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MEDICARE

Contractors and Private Plans Play a Major Role in Administering Benefits

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GAO Highlights

Highlights of [GAO-14-417T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Since the enactment of Medicare in 1965, contractors have played a vital role in the administration of the program. The original FFS program was designed so that the federal government contracted with health insurers or similar private organizations experienced in handling physician and hospital claims to process and pay Medicare claims rather than having the federal government do so. CMS now also contracts with private organizations that provide covered services under the MA program and the Part D prescription drug program.

This statement provides an overview of the manner in which CMS has contracted with private organizations to administer benefits in (1) original FFS Medicare, (2) MA, and (3) the Part D prescription drug program. It is based primarily on products that GAO has issued regarding CMS contracting with claims administration contractors to administer the FFS program, and with other private organizations as part of MA and the Part D prescription drug benefit programs. These products were issued from November 1989 through January 2014 using a variety of methodologies, including reviews of relevant laws, policies, and procedures; data analysis; and interviews with contractors, stakeholders, and CMS officials. We have supplemented information from our prior products with publicly-available data on Medicare private plan contracts and enrollment, CMS-issued guidance for Medicare private plans, and a review of relevant literature. GAO has made numerous recommendations to CMS in these previous products and is not making any new recommendations at this time.

View [GAO-14-417T](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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Contractors and Private Plans Play a Major Role in Administering Benefits

What GAO Found

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reformed the way the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, contracts with claims administration contractors. From its inception, the process for selecting Medicare fee-for-service (FFS) claims administration contractors was stipulated by Congress and differed from most other federal contracts in that, among other things, the Medicare contracts were not awarded through a competitive process. The MMA repealed limitations on the types of contractors CMS could use and required that CMS use competitive procedures to select new contracting entities to process medical claims and provide incentives for contractors to provide quality services. CMS has implemented the MMA contracting reform requirements by shifting and consolidating all claims administration tasks to new entities called Medicare Administrative Contractors. CMS is currently in the process of further consolidating these contracts. The agency also uses other contractors to review claims to ensure payments are proper and investigate potential fraud.

CMS contracts with private organizations to administer benefits under Medicare Advantage (MA), but has an important administrative and oversight role. MA is the private plan alternative to FFS and differs from FFS in that CMS contracts with private entities, known as Medicare Advantage organizations (MAOs), to provide covered health care services to beneficiaries who enroll. MAOs are paid a predetermined monthly amount for each beneficiary enrolled in one of their health plans and must provide coverage for all FFS services (except hospice care), but may also provide additional coverage. The government first began contracting with private plans in 1973. Several laws since then have changed how the MAOs are paid and the types of plans that can participate. While contract requirements for MAOs and parameters of the program are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with these requirements.

CMS also contracts with private organizations, called plan sponsors, to provide the outpatient prescription drug benefit under Part D. Through the Part D contracts, plan sponsors offer prescription drug plans which may have different beneficiary cost-sharing arrangements (such as copayments and deductibles) and charge different monthly premiums. The Part D program relies on sponsors to generate prescription drug savings through negotiating price concessions with entities such as drug manufacturers, pharmacy benefit managers, and pharmacies, and managing beneficiary use. While CMS contracts with plan sponsors to provide the Part D benefit, the agency has oversight responsibilities. For instance, CMS is responsible for making accurate payments to plan sponsors and ensuring the accuracy of information submitted by plan sponsors to the beneficiary-focused Medicare Plan Finder website. Medicare actuaries have attributed lower-than-projected expenditures in Part D to a combination of factors, including lower-than-projected Part D enrollment, slower growth of drug prices in recent years, greater use of generic drugs, and higher-than-expected rebates from pharmaceutical manufacturers to the prescription drug plans.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

We are pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) contracting in the agency's administration of the Medicare program. Since the enactment of Medicare in 1965, contractors have played a vital role in the administration of the program. In fact, the original Medicare program was designed so that the federal government contracted with health insurers or similar organizations experienced in handling physician and hospital claims to pay Medicare claims. In addition to contracting with organizations to process and pay claims in the original Medicare fee-for-service (FFS) system, CMS also contracts with private organizations to provide covered health services under the Medicare Advantage (MA) program, and outpatient prescription drug coverage under Medicare Part D.¹ With MA and the prescription drug program, private organizations that sponsor health plans are responsible not only for paying claims, but also for ensuring beneficiaries can access their benefits.

