United States Government Accountability Office

GAO

Report to Congressional Requesters

June 2006

MEDICARE PART D

Prescription Drug Plan Sponsor Call Center Responses Were Prompt, but Not Consistently Accurate and Complete

GAO-06-710

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-710, a report to congressional requesters

Why GAO Did This Study

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit, known as Medicare Part D. Private sponsors have contracted with the Centers for Medicare & Medicaid Services (CMS) to provide this benefit and are offering over 1,400 stand-alone prescription drug plans (PDP). Depending on where they live, beneficiaries typically have a choice of 40 to 50 PDPs, which vary in cost and coverage. MMA required each PDP sponsor to staff a toll-free call center, which serves as a key source of the information that beneficiaries need to make informed choices among PDPs. GAO examined (1) whether PDP sponsors provide prompt, courteous, and helpful service to Medicare beneficiaries and others and (2) the extent to which PDP sponsor call centers provide accurate and complete information to Medicare beneficiaries and other callers.

To address these objectives, we made 900 calls to 10 of the largest PDP sponsor call centers during March 2006, posing one of five questions about their Part D plans during each call. We tracked the amount of time it took to reach a customer service representative (CSR), the number of calls that did not reach a CSR, and the appropriateness and clarity of CSRs' language. We developed criteria for determining accurate and complete responses based on CMS information.

www.gao.gov/cgi-bin/getrpt?GAO-06-710.

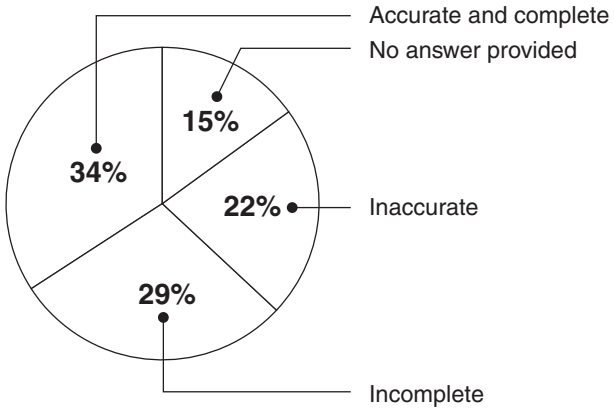
To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

What GAO Found

Call center service was generally prompt and courteous, and many CSRs offered helpful suggestions and information. GAO reached a representative in less than 1 minute for 46 percent of the calls CSRs fielded and in less than 5 minutes for 96 percent of the calls fielded. While GAO did not reach CSRs for 4 percent of the calls it placed, mainly because of disconnections, GAO found that 98 percent of CSRs with whom GAO spoke were easy to understand, polite, and professional. In addition, many CSRs provided helpful suggestions related to GAO's questions, such as details about a mail-order option to obtain drugs or lower-cost drugs.

However, CSRs at 10 of the largest PDP sponsor call centers did not consistently provide accurate and complete responses to GAO's five questions, which GAO developed using information from CMS and other sources. GAO obtained accurate and complete responses to about one-third of the 864 calls for which GAO reached a CSR. The overall accuracy and completeness rate for each call center ranged from 20 to 60 percent. CSRs were unable to answer 15 percent of the questions posed, primarily those related to plan costs. Furthermore, CSRs within the same call center sometimes provided inconsistent answers. For example, in response to questions about PDP cost comparisons for specified sets of drugs, CSRs at 3 call centers told GAO that it was against the sponsors' policies to identify any of their plans as lowest cost. However, other CSRs at each of these call centers did not cite this policy and did identify a plan as lowest cost.

Percentage of 864 Calls with Accurate and Complete, Incomplete, or Inaccurate Responses, and Those Where No Answer Was Provided, March 2006



Source: GAO.

In commenting on a draft of this report, CMS criticized the analysis as based on inaccurate, incomplete, and subjective methods that limit the report's relevance and validity. GAO maintains that its methods are sound and its findings are accurate. CMS officials told GAO at a May 2006 meeting that CSRs should have been able to accurately answer the questions GAO posed.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CSR	customer service representative
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
PDP	prescription drug plan

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

June 30, 2006

Congressional Requesters

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit, known as Medicare Part D, beginning January 1, 2006.[1] Seventy-nine sponsors, largely commercial insurers, have contracted with the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—to provide this benefit in 2006. These sponsors offer over 1,400 stand-alone Medicare prescription drug plans (PDPs) in one or more of 34 CMS-designated PDP regions.[2] Depending on where they live, Medicare beneficiaries typically have a choice of 40 to 50 PDPs, which vary in cost and coverage. Generally, beneficiaries had until May 15, 2006, to enroll in Part D without the risk of a penalty in the form of higher premiums; as of June 11, 2006, about 16.4 million beneficiaries had enrolled in stand-alone PDPs.

MMA requires each PDP sponsor to staff a toll-free call center. These call centers serve as key sources of the information that beneficiaries need to make informed choices among competing drug plans. Beneficiaries and others assisting them may contact call centers to obtain general information on Part D, ask detailed questions or verify information from other sources about a sponsor's PDPs, or enroll in a PDP.[3] Because beneficiaries have an opportunity to switch to another PDP during an

[1]Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-2152 (to be codified at 42 U.S.C. §§ 1395w-101—1395w-152).

[2]Although beneficiaries may obtain drug coverage through either stand-alone PDPs or Medicare Advantage (Medicare's private health plan option) drug plans, this report addresses only stand-alone PDP sponsor call centers. About 90 percent of Medicare beneficiaries are enrolled in traditional Medicare, rather than Medicare Advantage. Therefore, most beneficiaries will be making choices among stand-alone PDPs.

[3]Other sources of information about Part D and specific PDPs include sponsors' Web sites, and CMS's Medicare.gov Web site and 1-800-MEDICARE toll-free help line.

annual open-enrollment period, sponsor call centers will continue to play a significant role in informing current and prospective enrollees.[4]

You were interested in the quality of the service and information provided to beneficiaries by PDP sponsor call centers, as inaccurate or misleading benefit information could lead beneficiaries to choose a PDP that does not meet their needs. In this report, we examined (1) whether PDP sponsors provide prompt, courteous, and helpful service to Medicare beneficiaries and others accessing their toll-free call centers, and (2) the extent to which PDP sponsors provide accurate and complete information to Medicare beneficiaries and other callers.

To address these objectives, we made 900 calls to 10 of the largest PDP sponsor call centers, all of which operate in 30 or more PDP regions and offer two or three PDPs per region.[5] As of April 27, 2006, each of these sponsors served at least 100,000 beneficiaries. Each of our 10 sponsors has one toll-free call center, which we contacted from March 2 through March 31, 2006. We posed one of five questions about their Part D plans during each call, asking each question a total of 180 times—18 times to each of the 10 PDP sponsors.[6] We developed scenarios with zip codes and fictional relatives for each of the questions. To make them sound realistic and provide needed information, we specified additional details, such as drug dosage and frequency information, lack of current drug coverage, low-income subsidy eligibility, and preference for retail purchasing, if asked.[7]

In developing our five questions, we examined those addressed by the Frequently Asked Questions section of CMS's Medicare.gov Web site. We

[4]The 2006 open enrollment period is November 15, 2006, through December 31, 2006. Beneficiaries enrolling during this period will have coverage effective January 1, 2007. Certain beneficiaries (such as certain low-income beneficiaries) may switch PDPs at any time.

