



Getting The Runaround:

Problems with Obtaining Accurate Information from Part D Plans

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Medicare Rights Center (MRC) is the nation's largest independent source of Medicare information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get high-quality, affordable health care.

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INTRODUCTION

“Given the newness and complexity of the Part D benefit, it is critical that beneficiaries and their advisers, including members of their families, understand the available options so that beneficiaries can make informed decisions on whether to enroll in Part D, and if so, which drug plan to choose.” General Accounting Office (GAO) Report – GAO-06-654 (May 2006), p. 1

The Medicare Part D prescription drug benefit is now past its 9th month, and the next Annual Enrollment Period (AEP) – starting November 15th, 2006 – is fast approaching. As people with Medicare currently enrolled in a private Part D plan are navigating the drug benefit, with varying degrees of success, the federal Medicare agency (the Centers for Medicare and Medicaid Services (CMS)), private Part D plans, and consumer advocates are gearing up for the AEP, the one time during the year when most Medicare beneficiaries can make a choice about their prescription drug coverage for the following year.

One of the key lessons learned during the Part D start-up period at the end of 2005 and beginning of 2006 is that people with Medicare rely heavily on the information provided by Part D plans both to make enrollment decisions and to access the benefit once enrolled. The timeliness and accuracy of information provided through plan call centers, promotional material and marketing agents is crucial for making informed decisions and fully accessing the Part D benefit.

Regulatory oversight by CMS has failed to set adequate standards for the accuracy of information provided by plan call centers,

while the Medicare program itself has fallen short of providing people with Medicare with the Part D information they need. Similarly, adequate government oversight and policing of plan marketing activities and their representatives has been lacking.

This brief discusses CMS' regulation of Part D plan marketing activities, focusing on the activity of plan call centers and the customer service representatives (CSRs) that staff them. The authors of this brief recommend that, before the next enrollment period, CMS ensure that plan call centers are able to answer several basic – but crucial – questions about the Part D benefit, including how specific plans work, what they cover and what costs are borne by plan members. The coming Annual Enrollment Period will provide most people with Medicare their one chance to change plans for the year. CMS must act to ensure that Part D plans are providing timely and accurate information for these important enrollment decisions.

Consumer Information From Part D Plans

The Medicare Part D drug benefit is widely acknowledged as being bewildering to people with Medicare, in part due to the design of the benefit (especially the

coverage gap or “doughnut hole”), the variation in coverage and rules between the plans, and the sheer number of plans available through a wide range of companies. As noted by the General Accounting Office, “[w]idespread confusion among beneficiaries about the costs and coverage under the new benefit has been reported by the media and others.”¹

Given this landscape of confusion, it is important to realize how few people with Medicare used the plan comparison tools developed by Medicare or obtained advice from a trained counselor, relying instead on information from the plans themselves. According to a report by the Medicare Payment Advisory Committee (MedPAC) that included an analysis of how people obtained information about Part D coverage, “[i]n general, few focus group participants said they had used web-based tools or counselors to help them make decisions. They were more likely to mention company plan descriptions they received in the mail, phone calls to plans, and conversations with plan representatives at special events.”²

MedPAC’s research highlights the essential consumer information and education role played by plan customer service representatives and plan marketing efforts. This role extends not only to informing people with Medicare about the availability of Part D plans, but also to a host of other areas, including obtaining coverage of medications.

As MedPAC researchers discovered, however, this reliance on information provided by plans was problematic. For example, many focus group participants reported difficulty finding out whether their medications were covered when calling individual plan customer service centers.³ As discussed below, a report by the General Accounting Office found that 10 of the largest Part D plan’s call centers were only able to give accurate and complete responses to crucial questions concerning comparison of Part D plans about one-third of the time.⁴

Even after negotiating the enrollment process, more than one-third of Part D enrollees reported running into trouble obtaining coverage of one or more of their medications.⁵ Given the prevalence of these coverage obstacles, it is crucial that plan customer service representatives provide timely and accurate information, since they serve as the gateway to accessing medications under the Part D benefit.

