October 2, 2007

Acting Administrator Kerry Weems
Centers for Medicare and Medicaid Services
Department of HHS
Washington, DC 20201

Dear Administrator Weems:

The open enrollment period for Medicare Part D prescription drug plans is about to begin, and we understand that CMS will be issuing a new series of 'report cards' on the many plans available to beneficiaries.

We hope that this new report card effort will be a dramatic change from previous efforts. Consumers Union, the independent, non-profit publisher of *Consumer Reports*, urges you to scrap the current Part D plan quality rating system and instead over the next year provide a new and much simpler, much more useful system.

Consumers Union strongly believes that quality data should be made public, so beneficiaries can effectively shop for a plan – and we would not want this critique to be a basis for not making information public. But for consumers, the current rating system includes data that ranges from utterly confusing to utterly meaningless – which runs counter to the goal of giving beneficiaries clear information to make informed choices.

Many quality indicators have little meaning to consumers

Looking at 22 multi-state plans and using a California zip code, we believe 8 of the 14 quality indicators have either little relevance or meaningful difference in quality, serving

to merely confuse the consumer with useless information when it comes to selecting a plan.[1]

For example:

> On the Performance Measure that rates plans on keeping their drug information up-to-date on the Internet, every Plan scores between 95.3 percent and 100 percent (10 of the 22 plans score 100%) . Ensuring current data is very important for consumers, and should be a fundamental requirement for participation in the program. Plans that fail to keep the data updated should be dropped. But with this narrow 4.7 percent quality range, the rating is not very meaningful for consumers and just becomes clutter on the CMS website.
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> On the Performance Measure, "Percent of Plan Enrollment Records Matching CMS' Record for Beneficiaries Who Qualify for Low Income Subsidy," the reported quality range is quite narrow (99.9% to a low of 85.3%). But more important, since most LIS individuals are automatically assigned, most consumers who use the Website to shop for a plan wouldn't find this data useful, because it doesn't apply to them. Please hear us correctly: this quality indicator is <u>very</u> important for the most vulnerable patients, and CMS should issue a regulation that a plan will not be eligible to automatically receive LIS enrollees unless it has 99 percent record accuracy. But this measure is not relevant to most consumers using the Website and just adds clutter and confusion.
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> The Appeals and Grievances measures[2] are all very important, but because of the public's confusion about the precise details of these four Performance Measures, and the way the very small percentages are displayed (for example, on 'other complaints,' the quality ranges from 0% to 0.22% for the 22 multi-state plans), it is hopelessly confusing. We urge you to keep collecting this data and making it public in reports for analysts. But for purposes of helping consumers as they pick a Plan, we urge you to consolidate the appeals and grievances data into a single

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[1] As best we can determine from reviewing all 50 states, there are basically 22 companies that offer a variety of plans in most of the states. We understand CMS considers there to be 17 national companies, but our review of the states shows about 22 companies that can be compared across many states. Our review includes all the 17 listed by CMS as national plans, plus 5 others. Each of these multi-state companies appears to have a single set of national quality ratings, according to the Medicare.gov Prescription Drug Plans 'compare' website. In other words and as an example, Humana offers several different plans in each state, but on the CMS website, it has a single set of 14 different categories of quality ratings—there is no display of any quality difference between a Humana plan in California and a Humana plan in Maine. The website link is:
http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp?version=default&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home&ViewType=Public&PDPYear=2007&MAPDYear=2007&MPDPF%5FMPPF%5FIntegrate=N

[2] The four measures are "Benefits/Access Complaints Rate per 1000 Enrollees; Enrollment/Disenrollment Complaints per 1000 Enrollees; Pricing and Coinsurance Complaints Rate per 1000 Enrollees; Other Complaints Rate per 1000 Enrollees".

grade, and tell consumers whether a plan is in the best 5 or the worst 5 in terms of total complaints (see below).

Three other quality Performance Measures[3] relate to how well the plan works for the pharmacist trying to fill a beneficiary's prescription. These also are very important measures, but we believe most consumers are puzzled about the personal relevance of their inclusion, and just assume that of course 'complete enrollment records are available to the pharmacist.' If a plan cannot serve the pharmacist community, its contract should not be renewed, but the inclusion of these three quality indicators just adds to the clutter of the website for the average beneficiary. These three indicators should be pulled out and provided to the various national pharmacy trade organizations for use in helping their members decide which plans to participate in and which plans to avoid.

CMS's system of grading (three, two, and one stars) tells consumers almost nothing

Basically the system makes all plans look good and therefore tells the consumers nothing. As we have said before[4], CMS needs to stop treating all plans like they are from Garrison Keillor's Lake Woebegon: "all above average." There are poorer quality plans, and it should be made easy for consumers to identify them and avoid them.

