the HMO plans and speak to customer service representatives to get information about the drug benefit. Beneficiaries with Internet access can also gather plan information by using the Medicare Compare database located on the Medicare website (www.medicare.gov).

Beginning in 2000, HMO plans submitted information about their benefits to the new CMS database called the Plan Benefit Package database, which is a part of CMS' Health Plan Management System. For this report, we analyzed information provided by plans to the Plan Benefit Package database. We also called customer service representatives and reviewed *Summaries of Benefits* for a sample of HMO plans that limit drug benefits.

FINDINGS

Comparing the dollar limits on drug benefits can be a daunting task

There are a number of elements that beneficiaries should review when comparing and assessing plans' limits on drug benefits. Medicare beneficiaries enrolled in HMO plans with dollar limits on drug benefits received drug coverage ranging from \$200 to \$12,000 in the year 2001. While the amount of the dollar limit on a plan's drug benefit is an important element when comparing plans, other elements can significantly affect the value of a plan's drug benefit. These elements include the time period of the dollar limit, whether the plan allows beneficiaries to carry forward unused dollars, the types of drugs covered under the limit, whether drug formularies are used, the pricing method the HMO uses to determine the dollar amount applied to the limit for each prescription, and whether the HMO deducts copayments before applying the prescription's dollar amount to the limit.

The information that HMOs provide to beneficiaries about certain elements of the drug benefit is inconsistent, incomplete, and confusing

Medicare beneficiaries can obtain a variety of information about HMO drug benefits. However, we found that many HMO plans did not provide beneficiaries with the specific method being used to calculate the dollar amount applied to the limit for each prescription. When we telephoned plan representatives to ask them how they generally determined the amount applied to the dollar limit for prescription drugs, fewer than half provided the answer. Furthermore, when we asked them for specific prices for four commonly used drugs, 90 percent said they could not or would not provide the information. Even when information regarding the pricing method was provided in the CMS Plan Benefit Package database, *Summary of Benefits*, or by the plan's customer service representative, the information in one source was not always consistent with what a plan reported in another source. Dollar amounts and time periods reported by some plans were also not always consistent across sources. In addition, few HMOs provided information to beneficiaries about whether copayments are deducted from the prescription prices applied to the dollar limit.

Incomplete, inconsistent, and confusing information about a drug benefit's dollar limit makes it difficult for beneficiaries to know exactly what the drug benefit includes. It also may make it difficult to compare the value of drug benefits provided by different plans, thereby preventing a beneficiary from making an informed choice.

RECOMMENDATIONS

Our prior studies have shown that prescription drug coverage is one of the main factors that attracts beneficiaries to enroll in a managed care option under Medicare. Thus, every

practical effort should be made to help beneficiaries compare drug benefits among various plans. In order for beneficiaries to make informed choices regarding the value of a plan's prescription drug limit, they need accurate, comprehensive, and comparable information about the plan's drug benefit. To this end, CMS has taken numerous steps to ensure that beneficiaries receive information about drug plans in both the *Summary of Benefits* and the Medicare Compare database available on the Internet. We recommend that CMS also consider the following:

- ▶ Enhance and validate the drug limit information that is collected from plans for the Plan Benefit Package database.
- ▶ Enhance current educational efforts to ensure the plans' drug benefits are clearly explained.

AGENCY COMMENTS

The CMS reviewed our draft report. They agreed with our draft recommendations: (1) to enhance and validate the drug limit information currently collected in the Plan Benefit Package database, and (2) to provide beneficiaries with education regarding drug benefits. However, they felt our suggestions for how to provide such education were inappropriate. They also commented that we did not adequately acknowledge the drug benefit information that is already being provided to beneficiaries.

We acknowledge CMS' concerns, and have substantially revised our recommendations to respond to their comments. We have also modified our introduction and finding sections to reflect CMS' comments concerning the types of drug benefit information already being provided to beneficiaries and the inherent complexity of this information.

However, we continue to believe that pricing information is a key element when comparing plans' drug benefits. We understand that "drug benefit offerings in the pharmaceutical industry are complex and it is difficult for anyone (i.e., not only Medicare beneficiaries) to understand . . ." It is precisely for that reason that we continue to believe that beneficiaries need to understand and know pricing information to make an informed decision. The CMS suggested that beneficiaries would better understand a drug benefit and be able to compare it across plans if they could see what it would cost to obtain a prescription for one or two popular drugs. We agree that providing plans' actual prices for drugs would assist beneficiaries in making informed choices about the value of a plan to them. We encourage CMS to work toward making actual prices available to Medicare beneficiaries.

