



Medicare Rights Center

Testimony of Robert M. Hayes, President
Medicare Rights Center
On
“1-800 Medicare: It’s Time for a Check-Up.”
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Good morning Chairman Kohl, Ranking Member Smith, and other distinguished members of the Committee. I thank you for your long standing commitment to the common good and the welfare of people with Medicare. The persistent failures of the Medicare consumer hotline, 1-800-Medicare, cause daily harm to the health and well being of people with Medicare. The volunteers and staff of the Medicare Rights Center confront the hardships caused by these breakdowns daily. We are grateful for your efforts to shine light on the hotline’s failures as a first step toward correcting them.

The Medicare Rights Center is a national, non-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives that are drawn from our work with people with Medicare. We provide services through six different hotlines to individuals, care givers, and professionals who need answers to Medicare questions or help securing coverage and getting the health care they need. Our hotlines go well beyond 1-800-Medicare: we offer people with Medicare accurate information and, beyond that, needed advocacy and support to help them meet their health care needs.

We also teach people with Medicare and those who care for them, such as health care providers, social workers, and family members, about Medicare benefits and rights. Our primary tool in doing this is our free and publicly available web based consumer counseling tool, Medicare Interactive available at www.medicareinteractive.org.

In recent years Medicare has become, to put it mildly, more challenging for consumers to understand and navigate, particularly since enactment in 2003 of the Medicare Prescription Drug Improvements and Modernization Act (MMA). A wild west marketplace for Medicare coverage was launched and a system rich with opportunity to exploit people with Medicare was established. Regrettably, the Centers for Medicare and Medicaid Services (CMS) has failed to provide the most basic of tools to help people with Medicare navigate that marketplace.

As you know, in addition to the expanded Medicare Advantage marketplace, consumers faced both the opportunities and challenges of a dizzyingly complex drug benefit in January 2006. At

the same time, repeated reorganizations of CMS' bureaucracy have left CMS with neither a centralized consumer education office nor a coordinated approach to consumer education. Even worse, CMS at times has mixed notions of consumer education with ideological propaganda. Consumers are poorly served by information that is colored by a preference for Medicare Advantage plans and the political imperative to paint Part D in the best light. Consumers are left, all too often, with nowhere reliable to turn.

Since 2004, reports by the U.S. Department of Health and Human Services Office of Inspector General and the U.S. Government Accountability Office have demonstrated on-going problems with long wait times and difficulty accessing accurate information about Medicare.^{1,2} A 2007 HHS OIG report even shows that over time 1-800-Medicare has gotten worse, not better. For example, in 2007, 71 percent of callers reported being satisfied with their calls to 1-800-Medicare, compared to 84 percent in 2004. In addition, in 2007 more callers reported hanging up before receiving an answer to their call than in 2004. While improvements to 1-800-Medicare have been made since these investigations were conducted, our day to day experience shows that these problems still remain and that more must be done to ensure that people with Medicare have a reliable, accurate source of information and assistance.

Callers often spend long periods waiting on hold. Once they finally reach a representative, callers can spend well over an hour while the poorly trained operator tries to find an answer to a simple question or resolve a problem. Callers are often transferred to a number of different operators and must explain the problem over each time. After all of this, callers often hang up the phone with wrong information or without any answer.

Representatives lack proper training to answer callers' questions or assist in resolving problems. The scripts from which representatives read lack meaningful information and are not written in a way that most people can understand. Representatives often provide false, misleading or inaccurate information. While callers often call with complex problems that require the representative to have technical knowledge, representatives are unable to answer even basic questions accurately. Unfortunately, we hear this problem frequently:

- One client from New York, who is a Medicare Part D Low-Income Subsidy recipient, received a letter indicating that her Extra Help coverage was going to be terminated because she no longer met the criteria for coverage. The letter indicated that she should call 1-800-Medicare if she believed she received the letter in error. When she called, the operator did not understand why she was calling. The beneficiary had to read the letter to the representative. Even after that, the representative did not understand why the beneficiary was calling. Every year hundreds of thousands of people improperly lose their deemed status for Extra Help and receive a letter like this notifying them of the problem. 1-800-Medicare representatives should be well aware of this situation and very familiar with this letter, so that they can properly advise callers on the steps to take.
- Another client from New York called 1-800-Medicare to enquire about enrolling in Medicare Part B. She is 70 years old, enrolled in Part A, and has employer sponsored

¹ U.S. Government Accountability Office, Accuracy of Responses from 1-800-Medicare Help Line Should Be Improved, GAO-05-130, December 2004.

² U.S. Department of Health and Human Services Office of Inspector General, 1-800-Medicare: Caller Satisfaction and Experiences, OEI-07-06-00530, September 2007.

insurance. The customer service representative told the client that she would not be able to enroll in Part B until the following January, that coverage would not begin until July, and that she would be subject to a late enrollment penalty. All of the information provided by the representative was wrong. After calling the Medicare Rights Center and being given accurate information, the client went to her local Social Security Office to begin the process of enrolling in Medicare Part B.

