



**Public Advocate for the City of New York**

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## **Misleading Marketing: How HMOs Lure Medicare Beneficiaries**

**PUBLIC ADVOCATE BETSY GOTBAUM  
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**OFFICE OF THE NEW YORK CITY PUBLIC ADVOCATE**

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## **Introduction**

The number of Medicare beneficiaries in New York City receiving health care coverage through private “Medicare Advantage” plans rather than through the federal government’s traditional Medicare plan has reached an all-time high. Currently 24.2 percent of Medicare beneficiaries (252,439) in the City are enrolled in private plans, the vast majority of which are health maintenance organizations (HMOs).<sup>1</sup> Past research has shown that Medicare HMOs sometimes persuade beneficiaries to enroll in their plans by making incomplete, misleading, or false claims about plan offerings.<sup>2</sup>

In light of this research, the Office of the Public Advocate sought to assess current marketing practices of Medicare HMOs in New York City. This assessment is particularly timely. HMOs promoting coverage under Medicare’s Part D benefit began marketing to Medicare beneficiaries on October 1.<sup>3</sup> As the decision-making process for seniors becomes more complex, it is important that pre-existing marketing abuses be recognized and understood.

Additionally, beginning in 2006 Medicare will implement “lock-in” restrictions, which will prohibit beneficiaries from switching health care plans freely. These restrictions could have harmful consequences as beneficiaries who are dissatisfied with HMO care or services may be prevented from selecting different coverage.

This report not only critiques the marketing practices of Medicare HMOs in New York City, but also provides resources for beneficiaries, including information for those considering HMO coverage.

## **Background**

Medicare is the national health insurance program for people over 65, people with Amyotrophic Lateral Sclerosis (ALS), some disabled people under 65,<sup>4</sup> and people with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant. Medicare Part A generally covers inpatient hospital expenses, while Medicare Part B covers outpatient costs and doctors’ services. Part A is generally free for those who have a work history, while Part B requires a \$78.20 monthly premium.

Individuals with Medicare Part A and B coverage have the option of enrolling in “Medicare Advantage” Plans, which are administered by private insurance companies and offer various coverage options. Under Medicare Advantage, beneficiaries continue to

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<sup>1</sup> “Medicare Advantage Enrollment Reaches Record High,” *Greater New York Hospital Association-Skyline News*, July 11, 2005.

<sup>2</sup> Government Accountability Office, “Medicare+Choice: HCFA Actions Could Improve Plan Benefit and Appeal Information,” April 13, 1999. Mark Green, Public Advocate for New York City, “Managed Confusion: How HMO Marketing Materials Are Tricking the Elderly and the Poor,” Nov. 1995. Families USA, “Comparing Medicare HMOs: Do They Keep Their Members,” Dec. 1997.

<sup>3</sup> Part D will give Medicare beneficiaries a choice of prescription drug plans with various types of coverage. Enrollment will be voluntary. Individuals who enroll will pay a monthly premium (generally about \$37) and will make co-payments towards drug purchases.

<sup>4</sup> Disabled individuals under 65 must be receiving disability benefits from either Social Security or the Railroad Retirement Board for at least 24 months before being enrolled in Medicare.

pay their \$78.20 Part B premium to Medicare, while Medicare pays a set amount of money to private insurance companies to provide health coverage to beneficiaries. Most Medicare Advantage Plans in New York City are run by HMOs.<sup>5</sup>

Many Medicare Advantage HMOs provide additional benefits not available through traditional Medicare, such as vision and dental care, prescription drug coverage and more. But, like standard HMO coverage, these plans come with significant limitations. For example, Medicare HMO plans require that beneficiaries receive care through a network of doctors and hospitals. Some may also require that plan participants receive referrals from a primary care doctor before seeing a specialist. Additionally, care covered by an HMO is usually limited to a geographic service area.

In some cases, HMOs providing Medicare coverage may offer individuals better benefits and lower costs. However, the decision whether to enroll in a private plan depends upon each individual's health care needs and preferences.

### **Past Problems with Medicare Marketing**

Marketing materials from HMOs providing Medicare coverage sometimes present an incomplete or misleading view of plan offerings, and as a result, beneficiaries may not understand the limitations of some private plans. Some may not understand the network-based model of care and may not realize they will need to switch to an "in-network" primary care physician. Others may be misled into thinking that HMO coverage is free or costs less than traditional Medicare.