An earlier issue brief by CHA and MRC, released in February 2006 during Part D’s inaugural enrollment period, discussed the failure of Part D plans to provide critical information to prospective (and current)

Example: Mrs. T

Mrs. T, in an attempt to fill a needed prescription for her husband, an individual with Multiple Sclerosis who is enrolled in a Part D plan, for over four months tried to resolve a billing error related to incorrect computer data which resulted in \$1,500 charge. Mr. T. went without his medication for three weeks while trying to correct the mistake. Although they have filed a grievance, they have been forced to pay out \$3,800 and still the plan “ignored her requests” for assistance. Mrs. T. counted at least 40 different calls to various drug plan and Medicare representatives in an effort to resolve the problem, before reaching her local Health Insurance Counseling and Advocacy Program (HICAP) office for individualized help.

enrollees.⁶ In this brief, we argued that Part D plans were not following even minimal CMS guidelines regarding making information available, and we highlighted the difficulty people with Medicare faced finding out about utilization management, transition policies and exceptions and appeals processes. While CMS has made some incremental improvements in its requirements of plans,⁷ we still believe that current requirements are inadequate, and that CMS must force plans to provide a greater level of transparency and easier access to critical information to allow prospective and current enrollees to make meaningful, informed decisions about plan enrollment and coverage options.

CMS Oversight Of Plan Marketing

Unlike Medicare benefits covered under Parts A and B of Medicare, which people with Medicare can choose to access either through the original, fee-for-service program or a Medicare Advantage program (most commonly a managed care plan), a person with Medicare can only access Part D prescription drug coverage by purchasing a Part D insurance product. Even if the person with Medicare does not interact with a Part D plan during the enrollment process (because enrollment was automatic or performed with the help of Medicare or others providing assistance), a Part D enrollee must deal with his/her plan when trying to access Medicare covered benefits.

Medicare treats almost all information that Part D plans provide to people with Medicare under the broad rubric of “marketing.” CMS marketing rules govern plan written materials, plan call centers, and the conduct of agents or others who market and sell Part D coverage.⁸ Medicare rules define “marketing materials” broadly to include not only promotional material, but also the information that “explain[s] the benefits of enrollment in a Part D plan, or rules that apply to enrollees” and “how Medicare services are covered under a Part D plan, including conditions that apply to such coverage.”⁹

Examples of marketing materials include “membership communication materials” and “membership or claims processing activities.”¹⁰

CMS regulations require Part D plans to disclose specified plan information to both prospective and current enrollees.¹¹ For example, a current plan enrollee is entitled to a “plan description” that includes information about the plan’s formulary, including “the manner in which the formulary (including any tiered formulary structure and utilization management procedures used) functions”.¹² Different, less strict requirements seem to apply for requests made by “a Part D eligible individual” who has a right to “general coverage information” including the plan’s formulary, and “the procedures the Part D sponsor uses to control utilization of services and expenditures”.¹³

CMS offers more detailed sub-regulatory rules that apply to information provided by Part D plans in its Marketing Guidelines.¹⁴ Much of the document is devoted to the content, format and distribution of written Part D plan materials and CMS review procedures of those materials (some material is self-certified by plans under “file and

use” procedures; prior CMS approval of plan materials is not required). Curiously, a relatively small portion of the marketing guidelines relate to information that Part D plan call centers must provide to prospective and current Part D enrollees seeking information about how the plan works.¹⁵ Although these plan call centers are often the most important point of contact a person with Medicare has with his/her Part D plan, they are the among the least regulated aspect of Part D, and, as discussed below, one of the worst performing.

Plan Call Centers

Part D plans rely on their toll-free call centers to provide a range of services for prospective and current members. This includes providing information about how the plan works, what drugs plan covers and how much they cost, and how to troubleshoot problems, including filing exceptions or coverage determination requests.

Despite the importance of call centers in communicating to people with Medicare, the General Accounting Office (GAO) notes that CMS does not have requirements regarding the specific types of information plan CSRs

must be able to provide.¹⁶ Although CMS provides highly specific content requirements for written materials, like benefit summaries, it does not mandate the same level of specificity for call center scripts (the information that call center CSRs refer to when someone calls the plan). CMS’ Marketing Guidelines outline a list of inquiry topics to which plan CSRs must be able to respond, including “benefits”, “formulary”, “formulary transition process”, “How to access the grievance, coverage determination (including exceptions) and appeals process”, “benefit coverage” and “claim payment.”¹⁷ Inbound telephone scripts are “considered marketing materials” and CMS instructs plans to “develop scripts to respond to existing and prospective enrollees for [certain] situations” and to submit those scripts to CMS for “review and approval.”¹⁸ The lack of specificity as to the type of information call centers must provide means callers are not guaranteed access to crucial information from their current or prospective plan.