- One of the most egregious cases we have seen involved a client from New York who wanted to enroll in a prescription drug plan. She called 1-800-Medicare to request enrollment in a prescription drug plan. Instead, the representative enrolled her in a Medicare Advantage Private Fee-for-Service plan. As a result, the client incurred out of pocket expenses because her doctors did not accept the plan and she was unable to fill prescriptions because of the cost. After enlisting the assistance of the Medicare Rights Center, the client was enrolled into original Medicare with a prescription drug plan.
- Recently, one of our clients from Pennsylvania called 1-800-Medicare to determine whether a drug she takes will be covered by a Medicare prescription drug plan. The woman is 65 years old and currently has insurance through her employer. She will enroll in Medicare next year. The 1-800-Medicare representative told her that three plans in the area cover the drug. However, the representative based that answer on 2008 formularies. The representative failed to explain that formularies change and there is no assurance that a drug covered in 2008 will also be covered in 2009. In addition, the representative did not explain that the beneficiary could request an exception for a medically necessary drug, if it is not covered by the plan. Further the representative inaccurately explained the coverage gap and did not provide any information about catastrophic coverage.
- Approximately a month ago, one of our clients from New York called 1-800-Medicare and asked if Medicare would cover the cost of "Life Line" – a medical emergency alert system – and was told that if she paid for the system, Medicare would reimburse her at least 50 percent of the cost. This information was just wrong. These systems are not covered by Medicare and never have been.

Another area where 1-800-Medicare customer service representatives consistently fail to provide accurate information and assistance is when a beneficiary has been a victim of fraudulent or misleading marketing by a private "Medicare Advantage" plan. Because this problem is so widespread, CMS has assured us that all customer services representatives are well trained to handle these kinds of cases. This is not the case. In discussions with CMS last year, we were assured that every caller who has been fraudulently enrolled in a private Medicare plan will be assessed for retroactive disenrollment. The importance of this cannot be overstated, as thousands of dollars may be at stake for a client who is left with unpaid medical bills because they were enrolled fraudulently in a plan. In our experience, representatives are aware of the Exceptional Circumstances Special Enrollment Period (SEP), which allows people with Medicare to disenroll from a plan any time during the year under certain circumstances. Unfortunately, representatives appear only to understand how to help people disenroll from the plan prospectively. On most occasions, callers are not assessed for retroactive disenrollment. Even more concerning, a representative recently told one of our caseworkers that Medicare does not provide retroactive disenrollment, even for marketing fraud cases. When our caseworkers attempt to help clients request a retroactive disenrollment through the Exceptional Circumstances SEP, we are transferred from one representative to another, and often stay on the phone for more than an hour, awaiting a resolution. In the end, we are usually told the issue will be transferred to the regional office for a decision and that the client will receive a call within a week. More often

than not, our client never receives a call, and we are forced to advocate through other channels, channels not available to most people with Medicare.

The Medicare Rights Center has contacted CMS on multiple occasions explaining the problems with this process. The scripts used by 1-800-Medicare representatives for disenrollment from plans were improved and problems with prospective disenrollment have declined. But, retroactive disenrollment is still fraught with difficulties. This is particularly problematic because we have been told on a number of occasions when we call the CMS regional office that we must contact 1-800-Medicare. We can no longer circumvent 1-800-Medicare by working directly with the CMS regional office to effectuate a retroactive disenrollment.

Customer service representatives from 1-800-Medicare are also unable to assist callers when they call to determine why a Medicare Part A or Part B claim was denied. Prior to 2004, people with Medicare could call the Part A or B contractor – the private entity paid by Medicare to administer claims – and ask why a particular claim was denied. The customer service representative at the contractor could provide a reason for the denial, such as the improper code was used, and the beneficiary could take the necessary steps to resolve the problem to have the claim paid. Now, beneficiaries can no longer call the contractor, but must instead call 1-800-Medicare. However, customer service representatives at 1-800-Medicare can only tell the caller that the claim was denied and that they may file an appeal. Representatives do not have access to information that indicates why the claim was denied. If 1-800-Medicare is the only resource that beneficiaries have to resolve the problem, the operators at 1-800-Medicare must have access to this information. This was a sad step back for consumers.

Customer service representatives at 1-800-Medicare are also typically unable to address data exchange problems. Data exchange problems occur when the Centers for Medicare and Medicaid Services and some outside entity, such as a Medicare Advantage plan sponsor, must share information about a beneficiary and his or her coverage, but they do not do so properly or in a timely manner. This problem occurs in a variety of ways.

