

**Testimony of Jennifer Hatton
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Before the Committee on Health, Council of the District of Columbia

**Public Oversight Hearing on Medicare Part D and Health Insurance Plans for Seniors in
the District**

June 25, 2008

Introduction

Seniors in the District face numerous unnecessary challenges in accessing and understanding Medicare benefits that they receive through Medicare Parts C and D. With respect to the prescription drug benefits provided through Part D, clients routinely receive insufficient information about Part D plans and the District programs that help them access these benefits and unreliable information from the plans themselves. There are also serious data transmission problems between government agencies, resulting in consumers not receiving necessary medicine. When the Medicare Part D program was first being implemented, we testified before this Committee about our concerns that the new prescription drug benefit would be too difficult for our clients to navigate and that many people would not be able to receive their medications. Sadly, many of these fears came to pass despite the resolution of many of the early implementation problems.

We also continue to see evidence of the unscrupulous tactics of representatives of some Medicare Advantage plans through Medicare Part C. These are insurance plans run by private companies that are authorized by the federal government to provide Medicare services through a managed care model. These plans could work for some Medicare recipients by providing lower copayments or coinsurance and expanding covered services. However, a serious drawback to joining one of these plans is the potential loss of choice in medical providers. Furthermore, for low-income individuals who receive Medicaid or Qualified Medicare Beneficiary (QMB) benefits that pay Medicare's copayment, coinsurance, and deductibles, it is extremely unlikely that there would be any benefit to joining such a plan. Obviously, the decision to join such a plan should be a reasoned one in which the consumer has sufficient information and capacity to fully understand his or her options presented in an unbiased manner. We know, however, that this is not what happens.

The Legal Aid Society is pleased to participate in this hearing to highlight these broken systems. The experiences of Legal Aid's clients highlight the urgency of the need for their reform. We understand that many of the problems with Medicare Parts C and D can only be addressed at a federal level. But, there are several things that the District could do to improve the ability of District residents to access these benefits.

¹ The Legal Aid Society was formed in 1932 to "provide legal aid and counsel to indigent persons in civil law matters and to encourage measures by which the law may better protect and serve their needs." Over the last 76 years, tens of thousands of District residents have been served by Legal Aid staff and volunteers. Legal Aid provides assistance in public benefits, housing, domestic violence, and family law matters.

1. Provide improved outreach about Medicare Parts C and D and how to get help with these programs.
2. Provide improved outreach about Medicaid and QMB and their impact on Medicare.
3. Improve the ability of the District to transmit and receive data from the federal government for Medicare beneficiaries who receive Medicaid and QMB.
4. Dedicate funding to assist Medicare and Medicaid or QMB beneficiaries who are having difficulties accessing their drugs.

We understand that some of these solutions will require a modest amount of dedicated funds and look forward to working with this Committee regarding these proposals. However, we believe that the outreach and improving data transmission between the District and the federal government could be accomplished, at least in part, without additional resources.

Legal Aid's Clients Have Been Harmed

The population that receives Medicare is by definition elderly and/or physically or mentally disabled. The Medicare recipients we encounter at the Legal Aid Society face many other challenges as well, including low income, geographic isolation, and limited literacy. I will first address specific Medicare Part D problems and then address Part C.

Medicare Part D

At the beginning of the Medicare Part D program, we encountered numerous elderly and disabled clients (and their confused and anxious children) who simply did not understand the new rules and could not get their medications. The examples of crises and near crises abound – one woman with cancer could not get her anti-nausea drugs; one woman with mental illness (who testified before this Committee) could not get the medications that control her disease; and one man who had no legs could not get the Percocet he needed to control his pain.

Many of the early implementation problems have improved. Many of the individuals we work with at least have a basic understanding of the program and how it is supposed to work. The Part D plans, while still problematic in many respects, also have a greater familiarity with the rules and appear better equipped to deal with complaints. CMS, the federal Medicare agency, is now less overwhelmed and often provides helpful assistance in a reasonably timely manner.

Nevertheless, we are still concerned that the people who need help the most and are least equipped to deal with problems are having troubles. The problems that we still see are:

- (1) **Lack of information about Medicare Part D.** We still encounter people who do not fully understand how they are getting their prescriptions. More importantly, when problems arise in their coverage, they do not know how to address them. We fear that

many people are going without medications or borrowing from friends or family rather than challenging plan decisions because they do not know how to do so.