Basic training of call center employees is also crucial. Plan CSRs must know enough about Medicare and the Part D benefit to access situation-appropriate scripts.¹⁹

Example: Mrs. G

Mrs. G. is a 74 year old woman who tried repeatedly to obtain a “workable knowledge” of her Medicare Advantage prescription drug plan. She called both the plan and several pharmacists repeatedly over several weeks but they were “unable to explain” what expenses will apply toward her out-of-pocket costs. Mrs. G. wanted to find out if it would be best for her to use an online pharmacy, but when she called the plan, the representative would not provide her with any information about the costs of her prescriptions or guidance on using a pharmacy outside of her plan network. Once she contacted the her local Health Insurance Counseling and Advocacy Program (HICAP) office, she realized that any expenses outside of her plan pharmacy would not count as true out-of-pocket costs during the plan’s gap in coverage.

Example: Mr. L

Mr. L. contacted his Part D plan’s customer service representatives about their denial of coverage for an early refill request for heart medication. He was scheduled for a vacation and because he would be away from his local pharmacy and physician, he wanted to have his medication with him. Mr. L consulted with his pharmacist who indicated that even though he was paying the full price for the medication, the plan was refusing to allow for a ‘vacation override’ and approve his request. During a phone conversation, Mr. L. was assured that his request would be approved and “to allow “24 to 48 hours for the approval to go through to the pharmacist”, but on checking with his pharmacist - the approval never went through. Mr. L. lodged a complaint with the plan and specifically cited “management lacking management skills, understanding, nor recognition of customer problems, or the ability to appropriately resolve problems.” Mr. L.’s request was eventually approved, but not until considerable time and effort were spent by Mr. L. in trying to use the processes provided by the plan’s written coverage guidelines.

Although CMS may loosely define what types of information call centers must provide, CMS does not have performance standards governing the accuracy of Part D call centers, as it does for 1-800-MEDICARE customer service representatives.²⁰

Lack of appropriate oversight and regulation of Part D plan call centers has resulted in poor performance during the first year of Medicare Part D. These shortcomings have been documented in a June 2006 General Accounting Office (GAO) report that analyzed plan call center responsiveness.²¹ In this report, GAO surveyed CSRs at 10 of the largest PDP sponsors by asking 5 questions (“among the most critical questions regarding PDP comparison” including coverage, cost and utilization management for drugs).²² The GAO obtained accurate and complete responses to only about 1/3 of their calls, and found that the overall accuracy and completeness rates for the 10 PDP sponsor call centers varied widely, ranging from 20 to 60 percent.²³ In a separate survey of 8 of the 10 low-income benchmark Part D plans’ call centers in California, the National Senior Citizens Law Center (NSCLC) assessed the accuracy of plan CSRs with respect to key questions about exercising the plans’ exceptions processes, and found that plan representatives accurately answered questions 36 percent of the time and gave an inaccurate answer, incomplete answer, provided no answer or refused to answer 64 percent of the time.²⁴ These findings by the GAO and NSCLC are mirrored by the experiences of advocates trying to assist people with Medicare.

Recommendations

The privatized structure of the new drug benefit makes plan call centers a crucial communication tool for Part D coverage, but both independent surveys and anecdotal reports from counselors show serious lapses in the ability of Part D plans to provide accurate and timely information and to successfully guide people with Medicare seeking to access the benefit. CMS guidance for plan call centers lacks the necessary specificity and

Example: Mrs. B

Mrs. B., enrolled in a Medicare HMO and residing in a convalescent hospital, newly became eligible for Medi-Cal (Medicaid). Mrs. B’s son, with Power of Attorney, submitted a written disenrollment request to the Medicare HMO, citing her dual eligibility and residence in a long-term care institution, both of which entitle her to a Special Enrollment Period (SEP) to get out of her plan outside of regular enrollment periods. After the Medicare HMO sent him a written denial, Mr. B and the local HICAP manager called the HMO customer service center together but were told by a CSR that Mrs. B. had no SEP rights, even though it was explained that she is a dual eligible residing in a convalescent hospital (the CSR admitted that, in general, SEP rights existed, but she could not articulate any).