A 2000 study by the Inspector General at the U.S. Department of Health and Human Services found that Medicare beneficiaries who enroll in HMOs often do not understand the parameters of extra benefits, such as coverage for prescription drugs, eye exams, eye glasses, hearing aids, and more.<sup>6</sup> The Inspector General noted that "HMO enrollees are more likely to overestimate, rather than underestimate, the benefits their HMO provides."<sup>7</sup> In 1999, the New York City Public Advocate's Office under Mark Green analyzed managed care marketing materials targeting the Medicare and Medicaid populations, finding numerous examples of unclear, misleading, and false information.<sup>8</sup>

Research has also shown that lower-income individuals (specifically Medicare/Medicaid dual eligibles), beneficiaries over 80, as well as racial and ethnic minorities, experience greater dissatisfaction with certain aspects of managed care.<sup>9</sup> This may be attributable to

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<sup>5</sup> Medicare Advantage plan availability varies by county. Available plans are listed through Medicare's Personal Plan Finder at: <http://www.medicare.gov/MPPF/Include/DataSection/Questions/Questions.asp?version=default&browser=IE%7C6%7CWinXP&language=English&year=2005&defaultstatus=1&pagelist=Home>

<sup>6</sup> Office of the Inspector General, "Medicare + Choice HMO Extra Benefits: Beneficiary Perspectives," U.S. Department of Health and Human Services, Feb. 2000.

<sup>7</sup> Id.

<sup>8</sup> Mark Green, Public Advocate for New York City, "Managed Confusion: How HMO Marketing Materials Are Tricking the Elderly and the Poor," Nov. 1995.

<sup>9</sup> Mary Laschober, Ph.D., "Estimating Medicare Advantage Lock-In Provisions Impact on Vulnerable Medicare Beneficiaries," *Health Care Financing Review*, Spring 2005.

the fact that members of these vulnerable groups do not fully understand the limitations of HMO coverage prior to enrollment.

Marketing practices have improved in recent years. The Centers for Medicare and Medicaid Services (CMS), the federal entity which administers Medicare, has issued Medicare Managed Care Marketing Guidelines to help beneficiaries make informed decisions.<sup>10</sup> Under these standards, companies are no longer permitted to use certain misleading statements such as “free coverage” or “ranked number one,” in their materials. While there is no doubt that the restrictions have helped to improve the marketing practices of HMOs, problems persist.

As this report will make clear, misleading and incomplete advertisements for Medicare HMOs can be found throughout New York City. According to Robert M. Hayes, President of the Medicare Rights Center, a group which helps older adults and people with disabilities obtain high-quality affordable health care, “Over the last couple of years we have seen an increase in the number of individuals who need assistance disenrolling from their Medicare private plans. These were individuals who signed up for Medicare HMOs after being lured by plan incentives without a clear understanding of how Medicare private plans operate. They continue to use their red, white, and blue Original Medicare card even after signing up for an HMO, see doctors that are not in the plan’s network, and often do not realize that they need to obtain referrals to see specialists.

They only realize that they no longer have Original Medicare once they start receiving denials for services they received.”

### **Misleading Medicare Marketing in New York City**

The Public Advocate’s Office reviewed advertisements from area newspapers and obtained informational materials from Medicare Advantage HMO plans operating in the New York City area. The following are some of the misleading and/or incomplete statements noted in the materials reviewed:

- “\$0 Premium”

Many of the plan materials reviewed boast a \$0 premium. This claim can be misleading given that individuals must continue to pay their Medicare Part B premiums. Advertising a “\$0 premium” may lead individuals to mistakenly believe that they will not be responsible for the monthly Part B payment, which is generally referred to as a premium.

The degree to which companies explain that an individual must continue to pay his/her monthly Medicare Part B premium varies. Advertisements by Empire, Healthfirst, and Oxford all mention a \$0 premium but give no indication that beneficiaries must continue to pay their Part B premium. Similarly, a chart obtained from Aetna’s web site provides an overview of benefits available through two of its Medicare Plans.<sup>11</sup> Both list a \$0 monthly premium but Aetna gives no indication that

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<sup>10</sup> Center for Medicare and Medicaid Services, Medicare Managed Care Manual, Chapter 3: Marketing [http://www.cms.hhs.gov/manuals/116\\_mmc/mc86c03.pdf](http://www.cms.hhs.gov/manuals/116_mmc/mc86c03.pdf)

<sup>11</sup> See <http://www.aetna.com/index.htm>

the \$78.20 Part B premium still applies. A “Summary of Benefits” booklet provided by Oxford lists a “\$0 premium” relegating to a footnote the explanation that “You must continue to pay your Medicare Part B premium.”