- (2) **Lack of information about Medicaid and the Qualified Medicare Beneficiary program and the impact on Medicare of having these benefits.** The District should be commended for expanding eligibility for the Qualified Medicare Beneficiary (QMB) program through which the District pays a Medicare beneficiary's co-payments, coinsurance, and deductibles. Furthermore, being a QMB participant also results in lower co-payments and no premium payments for Medicare Part D. Nevertheless, we still encounter individuals who are eligible for QMB but have not been informed about the program or how to get the benefits. Systematic outreach is needed to make sure that eligible Medicare beneficiaries know about this benefit and how to access it.
- (3) **Problems with data transmission between the federal agencies and District agencies that deal with Medicare and Medicaid.** Our clients rely on the government agencies to transmit data relating to their eligibility for the low-income subsidy and their changes in enrollment. Unfortunately, significant delays and occasional glitches in the system fail to relay this information in a timely manner, and many people experience gaps in coverage as a result. One straightforward proposal would be to transmit to and receive data from the federal government more frequently than the current once a month transmission.
- (4) **Relaying of wrong information by plan customer service representatives, which delay the resolution of problems.** When Part D plans fail to transmit correct information to CMS, beneficiaries suffer serious consequences. One of my clients, after successfully switching Part D plans in December, could not get her drugs from her pharmacy in January because the data her plan provided to the pharmacy was wrong. In this case, her plan's inability to both capture and transmit her low-income subsidy status prevented her from getting her drugs. In another case, a client of mine, after successfully switching Part D plans, could not get his drugs for several days because of a glitch in the plan's database. This glitch essentially rendered my client's enrollment in the plan effective for only a day at a time. In order to get his drugs, my client had to call the plan every time he wanted to go to the pharmacy so that the plan could confirm his enrollment with the pharmacy. For a man who suffers from a number of serious medical problems, this was no easy task.
- (5) **Lack of a safety net for individuals in emergency situations.** As a result of these problems and the increased co-payments for individuals who used to receive their drugs through Medicaid and now receive their drugs through Medicare Part D, these low-income elderly and disabled individuals can find themselves in emergency situations in which they cannot get their medications. We would like to see the District commit funding in the next budget cycle towards an emergency assistance program that low-income Medicare beneficiaries could access when they cannot get their drugs through Part D.

These problems need to be addressed in order to make the Medicare prescription drug benefit work for people in a meaningful way. Although there is much that the District cannot solve,

additional outreach and education, improvement of data transmission, and appropriation of funding for emergencies could make a substantial difference in the quality of life for some of our most vulnerable beneficiaries.

Medicare Part C

While logistical challenges are pervasive in the context of Part D, far more sinister practices exist in the Part C context. We continue to see evidence that health insurance companies are misleading Medicare beneficiaries in an effort to enroll them in Medicare Part C plans. Because these Part C plans are usually ill-suited for dual beneficiaries or Medicare beneficiaries with QMB benefits, individuals should only enroll in such a plan if they fully understand the benefits and costs associated with the plan.

We know, however, that representatives of Medicare Part C plans have been targeting subsidized apartment buildings that serve low-income elderly and disabled individuals to try to get these individuals to enroll in their plans. They use illegal and misleading tactics – such as going door-to-door to sell their product, implying that they are with Medicare, misstating the potential benefits of the plan, and telling the individuals that their plan will replace Medicare and Medicaid. Given the challenges that many of these individuals face with literacy and capacity, people succumb to these tactics and, in the process, lose the ability to see their provider, and face medical bills that they should not have incurred.

The story of one of my clients, Ms. M, illustrates the significance of these barriers. Ms. M is a 74-year-old woman who is dually eligible for Medicare and Medicaid. She resides at a building that was targeted by Bravo, a company that offers both Part C and Part D plans. We first met Ms. M when she came to a Medicare Part D clinic that we organized. While we were helping her choose a prescription drug plan, we realized that her existing prescription drug coverage through Bravo was in connection with a Bravo managed care plan through Medicare Part C. We then learned that Bravo representatives came to her building in the summer of 2007 to sign up residents for their Part C plan. The representatives told residents that their plan offered a variety of free services, including prescription drug coverage. Further, Ms. M was told that she would not have to pay anything for this plan because she is a senior citizen. When Ms. M started to encounter problems with her coverage, however, she realized that there were indeed high costs associated with this plan. First, Ms. M started to receive medical bills for services that she thought would be covered. She also became frustrated when she learned that she was now going to have to get a referral from a newly-designated (and unfamiliar-to-her) primary care physician for most, if not all, of her services. It was only with the help of a lawyer that Ms. M was able to obtain retroactive disenrollment from Bravo, choose a prescription drug plan that better met her needs, and resolve a medical billing dispute that arose as a result of her enrollment in Bravo. While we are pleased with these results, we fear that there are many others who were similarly harmed but have not obtained legal counsel to help them resolve these issues.

Regarding the misleading practices of Part C plans, the federal Medicare regulations unfortunately appear to preempt any state or individual efforts to bring consumer protection actions against these companies under state law. Insurance commissioners have been frustrated in their inability to hold these agents and companies accountable for the state regulations they are

violating. New federal regulations by CMS might partially address this problem. Legislation has also been introduced, but not adopted into law, which would solve these problems.

However, there are some actions that the District can take. The District's Insurance Commissioner can take complaints and monitor the actions of agents and brokers. The District's Office of Aging and the District's Medicaid agency can reach out to the District residents they work with to ensure that they understand that these plans might not be right for them. They can also connect concerned people whom they encounter with an agency that can help them.

Conclusion

We want to thank you again for holding this hearing so that District residents can be educated about their rights under Medicare Parts C and D and hopefully gain a better understanding of what these programs entail. We hope that the executive branch will follow suit and do outreach and education on these programs and improve their operations with the federal government. We look forward to working with you and the Fenty administration to accomplish some of these goals.