In fiscal year 2014 the Medicare program will cover more than 50 million elderly and disabled beneficiaries at an estimated cost of \$595 billion.² In order to administer benefits to Medicare beneficiaries, CMS relies extensively on contractors to assist in carrying out its responsibilities, including program administration, management, oversight, and benefit delivery. In fiscal year 2014, approximately 38 million Medicare beneficiaries will be enrolled in original FFS Medicare and more than 1.2 billion claims will be processed and paid for those beneficiaries by claims administration contractors. In February 2014, Medicare had 571 contracts with MA organizations to provide medical benefits, and offer prescription drug benefits, to over 15.3 million beneficiaries, and an additional 85 contracts with organizations that provide prescription drug benefits outside of the MA program.

¹Medicare consists of four parts. Parts A and B are known as original Medicare or Medicare FFS. Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services. Part C is the private health plan alternative to Medicare FFS and primarily consists of plans that are offered under the MA program. Part D is the outpatient prescription drug benefit, which is provided through private plans.

²Congressional Budget Office, *Medicare—May 2013 Baseline*. (Washington, D.C.: May 14, 2013). This number only includes benefit payments.

This statement provides an overview of the manner in which CMS has contracted with private organizations to administer benefits under (1) original FFS Medicare, (2) Medicare Advantage, and (3) the Part D prescription drug program.³ It is based primarily on previous products that we have issued regarding CMS contracting with claims processors to administer the FFS program, and with other private organizations as part of the MA and Part D prescription drug programs. These products were issued from November 1989 through January 2014 using a variety of methodologies, including reviews of relevant laws, policies, and procedures; data analysis; and interviews with contractors, stakeholders, and CMS officials. We have made numerous recommendations to CMS in these previous products and are not making any new recommendations at this time. We have supplemented information from our prior products with publicly-available data on Medicare private plan contracts and enrollment, CMS-issued guidance for Medicare private plans, and a review of relevant literature. Our work was performed 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.

Medicare Modernization Act Reformed the Way CMS Contracts with Organizations to Process and Pay FFS Claims

From its inception, the process for selecting Medicare claims administration contractors was stipulated by Congress and differed from the process for awarding most other federal contracts in that, among other things, the Medicare contractors were not selected through a competitive process. Before Medicare was enacted in 1965, providers were concerned that the program would give the government too much control over health care. To increase providers' acceptance of Medicare, Congress ensured that health insurers like Blue Cross and Blue Shield would play a key role in administering Medicare, as they already had experience as payers for health care services to physicians and hospitals. Medicare's authorizing legislation required that the claims administration contracts be awarded to carriers and fiscal intermediaries—now referred

³Before July 1, 2001, CMS was known as the Health Care Financing Administration.

to as legacy contractors.⁴ By law, CMS was required to select carriers from among health insurers or similar companies and to choose fiscal intermediaries from organizations that were first nominated by associations representing providers, without the application of competitive procedures. In addition, CMS could not terminate these contracts unless the contractors were first provided with an opportunity for a public hearing, whereas the contractors themselves were permitted to terminate their contracts, unlike other federal contractors. The contractors were paid based on their allowable costs and generally did not have financial incentives that were aligned with quality performance.

Beginning in the 1980s, the Department of Health and Human Services (HHS) asked Congress to amend its authority related to the selection of claims administration contractors, citing several reasons. HHS wanted greater flexibility to administer the program and improve services to beneficiaries and providers. In addition, HHS wanted to promote competition by opening up the contracting process to a broader set of contractors, achieve cost savings, and increase CMS's ability to reward contractors that performed well. Congress included such reform in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).⁵ Specifically, the MMA repealed limitations on the types of contractors CMS could use and required that CMS

- use competitive procedures to select new contracting entities to process medical claims;
- provide incentives for contractors to provide quality services;
- develop performance standards (including standards for customer satisfaction);
- comply with the Federal Acquisition Regulation (FAR), except where inconsistent with provisions of the MMA;⁶
- implement contractor reform by October 2011; and

⁴Carriers handled the majority of Medicare claims for Part B services provided by physicians and other providers, including suppliers of durable medical equipment, while fiscal intermediaries administered claims for Part A and B services provided by hospitals, other institutions, and home health agencies.

