



## **THE PRIVATE MEDICARE TRAIN IS ALREADY OUT OF THE STATION**

Medicare was created in 1965 because over 50% of everyone 65 or older had no health insurance. Private insurance failed to meet their needs. Medicare, on the other hand, is a success. It increased the number of insured older adults to 95%. In 1972 Medicare coverage was extended to people with significant disabilities. But Medicare's success in providing access to healthcare for millions of people is in danger. Ironically, the threat comes from private insurance plans. Funded by windfall subsidies from taxpayer dollars, privatization is jeopardizing the cost-effective, dependable Medicare program.

Medicare wasn't broken, but because of the ever-increasing private Medicare options, it is breaking. The myriad private plans are creating confusion and barriers to care for real people. The Center for Medicare Advocacy is contacted everyday by people who were inappropriately marketed to, people who did not understand what they were getting into, people who have been unable to get the health care services they need from their Medicare Advantage (MA) plan, and people who are "locked into" their MA plan. Further, the Center gets calls for help from people who thought they had MA "on top of" their regular Medicare and/or Medigap and are surprised to find out that is not true when the service or provider they need is not covered by their MA plan.

Medicare privatization will cost taxpayers approximately \$150 billion over the next ten years, while it hurts many people with Medicare and strangles the traditional Medicare program. Consider these stories from just a few of our clients:

- Mrs. W called us with a Medicare Advantage (MA) problem. She went from a hospital to a nursing home and is now being billed for \$13,000 because the nursing home was out of her MA plan's network. She was told by both the hospital and nursing home staff that original Medicare would cover her nursing home stay, even though she had an MA plan. This is not the case. The beneficiary herself is extremely confused and was unable to answer any of the Center attorney's questions.
- The Center has a case pending for a gentleman who is in an MA plan in Connecticut and went out of network for doctor's services. He is now being billed \$5,000. This gentleman is functionally illiterate and states that he did not understand that he needed to go in network when he first signed up for the MA plan. He says he did not receive any booklets or anything in writing from the MA plan regarding the network's providers. Even if he did, he likely wouldn't have been able to read the information or comprehend the concept of a network.
- A Center attorney recently received a call from a woman with significant MA concerns. She and her husband were visited by an MA marketing representative for a Private Fee For Service Plan (PFFS). He came door to door and was absolutely not invited. The woman told our attorney that both she and her husband suffer from brain injuries and previous strokes and that they were both distressed when the agent came into their home. He told them that he wanted to talk to them about a "new kind of Medicare." She said that she listened but did not understand and that he gave too much information too fast. She said she filled out the form he had and said yes to all of his questions just to get him to leave her home; this all happened in January, 2007.

When the woman called the marketing representative to disenroll the representative told them to just send a letter to the plan and that would effectuate the disenrollment. She did so in January and has still not been disenrolled. In fact, they have needed and received medical services since then and are now being billed and sent to collection. For example, the husband requires shots from an oncologist which cost \$3000 each; he has had three. Other doctor's visits include a hospital CT scan, neurologist visits, and endocrinologist visits.

- Mr. N, one of the Center's clients had traditional Medicare along with a Medigap supplemental policy. He was approached by an MA plan *while at his dialysis unit*. He was told that the MA plan and the Medigap policy together would cover all his expenses. Our client's wife called today because they are now receiving bills for the balance of what the MA plan did not cover. When she contacted the Medigap representative, he told her that because she now is in an MA plan, the Medigap won't cover the balance. Mrs. N then called the MA plan to disenroll because she is worse off than before joining the MA. They told her she couldn't disenroll at this time.

The Center is working to retroactively disenroll Mr. N from the MA plan based upon the misinformation that he was given by the marketing representative. Hopefully, if the retroactive MA disenrollment is granted, the Medigap policy will provide retroactive coverage for the past bills.

- A Center attorney received a call from the daughter of a beneficiary who speaks very little English. Apparently an agent from an MA plan in Hartford, CT came door-to-door (without being invited, which is a marketing violation) visited this woman's mother and got her to sign an application. The representative told the mother that everything would be "free". The daughter called the plan and was able to get her mother disenrolled. But, Social Security is still deducting the monthly premium for the MA plan from her mother's SS check so she called the Center to get help with the premium problems. Her mother needs the money.
- The Center was recently contacted by the daughter of a woman who signed up for a particular MA plan. Apparently representatives from the MA plan called and asked if they could come to the mother's home. She, and the daughter, visited with the representatives and made it very clear that what they were looking for 100% coverage of the mother's dialysis treatments. The representatives told them that if she signed up her dialysis treatments would be covered 100%.

It soon became clear to the mother and daughter that the plan only covers 80% of dialysis treatments, the same as traditional Medicare. In addition, it became clear that the plan never should have offered to sign her up in the first place because she has ESRD which precludes her from signing up for this plan.

- Another gentleman called the Center. He was visited by an MA plan and was told that the plan was "free" which it is not. He just received a letter from SS saying that \$46.00 would be deducted from his Social Security check. This is how he found out that the plan was not "free."

"Medicare Advantage" is starving the successful traditional Medicare program and hurting beneficiaries. Studies by MedPAC, the Congressional Budget Office, and the Commonwealth Fund and numerous scholars confirm that taxpayers are spending between 12 – 19% more on private plans than it would cost to serve the same people in the traditional Medicare program. Meanwhile, private Medicare has proven far less able to provide secure health insurance and a wide choice of doctors and other healthcare providers for older people and people with disabilities.

The solution for the Medicare crisis is not to increase the eligibility age or decrease benefits, but to stop privatizing the program at the expense of older people and taxpayers.

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