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INTRODUCTION

PURPOSE

This report describes (1) elements that can help Medicare beneficiaries assess the value of a health maintenance organization's (HMO's) prescription drug benefit, and (2) how HMOs convey information about dollar limits on drug benefits to beneficiaries.

BACKGROUND

Health Plan Options for Medicare Beneficiaries

The 1997 Balanced Budget Act established the Medicare+Choice program. Under this program, the Centers for Medicare & Medicaid Services (CMS) contracts with a greater variety of health plans. Beneficiaries are now able to choose between the traditional fee-for-service Medicare program, private fee-for-service plans, and managed care plans. Managed care plans include those offered by HMOs, preferred provider organizations, and provider-sponsored organizations. This report focuses on HMO plans under contract with CMS.

Medicare HMO Drug Benefit

In addition to providing benefits covered by the Medicare fee-for-service program, HMO plans may provide extra benefits such as outpatient prescription drugs. According to a February 2000 report by the Office of Inspector General (OIG) entitled *Medicare+Choice HMO Extra Benefits: Beneficiary Perspectives* (OEI-02-99-00030), receiving extra benefits is a major incentive for beneficiaries to join HMO plans. When the OIG asked enrollees which of the plan's extra benefits were most important to them, 87 percent said prescription drugs. Moreover, one-third of HMO enrollees indicated that the drug benefit was the "single most important reason they chose their HMO."

Currently, HMO plans limit their drug benefit in various ways. One way is to limit coverage to a certain dollar amount. Of the HMO plans that offered an extra drug benefit in 2001, 87 percent limited the dollar amount of coverage. Plans can also limit the drug benefit by charging beneficiaries coinsurance or copayments, by only covering certain types of drugs (i.e., brand name or generic drugs), or only covering drugs on a formulary. A formulary, as defined by the National Pharmaceutical Council, is "a listing of prescription medications which are preferred for use by a health plan and which may be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan."

Sources of Information on HMOs' Drug Benefit

Beneficiaries can receive information about plans' drug benefits from a number of sources. One tool a beneficiary can use to compare drug benefits is the *Summary of Benefits*. This document describes a plan's benefits in a standardized format that makes it possible for a reader to compare benefits across different plans, and also to compare a plan's benefits to Medicare's traditional fee-for-service program. The CMS mandates each plan have a *Summary of Benefits* that can be provided to beneficiaries to assist them in making informed choices. The CMS currently requires that the *Summary of Benefits* state clearly whether there are limits to the drug coverage, and if so, state the dollar limits and the time period of the limits. In addition, plans must state whether unused dollars in one time period cannot be carried forward to the next period. Plans must also state the dollar amounts of any copayments, and whether the benefits are restricted to a formulary.

In addition to reading the *Summary of Benefits*, beneficiaries can phone HMO plans and speak to customer service representatives to get information about the drug benefit. Beneficiaries with Internet access can also use the Medicare Compare database located on the Medicare website (www.medicare.gov). This database contains descriptions of plan benefits according to service area. Like the *Summary of Benefits*, Medicare Compare explains benefits in a standardized format that allows beneficiaries to compare benefits across plans. Information required of the plans in the *Summary of Benefits* can also be found in Medicare Compare.

The HMOs are required to submit all the details of their contracted plan benefit packages to CMS for review and approval. Beginning in 2000, plans submitted information about their benefits to the new CMS database called the Plan Benefit Package database, which is a part of CMS' Health Plan Management System. The Plan Benefit Package database provides a standard structure for the description of all plan benefits. The *Summary of Benefits* is automatically generated from this database, and Medicare Compare is updated from this database. This database collects more detailed information about plans' drug benefits than HMOs have provided to CMS in the past.

METHODOLOGY

Plan Benefit Package Information

We obtained a copy of CMS' Plan Benefit Package database for contract year 2001. Using this database, we identified 484 managed care plans with a prescription drug benefit. Of these 484 plans, 410 had a dollar limit on drug coverage. From plans with dollar limits, we selected organizations that had a contract with CMS to provide benefits either through HMO plans only or through a combination of both HMO and HMO Point of Service (HMOPOS) plans. There were a total of 377 plans offered by contracted organizations with either all HMOs or a mix of HMO and HMOPOS plans. In this report, we will refer to these 377 plans as HMO plans.