By contrast, an Elderplan ad states that its plan requires “no extra monthly plan premium” and notes that, “You simply maintain the Medicare premium that you have now.”

- *“Unlimited generic and brand name prescription drug coverage”*

A recent ad by Elderplan reads: “Eligible for Medicare? Then you’re eligible for unlimited generic and brand name prescription drug coverage!” This claim is sure to appeal to Medicare beneficiaries with high drug costs. Unfortunately, it can be misleading. Elderplan uses a formulary, a list of limited prescription drugs which the plan will cover. Individuals considering Elderplan may not realize that only drugs that appear on the formulary will in fact be covered.

Similarly, a recent ad by WellCare claims that beneficiaries will receive “unlimited” generic drug coverage, while a mere footnote explains that “the plan utilizes a Preferred Drug List.” The term “unlimited” can cause confusion because a “Preferred Drug List” is, by definition, a limiting device. Medicare beneficiaries may be lured by the “unlimited” claim and may not understand what the term “preferred drug list” means.

- *“More benefits than Original Medicare”*

Plans that claim to offer more than original Medicare may in fact provide additional benefits such as dental services, prescription drugs, or others. Consumers, however, must understand that these added benefits come at a cost—namely, the freedom to use the doctor and hospitals of one’s choice.

A number of plans were found to make “more than” claims, including Aetna (“More Benefits Than Original Medicare”), Touchstone (“More Comprehensive Coverage than what Medicare offers”), and Oxford (“Offers More than Traditional Medicare”). Individuals need to review full plan materials to even begin to understand the freedom of choice they lose under an HMO. Additionally, consumers must consider out-of-pocket costs because added benefits often require costly co-payments.

- *“WellCare Pays Your Part B Premium for You”*

A recent ad for WellCare’s Medicare Advantage plan states that WellCare would pay beneficiaries’ Part B premiums, yet benefit information obtained from the company indicates that enrollees must continue to pay their \$78.20 towards Part B and wait to be reimbursed the amount.

Print materials are not the only source of incomplete, misleading, and otherwise problematic claims. There is also reason for concern regarding the practices of HMO

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sales representatives. According to the Medicare Rights Center, “We have seen more and more clients who reported that they signed up for HMOs because they felt pressure from insurance agents to sign up for their products.” Oxford Medicare Advantage and Empire Senior Plan Direct advertise information sessions, which are held each month, mostly at restaurants and coffee shops across the city. The companies promote these gatherings as an opportunity for beneficiaries to get answers to questions about Medicare. A staff member from the Public Advocate’s Office recently attended a breakfast seminar sponsored by Oxford Medicare Advantage and observed questionable tactics on the part of the sales representative.<sup>12</sup>

The Oxford representative explained various plan benefits and discussed relevant co-pays and deductibles. He did not, however, explain limitations applicable to the plan, such as the fact that individuals can only use doctors within Oxford’s network in order to receive coverage. He described the plan as a “win-win” situation in which enrollees receive “better benefits” with “cheaper out-of-pocket costs.” The representative talked about Oxford’s drug coverage but failed to mention the plan’s formulary and could not provide one when asked.

At the end of the seminar, the representative offered to help attendees complete their application materials—an offer that one man accepted. The applicant spoke English but indicated that Spanish was his first language. Despite this, the sales representative provided him with an English-language application. The Oxford representative proceeded to fill in the man’s application for him, line by line. It was unclear if the beneficiary understood what he was signing.

While just two HMOs were found to advertise informational seminars, the majority of the plans contacted by the Public Advocate’s Office attempted to arrange a home visit by a plan representative. Given the practices observed at the public breakfast seminar, there is reason for concern regarding the tactics of HMO representatives who visit the homes of Medicare beneficiaries.

### **Future Medicare Changes Likely to Compound Marketing Problems**

Changes to Medicare may intensify problems related to HMOs’ marketing practices. The Medicare market is now being flooded with materials promoting new plans under the new Part D drug benefit. Part D will give Medicare beneficiaries a choice of prescription drug plans with various types of coverage, and beneficiaries will need to look closely at the various options available. Purchasing Part D coverage may not be in the best interest of all individuals, and beneficiaries must be made to understand that this type of coverage is optional. The CMS has issued guidelines for Plan D marketing<sup>13</sup> and is in the process of developing model plan materials. It remains to be seen if Part D marketing materials will include incomplete, misleading, or otherwise problematic claims like those found in Medicare Advantage materials.

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<sup>12</sup> Oxford Medicare Advantage Breakfast Seminar, Aug. 10, 2005 at La Rosita Restaurant.