the agency has failed to provide adequate oversight of the quality of service. CMS should provide greater oversight of Part D plans by strengthening basic standards that plans must follow and ensuring that they are being met. Broadly, we believe that CMS should do the following:

- √ Create and enforce performance standards for Part D plan call centers;
- √ Monitor and set guidelines regarding plan CSR formalized training;
- √ Provide oversight of call centers;
- √ Ensure that prospective members are able to access the same information as current members (via the internet, phone, and mailing upon request).

CMS must also ensure that the training and scripts provided to call center operators allow them to properly explain enrollment options (including eligibility for a special enrollment period), benefit structure, formulary coverage, cost of medications the individual is taking, and the exceptions and appeals process. Call center operators must be able to provide answers that are specific to the plans provided and to the individual calling.

Part D plans must be able to provide information about the following:

Enrollment

Enrollment decisions can have serious, often unforeseen consequences, for people with Medicare. For example, enrollment in a Part D plan can cause the loss of existing coverage provided by a former employer, or the loss of coverage from a Medicare Advantage plan. Enrollment in a Medicare Advantage plan changes how people obtain coverage under Medicare since plan networks may bar access to long time family doctors. People with Medicare are locked in to their plan choice for the calendar year with the exception of individuals who qualify for a special enrollment period. Call center operators need to be knowledgeable enough to guide people through the enrollment process. For example,

CSRs should ask prospective enrollees the following questions:

- √ Do you currently have coverage from a former employer or union?
- √ Do you currently have other drug coverage or medical coverage from an HMO or other Medicare private health plan?

Medicare Advantage plan representatives speaking to prospective enrollees must also fully explain any network restrictions and that enrollment in the plan will change the way they receive their medical

coverage. Prospective enrollees should also be asked if they currently have supplemental coverage or coverage through Medicaid.

People with Medicare should not have to utter special code words like “special enrollment period” to obtain their rights under Part D. CSRs should also be able to determine if a prospective enrollee outside the open enrollment window may qualify for a special enrollment period by the answers to basic questions. For example,

- √ Did you recently receive a notice that you are eligible for Extra Help with Part D?
- √ Have you recently lost, or decided to drop, drug coverage from your former employer?
- √ Do you also have Medicaid?
- √ Do you receive help paying your Part B premium?

How the benefit works

Counselors at the Medicare Rights Center and California’s Health Insurance Counseling and Advocacy Program (HICAP) that work with California Health Advocates received many complaints from people with Medicare who were surprised that their Part D plan had a gap in coverage. Many also had difficulty understanding when they would reach the initial coverage limit and when they would reach the end of the coverage gap. Plan promotional material typically failed to mention the coverage gap, and plan call centers often provided misinformation on how the stages in the Part D benefit were calculated. Call center operators often described the standard Part D benefit outlined in the law, instead the actual plan the person is thinking about enrolling in. These failures need to be rectified so that people with Medicare can decide if it is worthwhile to pay extra for a plan without a coverage gap or prepare for the onset of the coverage gap. Part D call centers and promotional material should meet the following standards.

- √ Explain whether the plan has a coverage gap (doughnut hole) and how it affects their prescription drug coverage.
 - △ Plan call centers must disclose and adequately explain information about any applicable coverage gap when discussing a specific plan’s benefits
 - It must be clear that what the individual pays and the plan pays for prescriptions both count toward reaching the coverage gap, and at what dollar amount the coverage gap starts in that particular plan.
 - It must also be clear that it is only the individual’s out-of-pocket payments for covered drugs (not including premiums) that count towards reaching catastrophic coverage.

- It must be clear when drugs obtained outside the plan’s network or coverage area do not count towards their out of pocket expenses.

△ While documents such as an Evidence of Coverage tend to be more complete and include such information, people generally do not get those documents until they have enrolled in the plan. Brochures that are more frequently relied upon by people with Medicare are less clear about the coverage gap and do not adequately explain it (as discussed in current media reports, people are still surprised by the Part D coverage gap).

