

Summary of the Testimony of Kathleen Healey June 26, 2007

- **State Health Insurance Assistance Programs (SHIPs) have been in existence for more than 15 years and are designed to help seniors and people with disabilities understand their health care coverage options.**

- **Examples of predatory Medicare Advantage marketing practices include:**
 - Agents do not identify themselves as insurance agents.
 - Agents ask to see beneficiaries' Medicare cards for verification purposes. Later, the beneficiaries find out they were enrolled in the plan without their knowledge.
 - Agents ask beneficiaries to sign forms for verification purposes or to receive a free gift. What beneficiaries are actually signing is the plan's Medicare Advantage application form.
 - Agents will arrive early if they know that the Medicare beneficiary has requested a friend or relative to be there for the appointment with the agent. By the time of the appointment, and the arrival of the trusted third party, the agents have already enrolled the beneficiaries and gone on their way.
 - Agents misrepresent the product they are selling as supplements to Medicare.
 - Telemarketing by plans has been equally aggressive. Phone calls to beneficiaries have used scare tactics and deception. Telemarketers have also misrepresented the company or the plan.

- **Beneficiaries must receive information on how to prevent becoming a victim of unscrupulous marketing practices.**
 - There must be a prevention message about health insurance fraud aimed at Medicare beneficiaries. Medicare beneficiaries must know the red flags to look for and how they can protect themselves.
 - SHIP is ideally situated to deliver the insurance fraud prevention message as we already have the infrastructure in place. However, SHIPs are severely underfunded and consequently under-resourced so it is difficult for many SHIPs to provide the proper tools to beneficiaries.
 - The Alabama SHIP is in the process of developing an insurance fraud prevention campaign which includes tools that will empower our seniors. However, we do not have adequate funding to implement such a program. With less than a dollar per beneficiary for our entire program and more than 750,000 Medicare beneficiaries in our state alone, our task is daunting.
 - Preventing the deceptive enrollment into Medicare Advantage plans, particularly private fee for service plans, would greatly diminish the casework of SHIPs and CMS Regional Offices.
 - Help SHIPs provide the tools to prevent Medicare beneficiaries from becoming victims and give state enforcement agencies the teeth to bring both insurers and agents to task for unscrupulous and/or fraudulent actions.

**Testimony
of
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**Before the House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

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Thank you, Chairman Stupak, Ranking Member Whitfield and members of the Subcommittee for the opportunity to speak on the predatory sales practices in Medicare Advantage and the challenges facing our Medicare beneficiaries and State Health Insurance Assistance Programs (SHIPs) throughout the United States.

State Health Insurance Assistance Programs (SHIPs) have been in existence for more than 15 years and are designed to help seniors and people with disabilities understand their health care coverage options. We are state-administered grant programs funded by the Centers for Medicare and Medicaid Services (CMS). SHIPs are housed in state Departments of Aging, Departments of Insurance and, in one state, the Medicare Quality Improvement Organization. Nationally, SHIPs receive significantly less than \$1.00 per beneficiary. While some states receive state funding in addition to their federal grant, many states rely solely on federal funding.

SHIP is a volunteer-based program and we ask a lot of the volunteers who join us. Many programs operate with one or two staff members and rely on volunteers to educate, counsel, and assist Medicare beneficiaries in their community. The SHIP network is the

only personalized, community-based, systematic and established source of one-on-one Medicare beneficiary counseling in the United States. We must know all of Medicare-- from Parts A, B, C and D to coordination of benefits, Medigap, long-term care insurance, preventive benefits and Medicaid. Our services are free, unbiased and confidential. Our dedication is strong.

SHIPs respond on a community level to Medicare beneficiaries:

- SHIPs educate beneficiaries about Part D, the Medicare Prescription Drug benefit, and the extra financial help available through the Low Income Subsidy and Medicare Savings Programs.
- SHIPs help beneficiaries understand their Medicare benefits by explaining which services are covered under which part of Medicare.
- SHIPs help beneficiaries determine if a Medigap policy is good for them and explain the benefits of each policy.
- SHIPs help beneficiaries understand the various public and private long-term care financing options that are available.
- SHIPs help beneficiaries resolve disputes with Medicare or a private Medicare plan.

- SHIPs provide consistent, unbiased counsel for beneficiaries and their caregivers, often in times of crisis.
- SHIPs educate seniors, those with disabilities, caregivers, and providers of medical services on all aspects of Medicare.

In Alabama, our volunteers and staff have been interviewed on television and radio. We have been quoted in newspaper articles, newsletters and magazines. We are a trusted resource. Nationally, SHIP staff and volunteers have educated and counseled millions of people and have distributed hundreds of thousands of informational flyers and tip sheets at enrollment and educational events.