We analyzed the database information to identify how HMO plans establish the drug benefit's dollar limit. Of the 377 plans with a dollar limit, 3 plans did not answer most database questions about the limit. Therefore, much of our analysis is based on 374 plans. The variables we analyzed included: (1) dollar amount of the limit; (2) time period of the limit; (3) whether a beneficiary's unused coverage dollars could be carried forward from one time period to the next; (4) drug types included in the limit; (5) coverage of formulary and non-formulary drugs; (6) the pricing method (i.e., the method used by the HMO to determine the dollar amount applied toward the limit for a beneficiary's drugs); and (7) whether copayments are deducted from the drug's prescription price before that dollar amount is applied toward the beneficiary's limit.

We found inconsistencies within some HMO plans' responses to certain database questions. In order to analyze the data, we re-coded these responses based on other information provided by the plan in the database. Also, a majority of plans did not select one of the nine categories the database specified for pricing method. Instead these plans chose the response, "Other." For these plans, we used narrative explanations in the note fields to either re-code responses or create additional categories for pricing method. We did not contact HMOs to verify the Plan Benefit Package data they provided to CMS.

Customer Service Information

The 377 plans that we identified for analysis in the Plan Benefit Package database represented 118 contracts between CMS and HMOs. A single contract can be for one or more health plans. We phoned customer service staff at one plan representing each of the 118 contracts. When a contract had more than one plan, we selected one plan at random.

In our phone calls, we presented ourselves as consumers and asked questions about the dollar limit. The purpose of these calls was to determine how HMO plans explain the dollar limit to those who ask about it on the phone. We also attempted to find out what specific dollar amounts would be applied to the limit for four drugs commonly used by elderly Americans.

Of the 118 plans we attempted to contact, we were able to ask questions of 99 plans. We were not able to ask questions of the remaining 19 plans for the following reasons: 6 plans would not answer questions because they were not enrolling new members at the time of our call; 5 plans would not answer questions without personal information such as name, address, phone number, or ZIP code; 4 plans could not be reached with the phone numbers available; 2 plans said the person who could answer our questions would not be able to call us back because it was a long distance call; 1 plan was out of business; and 1 plan did not return our calls after multiple attempts to reach them.

Summary of Benefits Information

In addition to questions relating to the drug benefit's dollar limit, we asked each customer service representative to send us the plan's *Summary of Benefits*. Of the 93 plans whose

customer service representatives said they would send us a *Summary of Benefits*, we received this document from 58 plans. We reviewed the *Summaries of Benefits* to determine how HMO plans explain the dollar limit to beneficiaries in writing.

Comparison of Information that HMOs Provided to CMS and Consumers

In order to determine whether HMO plans provide CMS and beneficiaries the same information about the dollar limit, we compared information we collected from the three sources: the CMS Plan Benefit Package database, the phone calls to plans' customer service representatives, and the plans' *Summaries of Benefits*. When information from the *Summary of Benefits* was not available, we compared information plans provided to CMS with information plans provided to consumers on the phone. We determined whether information regarding five issues matched in the different sources. The five issues included (1) the existence of a prescription drug benefit, (2) the existence of a dollar limit on drug coverage, (3) the amount of the dollar limit, (4) the time period of the dollar limit, and (5) the pricing method for determining the amount applied toward the limit for a beneficiary's drugs.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Comparing the dollar limits on drug benefits can be a daunting task

There are a number of elements that beneficiaries should review when comparing and assessing plans' limits on drug benefits. While the amount of the dollar limit on an HMO plan's drug benefit is an important element when comparing plans, it is not the only factor that Medicare beneficiaries should consider when determining the value of a plan. Considering only the dollar amount, a beneficiary would assume that a plan with a limit of \$1,000 would have double the value of a plan with a \$500 drug limit. However, this is not necessarily true. Depending on the needs of the beneficiary, there are other elements that can significantly affect the value of a plan's drug benefit. These elements include the time period of the dollar limit, whether the plan allows beneficiaries to carry forward unused dollars, the types of drugs covered under the limit, the pricing method the HMO uses to determine the dollar amount applied to the limit for each prescription, and whether the HMO deducts copayments before applying the prescription's dollar amount to the limit.