√ If a person has Extra Help (the Low-Income Subsidy for Part D)

△ The plan should be required to inform individuals with Extra Help that they will have no deductible, no coverage gap, and that their catastrophic coverage will begin when both they and the plan together have paid \$5,100 (\$5,451 in 2007) for their drugs.

△ They should not be told in their Evidence of Coverage notices that they are reaching the coverage gap. It should still say, however, how much money they have spent out-of-pocket, and how much money Extra Help and the plan have paid on their behalf.

△ Plans must be able to advise people with Extra Help about what their appropriate cost-sharing is under the Extra Help program (before and during catastrophic coverage, based on the individual’s level of Extra Help), and update plan records if necessary.

√ Companies should not use the basic Part D outline of the “standard benefit” (e.g. \$250 deductible, 25% cost-sharing until \$2,250, etc.) to explain how the benefit works unless their plan actually looks like that. If a company has one plan that does not follow the basic outline set forth by the 2003 MMA and one that does not, they must be clear on this point and explain how the alternative plan works.

Formulary information

Many people with Medicare enrolled in Part D plans thinking their drugs were covered only to discover that utilization management tools restricted or prevented access. Plan call centers should provide ready access to this information at a level of detail sufficient to make an informed decision. No limitations on formulary information should be imposed on callers not yet enrolled in the plan.

△ Plans should be required to provide specific information on utilization management tools that apply to each of their covered drugs,

including the correct terminology for such tools. Information on such restrictions should be volunteered to any caller seeking information on coverage of a particular drug. Plan CSRs should be able to explain specific limitations

- if a drug is subject to step therapy, CSR should be able to explain which drugs an enrollee must try first;
- if a plan puts “quantity limit” next to a drug in their publicized formulary, it should indicate the exact quantity;
- if a drug is subject to prior authorization, CSRs should be able to explain the criteria for coverage or direct callers to the appropriate source of information.

- Δ Plan CSRs should be required to confirm and explain plan coverage for as many medications as a prospective enrollee/caller takes (advocates found that many CSRs are imposing limits on the number of drugs they would look up for some callers).
- Δ Plan CSRs must be clear that the decision to grant an exception to a formulary exclusion is up to the plan. (Some CSRs describe the exceptions procedure as “getting a note from your doctor.”)
- Δ Plan CSRs must be able to explain transition policies as well as “grandfathering” and notice rights for mid-year formulary changes.
- Δ Plan CSRs should be able to tell enrollees whether the plan will continue to cover medications they are currently getting under an exception request in the following calendar year. That information is essential in deciding whether a person should stay in the plan.

Part D plan call center operations should be strengthened in the following areas:

Language Access

- √ Plan call centers must expand internal capacity to accommodate non- and limited-English speakers:
 - Δ Less use of outside translation services, often staffed by individuals who have no Medicare background.
 - Δ Require linguistic and cultural competency training for CSRs.
 - Δ If outside services are used, require plan CSRs to remain on the line in order to provide requested information (advocates find that plans often disconnect when transferring to outside services).
- √ Requirements for providing marketing materials in other languages should be strengthened – lower “threshold” of 10% of a population in a plan service area to 5%, as is the standard under certain state Medicaid programs²⁵

Subject Matter Experts

Plans should have designated call center staff that are subject matter experts and are able to troubleshoot/specialize in certain issues/problems, instead of relying on under-trained CSRs to handle all problems. For example, Part D call centers should have:

- √ Enrollment/disenrollment experts— advocates find that many plans plead ignorance about and/or refer to CMS issues/questions relating to exercising Special Enrollment Period (SEP) rights, which according to CMS rules plans are supposed to administer;²⁶
- √ Premium/cost-sharing experts – to resolve issues of premium payment and cost-sharing issues, including inappropriate copays through the Extra Help program; e.g., advocates have found that when calling to update appropriate Extra Help copay amounts, most plans require them to send an SSA award letter as the only type of proof that someone has Extra Help; also, the current CMS guidance for plans to expedite adjusting copays for dual eligibles is not happening in a timely fashion -- generally 3-5 business days if it's happening at all;
- √ Exceptions and appeal experts – plans must have staff who are trained in the plan's exception and appeal processes, can provide timely and accurate information to people with Medicare, physicians and pharmacists and troubleshoot problems that arise

Government Resources Also Need Considerable Improvement

Although the structure of Medicare Part D discharges much responsibility of administering the Part D program from Medicare to private plans, many beneficiaries still seek counsel from and are directed to Medicare resources for information about Part D. The primary resources are the 1-800-MEDICARE telephone hotline and the www.medicare.gov website. Both of these resources require improvement in order to adequately serve Medicare beneficiaries who are exploring plan choices and/or trying to use their Part D coverage.