- A client from Florida joined a Medicare Advantage plan that, as part of its benefit package, paid the Medicare Part B premium on the beneficiary's behalf. However, the Part B premium continued to be deducted from his Social Security check. The client called the plan to determine why this was happening. The plan told him that the problem was on the Medicare side, that they had provided CMS with all the necessary information to stop the premium withholding from his Social Security benefits. According to the plan, CMS is supposed to approve enrollment in the plan and notify the Social Security Administration to stop deducting the premium. The plan told the client to contact 1-800-Medicare to resolve the problem. He called 1-800-Medicare three times, each time he was told that the problem would be referred and that he would receive a return call within one to two days. To date he has not received a phone call and the Medicare Part B premiums continue to be deducted from his Social Security benefits.
- Another of our clients from Indiana was enrolled in SecureHorizons, a Medicare Advantage plan with prescription drug coverage, through the end of the year. At the beginning of the next year she decided to enroll in a new plan, Today's Options. Soon after her enrollment, she realized that her doctors did not accept Today's Options. Still within the Open Enrollment period, she disenrolled from Today's Options and reenrolled in SecureHorizons. SecureHorizons told her that she was successfully reenrolled. A few

months later, she began receiving bills from her providers. She called 1-800 Medicare to find out why this was happening and was told that she was still enrolled in Today's Options. A customer service representative told her that someone would investigate the issue and call her back. She never received a call back.

Another typical data exchange problem occurs when a person with Medicare switches from one prescription drug plan to another during the Annual Coordinated Enrollment Period. The new plan does not have the beneficiary's Medicare Part D Low-Income Subsidy information; therefore, the beneficiary is charged the full co-payment for prescription drugs – a copayment that is unaffordable. When the beneficiary contacts 1-800-Medicare, the representative is able to confirm LIS enrollment, but is not able to resolve the problem because the representative is unable to update the plan's information or explain the best available evidence policy, which allows the beneficiary to provide evidence of Medicaid coverage or some other documentation that they qualify for the Low-Income Subsidy in order to receive the benefit of the subsidy. In these situations, beneficiaries contact us and we are able to help them make use of the best available evidence policy to access their medications at the LIS co-payment level immediately.

These cases highlight the types of data exchange problems that occur regularly and that 1-800-Medicare should be able to address, but cannot. This problem causes a great deal of harm to people with Medicare, because it prevents them from accessing services or results in financial hardship. To resolve these problems, people with Medicare cannot turn to 1-800-Medicare, the resource that was created to answer questions and resolve problems for people with Medicare; instead they must work with organizations like the Medicare Rights Center.

To improve the service provided by 1-800-Medicare and ensure its reliability for people with Medicare, the Centers for Medicare and Medicaid Services should increase oversight of the 1-800-Medicare contractor. CMS should re-establish an independent office focused on communication with people with Medicare that reports directly to the CMS Administrator. This office should have direct oversight over 1-800-Medicare. To ensure the quality of information provided, the office should be responsible for providing training materials and scripts for 1-800-Medicare operators. Currently, customer service representatives are not trained on Medicare policy, but rather on how to search a database for the proper script to answer the caller's question. This training model should be changed. Customer service representatives must have, at a minimum, a basic understanding of Medicare. All customer service representatives should have annual training on topics callers most frequently call about. This is how we train the volunteers and staff that answer our hotlines. This training should be reinforced with more frequent computer testing, or some other model of periodic training, to ensure continued understanding and ability to properly answer questions.

The office should also be responsible for conducting and coordinating quality control measures, including ensuring proper and on-going training of 1-800-Medicare staff. Further, a satisfaction survey should be developed and made available at the end of each call to 1-800-Medicare. This will provide information on a timely basis of the beneficiaries' experience with 1-800-Medicare.

In developing training materials and scripts, the office should seek feedback from a fully staffed and independent Medicare Ombudsman who can provide insight into systemic problems that people with Medicare experience, which will ensure that the materials truly address the needs of people with Medicare. Further, the office should vet consumer education and training materials

with community organizations that help people with Medicare. These organizations have staff members that are expert in assisting people with Medicare make coverage choices and navigate coverage issues. They have kept up with Medicare coverage rules and figured out what they mean for their clients. They are skilled in translating complex rules and regulations into “what does this mean for you” information.

To improve the retroactive disenrollment process through 1-800-Medicare, CMS must require that operators use CMS-approved scripts. In addition, 1-800-Medicare must be required to use a decision algorithm for responding to requests for both prospective and retroactive disenrollment. It is vital that 1-800-Medicare handle this process effectively, as CMS Regional Offices will no longer take requests for retroactive disenrollment from beneficiaries or their advocates.

In addition to providing better training and scripts to 1-800-Medicare customer service representatives, CMS needs to make a concerted effort to fix the data exchange systems problems. These data exchange systems are complicated and the solution is not an easy one. However, it has been three years since Medicare Part D began and five years since the Medicare Advantage program was expanded. It is time to acknowledge this problem exists and work to resolve it. Enough is enough.

The complicated systems that have been established to allow private companies compete for Medicare consumers make the operation of an effective and reliable hotline imperative. Providing such a hotline requires proper training and quality control measures that are focused on ensuring consumers get the information they need when they need it.