⁵Pub. L. No. 108-173, Title II, 117 Stat. 2066, 2167 (2003).

⁶The FAR establishes uniform policies for acquisition of supplies and services by executive agencies. 48 C.F.R. ch. 1.

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- recompetes the contracts at least once every 5 years.⁷

CMS implemented the MMA contracting reform requirements by shifting claims administration tasks from 51 legacy contracts to new entities called Medicare Administrative Contractors (MACs). Originally, CMS selected 15 MACs to process both Part A and B Medicare claims (known as A/B MACs) and 4 MACs to process durable medical equipment (DME) claims (known as DME MACs). CMS also selected 4 A/B MACs to process claims for home health care and hospice services. CMS began awarding the MAC contracts in 2006; however, bid protests and consolidation of some of the MAC jurisdictions delayed some of the MACs from being fully operational. By 2009, most of the legacy contracts had been transitioned to MACs and by December 2013, CMS completed that transition.

Under the FAR, agencies may generally select from two broad categories of contract types: fixed-price and cost-reimbursement. When implementing contractor reform, CMS chose to structure the MAC contracts as cost-plus-award-fee contracts, a type of cost-reimbursement contract. This type of contract allows CMS to provide a financial incentive—known as an award fee—to contractors if they achieve certain performance goals. In addition to reimbursement for allowable costs and a contract base fee (which is fixed at the inception of the contract), a MAC can earn the award fee, which is intended to incentivize superior performance. In 2010, we reviewed three MACs that had undergone award fee plan reviews and found that all three received a portion of the award fee for which they were eligible, but none of the three received the full award fee.⁸

In the new contracting environment, MACs are responsible for a variety of claims administration functions, most of which were previously performed by the legacy contractors. MACs are responsible for processing and paying claims, handling the first level of appeal (often referred to as redeterminations of denied claims), and conducting medical review of

⁷The MMA required that CMS provide for the application of competitive procedures at least every 5 years but also stipulated that contracts could be renewed from term to term without the application of competitive procedures if the contractors met or exceeded performance requirements.

⁸See GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, [GAO-10-71](#) (Washington, D.C.: March 25, 2010).

claims—which is done before or after payment to ensure that the payment is made only for services that meet all Medicare requirements for coverage, coding, and medical necessity.⁹ In addition, the MACs serve as providers' primary contact with Medicare, including enrolling providers, conducting outreach and education, responding to inquiries, and auditing provider cost reports.

CMS is moving toward further consolidation of MAC contracts in hopes that consolidation will further improve CMS's procurement and administration processes. Since the original implementation, CMS chose to consolidate the 15 A/B MACs into 10 jurisdictions and is in the process of that consolidation. Currently, there are 5 consolidated A/B MACs that are fully operational, 7 A/B MACs that will eventually be consolidated into 5 jurisdictions, and 4 DME MACs that are fully operational.

While CMS has relied on contractors to conduct claims administration functions since Medicare's inception and has worked to consolidate these contracts, the agency has been granted additional statutory authority in recent years to award new types of contracts to conduct specialized tasks within the Medicare program. From 1965 to 1996, the legacy contractors were not only responsible for paying claims but also for tasks related to program integrity, such as working with law enforcement on cases of suspected fraud. However, the Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, authorizing CMS to award separate contracts for program integrity activities such as investigating suspected fraud.¹⁰ These contracts are now handled by Zone Program Integrity Contractors and are generally aligned with the same jurisdictions as the MACs. In 2003, the MMA directed CMS to develop a demonstration project testing the use of contractors to conduct recovery audits in Medicare.¹¹ These contractors, known as recovery auditors, conduct data analysis and review claims that have been paid to identify improper payments. While other contractors that review claims are given a set amount of funding to conduct reviews,

⁹Medical review can also be conducted by some other types of CMS contractors. See GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*. [GAO-13-522](#) (Washington, D.C.: July 23, 2013).

¹⁰Pub. L. No. 104-191, §§ 201, 202, 110 Stat. 1936, 1992-98 (1996) (codified at 42 U.S.C. §§ 1395j(k)(4), 1395ddd).

