My Experience Helping People with Medicare and Medicaid in Minority Communities around New York City

My name is Pia Allocca. I am the Program Director of the Medicare and Medicaid Assistance Program at the Medicare Rights Center. I want to thank the National Association of Insurance Commissioners for holding this important hearing. I hope that it will lead to a halt of the deceptive and fraudulent marketing of Medicare Advantage plans that has victimized the people I serve, "dual eligibles," people who have both Medicare and Medicaid.

The **Medicare Rights Center** (MRC) is the largest independent source of health care information and assistance in the United States for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get good, affordable health care.

I have been at MRC for four years and for the last two years I have led the Medicare and Medicaid Assistance Project. Everyday, I visit senior centers in the poorest areas of New York City, including the Bronx, Queens, Brooklyn and Spanish Harlem. At the centers we provide personalized assistance with Medicare and Medicaid issues. I visit the same centers once a week, which has helped to establish a real, personal relationship: the people at the centers expect us every week and count on us being there for them. Two-thirds of the people we help do not speak English—and even when English is their first language it is difficult to understand the language of Medicare and Medicaid. The centers are understaffed and the older adults and people with disabilities we serve are unable to solve these problems without our help.

Almost every time I visit one of our sites in New York City, whether it is the Raíces Senior Center in Corona, Queens or the Casita Maria in Spanish Harlem, I meet someone who is running into problems with their medical coverage after they were signed up for a Medicare Advantage plan, usually an HMO. These are poor people, usually with both Medicare and Medicaid, who do not have the money to pay for medical care or medicine when they cannot get it covered by their plan.

There are many manipulative ways that representatives of Medicare Advantage plans in New York City get dual eligibles to sign up for their plans:

- An agent knocks on their door, posing as a representative of Medicare.
- Agents tell people that they will be dropped from Medicaid if they do not enroll in the plan.
- Agents tell them they will be hit with a "penalty" if they do not enroll.
- Agents roam the halls of senior housing complexes, knocking on doors and aggressively pitching their plans in people's living rooms.
- Agents get our clients to sign up for raffles and use their signatures and information to enroll them in a Medicare Advantage plan.

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- Plans reps park their vans outside senior centers and accost seniors on their way inside.

The sales pitch our clients receive tout the benefits of the plan, combining descriptions of real benefits—debit cards for use at local pharmacies are a powerful lure—with false promises. For example, immigrants have been told they will have full coverage in their country of origin. Others are enticed with benefits they already receive through Medicaid, such as dental care and transportation. What agents almost never explain are the network restrictions that prevent our clients from receiving care. Here is a story that illustrates what happens to these individuals after they are tricked into joining a Medicare Advantage plan:

- Patricia Correa is a disabled, mentally ill woman who suffers from severe bipolar disorder. Her mother, Genoveva Correa, asked for assistance after running into problems with a Medicare HMO. The Correa family (Patricia and her parents) were enrolled into the managed care plan by a very aggressive sales representative. The representative convinced Ms. Correa she was going to lose her Medicaid coverage if she did not sign up for a managed care plan. Patricia needed to see a therapist for her depression. Her therapist was not able to see her because he was not in the HMO's network. We worked with CMS to disenroll the entire family from the plan. Fortunately we were able to disenroll Patricia from her HMO and return her coverage to Original Medicare.

Besides being unable to see providers because of network restrictions, dual eligibles often have to pay copays for doctor visits and other services that they were not charged under Original Medicare with Medicaid.

- Manuel Armijos is a 68-year-old man from Corona, Queens who has both Medicare and Medicaid, and suffers from diabetes. In December 2005, he was approached at the bank by a sales representative from a Medicare HMO. The representative mentioned all the services the HMO provided for people with diabetes. Mr. Manuel was unaware of the fact that all the additional services the sales representative was touting were already covered under original Medicare and Medicaid so he signed up with the plan. When the client realized the plan was charging him a copay for every visit, he came to us asking for help disenrolling from the plan.

Our clients are targeted because they are dual eligibles, who, unlike most people with Medicare, can enroll or disenroll from a Medicare Advantage plan at any point of the year. Outside the open enrollment period, dual eligibles are a fruitful population for plans to target. Fortunately, because they can disenroll without restriction, it is often easier for us to help our clients switch back to Original Medicare.

Even so, our clients often experience disruptions in their care when they are signed up for an unsuitable plan. They may delay treatment if they cannot continue to see their doctor or specialist. Others find their new plan does not cover the drugs they already take; of

course, the representative's promise that the appeals process would be simple and easy is false.

Some clients are hit with high medical bills if their doctor does not accept the plan they signed up for unaware that there would be network restrictions. When that happens, they often cannot go back to their provider until their medical bills are paid, often after we help them retroactively enroll in Original Medicare.

CMS has recently taken some steps to make it easier for victims of marketing misconduct to return to Original Medicare, including on a retroactive basis, by calling 1-800-Medicare. While we are grateful for this action, in our experience, it is very difficult for our clients to go through the process, which can take one hour or more on the phone, without the help of a trained counselor. While we and other advocates try to help as many people as we can, there are many, many more that never get help. In addition, we have found that, even when our clients are promised a retroactive disenrollment from their Medicare Advantage plan, in some cases CMS does not follow through and they remain stuck in the plan.

Other clients find themselves charged copayments for medical services that they received for free under Original Medicare. These individuals are very poor, many get by on well under $800 a month in one of the most expensive cities in the world. A $20 copayment to see a specialist means they won't get the care they need.

Generally, dual eligibles should not pay any cost-sharing for Medicare medical services by virtue of their enrollment in the Qualified Medicare Beneficiary program, which covers individuals living below the poverty line.

This means that dual eligibles enrolled in Medicare Advantage programs should not pay copayments for medical services and Medicare Advantage plans should not charge them copayments. States have an obligation to pick up this cost-sharing if their rates for services are high enough to allow for it.

Medicare Advantage plans that market to dual eligibles have a responsibility to educate all their providers not to charge dual eligibles the copayments and coinsurance that applies under their plan. If the plans cannot ensure that their dual eligible members will not pay more for their care after they enroll in the plan, they should not market their products to dual eligibles. At a minimum, plans that cannot make that assurance should warn prospective enrollees who are dual eligibles that they may pay more for their care after they sign up. In our experience, that never happens.

There has been a lot of publicity about abusive marketing by Medicare Advantage plans. As a result of the attention to this problem, seven private fee-for-service plans temporarily stopped marketing under an agreement with CMS. I have not seen any decrease in complaints from my clients about these marketing practices. I continue to see people who cannot get the care they need because they were tricked or deceived into joining a plan that does not meet their needs.

The Medicare Rights Center has instituted a protocol whereby we report marketing fraud in New York to the New York Department of Insurance. However, our clients are reluctant to provide detailed information about their fraudulent enrollment to the Department of Insurance. The majority of those clients are immigrants, have low incomes and low literacy levels. They are often people who fear the system and the possible consequences of reporting a powerful company.

I did not name the plans that we see engage in this marketing misconduct. But let me assure you, it is the same plans over and over again that are at the center of these marketing complaints. These are not rogue brokers. This is a consistent pattern of marketing misconduct by specific plans. Plans need to be held accountable for the actions of their representatives. They need to pay a price when they are found engaging in abusive marketing practices. That is the bottom line. That is what your work here must achieve. We need a system that punishes plans for engaging in deceptive, abusive and fraudulent marketing so that they stop these practices.

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