[5]We placed calls at different times of the day and days of the week to match the typical pattern of calls reported by the 1-800-MEDICARE help line for January 2006. (CMS requires that each PDP sponsor operate its toll-free call center 7 days a week from at least 8:00 am to 8:00 pm in the time zones in which it offers PDPs.) The population contacting 1-800-MEDICARE is likely to be very similar to the population contacting PDP sponsor call centers.

[6]During our actual calls, CSRs were not aware that their responses would be included in a research study.

[7]We used drug dosages and frequency information based on actual prescriptions.

also reviewed materials from policy analysts that identified information critical to making a choice among competing plans.[8] In addition, we spoke with representatives of beneficiary advocacy groups about the types of information beneficiaries need to consider when selecting a PDP plan. Finally, we asked CMS officials what types of information they required or expected call center customer service representatives (CSR) to be able to provide the public and developed our questions from this information. Although CMS does not have requirements regarding the specific types of information CSRs must be able to provide, agency officials told us that CSRs should be able to accurately answer questions about the relative costs of a sponsor's PDPs, the availability of a plan for beneficiaries eligible for Medicare's low-income subsidy, actions that beneficiaries could take if their drugs are not covered by the plan, and types of restrictions plans use to manage their formularies.

To evaluate the extent to which sponsor call centers provided prompt, courteous, and helpful service during our calls, we analyzed information on the amount of time it took to reach a CSR and the number of calls for which we could not reach a CSR. In addition, our callers noted if they had concerns about the appropriateness and clarity of CSRs' language. In such cases, we evaluated whether the CSR was difficult to understand, impolite, or unprofessional. We also noted any helpful suggestions or information provided to the caller.

We developed criteria for accurate and complete responses for each question from information provided on CMS's Web-based PDP finder tool on Medicare.gov[9] and information that CMS has approved for use by its 1-800-MEDICARE CSRs (see table 1). Excluding calls for which we did not reach a CSR, we report results on the accuracy and completeness of

[8]See J. Antos, "Cutting through Confusion in Part D," *American Enterprise Institute for Public Policy Research: Health Policy Outlook*, no. 2 (2006): 1-7, and J. Hoadley, statement before the Government Reform Committee Briefing on the Medicare Drug Benefit, January 20, 2006.

[9]For the three questions about PDP costs, the source of our answer was Medicare.gov. We periodically checked that Web site and updated our answers, as needed. We also confirmed the accuracy of these data by checking PDP sponsor Web sites, where possible.

information obtained during the remaining calls.[10] We considered an answer accurate and complete if the CSR's response met all of our criteria and we considered an answer incomplete if the CSR's response met one, but not both of our criteria. We considered an answer inaccurate if the CSR's response did not meet any of our criteria. If the CSR stated that they did not know or could not provide an answer, we classified the call as "no answer provided."

[10]CMS does not have performance standards governing the accuracy rate of PDP call centers. However, the agency does have such a standard for 1-800-MEDICARE CSRs, striving for a 90 percent accuracy rate. In 2004 and 2006, we reported on the accuracy of information provided by 1-800-MEDICARE CSRs. See GAO, *Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved*, GAO-05-130 (Washington, D.C.: Dec. 8, 2004) and GAO, *Medicare: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved*, GAO-06-654 (Washington, D.C.: May 3, 2006).

Table 1: Questions, Scenarios, and Criteria Used to Assess Response Accuracy and Completeness

Question	Scenario	Criteria for an accurate and complete response
1. PDP comparison for a low-utilization beneficiary[a]	My mother takes the following drugs: Norvasc, Fosamax, and warfarin sodium. Which of the sponsor's plans would cost her the least amount annually and what is its annual cost?	The name and annual cost (within 5 percent) of the sponsor's PDP that would cost the beneficiary the least annually for the three drugs she uses.
2. PDP comparison for a high-utilization beneficiary[a]	My mother-in-law takes the following drugs: Aciphex, Benicar, Evista, Levoxyl, Pravachol, Synthroid, Zetia, and Zoloft.[b] Which of the sponsor's plans would cost her the least amount annually and what is its annual cost?	The name and annual cost (within 5 percent) of the sponsor's PDP that would cost the beneficiary the least annually for the eight drugs she uses.
3. Low-income subsidy	My mother automatically qualifies for extra help because Medicaid[c] pays part of her Medicare premiums. Does the sponsor offer a plan that she can join without having to pay a premium?	The name of the sponsor's PDP, if any, for which the beneficiary would not pay a premium.
4. Nonformulary drugs	If some of my grandfather's drugs are not covered, will he have to pay full price for them, or are there other things he can do?	A beneficiary may (1) switch to a covered drug, and (2) ask for an exception to the formulary.
5. Utilization management tools	If some of my grandfather's drugs are covered, but subject to restrictions, what does that mean?	Descriptions of at least two of the following: for some covered drugs (1) beneficiaries need approval from their PDP before they can fill their prescription; (2) the PDP limits the amount of the drug that it covers over a certain period of time; (3) the PDP requires that the beneficiary first try a less expensive drug for their condition before it will cover the beneficiary's prescribed drug; or (4) when there is a generic substitute available, the PDP will automatically provide the generic, unless the beneficiary's doctor specifically orders the brand-name drug.

Source: GAO.

Note: We considered an answer accurate and complete if the CSR's response met all of our criteria. We considered an answer incomplete if the CSR's response met one, but not both, of our criteria. Specifically, for questions 1 and 2, a response was incomplete if the CSR accurately named the lowest annual cost plan, but either inaccurately calculated or could not provide the annual cost. An incomplete answer was not possible for question 3, as it had only one criterion for accuracy and completeness. A question 4 response was incomplete if the CSR either stated that the beneficiary could switch to a covered drug or that they could ask for an exception, but did not state both these possibilities. Finally, a question 5 response was incomplete if the CSR accurately described only one utilization management tool. We considered an answer inaccurate if the CSR's response did not meet any of our criteria. If the CSR stated that they did not know or could not provide an answer, we classified the call as "no answer provided."

[a]In 2003, 46 percent of all seniors reported taking five or more prescription drugs. Based on this survey finding, we specified three drugs for the low-utilization beneficiary and eight drugs for the high-utilization beneficiary. See Health Affairs—Web Exclusive: *Prescription Drug Coverage And Seniors: Findings From A 2003 National Survey*, April 19, 2005.

[b]This scenario is based on a list of medications provided to us by a Medicare beneficiary. We recognize that Levoxyl and Synthroid are the same chemically, but retained both drugs in this scenario to make the calls as realistic as possible. Specifying that a beneficiary is taking both of these drugs did not preclude the ability of CSRs to determine the least costly plan and its annual cost.

[c]Medicaid provides health care coverage to eligible low-income people and is jointly financed by the federal government and the states.