Wherever Medicare beneficiaries have gathered, SHIPs have been there. We make presentations to retirees and also visit senior centers, congregate housing sites, libraries and churches. We also make presentations to state and county provider groups. Over the past two years, with the implementation of Medicare Part D (drug benefit) and the rapid expansion of Medicare Advantage plans, SHIPs have educated beneficiaries and their caretakers, provided enrollment assistance, counseled and resolved problems encountered by beneficiaries. We continue to monitor ongoing issues that have not been resolved, and provide reassurance to beneficiaries that there is an entity they can turn to when they do not know where else to go. We have worked with our CMS Regional Offices, hosted CMS Mobile Office Tour events, and implemented new CMS mandates. We have

reached out to create partnerships to better serve Medicare beneficiaries and to reach hard-to-reach populations.

Medicare's environment today is very complex. The numerous and varied options offered by private plans has exponentially increased the demand for SHIP services. Demand has increased not just from Medicare beneficiaries and their families and caregivers, but also from health care providers and community leaders. SHIPs are the essential, local resource for seniors and people with disabilities.

The Advent of Medicare Advantage and Prescription Drug Coverage

These new products, from stand-alone prescription drug plans to Medicare Advantage plans offered by private companies, have presented a challenge for Medicare beneficiaries unaccustomed to myriad of choices. Never before have beneficiaries had to select from so many different plans offering various options and levels of coverage. Never before have they had so many independent agents, whether welcome or unwelcome, selling health insurance plans. It is a new experience for many of our clients and this opportunity for choice has also created significant challenges.

Many times SHIPs have said that having choices, especially with prescription drug coverage, can be a good thing. At the same time, SHIP staff and volunteers have warned Medicare beneficiaries to guard their information; to keep their Medicare card as safe as possible as they would their credit card or Social Security number. The warnings have been inadequate because unscrupulous agents continue to lure unsuspecting and ill-

informed beneficiaries into plans they do not want nor necessarily need—especially if they are on both Medicare and Medicaid (also known as dual-eligible).

Keep in mind, Medicare Advantage products may provide good coverage for some beneficiaries. If a beneficiary makes an informed choice, has sufficient resources to cover co-payments and knows that his health care providers will accept it, private fee for service (PFFS) and other Medicare Advantage plans can work very well. It is not that people with Medicare are incapable of making a wise choice; it is that the system often prevents an informed choice. The choices available are not meaningful when Medicare beneficiaries do not understand how the plans are structured or how to discern true benefits from the flood of sales material coming their way. Unscrupulous agents, seeking only a fast, and high, commission, provide misleading information or utilize questionable sales tactics to encourage beneficiaries to sign up for their plan.

Medicare Advantage Marketing Practices

Let's look at some widespread examples from Alabama that our SHIP clients have experienced:

- Despite the prohibition of door-to-door marketing, agents arrive on residents' doorsteps stating that "the President" sent them or that they represent Medicare. These agents bear business cards touting themselves as "Medicare specialists" or "senior services specialists," not insurance agents.

- Agents ask beneficiaries to show them their Medicare cards and, if applicable, their Medicaid cards, to verify that the beneficiaries are on Medicare. Later, the beneficiaries find out they were enrolled in the plan without their knowledge. If they are dual-eligibles, the applications often state that the beneficiaries are not Medicaid recipients.

- Agents ask some beneficiaries, after an initial visit, to take them around their apartment building or neighborhood so the agent could visit and sign up their neighbors. These agents ask the beneficiaries to introduce them to friends and relatives who are Medicare beneficiaries and who may or may not live in the same neighborhood. In one situation, an agent told the residents of a senior residential apartment complex that Medicare and a specific PFFS company had assigned the agent to that apartment building and that no other company was supposed to be there.

- After a sales presentation, agents ask beneficiaries to sign forms merely verifying that the agents have met with beneficiaries or they ask beneficiaries to sign forms in order to receive “free” gifts. What the beneficiaries are actually signing is the plan’s Medicare Advantage application form.

- Agents encourage beneficiaries to enroll in plans stating the beneficiaries would not pay anything for medical care and if they did not sign up, the beneficiaries

would be penalized by Medicare. Not wanting this “penalty,” the beneficiaries, who are often dual-eligible, enroll in the plans.

- Agents tell beneficiaries that the private fee for service (PFFS) plan they are offering is supplemental insurance.