Dollar Limit and Time Period

In 2001, 374 Medicare HMO plans reported dollar limit amounts in the CMS' Plan Benefit Package database. Beneficiaries enrolled in these plans would receive drug coverage ranging from \$200 to \$12,000 in the year 2001. Most of the plans (67 percent, 249 of 374) had limits that would result in \$1,000 or less in drug coverage for 2001. Only 10 plans provided coverage totaling \$3,000 or more for the entire year.

Table 1 shows the range of dollar limits and associated time periods for the 374 plans with dollar limits. Higher dollar limits are not always associated with longer time periods. For example, there are plans with dollar limits of \$200 per year, and plans with limits of \$1,000 per month. The drug benefit's value, therefore, depends on the time period as well as the amount of the dollar limit.

Table 1. Variation in the Time Period and Dollar Limit of Drug Benefit

Time Period	Number of Plans	Percentage of Plans	Range of Dollar Limits	Median Limit
Annual	189	51%	\$200-\$3,500	\$1,000
Semi-annual	24	6%	\$250 - \$1,500	\$500
Quarterly	139	37%	\$62 - \$1,000	\$175
Monthly	22	6%	\$45 - \$1,000	\$50

Source: 2001 Plan Benefit Package database in CMS' Health Plan Management System

The drug benefit's value is also affected by whether the plan allows unused dollars to be carried from one time period to the next. In 2001, only 12 percent of plans (46 of 377) allowed beneficiaries to carry forward unused dollars. This is a component of the dollar limit that beneficiaries should consider when comparing plans. If a beneficiary were in a plan that limited coverage to \$250 per quarter and the beneficiary used only \$50 in one quarter, the remaining \$200 would be lost. Beneficiaries who use little or none of their drug benefit in one time period but have extensive prescription drug needs in another time period might find themselves without enough coverage if their plan does not allow unused dollars to be carried forward.

Type of Drugs Included in Limit

Not all HMO plans cover all types of drugs under the drug benefit. For the plans reviewed, 90 percent (336 of 374) reported using some type of drug formulary. However, approximately half of these plans (58 percent, 195 of 336) also allowed beneficiaries to obtain non-formulary drugs.

While some plans include all covered drugs under the dollar limit, some plans only include specific drug types. The types of drugs included in the dollar limit play a significant role in determining the value of the drug benefit to an individual beneficiary. One-third of the plans reviewed (33 percent, 122 of 374) included only brand drugs in their dollar limit. The remaining two-thirds of plans (252 of 374) included generic drugs or a combination of generic and brand drugs in their dollar limit.

When comparing HMO plans, beneficiaries need to consider the types of drugs they use and whether the plans they are considering include these drugs in the dollar limit. For example, a beneficiary who uses only generic drugs may compare two plans — both with annual limits of \$1,000 — and believe the two plans offer the same value. However, if one plan includes only brand-name drugs in the annual limit, and the other plan limits both brand and generic drugs, the value to the beneficiary is considerably different. For a beneficiary who uses only generic drugs, the plan that does not include generic drugs in the annual limit would provide better value since the cost of those drugs would not be deducted from the limit. If this beneficiary chose the other plan, each prescription would be deducted until the annual limit was reached. Upon reaching the limit, the beneficiary would be faced with out-of-pocket costs.

Pricing Method Applied to Limit

The pricing method determines the amount that will be deducted from the beneficiary's dollar limit each time a prescription is filled. The amount applied to the limit for the same exact drug can differ substantially among HMO plans that use different pricing methods. According to the Plan Benefit Package database, plans used at least 15 different pricing methods in 2001. Most plans (81 percent) used one of six different methods. As shown in Table 2, the most frequently used pricing method was discounted average wholesale price (AWP), either with or without a dispensing fee. Information on all the pricing methods is available in Appendix A.

Table 2. Top Six Pricing Methods Used by HMO Plans with Dollar Limits on Drug Benefit

Pricing Method	# of Plans	% of Plans
Discount % of Published AWP	72	19%
Discount % Published AWP Plus Dispensing Fee	70	19%
Medicare+Choice Organization Acquisition Cost Plus (\$__)	56	15%
Published National AWP	40	11%
Medicare+Choice Organization Acquisition Cost Plus Dispensing Fee	36	10%
Published AWP Plus Dispensing Fee	28	7%
TOTAL	302	81%

Source: 2001 Plan Benefit Package database in CMS' Health Plan Management System

Even within one specific pricing method there can be a number of variations. Plans that used a discount percentage of AWP reported discounts ranging from 10 to 85 percent. Most of the discounts, however, were between 10 and 20 percent. For plans that included dispensing fees in their pricing method, the reported dispensing fees ranged from \$1.00 to \$7.50.