The results from our 900 calls are limited only to those calls and are not generalizable to the population of calls routinely made to sponsor call centers by beneficiaries and other callers. Although the five questions we posed are among the most critical questions regarding PDP comparison, they do not encompass all of the questions callers might ask. We did not contact PDP sponsors other than posing questions to the call centers. In addition, we did not examine other issues related to the performance of call centers, such as CSR qualifications and training, nor did we evaluate CMS oversight of sponsor call centers. We conducted our work from February 2006 through June 2006 in accordance with generally accepted government auditing standards.

Results in Brief

Call center service was generally prompt and courteous, and many CSRs offered helpful suggestions and information. We reached a representative in less than 1 minute for 46 percent of the calls CSRs fielded, and in less than 5 minutes for 96 percent of the calls fielded. While we did not reach CSRs for 36 calls—4 percent of the 900 calls we placed—mainly due to disconnections, we found that 98 percent of the CSRs with whom we spoke were easy to understand, polite, and professional. Many CSRs also provided helpful suggestions related to our questions. For example, for our question on the PDP comparison for a high-utilization beneficiary, CSRs provided the caller with information about lower-cost drugs in 41 percent of the calls.

CSRs at 10 of the largest PDP sponsor call centers did not consistently provide accurate and complete responses to our five questions. Excluding the calls for which GAO did not reach a CSR, GAO obtained accurate and complete responses to about one-third of our 864 calls. The overall accuracy and completeness rates for the 10 PDP sponsor call centers varied widely, ranging from 20 to 60 percent. Only 1 sponsor call center had an overall accuracy and completeness rate of greater than 50 percent and 2 sponsor call centers had rates of 25 percent or less. CSRs were unable to provide an answer for 15 percent of our questions, primarily those related to plan costs. Furthermore, CSRs within the same call center sometimes provided inconsistent answers. For example, in response to questions regarding PDP comparisons, CSRs at 3 call centers told us that it was against the sponsor's policies to identify any of their plans as having the lowest annual cost. However, other CSRs at each of these call centers did not cite this policy and did identify a plan as having the lowest annual cost.

In written comments on a draft of this report, CMS stated that our analysis was based on inaccurate, incomplete, and subjective methods that limited our report's relevance and validity. We maintain that our methods are sound and that our findings are accurate. In conducting this review, we identified topics that CMS, policy analysts, and beneficiary advocacy groups indicated were key to making an informed plan choice, posed questions as we expected beneficiaries' family members to do, and relied on information from CMS to develop criteria to assess the accuracy and completeness of the responses we received. Further, CMS officials told us at a May 2006 meeting that CSRs should have been able to accurately answer the questions we posed. Our findings indicate that beneficiaries may have difficulty getting appropriate information from PDP sponsors' call centers. CMS also stated in its written comments that we were right to be concerned about whether beneficiaries are getting effective services from plan call centers.

Background

Medicare Part D coverage is provided through private sponsors that offer a choice of PDPs with different costs and coverage. The largest sponsors offer PDPs to beneficiaries throughout the United States and generally have experience in providing Medicare coverage and with call center operations.

Key Features of Medicare Part D

Under Part D, each PDP may offer the standard prescription drug benefit or coverage that is different, but at least actuarially equivalent, to the standard benefit.[11] According to the Medicare Payment Advisory Commission, for 2006, 9 percent of PDPs offer the standard benefit, 48 percent offer a basic plan that has the same actuarial value as the standard benefit but with a different design, and 43 percent offer enhanced coverage that exceeds the standard benefit.[12] Therefore, the specific

[11]As defined in MMA, for 2006, the standard benefit includes a $250 deductible, and 25 percent coinsurance for costs after the deductible has been met, but before the initial limit of $2,250 in total drug spending is reached. Once this initial limit is reached, beneficiaries must pay 100 percent of their drug costs until total drug spending reaches the catastrophic limit of $5,100 ($3,600 in out-of-pocket spending). The amount between $2,250 and $5,100 is referred to as the "coverage gap." Once beneficiaries reach the catastrophic limit, they pay only 5 percent of their drug costs for the rest of the calendar year, with Part D paying 95 percent.

[12]Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (Washington, D.C. June 2006), 145.

premium, deductible, and copayment or coinsurance amounts, as well as the coverage gap—the period during which beneficiaries must pay 100 percent of their drug costs—of each PDP may vary.

In addition, MMA and CMS regulations require plan formularies—the list of drugs a PDP covers—to meet certain standards, but within these standards, the drugs that are covered and the utilization management tools that are used to control costs may vary.[13] If beneficiaries' drugs are not on their PDP's formulary, rather than paying full (retail) price for them, beneficiaries may switch to a similar drug that is on the formulary. Beneficiaries may also request that the plan make an exception to the formulary and cover their drugs.[14] If the PDP denies that request, CMS regulations require that beneficiaries generally be able to appeal the decision to the sponsor.[15]

Although certain drugs may be on a PDP's formulary, they may be subject to one or more of several utilization management tools—the most common of which are prior authorization, quantity limits, step therapy, and generic substitution. For drugs subject to prior authorization, beneficiaries need approval from their PDP before they can fill their prescription and for drugs subject to quantity limits, the plan limits the amount of the drug it covers over a certain period of time. For drugs subject to step therapy, the PDP requires that the beneficiary first try a less expensive drug for their condition before it will cover the beneficiary's prescribed drug. Finally, generic substitution means that when there is a generic substitute available, the PDP will automatically provide the generic, unless the beneficiary's doctor specifically orders the brand-name drug.

[13]MMA requires that formularies include at least two drugs in each approved category and class (unless only one drug is available for a particular category or class). MMA 117 Stat. 2085 and 69 *Fed. Reg.* 46,632, 46,660 (Aug. 3, 2004). Formularies often consist of different "tiers," which are categories of drugs grouped according to their cost.

[14]42 C.F.R. § 423.578(b) (2005).

[15]42 C.F.R. § 423.580 (2005).

To help cover costs under Part D, Medicare provides subsidies to certain low-income beneficiaries. For example, Medicare beneficiaries for whom Medicaid[16] pays their Medicare Part B[17] premium automatically receive the full low-income subsidy. This subsidy provides the beneficiary with reduced copayment amounts, covers any deductible, provides drug coverage during the coverage gap, and helps pay their PDP premium, up to a certain amount.[18] Other Medicare beneficiaries, however, must apply for the low-income subsidy through the Social Security Administration, and may receive only a partial subsidy.

Characteristics of PDP Sponsors

For 2006, 79 sponsors are offering over 1,400 PDPs, each of which has been approved by CMS to ensure that it meets established standards. Ten of these sponsors are offering PDPs in all 34 PDP regions, and they account for nearly 62 percent of PDPs nationwide.[19] The largest PDP sponsors are either in the commercial insurance or pharmacy benefit management and services sectors and generally have prior experience with call center operations.[20] In addition, the largest PDP sponsors all have some prior experience with Medicare. Most offered a Medicare prescription drug discount card or partnered with a company and most offer Medicare Advantage plans.[21]

CSRs Generally Provided Prompt, Courteous, and Helpful Service

Almost all of the calls we placed were answered by a CSR with minimal delay. A limited number of calls were not answered by CSRs, mainly due to disconnections. Further, we found that most CSRs with whom we spoke

[16]Medicaid provides health care coverage to eligible low-income people and is jointly financed by the federal government and the states.

