OIG NEWS

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Medicare Drug Plans Have Not Met Requirements for Tracking Out-of-Pocket Costs

OIG Report Recommends Stronger Program Oversight

Washington, DC — Inspector General Daniel R. Levinson announced today that the Office of Inspector General (OIG) for the Department of Health and Human Services found that Medicare drug plans have not met all requirements for tracking out-of-pocket spending by beneficiaries in the Medicare Part D prescription drug program. Accurate tracking of beneficiaries' true out-of-pocket (TrOOP) costs is critical to ensuring appropriate cost sharing under the Part D program.

TrOOP costs are the prescription drug expenditures that count toward the annual out-of-pocket threshold that beneficiaries must reach before catastrophic drug coverage begins. Yet in 2006, the Part D plans did not consistently meet requirements for reporting information to the Centers for Medicare & Medicaid Services (CMS) and its contractors and CMS conducted limited oversight of the process.

"Implementing the program has been a large undertaking for CMS, its contractors, and the private Part D plans," said Levinson. "TrOOP spending levels are critically important and now that the program has been in place for almost two years, CMS should place more emphasis on conducting Part D oversight activities."

Tracking TrOOP is very important because of the design of the Medicare Part D benefit. Although individual plan designs can vary widely, for 2007 in the first phase of the standard benefit, after paying a deductible, beneficiaries pay 25 percent of their eligible drug costs up to total plan and beneficiary payments of $2,400. Then beneficiaries enter a coverage gap and are required to pay

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100 percent of drug costs until their TrOOP costs reach $3,850. At that point catastrophic coverage begins and beneficiaries pay just 5 percent of the cost of eligible drugs.

Therefore, knowing when TrOOP payments have reached the various thresholds is critical in determining what level of benefits will be provided during the Part D benefit cycle. Yet, the OIG review found that in 2006:

- Twenty-nine percent of Part D plans did not submit information to CMS as required on enrollees' additional drug coverage data, such as payments made by a group health plan or an automobile insurer. This process is important to ensure that plans appropriately account for payments made by these third party payers so that the beneficiary is in the correct phase of the benefit.

- Sixty-three percent of Part D plans cited problems with transferring TrOOP information when an enrollee changed plans during a benefit year. If these data are not received by the new plan or are not accurate, it will not be clear in which benefit phase the beneficiary should be placed.

- CMS has conducted limited oversight of Part D plans' tracking of TrOOP costs. The oversight that CMS has conducted thus far relied on plans' self-reported data. About half of the plans were not in compliance with one or more of four CMS requirements specifically related to calculating TrOOP costs.

- Thirty-four percent of Part D plans did not submit prescription drug event data to CMS in the required timeframes. These plans covered 49 percent of all Part D enrollees. This affects CMS's ability to oversee plans' tracking of TrOOP because without these data, CMS cannot verify that plans have calculated beneficiaries' TrOOP costs correctly.

To ensure accurate tracking of TrOOP costs, OIG recommendations to CMS include ensuring that Part D plans collect, process, and submit all data required to track enrollees' TrOOP costs in a timely manner and beginning or completing implementation of oversight activities regarding tracking TrOOP costs.

To read the OIG Report in full, please go to:
http://oig.hhs.gov/oei/reports/oei-03-06-00360.pdf

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