For example, in Colorado all the 22 multi-state plans received the maximum 3 stars for the time it took plans to answer the telephone. Yet the hard data behind the 3 stars shows a range of 5 seconds to 222 seconds. Why not give 3 stars to the third of plans with the fastest answer time, and one (or none) to the bottom third? Alternatively, list the 5 best and the 5 worst plans? In addition, on this Performance Measure, a recent report by the HHS Inspector General (see below) shows that by more than 2 to 1, beneficiaries value accuracy over speed. It is important to build an accuracy index into this Performance Measure. There is no glory in rapid wrong answers.

The criteria for determining who gets three, two, or one stars seems to be far too lax. For example, in Colorado, for the measure 'Enrollment / Disenrollment Complaints Rate per 10,000 Enrollees', only one plan falls in the one star category at 2.44, two plans fall in the two star category ranging from 0.83 to 0.65, and twenty plans fall into the three star category which ranges from 0.6 to 0.04 (and for one plan there was insufficient data). If 20 of 24[5] plans fall under 0.6, why not set the bar for getting three stars at a higher level?

Questions about accuracy of the reported data

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[3] "Pharmacist Support Wait Time," "Pharmacist Support Percent of Dropped Calls," and "Percent of Members with Complete Enrollment Records Available to Pharmacists."

[4] CU letter of December 4, 2006 to CMS.

[5] The 22 multi-state or national plans, plus 2 local Colorado plans.

It appears that data has been posted that is nearly impossible, and we question whether it has been adequately verified.

> For example, among the 22 multi-state plans in California, NMHC Group Solutions (S8841) company had the worst (highest) rating in the two categories of "Benefits/Access and Enrollment/Disenrollment Complaints Rate per 1000 Enrollees" and was below average quality in "Pricing and Coinsurance Complaints per 1000 Enrollees." Yet in the category, "Other Complaint Rate per 1000 Enrollees," it had zero (0%) complaints. It seems likely that this is simply an accounting or bookkeeping issue: the first three complaint categories are probably too high, and 'Other' is too low. This type of information makes consumers skeptical about the value of the website.
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> On the speed of answering calls Performance Measure, we believe that even more fundamental than speed is the <u>question of accuracy</u>. In the just-released, very critical and disappointing HHS Inspector General report on CMS's internal call centers[6], it was noted that 61 percent of consumers rate the accuracy of the answer as the most important issue, compared to 24 percent who rated speed of response as the highest priority. It would be nice to have both—but the current Part D Plan Performance Measure gives no hint of whether or not the Plans are giving accurate responses. <u>We urge you to start a system of test calls to the Plans and developing a combination accuracy/speed of answer index for use in next year's (2008-2009) open enrollment season</u>.

For all these reasons, we urge you to redo the entire quality effort to make it useful for Medicare consumers and taxpayers. We recommend a system below, that would be available with a single click on the computer screen, and <u>which should appear before any final on-line enrollment action and on any written enrollment application just prior to the signature line</u>.

Obviously, before making a major change like this, we urge you to convene a panel of consumer, education, language and literacy experts to advise on a simple, understandable, usable model. <u>The following is a discussion idea for a sample form</u>. We know this is not a 'perfect' form—but the current process needs a major revision.

Model Consumer Disclosure Form

1. Did the Plan drop any drugs from its formulary during the previous plan year[7]?
Yes/No___

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[6] HHS OIG, September 2007, OEI-07-06-00530, "1-800-Medicare: Caller Satisfaction and Experiences."
[7] CMS would of course adjust this data to reflect any drugs pulled for FDA safety reasons or production disruption reasons beyond the control of the company

2. Where a brand drug and a generic drug are available, the percent of time that the generic is dispensed (the higher the number the lower the cost to you and fellow taxpayers) _____% Is the Plan in the top 5 generic users? __Yes/No

3. What is the percent of drugs on the Plan formulary that increased in price during the previous year? _______% Is the Plan in the top 5 of all Plans for drug price stability? Yes/No

4. What was the largest price increase of any drug on the formulary in percent and dollar terms? _____% $_________

5. Is the plan among the top five plans in speed and accuracy of answering (and not disconnecting) telephone inquiries? Yes___ Is it among the worse 5? Yes___

6. What are the total complaints per 1000 enrollees? ______
Is it among the best five? Yes___ Worst five? _________

7. When a plan denies a complaint or access to a specific drug, and the patient appeals the decision, what percent of the time do independent experts at the appeal body agree with the plan (a high number is better because it shows that the plan probably was justified in the initial denial)? ________Percent. Is the Plan among the five best? Yes/No____

8. For a package of 20 safe and effective drugs for common conditions, is this plan among the top five plans in terms of lowest expected annual cost? Yes/No.

Discussion

First, it is essential to make the quality website less confusing and more useable. As the *Chicago Tribune* reported on September 25, 2007, ninety million people in the US struggle with health literacy according to the American Medical Association, and a new study at the Northwestern University School of Medicine indicates that a quarter of seniors have trouble interpreting the most basic of drug bottle labels. Obviously, the current complex web-based quality rating system of Part D plans is useless to many in this population.