[17]Medicare Part B provides coverage for certain physician, outpatient hospital, and other services to beneficiaries who pay monthly premiums.

[18]The amount of the subsidy varies by PDP region and does not cover the entire premium of all PDPs. Accordingly, not all PDP sponsors have a plan for which the subsidy covers the plan's entire premium.

[19]The Henry J. Kaiser Family Foundation, *The Landscape of Private Firms Offering Medicare Prescription Drug Coverage in 2006* (Washington D.C.: March 2006).

[20]Many employer-sponsored health plans and insurers contract with pharmacy benefit managers for services such as negotiating price discounts with retail pharmacies, operating mail-order prescription services, and formulary development and management.

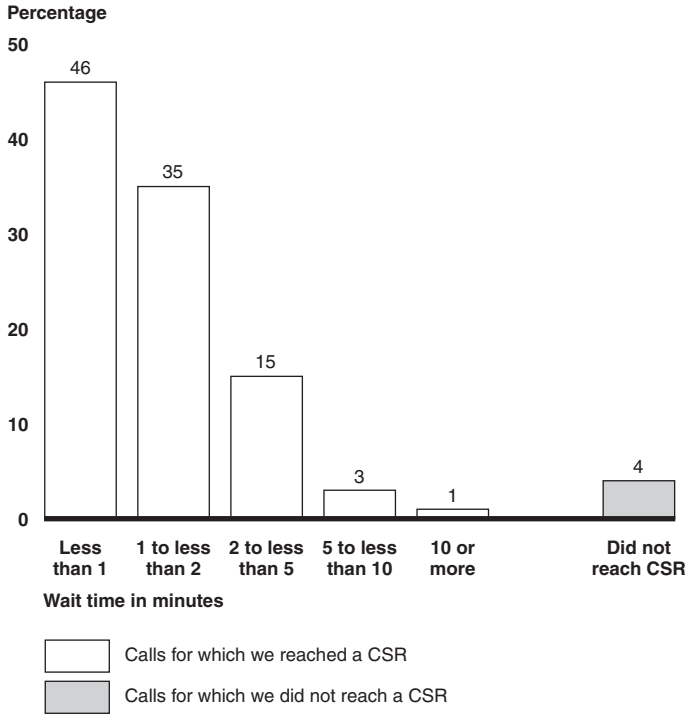
[21]The prescription drug discount card was a program authorized by MMA to give beneficiaries access to lower-priced drugs from 2004 through 2005.

were easy to understand, polite, and professional, and many provided helpful suggestions and information.

Call centers generally provided prompt service in answering our calls. The wait time to reach a CSR was generally short—46 percent of the 864 calls CSRs fielded were answered in less than 1 minute and 96 percent of the calls were answered in less than 5 minutes (see fig. 1). Only 9 calls (1 percent) were answered in 10 minutes or more, with the longest wait time being 25 minutes (1 call). For a small number of calls—36 of the 900 calls we placed (4 percent)—we did not receive an answer to our questions because we did not reach a CSR. For almost all of these calls (33), this occurred because we were disconnected.[22]

[22]We did not reach a CSR for the remaining three calls due to system errors or because the calls were misdirected, such as if the interactive voice response stated that the sponsor's call center was closed and that the caller should call back during certain specified hours. However, the call had been placed during those hours.

Figure 1: Percentage of Calls by Wait Time to Reach a CSR, and Percentage of Calls Where We Did Not Reach a CSR, March 2006



Source: GAO.

Note: Percentages of calls by wait time to reach a CSR are based on the 864 calls for which we reached a CSR. Percentage of calls where we did not reach a CSR is based on the total number of calls (900) we placed.

CSRs generally provided courteous service. Our callers noted that many were helpful and friendly, and we found that CSRs were easy to understand, polite, and professional in 98 percent of the calls. In addition, if a CSR did not know or could not answer a question, many provided additional resources for obtaining the answer, most commonly during calls on the low-income subsidy (question 3). While CSRs did not provide an answer for over one-third of the calls for this question, in over 80 percent of these cases, CSRs suggested another source the caller could contact to obtain the answer—most commonly Medicare or the Social Security Administration.

Many CSRs also provided callers with helpful suggestions that related to our questions. For example, during question 1 calls on the PDP comparison for a low-utilization beneficiary, CSRs provided information

about a mail-order option to obtain drugs in 22 percent of the calls. For question 2 on the PDP comparison for a high-utilization beneficiary, CSRs provided the caller with information about lower-cost drugs in 41 percent of the calls and inquired as to whether the beneficiary was eligible for the low-income subsidy in 24 percent of the calls.

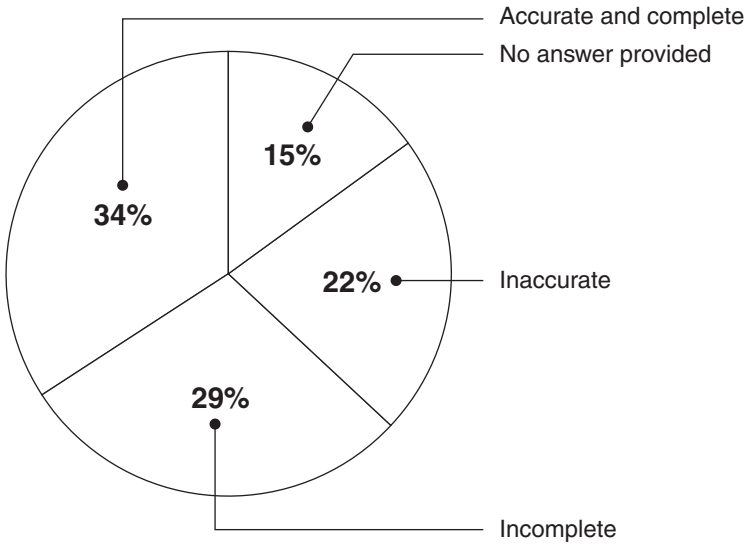
PDP Sponsor Call Centers Did Not Consistently Provide Callers with Accurate and Complete Information

CSRs at the 10 PDP sponsor call centers we contacted provided accurate and complete responses to about one-third of the calls they fielded, although the accuracy and completeness rates for each of the 10 sponsor call centers and for each of the five questions varied. CSRs were unable to provide an answer for 15 percent of the questions posed, primarily those related to plan costs. In addition, we found that CSRs within the same call centers sometimes provided inconsistent responses to our questions.

About One-Third of CSR Responses Were Accurate and Complete

Excluding the 4 percent of calls for which we did not reach a CSR, we obtained accurate and complete responses to 34 percent of the calls—294 of 864—and obtained incomplete responses to another 29 percent of the calls (see fig. 2).