- One agent continued to visit a building where he enrolled many of the residents. When residents complained to the agent about receiving bills for co-payments from their health care providers, the agent took the bills and said that he would straighten them out with the plan and call the beneficiaries back. They did not hear from him again and the unpaid bills were turned over to collection agencies.

- Agents have repeatedly used red, white and blue business cards that look like miniature Medicare cards.

- Telephone marketing has been equally aggressive. Repeated phone calls to beneficiaries have become increasingly threatening, using scare tactics and misrepresentation. One plan called the same person five times in one day. Telemarketers have called beneficiaries stating that Medicare needs to send an agent to their homes to correct a mistake in the *Medicare and You* handbook that all beneficiaries receive. Some telemarketers insist that they are calling from Medicare and they tell beneficiaries that they will lose their Medicare if they do not sign up for the telemarketer’s plan. Telemarketers have told beneficiaries they

have the plan that the government won't tell beneficiaries about and it could save beneficiaries money. Telemarketers have told beneficiaries that Medicare is going out of business or that Medicare is being turned over to the plan.

- Agents will arrive early if they know that the beneficiaries have requested friends or relatives to be with them during the appointment. By the time of the appointment, and the arrival of a trusted third party, the agents have already enrolled the beneficiaries and gone on their way.

In many instances, beneficiaries do not even realize they are no longer enrolled in Original Medicare. Beneficiaries learn of their enrollment into Medicare Advantage plans when a health care provider refuses to see them because the provider does not accept the terms and conditions of the new plan—most often a private fee for service (PFFS) plan—the provider is out of the plan's network, or the beneficiary begins to receive bills from providers for unpaid services or co-payments.

When beneficiaries learn that they have been deceptively enrolled in Medicare Advantage plans, they try to sort out the challenges and problems on their own. Too often they discover that it is not an easy problem to fix and that they require assistance. SHIPs provide that needed help. Deceptive marketing has a profound impact on a person's access to health care and well-being. The best way to have a clear picture of the problem is to have the rest of the story—the before and after the misrepresentation or deception by the agent:

Example 1:

Ms. J is a 61-year-old disabled woman. She has had both Medicare and Medicaid (a dual-eligible) for several years. In January 2007, she went to her local pharmacy for assistance in finding a Part D plan. Her pharmacist signed her up with Company D's prescription drug plan. Several months later, an agent with Company D came to her home and asked her if she would like to sign up for free supplemental insurance since she did not have any. He also told her that by signing up she would not lose any of her current benefits and she would receive additional coverage that Medicare does not provide.

In May 2007, she went to her family doctor and discovered that she was no longer covered by Original Medicare and that her doctor did not take Company D's private fee for service (PFFS) plan. She contacted Social Security and was given the number for SHIP.

SHIP discovered that Ms. J was not enrolled in the Part D plan that could save her the most money, so we changed her drug coverage plan to something that would work better for her. At the same time, we also faxed and mailed a request for her to be disenrolled from Company D's private fee for service plan.

Example 2:

Ms. F is an 80-year-old widow. She has been on Original Medicare with Company X's Medigap policy providing her with supplemental insurance. Ms. F takes care of Ms. G

who is her 55-year-old disabled daughter. Ms. G has been a full dual-eligible (which means she has both Medicaid and Medicaid) for many years. Ms. F chose Company X's prescription drug plan (PDP) for herself and her daughter in January 2007. In February 2007, an agent from Company X came to her home and asked her if she would like to make her life easy by having her and her daughter's medical coverage simplified by having Company X serve as their supplemental insurance. She explained that her daughter had Medicare and Medicaid; therefore, she did not need supplemental insurance. The agent countered this by saying she would get extra benefits for her and her daughter at no additional cost and that their current benefits would not be affected. Ms. F then enrolled herself and her daughter into Company X's plan—a private fee for service (PFFS) plan.

Two months later, Ms. F took her daughter to see her specialist. When they arrived, Ms. F was asked to make a co-payment. When she inquired why (because they had never paid one before), she was told that her daughter no longer had Medicare and Medicaid. Ms. F went home and contacted the agent who sold her the plan and was told that she could not get out of the plan. Ms. F contacted SHIP. Our office contacted Company X and was told she could disenroll. We then faxed and mailed a request for Ms. G and Ms. F to be disenrolled from the plan.