The variation in pricing methods among HMO plans can have a major impact on how quickly a beneficiary reaches the drug benefit limit. Studies of prescription drug reimbursements indicate that the use of some pricing methods result in better prices. For example, prices based on the acquisition costs of managed care organizations are generally lower than prices based on AWP. Furthermore, prices based on a discounted AWP will be lower than prices based on a non-discounted AWP. Therefore, it is important that a beneficiary have information about plans' pricing methods when choosing between plans. The beneficiary can then differentiate if one of the pricing methods is likely to result in fewer dollars being deducted from the limit. The plans with pricing methods that result in lower prices would provide a better value to the beneficiary, since it is likely that more prescriptions could be filled before reaching the dollar limit.

Copayment Deducted from Drug Amount

The value of the drug benefit is also affected by whether the HMO plan deducts the copayment from the dollar amount applied to the limit for each prescription. Eighty-five percent of plans that reported requiring copayments for drugs (307 of 360) also reported that the copayment was deducted from the drug amount applied to the limit. The remaining 15 percent of plans (53 of 360) reported that the copayment was not deducted from the drug amount.

All other things being equal, a plan that deducts the copayment from the drug amount offers a more valuable pharmacy benefit than a plan that does not deduct the copayment. To

illustrate, Plans A and B both charge a \$10 copayment for a drug that costs \$50. However, Plan A deducts the copayment for the amount applied toward the limit and Plan B does not. In this example, Plan A would apply \$40 toward the limit ($\$50 - \$10 = \40), while Plan B would apply \$50 toward the limit. Consequently, after this prescription, a beneficiary at Plan A would have more dollars left in coverage than the beneficiary in Plan B.

The information that HMOs provide to beneficiaries about certain elements of the drug benefit is inconsistent, incomplete, and confusing

Inconsistent, incomplete, and confusing information about a drug benefit's dollar limit makes it difficult for beneficiaries to know exactly what the HMO plan's drug benefit includes. It also may make it difficult to compare drug benefits provided by different plans, thereby preventing a beneficiary from making an informed choice. Having information about the dollar limit can help a beneficiary see more clearly how the value of the benefit differs among plans.

We reviewed several sources that may be used by beneficiaries to acquire information about a plan's drug benefit. We reviewed two sources provided directly from the HMO plan to the beneficiary: the *Summary of Benefits*, and information collected by phone from the plan's customer service representative. We also reviewed the information that HMO plans provided to CMS' Plan Benefit Package database. Some of this data is used to update plan information that beneficiaries can view on the Medicare Compare website.