Figure 2: Percentage of Calls with Accurate and Complete, Incomplete, or Inaccurate Responses, and Those Where No Answer Was Provided, March 2006

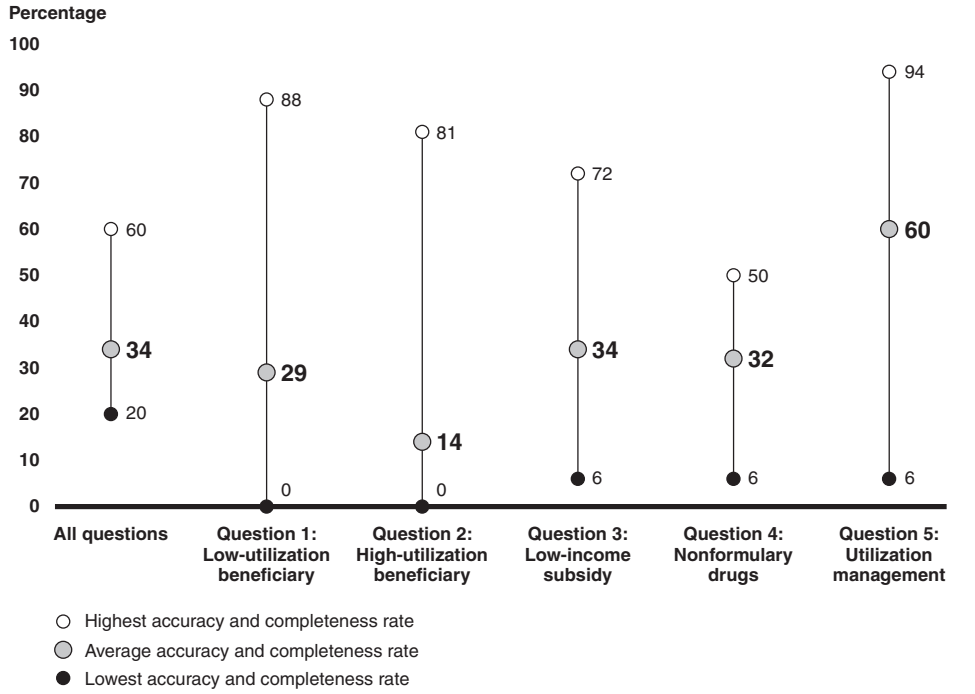


Source: GAO.

Note: Percentages are based on the 864 calls for which we reached a CSR and exclude the 36 calls for which we did not reach a CSR. An incomplete answer was not possible for question 3. Calls were categorized as "no answer provided" if the CSR stated that they did not know or could not provide an answer.

The overall accuracy and completeness rates for each of the 10 PDP sponsor call centers varied widely, ranging from 20 to 60 percent (see fig. 3). Only 1 sponsor call center had an overall accuracy and completeness rate of greater than 50 percent and 2 sponsor call centers had rates of 25 percent or less. No sponsor's call center consistently had the highest or lowest accuracy and completeness rate for all questions. For example, although 1 call center had the highest accuracy and completeness rate for both question 1 (the PDP comparison for a low-utilization beneficiary) and question 2 (the PDP comparison for a high-utilization beneficiary), it had the second-lowest accuracy and completeness rate for question 4 (nonformulary drugs).

Figure 3: Lowest, Highest, and Average Sponsor Call Center Accuracy and Completeness Rate, by Question, March 2006



Source: GAO.

Note: Percentages are based on the calls for which we reached a CSR and exclude the calls for which we did not reach a CSR. We placed 180 calls for each question; we reached a CSR 170 times for question 1, 169 times for question 2, 174 times for question 3, 176 times for question 4, and 175 times for question 5.

Variation across call centers was due, in part, to differences in the resources that CSRs said were available to them. For example:

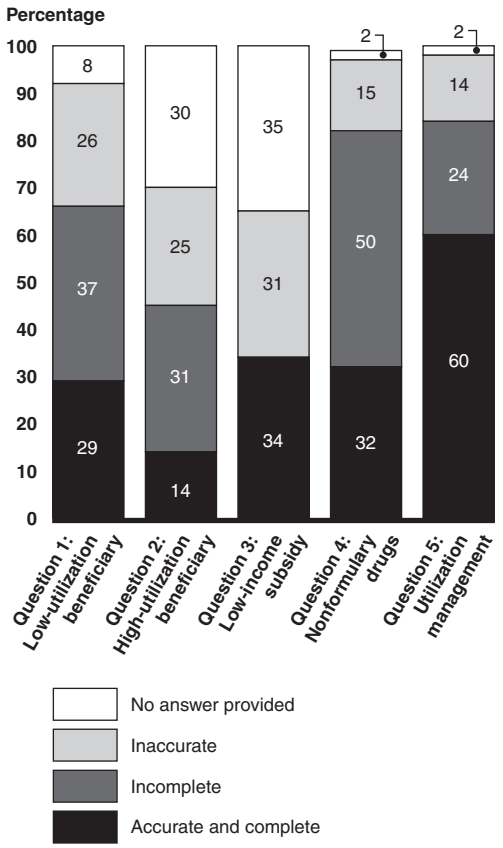
- In response to questions 1 and 2, CSRs at two call centers indicated that they were able to compute the annual cost of the least expensive plan because they had access to a computerized "cost calculator." However, CSRs at other call centers stated that they could not compute an annual cost because they did not have access to such a resource. We located cost calculators on the Web sites of seven sponsors, each of which had call center CSRs who stated that they did not know or could not calculate an annual cost.

- CSRs at six different sponsor call centers stated that they could not calculate the annual cost of the least expensive plan because they did not have access to the retail prices of the beneficiary's drugs.[23] In contrast, CSRs at two other call centers stated that they did have access to these prices, and were able to use them in calculations.

  For each of the five questions, accuracy and completeness rates varied, but were generally low. They ranged from 14 to 60 percent (see fig. 4).

[23]In estimating the amount a beneficiary pays annually, information on the plan's negotiated retail price is required, for example, to account for the purchase of any nonformulary drugs or the purchase of drugs during the coverage gap. In both these instances, the beneficiary typically pays the plan's negotiated retail price for the drug.

Figure 4: Percentage of Calls with Accurate and Complete, Incomplete, or Inaccurate Responses, and Those Where No Answer Was Provided, by Question, March 2006



Source: GAO.

Note: Percentages are based on the calls for which we reached a CSR and exclude the calls for which we did not reach a CSR. We placed 180 calls for each question; we reached a CSR 170 times for question 1, 169 times for question 2, 174 times for question 3, 176 times for question 4, and 175 times for question 5. An incomplete answer was not possible for question 3. Calls were categorized as "no answer provided" if the CSR stated that they did not know or could not provide an answer. Total may not add to 100 due to rounding.

Relatively few CSRs were able to accurately identify the least costly plan and calculate its annual cost.[24] In addition, the annual cost estimates that CSRs provided were often substantially different from the plans' actual costs. For example:

- For the low-utilization beneficiary (question 1), about 1 in 3 responses were incomplete; that is, CSRs identified the least costly plan, but either inaccurately calculated its annual cost or stated that they could not provide any annual cost. Over half of the CSRs that provided an inaccurate response quoted a cost that was greater than the actual cost.
- For the high-utilization beneficiary (question 2), about 3 in 10 responses were incomplete. Among the 23 CSRs that correctly identified the least costly plan, but gave an inaccurate annual cost, almost all provided a quote that was less than the actual cost, and in 11 cases over $1,000 less.[25]

About two-thirds of the CSRs were unable to accurately report whether the sponsor offered a PDP for which a Medicare beneficiary that received help from Medicaid would not have to pay a premium (question 3). Specifically, CSRs fielding this call answered inaccurately 31 percent of the time and did not provide an answer 35 percent of the time. For most of the inaccurate answers, CSRs stated that a certain PDP would not require a premium from the beneficiary, but, in fact, it would. Other inaccurate responses showed a poor understanding of the low-income subsidy benefit; for example, two CSRs incorrectly stated that the low-income subsidy did not help offset the premium at all.