Example 3:

Mrs. H and Mr. I are in their seventies. Both have been on Original Medicare for years and have a supplemental insurance policy (a Medigap) with Company M. In March 2007,

Mrs. H received a call from Company B's agent inquiring about her supplemental coverage. He wanted to know how expensive the coverage was. Mrs. H told him that it was rather expensive and that she was concerned because it was going up every year. He then asked if he could come by and talk to her and her husband about a supplemental plan with his company that was not expensive. Once the agent arrived, he told them they were eligible for a free supplement to Medicare through his company. Mrs. H inquired about the cost that they would have to pay up front to see their doctor and was told that they would only have to pay a \$10 co-payment and that they could drop their policy with Company M.

Two days after enrolling in the plan, Mrs. H and Mr. I went to their local senior center and heard a presentation given by the SHIP coordinator on Medicare Advantage. It was not until they heard the presentation that they realized the agent had given them misleading information.

After leaving the senior center, Mrs. H went home and contacted the plan and asked if she and her husband could be disenrolled. She was told they could not. She contacted SHIP. We sent a request to be disenrolled for Mrs. H and Mr. I. They were successfully disenrolled on May 1, 2007.

Example 4:

Ms. C is disabled. She has been a dual-eligible, having both Medicare and Medicaid, for many years. She has suffered from seven strokes and is required to see numerous

specialists. In January 2006, she was auto-enrolled in Company A's prescription drug plan (PDP). In April 2006, she was suddenly disenrolled from Company A because she had been auto-enrolled into five other prescription drug plans, all of which began to cancel each other out.

In May 2006, Ms. C was not enrolled in a PDP and she had to pay for her medications without any help. One day in May 2006, she was shopping with her parents at a retail store and saw a Company A agent. She asked the agent if he could sign her up for the stand-alone prescription drug plan (PDP) she first had in January 2006; however, the agent, knowing she was receiving Medicaid benefits, signed her up for Company A's private fee for service (PFFS) plan even though she repeatedly told him she only wanted drug coverage.

After Ms. C enrolled with what she thought was Company A's PDP, she received a card from Company B, another company. Company B paid for her prescriptions until August 2006. Company B was cancelled in August because Company A (the plan into which she was enrolled in May) reflected on the Medicare system in August. Ms. C decided it was best to contact CMS about her problems. CMS filed a complaint on her behalf.

Meanwhile, she began receiving calls and bills from her physicians as a result of unpaid medical bills. Ms. C was shocked because she was under the assumption that Medicare and Medicaid were still paying her bills. She had no idea that Company A was supposed to be paying. When she tried to get her physicians to file with Company A, she

discovered that they did not accept Company A. Ms. C contacted CMS again because she had over \$900,000 in unpaid medical bills. CMS forced Company A to pay the unpaid bills and to process her disenrollment from its plan.

Unfortunately for Ms. C, she began receiving collection letters from Company A because of unpaid premiums. The premium was over \$33 per month. Her income was \$643 per month. Ms. C contacted Company A and the collection agency because she did not think she should have to pay for the plan since she never asked for it. Both Company A and the collection agency told her that there was nothing she could do but pay the bill. Ms. C began to send regular payments of whatever amount she could afford. The collection attempts still continued, only stronger.

Ms. C found out about the SHIP program and contacted our office. We have worked with Ms. C to stop the collection efforts and to have the premiums written off by Company A. In late June 2007, we received a letter stating that the plan would not seek payment for the premiums.

These are just some of the examples of how the marketing practices impact Medicare beneficiaries and impede their access to health care. We send complaints to the CMS Regional Office when we need a retroactive disenrollment and to provide examples of what we are seeing at the local level.

CMS has told SHIPs on several occasions that the responsibility to resolve problems lies squarely with Medicare Advantage plans. Consequently, SHIPs contact the plans. In some instances, we must also contact 1-800-MEDICARE as we piece together a case history.

There are two main stumbling blocks which often stymie SHIP case resolution efforts:

1. SHIP has no official, dedicated lines to plans or 1-800-MEDICARE

SHIPs have had to be resourceful to serve the beneficiaries. With no “named” plan contacts from CMS nor required dedicated phone lines for SHIPs to utilize in case resolution for plans or 1-800-MEDICARE, state SHIPs have developed workable solutions to get the job done. We find our own contacts at plans. When we run into issues where the “scripts” used by the customer service representatives with the plans and with Medicare are incorrect or miss the point, we muscle our way up the chain of command to find someone who can solve the problem. We try not to refer cases to the CMS Regional Offices if we can solve them ourselves because we know of the backlogs and time delays that can result. These time delays often cause additional issues as beneficiaries hesitate to seek necessary medical care, unsure of their health insurance coverage.

