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Senate Special Committee on Aging  
1-800 Medicare: It's Time for a Check-Up  
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Statement for the Record  
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Center for Medicare Advocacy, Inc.

The Center for Medicare Advocacy, Inc., (the Center) submits this written statement to the Senate Special Committee on Aging for inclusion in the record of its hearing, "1-800 Medicare: It's Time for a Check-Up," held on September 11, 2008. The Center is a national non-profit, non-partisan organization that provides education, advocacy, and legal assistance to help elders and people with disabilities obtain Medicare and necessary health care. We thank the Special Committee on Aging for holding this hearing and for the opportunity to submit written comments.

Each year, the Center represents thousands of individuals in appeals of Medicare denials. The work of the Center includes responding to approximately 7000 telephone and email inquiries each year. The Medicare hot-line, 1-800-Medicare, is an important information source for the Medicare beneficiaries and their families that we assist. Advocates also contact the hotline, for example, to file complaints against private health insurance plans or to get referral information to certain Medicare contractors. Their experience is not pleasant.

Many of the complaints about 1-800-Medicare center on long wait times, especially during the annual enrollment period when Medicare beneficiaries seek information about prescription drug and other private plan options. Our clients, and we ourselves, have been placed on hold for too long while waiting for our call to be answered. Rather than discuss the problems caused by such waits, we focus our testimony instead on two other issues, the process for getting into the hotline and the information dispensed by its customer services representatives (CSRs).

The Centers for Medicare & Medicare Services (CMS) promotes 1-800-Medicare as one of its two primary sources of information for Medicare beneficiaries. The other source, [www.medicare.gov](http://www.medicare.gov),

provides information to those beneficiaries who use the Internet, but it is not a mechanism for beneficiaries to get answers to individual questions or to report complaints or concerns about their health care providers or health plans. Beneficiaries are required to call 1-800-Medicare to ask individualized questions or to report complaints.

Even when another entity is the proper source for information or an answer, the beneficiary, family member or advocate must go through 1-800-Medicare. For example, a beneficiary may need to contact one of the Medicare administrative contractors with questions about a claim or to find out whether a service is covered. Yet there is no way for a beneficiary to get to any of these organizations directly. The *Medicare & You Handbook*, which is sent to every Medicare beneficiary each year, only tells people to call 1-800-Medicare. It does not even list the contractors such as fiscal intermediaries or carriers as places to call to get help.<sup>1</sup>

If the beneficiary goes to the Medicare web site and clicks on a link to “find helpful phone numbers and websites,” once again the beneficiary will not get a direct phone number to the appropriate Medicare administrative contractor. The 1-800-Medicare phone number is given as the telephone number for each contractor. The Medicare web site may provide links to the web sites of the contractors but, when the links work (which is not always the case), the contractors’ web sites also do not include their direct access phone numbers. As a result, beneficiaries must call 1-800-Medicare to get to the entity with which they really need to speak. Not only does this cause delays for the beneficiaries, this results in additional calls to clog up the already congested 1-800- Medicare system.

Calling the hotline itself can be an ordeal. The interactive voice response (IVR) system is confusing, difficult to use, and, again, time consuming. As a beneficiary from Texas stated in an e-mail, “Talking to Medicare on (sic) telephone is a problem for us and many friends. We find it complicated, have hearing problems, and just don’t understand the options.”

The options under the IVR system are so long and varied that CMS devotes a page of the *Medicare & You Handbook* to explaining what callers should say to by-pass the system and to address their particular problem. For example, a beneficiary who is calling about a claim or billing or about appeals is told to say “claims” or “billing.” All beneficiaries are advised to just say “agent” at any time.<sup>2</sup> For people who don’t know the proper words, or who cannot figure out when to say the words, it can take up to 2 minutes to navigate the IVR before finding out how long the wait until a live person comes on the phone.

The IVR system, as all voice response systems, is particularly problematic for voice types not recognized by the system. High pitched voices, soft voices, raspy voices, accented voices often are not picked up. Again, this causes increased delays and additional frustration. As the Texas beneficiary said, people with hearing problems have difficulty hearing some of the options. And some of the options move too quickly for people with slower reflexes, slowing capacity, and less familiarity with IVR systems.