Half of the CSRs responding to question 4 incompletely described the options available to a beneficiary taking a nonformulary drug. Of the incomplete responses, about 4 in 5 CSRs mentioned that the beneficiary could request an exception to have the plan cover the nonformulary drug,

[24]Inaccurately identifying the sponsor's least costly plan and its annual cost could have financial consequences for beneficiaries because the actual cost differences among sponsors' PDPs were often substantial. In the low-utilization beneficiary scenario, for 8 of the 10 sponsors, the cost differences between the least costly and the next-to-least costly PDP ranged from $106 to $388 per year. For the remaining 2 sponsors, the differences were less than $25. In the high-utilization beneficiary scenario, for 3 of the 10 sponsors, the cost differences between the least costly and the next-to-least costly PDP ranged from $517 to $2,346 per year. For the remaining 7 sponsors, the differences were less than $200.

[25]For question 2 regarding the high-utilization beneficiary, the annual cost of the least expensive PDP for each sponsor ranged from $3,659 to $7,122.

but not that the beneficiary could switch to a drug that the plan covers.[26] In addition, 15 percent of CSR responses included neither possibility, with many CSRs stating that the beneficiary's only option would be to pay full price for nonformulary drugs.

Finally, CSRs accurately described at least two utilization management tools in 60 percent of our calls for question 5—the highest accuracy and completeness rate of our five questions. Other CSRs identified, but could not accurately describe, specific tools. For example, one CSR incorrectly stated that quantity limits—a limit on the amount of a drug that the plan will cover over a certain period of time—means that a pharmacy may not have enough of a drug to fill the beneficiary's prescription.

CSRs Did Not Provide Answers to 15 Percent of Calls, Most Often for Questions regarding Plan Costs

Overall, CSRs stated that they did not know or could not answer our question for 15 percent of the calls. This was most common for the questions related to PDP costs (the PDP comparison for a low-utilization beneficiary, the PDP comparison for a high-utilization beneficiary, and the low-income subsidy).

For question 2 calls regarding the PDP comparison for a high-utilization beneficiary, 30 percent of the CSRs stated that they were unable to tell the caller which PDP would cost the beneficiary the least annually. In contrast, only 8 percent of CSRs provided this response for question 1 on the low-utilization beneficiary. This difference in the percentage of calls for which an answer was provided is likely due to the added complexity of comparing PDPs and calculating the annual cost for a beneficiary using eight drugs versus a beneficiary using three drugs. However, reliance on at least five drugs is common in the Medicare population.[27]

Question 3 regarding the low-income subsidy had the highest "no answer provided" rate—35 percent. Of the CSRs that did not provide an answer to this question, almost all stated that they did not know the subsidy amount the beneficiary would receive. Because they did not recognize that beneficiaries with both Medicare and Medicaid automatically receive the

[26]A few CSRs mentioned that certain drugs (such as barbiturates, which are often used for seizure disorders or to relieve anxiety, and benzodiazepines, which are often used to treat anxiety and insomnia), are excluded from Part D completely and can never be covered.

[27]See Health Affairs—Web Exclusive: *Prescription Drug Coverage And Seniors: Findings From A 2003 National Survey*, April 19, 2005.

full low-income subsidy, they could not effectively determine whether that subsidy would cover the sponsor's PDP premiums.

CSR Responses within Sponsor Call Centers Were Inconsistent

CSRs within the same call center sometimes provided inconsistent responses to our five questions. For example, within each of six different call centers, among CSRs who accurately identified the least costly plan for the low-utilization beneficiary (question 1), some CSRs calculated an accurate annual cost, some calculated an inaccurate annual cost, and others stated that they could not calculate an annual cost. In response to question 2 regarding the high-utilization beneficiary, different CSRs within five call centers identified each of their sponsor's PDPs as the least costly. In addition, in response to questions 1 and 2, CSRs at three call centers told us that it was against the sponsor's policies to identify any of their plans as having the lowest annual cost.[28] However, other CSRs at each of these call centers did not cite this policy and did identify a plan as having the lowest annual cost.

In part, these inconsistencies were due to differences in CSRs' knowledge about their sponsor's plans. For example, CSRs' varying knowledge related to the low-income subsidy question (question 3) produced contradictory responses. Within each of the 10 sponsor call centers, different CSRs answered accurately, inaccurately,[29] or stated that they did not know or could not answer the question. When asked about the options for a beneficiary using nonformulary drugs (question 4), different CSRs within each of 6 sponsor call centers stated that a beneficiary could either switch to a covered drug or apply for an exception, stated only that the beneficiary could switch to a covered drug, stated only that the beneficiary could apply for an exception, or stated neither possibility. Among CSRs that stated neither possibility, the specific responses differed. For example, at 1 of the above call centers, although five CSRs answered the question accurately, one erroneously stated that the beneficiary's only option was to pay full price for nonformulary drugs, and another erroneously stated that any drugs not covered by the PDP would be covered under Medicare Part B.

[28]In three of these calls, the CSR further stated that it was the individual's responsibility to determine the least costly plan.

[29]Inaccurate responses include CSRs that stated there was one plan without a premium (when there was not), there was no plan without a premium (when there was), and that none of the sponsor's plans had a premium.

In answering question 5 on utilization management tools, different CSRs within the same call center provided varying descriptions of the utilization management tools PDPs use. For example, although four CSRs within one call center provided accurate descriptions of at least two tools, three other CSRs within this call center each provided a different, and inaccurate, description of utilization management tools.[30] At another call center, two CSRs stated that they could not describe any tools without knowing the specific drugs the beneficiary was taking—even though eight other CSRs at that call center were able to accurately describe at least one tool without knowing the beneficiary's drugs.

Concluding Observations

Our calls to 10 of the largest PDP sponsors' call centers show that Medicare beneficiaries face challenges in obtaining the information needed to make informed choices about the PDP that best meets their needs. Call center CSRs are expected to provide answers to drug benefit questions and comparative information about their sponsors' PDP offerings. Yet we received accurate and complete responses to only about one-third of our calls. In addition, responses to the same question varied widely, both across and within call centers. Sponsor call centers' poor performance on our five questions raises questions about whether the information they provide will lead beneficiaries to choose a PDP that costs them more than expected or has coverage that is different than expected. Rather than consider PDP options solely on the basis of the call centers' information, callers may benefit from consulting other information sources available on Medicare Part D when seeking to understand and compare PDP options.

Agency Comments and Our Evaluation

CMS reviewed a draft of this report and provided written comments, which appear in appendix I.