2. 1-800-MEDICARE refers directly to SHIPs

Throughout the existence of Medicare Advantage and Part D, SHIPs have consistently experienced Customer Service Representatives (CSR) at 1-800-Medicare referring beneficiaries to SHIPs for assistance. The CSRs follow scripts for the calls. It is not

unusual to have a SHIP counselor or even a SHIP director or program staff member contact 1-800-MEDICARE for assistance only to be referred back to the state SHIP.

Each SHIP has seen an increase in casework volume. These cases are also increasingly complex and require an extraordinary amount of time to resolve. However, we have been doing the best we can given our limited federal funding and staff resources. Mandatory access to plans and the necessity that these companies recognize SHIP and our efforts on behalf of beneficiaries would be one key to more efficiency in handling the complaints and problems we receive. After all, access is critical to handling cases in a timely fashion. That still does not address fundamental marketing problems and processing delays that get the beneficiary in the pickle in the first place.

Are the solutions proposed by CMS to address predatory marketing practices enough?

The most recent solutions presented by CMS and the state Departments of Insurance are a start, however, they are not the complete answer. Yes, a State Department of Insurance can pass regulations that would require each insurance agent to leave a business card with the beneficiary. And yes, they could also require agents to identify themselves as insurance agents and inform the person that they are representing a product, not Medicare or Medicare supplements. And, if they violate these provisions and other marketing guidelines, these agents could be subject to discipline. As you know, CMS will be requiring more of the plans beginning in 2008.

Is the problem real?

In a recent press release CMS has stated that it has received only 2,700 complaints nationwide, a relatively minimal number. It is my impression that not all cases are being reported. For example, SHIPs do not refer all cases to CMS. We handle them ourselves. Additionally, from my involvement with elder abuse and legal assistance with our agency, I have learned that for all the elder abuse cases that are reported, there are just as many or more that go unreported. Perhaps a better gauge is the number of Medicare Advantage disenrollment requests that have been filed.

Beneficiaries must receive information on how to prevent becoming a victim of unscrupulous marketing practices

CMS has taken steps in the right direction by announcing some new corrective actions. However, CMS has failed to mention the prevention message that must be delivered to Medicare beneficiaries. It does no good to establish rules and regulations about what agents may or may not do, or what type of marketing the plans may or may not undertake, and not speak directly to the very population these plans and agents are targeting. How would a beneficiary know that they should be very suspicious of an insurance agent who comes to his or her door unannounced and without an appointment?

There must be a prevention message—not about health care—about health insurance fraud aimed at Medicare beneficiaries. Medicare beneficiaries must know the red flags to look for and how they can protect themselves. A comprehensive media campaign with a simple message would be a start.

SHIP is ideally situated to deliver the insurance fraud prevention message to Medicare beneficiaries since we already have the infrastructure in place. I have seen it work in Alabama. Our SHIP has been able to educate beneficiaries and those who have heard the message have been empowered. For example, an agent attended a senior center when the director was absent hoping to make a sales presentation and enroll attendees.

Unfortunately for the agent, the seniors had also been taught by SHIP what questions to ask agents and how the PDPs and Medicare Advantage plans work. The seniors were able to determine fact from fiction and literally ran the agent out of the building.

However, SHIPs are severely under-funded and consequently under-resourced so it is difficult for many SHIPs to provide the proper tools to beneficiaries. An adequately funded, comprehensive educational and media campaign with a unified message aimed at beneficiaries would achieve dramatic results. The campaign could arm Medicare beneficiaries with the information they need to protect themselves from unscrupulous insurance companies and their agents.

The Alabama SHIP is in the process of developing an insurance fraud prevention campaign which includes tools that will empower our seniors. However, we do not have adequate funding or resources to implement such a program. With less than a dollar per beneficiary for our entire program and more than 750,000 Medicare beneficiaries in our state alone, our task is daunting. Developing the media campaign and printing and

disseminating these materials to the target population is expensive. I urge you to support an increase in SHIP funding nationwide.

Preventing the deceptive enrollment into Medicare Advantage plans, particularly private fee for service (PFFS) plans, would greatly diminish the casework of SHIPs and CMS Regional Offices. Please help SHIPs provide the tools to prevent Medicare beneficiaries from becoming victims and give state enforcement agencies the teeth to bring both insurers and agents to task for unscrupulous and/or fraudulent actions.

I want to thank the Committee for holding this hearing. I have shared with you only a handful of examples; they are not the only ones, or even the most egregious. Rather, they are representative of the problems experienced by thousands of beneficiaries nationwide. I hope the experiences I have shared with you will help serve as a catalyst for the development of real solutions so Medicare beneficiaries may rest assured that their health care—whether it is Original Medicare or Medicare Advantage—is truly their choice.