¹¹Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57 (2003).

recovery auditors are paid contingency fees on claims they have identified as improper. To increase efforts to identify and recoup improper payments, Congress passed the Tax Relief and Health Care Act of 2006, which, among other things, required CMS to implement a permanent and national recovery audit contractor program.¹²

Private Plans Administer Benefits for Beneficiaries Enrolled in Medicare Advantage, But CMS has an Important Administrative and Oversight Role

Unlike Medicare FFS, in which contractors process and pay claims, in Medicare Part C, CMS contracts with private organizations, known as Medicare Advantage organizations (MAOs), to offer MA health plans and provide covered health care services to enrolled beneficiaries. CMS pays MAOs a pre-determined, fixed monthly payment for each Medicare beneficiary enrolled in one of the MAO's health plans. MA plans must provide coverage for all services covered under Medicare FFS, except hospice care, and may also provide additional coverage not available under Medicare FFS.¹³ MA plans, with some exceptions, must generally allow all Medicare beneficiaries who reside within the service area in which the plan is offered to enroll in the plan.¹⁴ In addition, MA plans must meet all federal requirements for participation, including maintaining and monitoring a network of appropriate providers under contract; having benefit cost-sharing amounts that are actuarially equivalent to or lower than Medicare FFS cost-sharing amounts; and developing marketing materials that are consistent with federal guidelines.

Medicare beneficiaries can generally elect to enroll in an MA plan if one is offered in their community.¹⁵ As of February 1, 2014, approximately

¹²Pub. L. No. 109-432, §302, 120 Stat. 2922, 2991-92 (2006) (codified at 42 U.S.C. § 1395ddd(h)).

¹³Most MA plans also provide prescription drug coverage.

¹⁴Exceptions include special needs plans (SNP) and employer group plans. SNPs offer benefit packages tailored to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions. Employer group plans can be offered to employers' or unions' Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans.

¹⁵Medicare beneficiaries with end-stage renal disease (ESRD) may only enroll in an MA plan if they meet certain criteria. For example, beneficiaries with ESRD may enroll in an MA plan if (1) they were already enrolled in the MA plan when they developed ESRD; (2) they are eligible for a plan offered by their current or former employer or union that has opted to enroll beneficiaries with ESRD; or (3) they had a successful kidney transplant.

15.3 million beneficiaries—nearly thirty percent of all Medicare beneficiaries—were enrolled in MA plans—an all-time high. Those plans were offered through 571 contracts between MAOs and CMS.¹⁶

Substantial changes in the law regarding contract requirements and other parameters of the program—including payment rates—have contributed to fluctuations in the number of contracts and enrolled beneficiaries over the years. Under authority provided by the Social Security Amendments of 1972, CMS first began contracting with private plans to provide care to enrolled beneficiaries in 1973.¹⁷ The law required plans to provide benefits covered under Medicare FFS and to meet certain other standards. Plans were generally paid on the basis of their costs during these early years of contracting. By 1979, the government had 33 contracts with organizations offering private plans.

A decade after the Social Security Amendments of 1972, the Tax Equity and Fiscal Responsibility Act of 1982 authorized the first full-risk plans that were paid a fixed monthly amount per beneficiary that was set at 95 percent of the expected spending for beneficiaries in Medicare FFS.¹⁸ The payment for each beneficiary was adjusted by demographic and other factors. The accuracy of this adjustment was criticized by us and other researchers. The demographic payment adjusters resulted in excess payments to those plans that enrolled healthier beneficiaries with below-average health care costs. This, in part, encouraged continued growth in Medicare private plans and by May 1, 1997, 4.6 million beneficiaries—nearly 12 percent of all Medicare beneficiaries—were enrolled in private plans under 280 contracts. At the same time, concerns were raised that basing plan payment rates on local Medicare FFS spending—the methodology used to geographically adjust payment rates—resulted in no or low plan participation in some areas, particularly rural areas.

¹⁶An MAO may have multiple contracts—for example, covering different geographic areas or offering different types of plans—and each contract may include multiple health plan benefit packages.

¹⁷Pub. L. No. 92-603, § 226, 86 Stat. 1329, 1396 (1972).

¹⁸Pub. L. No. 97-248, § 114, 96 Stat. 324, 341 (1982).