1-800-MEDICARE HOTLINE

Several reports have highlighted the deficiencies of hotline Customer Service Representative (CSRs) responses, including, most recently, with respect to providing information about Part D. According to the May 2006 General Accounting Office (GAO) report on CMS communications on Part D, customer service representatives (CSRs) at 1-800-MEDICARE provided inadequate or incorrect answers regarding Part D approximately 1/3 of the time (p. 6). This GAO report, focusing on CMS information relating to Part D, was issued almost a year and a half after another report on the accuracy of Medicare hotline responses to general Medicare questions, finding a 61% accuracy rate of questions posed by the GAO. GAO report Medicare – Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved – December 2004 (GAO-05-130)(p. 4). Experiences of advocates generally mirror the findings of the GAO with respect to the accuracy of information from 1-800-MEDICARE.

MEDICARE WEBSITE (www.medicare.gov)

The May 2006 GAO report on Medicare's communication to beneficiaries on the drug benefit also evaluates Medicare's written promotional materials and the program's Web site. In trying to measure the utility of the website to Medicare beneficiaries, the GAO performed an "evaluation of overall [website] usability – the ease of finding needed information and performing various tasks – [and] found usability scores of 47 percent for seniors and 53 percent for younger adults, out of a possible 100 percent." (GAO-06-654, p. 7) Perhaps more troubling than the usability of the Medicare website,

though, is the accuracy of the information it contains on individual Part D plans, including covered drugs, restrictions on accessing those drugs, and cost-sharing amounts. During the roll-out of Medicare Part D, many beneficiaries and advocates found that the information contained in the Plan Finder tool was different than information obtained separately through the plan. For example, drugs that are shown as covered by a particular plan on the Plan Finder turn out not to be covered when a beneficiary shows up at the plan's contracting pharmacy, or not covered in the dosage prescribed; alternatively, the correct drugs may be listed on the Plan Finder tool, but the tool might not show the correct price charged for the drug and/or doesn't give details about dosage or plans' utilization management tools. Although CMS is making improvements in monitoring the accuracy of plan information posted on their website, problems persist.

Recommendations

According to the Government Accountability Office, CMS must improve the quality and capacity of their call center, web site and written materials so that Medicare beneficiaries can better assess their options under Medicare Part D. We echo the recommendations made in this report (and the December 2004 report) concerning improving the quality of information from Medicare resources, particularly 1-800-MEDICARE. In addition, we recommend:

- √ That 1-800-MEDICARE customer service representatives (CSRs) be able to provide the information outlined in this brief in the recommendations for Part D plan call centers;
- √ CMS develop an appropriate intake and referral protocol for incoming calls that minimize referrals back to Part D plans – often CSRs send beneficiaries and advocates back to their Part D plan to resolve issues and answer questions (for example, when it is clear to the CSR that an individual has been unsuccessful in resolving an issue with his/her plan, the problem should be addressed by the Medicare CSR);
- √ CMS improve language access capacity of its 1-800-MEDICARE CSRs and the translation scope of their written materials.

Conclusion

Broadly speaking, the very structure of Part D poses particular challenges for people with Medicare who wish to research and select a Part D plan on their own. The fact that enrollment into the benefit, along with its administration, is performed solely by private companies leads to particular pitfalls facing prospective enrollees which will be compounded by an increase in the number of plans that will be available in California in 2007. This structure creates challenges for people with Medicare who are trying to select a plan as well as problems with the enrollment and disenrollment process.

In order to fix these problems, we believe that a major overhaul of the Part D program is required. Among other things, the Part D benefit should be available through the Medicare program itself, enrollment should be a government function as it is for Parts A and B, and Part

D plans and benefit packages should be standardized in order to alleviate mass confusion and complexity apparent in the myriad of problems today.