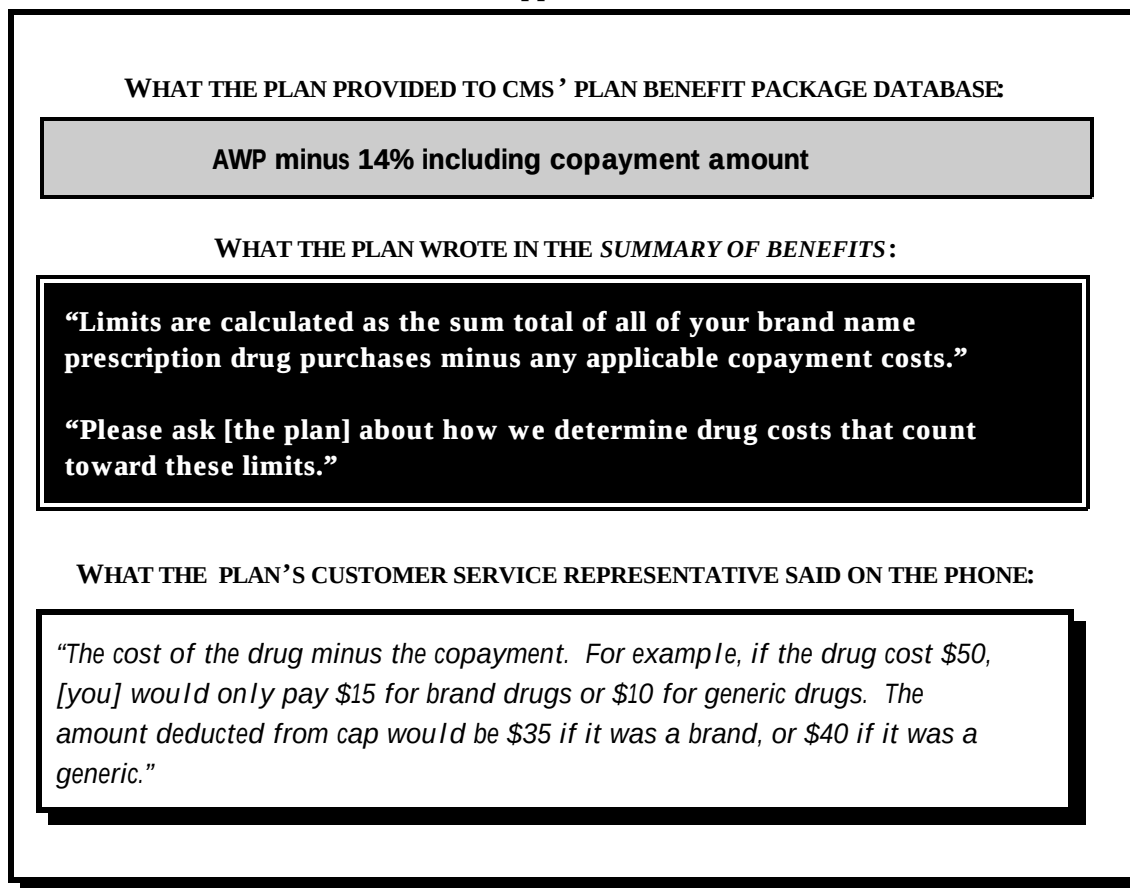
Many HMOs did not provide beneficiaries with specific pricing methods, and when they did, the information in one source was not consistent with what they reported in another source

The majority of *Summaries of Benefits* (32 of 58) instructed the beneficiary to call the plan to find out how a drug's dollar amount is determined before it is applied to the dollar limit. However, when we phoned HMO plans and asked how the plan determined the amount applied to the dollar limit, less than half the plans (40 of 91) mentioned a specific pricing method. Most of the other plans said, "the price of the drug" or "the cost of the drug" is what is applied toward the limit. Such vague explanations do not provide beneficiaries with actual pricing methods that can be used to compare the value of plans. In addition, when we asked plan representatives to provide the specific dollar amounts that would be applied to the limit for four drugs, 90 percent said they could not or would not provide this information for any of the drugs. Therefore, beneficiaries are left to make decisions about the value of a plan's drug benefit based only on vague and undefined pricing method information.

Even when HMO plans furnished some type of information about how they determine the drug dollar amount applied to the dollar limit, the details provided were not always consistent across information sources. Nearly 90 percent of plans (79 of 91) provided different information about pricing methods among the sources reviewed. There were even cases wherein the information provided by a plan to all three sources (Plan Benefit Package database, *Summary of Benefits*, consumers calling plan's customer service number) differed.

Figure 1 illustrates differences in the information about pricing methods among the sources we reviewed. As the example shows, the data reported to CMS provides specific details about what pricing method this plan uses to determine the drug amount applied to the limit. The *Summary of Benefits* tells the beneficiary to call the plan and ask how drug costs are determined. However, when a beneficiary calls the plan, the customer service representative uses a non-specific term like "cost of drug" that provides no real pricing method detail. Furthermore, information provided on the phone and the *Summary of Benefits* makes it clear that copayment amounts paid by the beneficiary are not applied to the limit, but the information reported in the Plan Benefit Package says that copayment amounts are applied to the limit. In addition, the customer service representative talks about both brand and generic drugs when discussing the limit. However, the *Summary of Benefits* refers only to brand name drugs.