In its comments, CMS characterized our analysis as based on inaccurate, incomplete, and subjective methods that limit the report's relevance and

[30]Specifically, one CSR at the call center stated that, for drugs subject to utilization management, the beneficiary may have to get a new prescription each time they obtain their drugs, rather than obtaining refills at the pharmacy. Another CSR at this call center stated that, for drugs subject to utilization management, the beneficiary will need a prescription for any "addictive" drugs. A third CSR said that utilization management means that certain drugs may only be covered at select pharmacies and specific strengths of certain drugs may not be covered.

validity. However, CMS went on to say that despite its view on the study's limitations, GAO is right to be concerned about whether beneficiaries are getting effective service from plan call centers.

CMS asserted that our questions did not reflect the usual questions received by PDP sponsor call centers. As noted in the draft report, we selected topics that were addressed in the Frequently Asked Questions section of the Medicare.gov Web site and regarded by policy experts and beneficiary advocates as important to making an informed plan choice. Furthermore, at a May 2006 meeting with CMS officials, the agency's Deputy Administrator stated that CSRs should be able to accurately answer all of the specific questions we posed during the study.

CMS also stated that we asked for information that CSRs are not required to provide. Specifically, for questions 1 and 2 on PDP comparisons for low and high-utilization beneficiaries, CMS stated that it does not require sponsor call centers to provide information on the annual costs of their PDPs. However, while not necessarily required, agency officials had indicated that the information we sought from CSRs was within the scope of plan sponsor customer service efforts. In a discussion held before we conducted our March calls, CMS officials told us that the agency had not established any requirements regarding the specific types of information plan CSRs must be able to provide, but that it was reasonable to expect CSRs to give callers accurate information on the topics we included in our review.

In addition, as noted in the draft report, some call centers were relatively successful in providing accurate and complete answers to questions 1 and 2, indicating that call center CSRs can handle such questions appropriately. One call center's CSRs answered the question accurately and completely in 88 percent of the calls for the low-utilization beneficiary, and one call center's CSRs responded correctly in 81 percent of the calls for the high-utilization beneficiary. In addition, we found that 7 of the 10 PDP sponsors had cost calculators on their Web sites that could have been used to answer these questions.

CMS commented that, to be counted as providing a complete response to questions 1 and 2 on PDP comparisons, we expected CSRs to recommend a specific plan to the caller, a practice that often constitutes "steering,"

which is prohibited under Medicare marketing guidance.[31] As noted in the draft report, our callers identified themselves as family members wishing to assist beneficiaries in choosing a drug plan. Providing assistance to beneficiaries—which is encouraged by CMS—generally consists of learning the characteristics of various PDPs and assessing their relative merits given the potential enrollee's needs. This is clearly allowed in CMS's Marketing Guidelines, which distinguish between assistance based on objective information and steering to a drug plan for financial gain.

CMS also took issue with how we counted a specific CSR response to questions 1 and 2. The agency incorrectly claimed that a CSR's referral to 1-800-MEDICARE was categorized as an incomplete response. As noted in the draft report, we categorized responses as incomplete if the CSR accurately named the lowest annual cost plan, but either inaccurately calculated or could not provide the annual cost. If the CSR did not answer the question and instead referred the caller to 1-800-MEDICARE for information on PDPs, we classified the response as "no answer provided."

CMS stated that the wording of question 3 on the low-income subsidy was inaccurate and therefore misleading. This question specifies that the beneficiary automatically qualifies for extra help because Medicaid pays part of her Medicare premiums. According to CMS, the wording of question 3 is incorrect because only Medicare pays the drug premium for low-income beneficiaries and Medicaid would fully (not partly) pay the Part B premium. However, CMS's comment conflicts with the information we obtained from its Medicare.gov Web site in developing the wording and answer for this question. Using the Web-based PDP finder tool on this Web site, the user can select one of several options specifying why the beneficiary qualified for extra help. We selected the option specifying that the beneficiary automatically qualified for extra help because they receive "help from [the] State paying Medicare premiums." We agree that only Medicare, and not Medicaid, pays the Medicare Part D premium for low-income beneficiaries and Medicaid would fully (not partly) pay the Part B premium. Therefore, for such a beneficiary, Medicaid would pay part of the beneficiary's Medicare premiums.

CMS also stated that, for certain questions, many reasonable answers were not counted as correct. The agency cited our question regarding a

[31]Steering constitutes an attempt to guide beneficiaries to a specific PDP or group of PDPs to further financial or other interests.

beneficiary's options should he or she be prescribed a nonformulary drug, and asserted that our criteria for a correct response—switching to a covered drug or asking for an exception—was too limited. The agency stated that other reasonable answers should have been counted as correct because we conducted our calls at a time when all plans covered all Part D drugs.[32] We obtained the answer to this question from a script that CMS approved for use by CSRs operating its 1-800-MEDICARE help line. In addition to the two options we used as criteria for an accurate and complete answer, the script mentioned that PDPs are required to provide beneficiaries with temporary transitional coverage (generally for 30 days after enrollment) of drugs not on the PDP's formulary. However, according to CMS, the purpose of this temporary coverage is to provide beneficiaries with sufficient time to switch to another drug or to request an exception to the formulary. Therefore, in specifying our criteria for an accurate and complete answer, we chose to include only the two options that CMS sees as longer-term solutions for the beneficiary.

CMS stated that we did not examine certain features of the support services that plan sponsors' call centers are required to provide, such as hours of operation, wait times, disconnection rates, and language services. It also noted requirements that plans report a range of performance measures, such as beneficiary complaint rates and timeliness of exceptions and appeals decisions. As noted in the draft report, the scope of our review was limited to the accuracy and completeness of information disseminated to the public by PDP sponsors' call centers—a feature of plan customer service for which CMS has established no performance requirements.

Finally, CMS believes that, as written, our study provides little practical guidance of value in improving the drug benefit and that our conclusion—that callers may benefit from consulting other information sources available on Medicare Part D when seeking to understand and compare PDP options—is obvious. In quoting our conclusion, CMS omitted the key part of the paragraph preceding the quoted phrase where we state that "sponsor call centers' poor performance on our five questions raises questions about whether the information they provide will lead beneficiaries to choose a PDP that costs them more than expected or has

[32]Because all PDPs do not routinely include all Part D drugs on their formularies, we assume that CMS's comment refers to the requirement that all beneficiaries enrolled in January or February 2006 receive temporary drug coverage through March 2006, and that all beneficiaries enrolled thereafter receive temporary drug coverage for at least 30 days.

coverage that is different than expected. . . .” We continue to believe that plan sponsors should be accountable for the accuracy of their information and make maintaining effective call centers a priority.

CMS also provided us with detailed, technical comments, which we incorporated where appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies to the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report is also available at no charge on GAO’s Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (312) 220-7600 or aronovitzl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made contributions to this report are listed in appendix II.