The Balanced Budget Act of 1997 (BBA) formally established private plans as Part C of Medicare and introduced additional changes to the program.¹⁹ These changes to the program included new types of plans that could be offered,²⁰ the standards applied to the contracts, beneficiary enrollment rules, and payment rules. In an effort to refine the payment methodology, the BBA required CMS to use health status measures to adjust payments to plans,²¹ added a payment methodology establishing a minimum amount or floor rate, and limited rate updates in higher payment counties that, with other refinements, resulted in reducing some of the payment differences between high and low spending areas. Following these changes, and coincidental with broad-based dissatisfaction with managed care practices more generally, organizations offering Medicare private plans reversed what had been a rapid expansion in the mid-1990s and began a period of plan withdrawals and declining beneficiary enrollment in plans. For example, from 1999 through 2003, the number of Medicare contracts with private plans fell from 309 to 154. During the same period, private plan enrollment fell from about 6.3 million to 4.6 million beneficiaries. Subsequent legislation providing new methods of adjusting payments to account for health status, among other things, did little to entice them back into the program.²²

Private plan participation in Medicare began to rebound after passage of the MMA. The law made the program more attractive to plans by establishing minimum payments of 100 percent of Medicare FFS spending and pegging the minimum increase to the Medicare national per capita growth rate, providing substantial annual increases over those authorized under the BBA. As of December 2009, enrollment had grown to about 10.9 million beneficiaries.

¹⁹See Pub. L. No. 105-33, § 4001, 111 Stat. 251, 274 (1997).

²⁰For example, CMS was authorized to contract with Preferred Provider Organizations (PPO). Beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services.

²¹The BBA uses the term “risk adjustment factors.”

²²See the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, Title V, §§ 501 et seq., 113 Stat. 1501, 1501A-378 (1999) and the Medicare, Medicaid and SCHIP Improvement Act of 2000, Pub. L. No. 106-554, App. F, Title VI, Subtitle A, §§ 601 et seq., 114 Stat. 2763, 2763A-554 (2000).

The Patient Protection and Affordable Care Act (PPACA) included several changes to the MA program, such as bringing payments to plans closer to Medicare FFS, and rewarding plans for quality.²³ Since March 2010, enrollment in MA plans has grown from 11.0 million to 15.3 million—an increase of about 39 percent. While contract requirements for MAOs and parameters of the program are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with these requirements. The agency’s responsibilities include, among other things, making monthly payments to MA plans, implementing health status adjustments to the payments, establishing processes for enrolling and disenrolling beneficiaries, reviewing marketing materials, providing for independent review of coverage appeals, conducting audits, and enforcing compliance. The audits typically involve a combination of desk reviews of documents submitted by MA plans, and at CMS’s discretion, site visits. To ensure compliance, CMS may take a variety of enforcement actions, ranging from informal contacts offering technical assistance to civil money penalties or plan suspension for egregious or sustained noncompliance.

Private Plans Also Administer Prescription Drug Coverage Under Part D

Whereas MA offers beneficiaries an alternative way to access their Part A and B benefits, Part D is structured to provide benefits only through private organizations under contract to Medicare.²⁴ Under the Part D program, which began providing benefits on January 1, 2006, CMS contracts with private organizations called plan sponsors.²⁵ Part D plan sponsors offer outpatient prescription drug coverage either through stand-alone prescription drug plans for those in original FFS Medicare, or through MA prescription drug plans for beneficiaries enrolled in MA. Through the Part D contracts, plan sponsors offer prescription drug plans

²³See Pub. L. No. 111-148, Title III, Part III, Subtitle C, §§ 3201 et seq., 124 Stat. 119, 442 (2010). For purposes of this testimony, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (2010).

²⁴In some cases beneficiaries can enroll in a prescription drug plan that is offered by an employer or union. Those plans also contract with CMS.

²⁵Plan sponsors include health insurance companies and pharmacy benefit managers. Although pharmacy benefit managers typically manage prescription drug benefits for third-party payers, some pharmacy benefit managers have contracted directly with Medicare to offer Part D plans.

which may have different beneficiary cost-sharing arrangements (such as copayments and deductibles) and charge different monthly premiums.