Figure 1: Example of One Plan's Inconsistent and Confusing Information About the Drug Amount Applied to the Limit



Sources: 2001 Plan Benefit Package database in CMS' Health Plan Management System; Phone call to plan's customer service representative (January/February 2001); and 2001 *Summary of Benefits*

In addition, dollar amounts and time periods reported by some HMO plans were not always consistent across sources

Overall, 16 percent of reviewed HMO plans (15 of 93) provided inconsistent data on the dollar amount or time period of their limit across information sources. More than half of these (8 of 15) reported contradictory information for both dollar amount and time limit. For example, one plan told a consumer on the phone the dollar limit was \$1,000 per year but reported to CMS and in the *Summary of Benefits* that the dollar limit was \$125 every 3 months.

Few HMOs provided information to beneficiaries about whether copayments are deducted from the amount applied to the dollar limit

The CMS does not currently require HMO plans to provide information, in the *Summary of Benefits*, about whether they deduct copayments from the prescription price before applying this amount to the dollar limit. Only 12 percent of plans (7 of 58) provided this additional piece of information to beneficiaries in the *Summary of Benefits*.

RECOMMENDATIONS

Our prior studies have shown that prescription drug coverage is one of the main factors that attracts beneficiaries to enroll in a managed care option under Medicare. Thus, every practical effort should be made to help beneficiaries compare drug benefits among various plans. In order for beneficiaries to make informed choices regarding the value of a plan's prescription drug limit, they need accurate, comprehensive, and comparable information about the plan's drug benefit. To this end, CMS has taken numerous steps to ensure that beneficiaries receive information about drug plans in both the *Summary of Benefits* and the Medicare Compare database available on the Internet. We recommend that CMS also consider the following:

- ▶ Enhance and validate the drug limit information that is collected from plans for the Plan Benefit Package database.
- ▶ Enhance current educational efforts to ensure the plans' drug benefits are clearly explained.

AGENCY COMMENTS

The CMS reviewed our draft report. They agreed with our draft recommendations: (1) to enhance and validate the drug limit information currently collected in the Plan Benefit Package database, and (2) to provide beneficiaries with education regarding drug benefits. However, they felt our suggestions for how to provide such education were inappropriate. They also commented that we did not adequately acknowledge the drug benefit information that is already being provided to beneficiaries.

We acknowledge CMS' concerns, and have substantially revised our recommendations to respond to their comments. We have also modified our introduction and finding sections to reflect CMS' comments concerning the types of drug benefit information already being provided to beneficiaries and the inherent complexity of this information.

However, we continue to believe that pricing information is a key element when comparing plans' drug benefits. We understand that "drug benefit offerings in the pharmaceutical industry are complex and it is difficult for anyone (i.e., not only Medicare beneficiaries) to understand" It is precisely for that reason that we continue to believe that beneficiaries need to understand and know pricing information to make an informed decision. The CMS suggested that beneficiaries would better understand a drug benefit and be able to compare it across plans if they could see what it would cost to obtain a prescription for one or two popular drugs. We agree that providing plans' actual prices for

drugs would assist beneficiaries in making informed choices about the value of a plan to them. We encourage CMS to work toward making actual prices available to Medicare beneficiaries.

Pricing Methods Used by HMO Plans with Dollar Limits in 2001

Pricing Method	Number of Plans	Percentage of Plans
Discount % of Published AWP	72	19.25%
Discount % of Published AWP Plus Dispensing Fee	70	18.72%
Medicare+Choice Organization Acquisition Cost Plus (\$__)	56	14.97%
Published National AWP	40	10.70%
Medicare+Choice Organization Acquisition Cost Plus Dispensing Fee	36	9.63%
Published AWP Plus Dispensing Fee	28	7.49%
Brand - Discount % of Published AWP Plus Dispensing Fee and Generic - Maximum Allowable Cost Plus Dispensing Fee	13	3.48%
Published Wholesale Price	11	2.94%
Brand - Discount % of Published AWP Plus Dispensing Fee and Generic - Discount of Published AWP or Maximum Allowable Cost Plus Dispensing Fee	11	2.94%
Brand - Discount % of Published AWP Plus Dispensing Fee and Generic - Maximum Allowable Cost or Federal Upper Limit Plus Dispensing Fee	9	2.41%
Published Medicare+Choice Organization Fee/Charge Schedule	6	1.60%
Actual Acquisition Cost x 1.25	6	1.60%
Published Retail Price	5	1.34%
Medicare Fee Schedule	1	0.27%
Lesser of Usual & Customary, or, Brand - Discount % of Published AWP Plus Dispensing Fee and Generic - Medicare+Choice Organization Acquisition Cost Plus Dispensing Fee	1	0.27%
Other (not specified)	9	2.41%
TOTAL	374	100%