Absent a major overhaul of Part D, we assert that CMS must follow the recommendations we outline above in order to provide more timely, accurate and useable information to people with Medicare who are trying to navigate the Part D program. As we approach the next Annual Enrollment Period in November, people with Medicare and those that help them will be seeking information about how different plans work and what they cover. CMS must ensure that people with Medicare are able to make informed decisions based upon any and all information they need from both the government and the Part D plans.

FOOTNOTES

- 1 GAO-06-654, (May 2006) p. 3
- 2 MedPAC Report to Congress: Increasing the Value of Medicare (June 2006), p. 189, at http://www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf
- 3 MedPAC Report to Congress: Increasing the Value of Medicare (June 2006), p. 189, at http://www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf
- 4 General Accounting Office (GAO) Report: Medicare Part D: Prescription Drug Plan Sponsor Call Center Responses Were Prompt, but Not Consistently Accurate and Complete (June 2006) GAO-06-710
- 5 Kaiser Family Foundation, Seniors' Early Experiences with Their Medicare Drug Plans (July 2006), Chart 14, at: <http://www.kff.org/kaiserpolls/upload/7546.pdf>
- 6 California Health Advocates and Medicare Rights Center "The Knowledge Gap: Drug Plans Fail to Provide Critical Information to People With Medicare" (February 2006) at: <http://www.cahealthadvocates.org/advocacy/2006/02.html> and <http://www.medicarerights.org/CHABrief2.2.2006.pdf>, hereinafter referred to as "Issue Brief #2"
- 7 See, e.g., CMS Memo to Part D plans "Information to Assist Pharmacists in Completing Pharmacy Transactions" including requests for increased Part D call center staffing and direction (January 4, 2006); CMS Memo to Part D sponsors "Review of Important 2007 Plan Requirements" including 2007 exception and appeal website requirements (May 26, 2006), and July 2007 update to Marketing Guidelines, discussed below.
- 8 See 42 CFR §423.50(c), (f)
- 9 42 CFR §423.50(b)
- 10 42 CFR §423.50(c)(5), (7)
- 11 See, e.g., 42 CFR §423.128
- 12 42 CFR §423.128(a), (b)(4)(ii)
- 13 42 CFR §423.128(c)(1)(E)(v), (c)(2).
- 14 CMS' Medicare Marketing Guidelines for MA, MA-PDs, PDPs, and 1876 Cost Plans (2nd Revision, July 25, 2006), at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf>
- 15 See, e.g., CMS Marketing Guidelines, "Informational Inbound Telephone Scripts", p. 134.
- 16 General Accounting Office (GAO) report: Medicare Part D: Prescription Drug Plan Sponsor Call Center Responses Were Prompt, but Not Consistently Accurate and Complete (June 2006) GAO-06-710, page 3.
- 17 CMS Marketing Guidelines, pages 134-5
- 18 CMS Marketing Guidelines, page 134
- 19 See, e.g. a 2004 GAO report on 1-800-MEDICARE CSRs highlighting the problem that "[i]n general, CSRs erred because they did not understand enough about the Medicare program to access the script with information to answer the question or clearly explain the material in it." GAO Medicare – Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved (December 2004) (GAO-05-130) p. 8.
- 20 GAO Report, GAO-06-710, page 4.
- 21 GAO Report: Medicare Part D: Prescription Drug Plan Sponsor Call Center Responses Were Prompt, but Not Consistently Accurate and Complete (June 2006) GAO-06-710)
- 22 GAO Report, page 6
- 23 GAO Report, page 6
- 24 National Senior Citizens Law Center report: "Prescription Drug Plans Often Wrong: Representatives Lack Training to Inform Medicare Beneficiaries of Plan Exception Procedures" (August 2006), at: http://www.nslc.org/news/06/08/PDPsoftenwrong_0806.pdf (report found that plan CSRs offered inaccurate information 31% of the time, incomplete information 14% of the time, indicated that they did not know the answer 10% of the time and refused to answer 9% of the time, p. iii).
- 25 See Marketing Guidelines, p. 92
- 26 See, e.g., CMS' PDP Enrollment Guidance, section 20.3, at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CurrentPDPEnrollmentGuidance.pdf>