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General Comment

If the "combined standardized document" being proposed is the Evidence of Coverage (EOC), it should not be used as a tool to communicate plan changes before their effective date because:

- Lock-in has created a massive marketing situation for Medicare Beneficiaries. During the last three months of the year Medicare Beneficiaries are deluged with information from (what may be) more than 50 plans. The chances increase exponentially that the EOC will get lost or discarded, being perceived as just one more piece of marketing material or junk mail.
- Existing members already have a current EOC in hand. They need easy to read and use information to help them make sound decisions about their coverage for the future. Thus, a Summary of Benefits (SOB) was created. It contains the same benefit categories, but in a more concise format, and allows a member to perform an apples-to-apples comparison when determining which plan is best for them in the coming year. A 100+ page EOC is less easy to use and doesn't lend itself to making plan decisions. Members will have to compare the EOC to the other 50 SOBs they receive before they can make their plan choice. The choice becomes confusing and more difficult, if not impossible, to make.

- Providing members with an inaccurate EOC will not be helpful. Why is the EOC inaccurate? For these reasons:

    - Direct bill members will not yet have chosen their benefits for the next year when they receive the EOC in October. If they decide after October to change to a different plan, they will then receive another EOC within a short period of time. Usually, two matching documents will cause confusion about which one is accurate.

    - Members with Employer Group coverage are also at a disadvantage. Their employer may not make the decision of what benefits will be provided until December 1. In New York State, commercial rates often are not published until December 1. Employer Groups wait until then to make their decision on what benefits to provide to their active employees, and that cost drives their decision on what benefits they will offer their retired employees. Thus, a member will receive one EOC in October for the 2009 plan year that reflects the 2009 benefits, but the 2008 benefits their employer chose, and then they'll get another EOC in January which may have different 2009 benefits. Again, two EOCs for one plan year will result in Medicare Beneficiary confusion.

    - It is costly to provide members with two EOCs each year ????????? one from which to choose benefits and one with the chosen benefits. Members regularly complain that we, as health plans, mail them too much information and waste their premium dollars on printed materials. This fuels their fire even more and, in the long run, increases their dissatisfaction with Medicare as well. The overwhelming size of plan materials may have the opposite affect than what CMS is going for, it may dissuade members from changing plans. Making it impossible for them to compare plans may force them to stay with their existing plan, even though it would be in their best interest to switch at that time.

> Our job is to help members understand their health plan and make knowledgeable decisions regarding their coverage. The Summary of Benefits functions as a more concise and more easily understood vehicle for communicating important information on plan changes to potential and existing members. The Older Americans Report (April 14, 2008) hits hard on the issue of "Clear Communication Essential for Quality Care and Outcomes" with older adults whose health literacy levels are dropping at an alarming rate. Our call to action nationwide is to do all that "we" can - meaning government agencies, insurance companies, health care systems, and on down the line to health centers and doctors - to help our growing older population navigate health care and coverage. Making that process more labor intensive and confusing won't help.

Response: CMS believes it is important that all beneficiaries receive comprehensive information in order to make an informed decision about their health care options prior to the Annual Election Period (AEP). The combined ANOC/EOC has been improved this year to provide beneficiaries with better and more understandable information. For example, to ensure that important information can be easily identified by beneficiaries, the ANOC/EOC has been redesigned to display the benefits section in the ANOC as the very first item for review. Organizations also have the option of sending the ANOC/EOC as a collection of smaller booklets so that beneficiaries can quickly find information on their healthcare benefits. Since the SB also provides a summary and comparison of the plan's benefits with Original Medicare, organizations still have the option to mail the SB along with the ANOC/EOC. CMS also requires plans to have the SB available upon request.

With regard to the issue of a beneficiary receiving two EOCs in a year, this would only occur if an existing beneficiary has decided to enroll in another health plan during the AEP. Organizations are only required to send the ANOC/EOC annually to existing members and the EOC to new members upon enrollment into a new plan. We feel that sending a second EOC from a new plan will not be confusing since the benefits and plan will be different from the existing plan type.