Source: 2001 Plan Benefit Package database in CMS' Health Plan Management System

Centers for Medicare & Medicaid Services' Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

 Administrator
 Washington, DC 20201

DATE: DEC 17 2001

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully *Tom Scully*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Dollar Limits on Medicare HMO Drug Benefits*, (OEI-03-00-00430)

Thank you for the opportunity to review the above-referenced report. We agree that the Centers for Medicare & Medicaid Services (CMS) and Medicare + Choice Organizations (MCOs) should perform additional beneficiary education regarding drug benefits, but we believe that the OIG's suggestion for how to provide such education is inappropriate. This is primarily due to the level of complexity that the OIG suggests we provide in our educational efforts. In addition, we believe that the OIG has failed to adequately acknowledge in its report the information that CMS and MCOs already provide in educational and marketing materials and the extent to which CMS already uses the Plan Benefit Package (PBP) to develop these materials. Our specific comments regarding the report's recommendations and other aspects of the report follow.

OIG Recommendation:

CMS should educate Medicare beneficiaries about the elements of a limited drug benefit they need to consider in order to assess the benefit's value. CMS should make sure that beneficiaries are educated about the following elements:

- the dollar amount of the limit on drug coverage
- the time period of the dollar limit
- whether a beneficiary's unused dollars in one period can be carried forward to the next period
- which types of drugs (i.e., brand-name or generic) are included in the dollar limit and which are unlimited whether drug formularies are used and the types of drugs included on the formulary
- whether drug formularies are used and the types of drugs included on the formulary

CMS Response:

The CMS currently provides information to beneficiaries concerning the items listed above, in a standardized, easy to understand format in the Summary of Benefits (SB) in *Medicare Compare* and through the 1-800-MEDICARE toll-free line.

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While we agree that beneficiaries could benefit from clearer explanations about Medicare + Choice (M+C) drug benefits, it is unlikely that the level of detail suggested by the OIG would be beneficial. Drug benefit offerings in the pharmaceutical industry are complex, and it is difficult for anyone (i.e., not only Medicare beneficiaries) to understand, as suggested by the OIG, the "pricing method used to determine how much money is applied to the limit per prescription." Instead, we believe beneficiaries are far more likely to understand a benefit and to be able to compare it across plans when they can see, for example, what it would cost to fill a prescription for one or two popular drugs on the market. Therefore, while we agree that CMS and the MCOs could perform additional beneficiary education to clarify drug benefits, we believe that providing extremely detailed information as suggested by the OIG is not useful to beneficiaries.

When CMS began the development of the standardized SB, beneficiary advocacy groups and industry personnel were consulted. After much debate and discussion over a period of days, it was determined that there is not one consistent pricing methodology used by health plans. Further, it was determined that much of the information on pricing would be too complex and not make much sense to the beneficiaries. The information now included in the SB (for example: the dollar amount of the limit, time period of the dollar limit, whether unused dollars can be carried forward to the next period, and whether or not formularies are used) was determined to be the most reasonable way to present information to the beneficiary for comparison purposes. We came to this determination through consultation with the managed care industry and beneficiary advocacy groups. Although more beneficiary education is needed, it is critically important that the information provided to beneficiaries is the most relevant to making informed choices.

The CMS has spent considerable time in the past 2 years obtaining comments from the industry regarding how best to display information in the PBP and SB regarding the drug dollar limits. Each year, we strive to make the information presented more representative of plan offerings and more useful to beneficiaries.

OIG Recommendation:

CMS should work with contracted HMO plans to ensure that beneficiaries are receiving the information about drug benefit limits that they need to make informed decisions about a plan's value. The CMS might also consider whether information from the PBP database could be used in the *Summary of Benefits* and in Medicare Compare so that beneficiaries can have access to more elements about the drug benefit.

CMS Response:

Information in the PBP is already used in the *Summary of Benefits* and in *Medicare Compare*. For example, the PBP creates Medicare Compare as well as Sections 1 and 2 of the *Summary of Benefits*. In addition, information in Section 3 of the *Summary of Benefits* must be in the PBP in order to receive approval from the ROs.

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However, we do agree that it may be helpful for CMS to develop methods for enhancing and validating the drug limit information that is currently collected in the PBP database.

Attachment

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