Question number 2 is important because according to CMS data, at the end of the second quarter of 2006, PDP plan generic dispensing rates varied between a low of 43.5 percent and a high of 68.2 percent The difference between low and high generic use plans easily costs beneficiaries and taxpayers millions, perhaps billions, of dollars a year.

Question number 3 and 4 are important because, while Medicare beneficiaries sign up with a Plan for a year after presumably shopping for the best drug prices, the Plan can increase (or decrease) what it charges for that drug anytime it wants, thus increasing

copays and/or speeding the day that the beneficiary falls into the 'donut hole' where they pay totally out of pocket.

In some cases, plans seem to be practicing bait and switch. For example, in September 2007, Consumers Union found that in New York, Rx 1 drug plan went from being the third lowest-cost on our five sampled drugs in February 2007, to being the 14th in September. In Texas, Blue Medicare Rx Standard went from first (lowest cost) to eighth . In the latest period tracked – from February to September 2007 – CU found that 95 percent of the plans offered in the five large states we have been monitoring raised their drug costs. A quarter of all plans raised prices by 5 percent or more during that time. The average state increase during the seven-month period was $140. Only 15 of the 289 plans in the sampled areas lowered their prices. The worst increase was in Blue Medicare Rx-Standard in Illinois, which according to CMS's webside, increased its costs for the five monitored drugs by 28 percent, or $679, during that time.

Consumers have a great interest in knowing whether the plan they are joining is price stable, or whether it dramatically increases prices on a range of drugs.

Question number 5 is a simple key service question: can the company answer its phones quickly, without 'dropping' people, and give accurate responses. Currently these two quality markers are separate items on the Medicare website. We urge that they be combined into a single telephone service index. Most companies are very good about not dropping calls, but according to the CMS website, one multi-state plan, Envision Rx (S7694), dropped a phenomenal 23 percent of calls. This kind of egregious lack of service should be incorporated into a phone index. For example, one could say that for every 5 percent of calls dropped, a minute is added to the average telephone response wait-time figure.

Question number 6 is very important. The current website lists five different complaint and appeal Performance Measures. The low level of complaints speaks to the difficulty beneficiaries have in understanding and using the Part D appeals and grievance system. It appears the level of appeals is about one-fifth the Part C managed care appeals rate. We believe this does not mean Part D plans are providing better quality; we believe that it means seniors and people with disability are having a very difficult time using the system. The low level of recorded complaints means that differences among the plans seem insignificant. Therefore we urge that all these numbers be cumulated. In addition, the important performance measure "Rate per 10,000 Enrollees in which a Plan Did Not Make a Timely Appeals Decision," should be converted into a number that can be included in the cumulated complaint number. In California, most multi-state plans have very low "not timely" appeals numbers; but several were around 7, Health Spring Prescription Drug Plan was an outlier with an unacceptable 100.9/10,000, and a large regional plan, Blue Shield of California, was late 19.1/10,000. We would suggest that each 1/10,000 late appeals result in an increase in complaint numbers of, for example, 0.50.

Question number 7 is important because it shows whether a plan arbitrarily denies service or whether its actions are based in the mainstream of medical decision-making. Consumers Union recently criticized the multi-state plan WellCare for requiring its Low-Income Subsidy enrollees to pay multi-thousand dollar copays on some very commonly prescribed drugs (i.e., effectively not covering these drugs for Medicare-Medicaid dually eligible individuals). The company responded that people could get the drugs upon appeal. As the CMS quality data shows, the company has the next to worst record on appeals, and therefore it does, indeed, deny some of our most vulnerable citizens access to needed drugs.

Question number 8 is perhaps the most useful. Is the plan a good value and does it cover good drugs for common conditions—conditions that may arise during the year after an individuals selects a plan. CMS could use the work of the Drug Effectiveness Review Project at the Oregon Health and Science University to identify 'best buy' type drugs that have been determined on the basis of the best available evidence to be the safest, most effective drugs. The plan's cost of providing such a package is a key consumer issue—and this type of key information should be available to beneficiaries before they commit to a year's contract with the plan.

We hope these suggestions are useful. They are obviously just suggestions and exact details would have to be developed after wide consultation. We raised some of these issues in our letter of December 4, 2006, (and other letters throughout 2006), and we appreciate CMS doing more to monitor and report on price changes.

Still, the entire premise of Part D is that consumer shopping will drive competition and hold down prices. When prices can change anytime and negate the effect of shopping, then consumers need to at least have useable quality data. The current data is not useful. We urgently need immediate improvement.

Thank you for your consideration.

Sincerely,

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Health Policy Analyst	Senior Policy Analyst	Health Policy Analyst