Both the IVR system and the CSRs are ill-equipped to help limited English proficient beneficiaries,

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1 Beneficiaries receive a *Handbook* that is specific to their region. The *Handbook* therefore could contain the direct phone numbers for the contractors that serve their region.

2 *Medicare & You Handbook*, page 95, <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

particularly those whose primary language is other than Spanish. Beneficiaries have to understand or speak some English to get to a live person. When they do, they often cannot make themselves clear, and LEP beneficiaries report being treated rudely by some CSRs. There is no real capability to assist someone who calls directly, causing frustration and inability to get the required information.

Beneficiaries are asked to give their Medicare number, both as part of the initial IVR and when they finally connect with a CSR. Although CMS advises beneficiaries not to disclose Social Security/Medicare numbers unnecessarily, its hotline asks all callers for their number regardless of whether the Medicare number is relevant to the call. Why should a beneficiary need to disclose her personal information if she is requesting publications or a phone number? What happens to someone who is nearing Medicare age wants a publication and does not have a Medicare number? There may be privacy concerns as well. Beneficiaries who are calling to report complaints about health plans or providers may not want to disclose their name and/or Medicare number for fear of retribution by the plan or provider. Disclosing a Medicare number is a barrier for people who do not have their Medicare card with them when they call, who do not have a Medicare number, or who do not want to disclose personal information unnecessarily.

Once a beneficiary, family member, or advocate connects with a CSR, the problems do not go away. The beneficiary often must use a magic word or words to get the information he or she needs. For example, beneficiaries who want to file complaints against their private health plan have to tell the CSR that they want their complaint to be recorded in the complaint tracking module. If they do not, they often are referred back to the health plan about which they are complaining, even if they have already gone through the plan's grievance process, and even if their complaint involves a plan's failure to comply with Medicare rules. A caller who told the CSR that she wanted to complain about her doctor was automatically given the fraud and abuse hotline, without any further discussion, even though her concern was with the quality of the care she received.

Other callers have to make several phone calls on the same question because of disconnected lines or a failure of the CSR to be able to answer their questions. Advocates report that CSRs who say they will call back after gathering more information rarely do so. If they do return a call, it is not within the time frame originally promised. When a CSR does not return a call, the beneficiary or advocate must call the hotline again and begin the inquiry with another CSR

Callers cannot be assured that the information they receive from the CSR who finally answers their call is accurate and complete. Examples of problems include:

- Beneficiaries who moved to another state were told that they could not change to a prescription drug plan in their new state until the next annual enrollment period;
- Beneficiaries who are dually eligible for Medicare and Medicaid were told that they could not change drug plans until the next annual enrollment period;
- Beneficiaries who were fraudulently enrolled in a Medicare Advantage plan were told that they had no right to disenroll;
- Beneficiaries who worked past age 65 have been told that they must wait to the next general enrollment period to enroll in Part B instead of being given information about the special enrollment period;

- Beneficiaries who want to file complaints about the hotline or other Medicare contractors have been told that there is no process for doing so.

These questions are common; their answers are simple. There is no excuse for providing incorrect information to callers who rely on the Medicare hotline.

CMS can take several steps to improve operations of 1-800-Medicare, beginning with more oversight of the contractor that operates the hotline. Additional recommendations include:

- Informing beneficiaries upfront
  - How to by-pass the IVR system;
  - How to get assistance in a wider range of languages other than English;
- Improved training and periodic testing of all CSRs;
- Development of a system to enable callers to check on the status of an inquiry when a CSR does not return a call as promised,
  - Such a system should provide for an adequate number of CSRs to answer the increased number of calls from beneficiaries who want to speak with a live individual;
- Development of a direct access line for all state health insurance assistance programs (SHIPs) and other advocacy organizations;
- Providing beneficiaries and advocates with direct access to phone numbers for other Medicare contractors
- Development of a process for the continuous review of all scripts that includes
  - A task force of SHIPs and other advocates to review scripts and training materials
  - A review of questions by callers asked to ensure that scripts reflect wording used by beneficiaries
  - A review of the accuracy of scripts in light of changes to Medicare law.

Thank you for the opportunity to provide these written comments.