Medicare pays plan sponsors a monthly amount per enrollee independent of each enrollee's drug use, therefore creating an incentive for the plan sponsor to manage spending. Payments to prescription drug plan sponsors are adjusted according to the risk factors—including diagnoses and demographic factors—of beneficiaries enrolled in a sponsor's plans. However, sponsors still have an incentive to control spending to ensure it remains below the adjusted monthly payments received from CMS and payments received from enrolled beneficiaries. Sponsors can lower drug spending by applying various utilization management restrictions to drugs on their formularies.²⁶ The Part D program also relies on sponsors to generate prescription drug savings, in part, through their ability to negotiate price concessions, such as rebates and discounts, with entities such as drug manufacturers, pharmacy benefit managers, and pharmacies.

The MMA required that plan sponsors offer beneficiaries a standard benefit plan, with specified deductible and coinsurance amounts, or a plan with benefits that are actuarially equivalent to the standard plan. Actuarially equivalent plans have the same average benefit value as the standard benefit plan but a different benefit structure. If a sponsor offers the standard benefit or an actuarially equivalent plan, it may also offer an enhanced plan with a higher average benefit level in the same area. For instance, an enhanced plan may offer lower cost sharing, an expanded formulary, or coverage in the coverage gap.²⁷ According to the Medicare Payment Advisory Commission, about 94 percent of enrollees in stand-

²⁶A formulary is a list of the prescription drugs that a plan covers and the terms under which they are covered.

²⁷Prior to 2011, enrollees exceeding an initial coverage limit were responsible for paying the full cost of covered drugs until they reached an out-of-pocket maximum. Beginning in 2011, PPACA established the Medicare Coverage Gap Discount Program to assist beneficiaries who do not receive Part D's low-income subsidy with their drug costs when they reach the coverage gap. See GAO, *Medicare Part D Coverage Gap: Discount Program Effects and Brand-Name Price Trends*, [GAO-12-914](#) (Washington, D.C.: Sept. 28, 2012).

alone prescription drug plans in 2012 were enrolled in actuarially equivalent or enhanced benefit plans.²⁸

While CMS contracts with plan sponsors to offer the Part D benefit, the agency has an oversight role. As with MA, CMS is responsible for ensuring that the payments it makes to plan sponsors are accurate. Given that final payments to plan sponsors are based, in part, on the price concessions that plan sponsors have negotiated, CMS is responsible for ensuring that data plan sponsors submit on price concessions are accurate.²⁹ CMS also ensures that plan sponsors submit accurate information to the Medicare Plan Finder interactive website,³⁰ which helps beneficiaries compare different plans and identify the plan that best meets their needs.³¹ CMS oversees the complaints and grievances processes and may rely on complaints and grievances data to undertake compliance actions against specific plan sponsors.³² CMS also oversees Part D sponsors' fraud and abuse programs, which include compliance plans that must include measures to detect, correct, and prevent fraud, waste, and abuse.³³

Medicare spending on the Part D program has been lower than originally anticipated. Medicare's actuaries have attributed lower-than-projected expenditures to a combination of factors, including lower-than-projected Part D enrollment, slower growth of drug prices in recent years, greater

²⁸Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, (Washington, D.C.: March 2013).

²⁹See GAO, Medicare Part D Prescription Drug Coverage: Federal Oversight of Reported Price Concessions Data, [GAO-08-1074R](#), (Washington, D.C.: Sept. 30, 2008).

³⁰See www.medicare.gov/find-a-plan.

³¹See GAO, *Medicare Part D: CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability*, [GAO-14-143](#), (Washington, D.C.: Jan. 10, 2014).

³²If beneficiaries are not satisfied with certain aspects of the Part D program, they may file a complaint with CMS, a grievance with their plan sponsor, or both. See GAO, *Medicare Part D: Complaint Rates Are Declining, but Operational and Oversight Challenges Remain*, [GAO-08-719](#), (Washington, D.C.: June 27, 2008).

³³42 C.F.R. § 423.504(b)(4)(vi) (2013). See GAO, *Medicare Part D: CMS Conducted Fraud and Abuse Compliance Plan Audits, but All Audit Findings Are Not Yet Available*, [GAO-11-269R](#), (Washington, D.C.: Feb. 18, 2011).

use of generic drugs, and higher-than-expected rebates from pharmaceutical manufacturers to the prescription drug plans.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, this completes our prepared statement. We would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

If you have any questions about matters discussed in this testimony, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other key contributors to this report include Lori Achman, Sheila K. Avruch, George Bogart, Christine Brudevold, Christine Davis, Christie Enders, and Gregory Giusto.

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