Leslie G. Aronovitz
Director, Health Care

List of Requesters

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Appendix I: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUN 15 2006

TO: Leslie G. Aronovitz
Director, Health Care
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid services

SUBJECT: Government Accountability Office's (GAO) Draft Report: "MEDICARE Part D: Prescription Drug Plan Sponsor Call Centers Do Not Consistently Provide Accurate and Complete Information" (GAO-06-710)

Thank you for the opportunity to review and comment on the GAO's draft report entitled, "MEDICARE Part D: Prescription Drug Plan Sponsor Call Centers Do Not Consistently Provide Accurate and Complete Information." Plan call center performance is very important for our beneficiaries, and so any important gaps in plan performance must be addressed promptly. Since the drug benefit began, we have identified areas where plan performance has fallen short and have directed plans to correct deficiencies. For example, we directed plans to reduce excessive call center wait times at the beginning of the year. We are pleased that your one-time evaluation in early March found results similar to our ongoing plan monitoring: plans generally are achieving low caller wait times and high call completion rates. But we are concerned about inaccurate, incomplete, and subjective methods in GAO's analysis that limit its relevance and validity. These problems appear to affect all five questions in GAO's analysis.

As you note, customers must receive both timely and effective service when they use a plan help line. However, while GAO's five questions reflect topics of clear interest to many Medicare beneficiaries in choosing a drug plan, they do not reflect the usual questions received by plan call centers or the support services that plan call centers are required to provide. In addition, some of the answers that GAO viewed as right, wrong, or incomplete contradict the guidance and requirements that Medicare has provided to plans.

Some GAO questions asked customer service representatives for information that they are not required to provide, and may even be prohibited from providing. For example, during the open enrollment period, we strongly encouraged beneficiaries to contact 1-800-MEDICARE or to use the computerized resources available at medicare.gov or through literally thousands of independent counseling partners around the country. These resources enable beneficiaries to get comparative pricing information on all available plans. Contacting one plan after another is an unnecessarily time-consuming approach that may not provide consistent information. For this reason, Medicare has never

required drug plan call centers to provide detailed information about the prices of specific combinations of drugs. Despite this fact, two of GAO's five questions were on this topic. Moreover, according to GAO, a "complete" answer required recommending a specific plan to a caller, even though this practice often constitutes "steering" that is prohibited under Medicare's marketing guidance. And GAO counted as an incomplete answer what we recommend that plans do in these cases: refer callers to 1-800-MEDICARE for one-stop, objective information on all available plans.

Another GAO question was factually inaccurate, and therefore misleading. It is not the case for any beneficiary that "My mother automatically qualifies for extra help because Medicaid pays part of her Medicare premiums." Only Medicare pays the drug premium for low-income beneficiaries, and Medicaid would fully (not partly) pay the non-drug, Part B premium. Because this is a statement that is unlikely to occur among actual callers, it is understandable that the customer service representative might not name a plan option for which the beneficiary pays no premium, since the description would not obviously apply to any beneficiary. Why didn't GAO simply phrase the question as: "My mother automatically qualifies for extra help because she has Medicare and Medicaid," or (what we hear much more commonly) "My mother has Medicaid and Medicare"?

Finally, for some questions, GAO's questions were generally worded and many reasonable answers were not counted. For example, when GAO conducted its survey in March, every plan was covering every Part D drug for every beneficiary. And some of the most popular plans have open formularies that cover all or essentially all drugs. As a result, the two specific answers counted as "correct" for GAO's question about nonformulary drugs – switching to a covered drug or asking for an exception – do not constitute a full set of reasonable answers.

In our Detailed Comments, we describe other questionable features of GAO's methods that raise further questions about whether GAO's findings reflect problems in study design rather than plan response.

Despite all of these limitations, GAO is right to be concerned about whether beneficiaries are getting effective service from plan call centers. Medicare beneficiaries should be able to count on the customer service from their plans. For this reason, CMS has implemented a broad set of requirements for call centers that reflect the services they should be expected to provide reliably. Plan sponsors must maintain a toll-free customer service call center that is open during usual business hours and provides customer telephone service in compliance with standard business practices. This means that the Plan sponsors must comply with at least the following:

- Call center operates during normal business hours, but not less than seven days a week from 8:00 AM to 8:00 PM for those time zones in which the Applicant offers a PDP ;
- Eighty percent of all incoming customer calls are answered within 30 seconds;
- The abandonment rate of all incoming customer calls does not exceed 5 percent;

- Call center provides thorough information about the PDP benefit plan, including co-payments, deductibles, and network pharmacies;
- Call center features an explicit process for handling customer complaints; and;
- Call center shall provide service to non-English speaking and hearing impaired beneficiaries.

In addition to these requirements, CMS requires plans to report on a broad range of performance measures, many of which would indicate problems in the practical uses of customer service lines. For example, plans report complaint rates per 1,000 beneficiaries, timeliness of exceptions and appeals reporting, and grievances to CMS on a quarterly basis. Unfortunately, the GAO analysis did not look at any of these practically important features of plan customer service lines. Further, CMS is tracking complaints made through our 1-800 lines, regional offices, or partner organizations to identify patterns that would indicate a significant problem with a plan customer service line.

More generally, it is worth noting that CMS has implemented a comprehensive Part D oversight program that incorporates training of Part D sponsors on programmatic, systems, and compliance issues; continuous oversight and formal compliance action as necessary, and peer comparison and public reporting on key performance metrics. The goals of CMS' oversight strategy are to assist with Part D plans' start-ups, continuously identify Part D program vulnerabilities, assure strict adherence to Part D regulatory and program requirements, to use oversight and formal compliance actions as necessary, and to detect and prevent fraud, waste, and abuse. CMS expects to accomplish these objectives without impeding the ability of Part D contactors to deliver industry standard performance. Since these strategies, we have seen progress over the last several months in plans' responsiveness, including improvement in call center wait times, as well as a decreasing number of complaints made by beneficiaries and providers.

As a final general comment, we would again request that GAO share details of their methods in advance, or at least in the course of review, so that the validity issues and the disconnect between Medicare requirements and GAO evaluation criteria can be avoided. Transparency and clarity from GAO would also help CMS identify actual gaps in plan performance that require further action; as written, the GAO study provides little practical guidance of value in improving the drug benefit.

Indeed, GAO's principal conclusion – "callers may benefit from other information sources available on Medicare Part D when seeking to understand and compare PDP options" – has been obvious from the start and is the reason we have invested so much in providing objective assistance to beneficiaries and in working with thousands of partner organizations to do so. For many types of questions (i.e., 1-800-MEDICARE, www.Medicare.gov, and individual counseling through a vast network of partners), these other objective, independent sources can provide more complete and efficient personalized assistance, particularly for evaluating plan choices. Fortunately, millions of Medicare beneficiaries took advantage of these sources. They are also reporting relatively low rates of complaints about the plans, indicating that plan customer service is effectively complementing these additional sources of assistance for most people. As a

result, beneficiaries are filling around 3 million prescriptions daily using their Medicare drug coverage, at a much lower cost than had been predicted.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Leslie G. Aronovitz, (312) 220-7600 or aronovitzl@gao.gov

Acknowledgments

In addition to the contact named above, Rosamond Katz, Assistant Director; Manuel Buentello; Jennifer DeYoung; and Joanna L. Hiatt made major contributions to this report. Other contributors include Lori D. Achman, Diana B. Blumenfeld, Gerardine Brennan, Laura Brogan, Lisa L. Fisher, M. Peter Juang, Martha R.W. Kelly, Ba Lin, and Michaela M. Monaghan.

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