<sup>13</sup> Center for Medicare and Medicaid Services, “Plan D Marketing Guidelines,” 2005. Available online at <http://www.cms.hhs.gov/pdps/PrtDPlnMrktngGdlns.asp>.

In addition, Medicare will soon begin limiting the number of times an individual can change health plans. Currently, beneficiaries may switch plans freely—an important protection for individuals who are disappointed by the benefits or services provided.<sup>14</sup> Beginning in 2006, however, Medicare beneficiaries will be able to change plans (including a return to traditional Medicare) only during the “open enrollment period,” which will run from January to June 2006. In 2007, beneficiaries will only be able to make changes between January and March. This so-called “lock-in” provision is likely to pose problems for Medicare beneficiaries, particularly low-income individuals, beneficiaries 80 and over, as well as ethnic and racial minorities, all of whom, as previously noted, have been found to experience greater dissatisfaction with certain aspects of managed care.<sup>15</sup>

### **Conclusion and Recommendations**

For some people, a Medicare HMO plan may offer the best available coverage, but for others this is not the case. Seniors and other beneficiaries must read detailed plan information, including footnotes, and look for hidden costs. They should be clear about available benefits and understand plan limitations. For example, before enrolling in a Medicare HMO plan, individuals should determine whether they are willing to switch doctors and obtain referrals for visits to specialists. They should understand the type of care and services that will and will not be covered and should inquire about applicable co-pays and deductibles. They should also understand that under an HMO their benefits may not extend outside of their geographic area. Because of the complexity of coverage decisions, individuals may wish to receive individual counseling from one of the Health Insurance Information Counseling & Assistance Programs (HIICAPs) in New York City.<sup>16</sup>

To protect the interests of seniors and other Medicare beneficiaries, the Public Advocate recommends that the Centers for Medicare and Medicaid Services:

- **Develop more stringent standards governing Medicare Managed Care marketing materials.** The current Managed Care Marketing guidelines are a step in the right direction but must go further to ensure that HMOs do not take advantage of beneficiaries by making incomplete, misleading, and false claims.
- **Block Medicare Advantage plans from awarding sales representatives a commission until an individual has been enrolled in a plan for a specific amount of time. The Medicare Rights Center has previously suggested a three-month waiting period.**<sup>17</sup> Sales representatives may be motivated to enroll individuals in a plan by the commission they receive when an individual’s application is processed. A wait-time before a commission is awarded would

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<sup>14</sup> Mary Laschober, Ph.D., “Estimating Medicare Advantage Lock-In Provisions Impact on Vulnerable Medicare Beneficiaries,” *Health Care Financing Review*, Spring 2005.

<sup>15</sup> *Id.*

<sup>16</sup> HIICAPs are listed in the Resources section at the back of this report.

<sup>17</sup> The Medicare Rights Center, “Medicare HMO Marketing in the Information Age,” Jan. 1999.

lessen the incentive for sales representatives to misrepresent the products they promote.

- **Reconsider the “lock-in” rule set to take effect next year.** There is a real need to prevent beneficiaries from “gaming” the system by switching plans throughout the year, but individuals can experience serious harm when stuck in an HMO plan that does not meet his/her needs or is otherwise problematic. Beneficiaries with just cause must be permitted to switch plans as necessary. Such protection is particularly important given the vulnerability of the Medicare population.

The Public Advocate also recommends the following:

- **In response to introduction of new materials associated with Medicare Part D and the impending “lock-in” rule, the New York Attorney General’s Office should increase its monitoring of managed care organizations marketing to the Medicare population and take action against companies found to violate Section 350 of the General Business Law,<sup>18</sup> or other relevant statutes.**

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<sup>18</sup> Section 350 of the General Business Law relates to consumer protection from deceptive acts and practices.

## **Medicare Resources**

### The Public Advocate

The Office of the Public Advocate for the City of New York solves problems on behalf of all New Yorkers. Individuals with questions, problems, or complaints can contact the Public Advocate's Ombudsman Services.

#### Ombudsman Services

212-669-7250

Mon.-Fri. 9:00am-5:00pm

<http://pubadvocate.nyc.gov/index.html>

### Medicare

For general Medicare information and information about health plans, contact Medicare 24 hours a day, 7 days a week for assistance. English and Spanish-speaking customer service representatives at this number can answer questions about the Original Medicare Plan and provide up-to-date information regarding the health plans available in your area.

1-800-MEDICARE /(800) 633-4227

[www.medicare.gov](http://www.medicare.gov)

### Individual Counseling:

It's very important to get individual counseling to select the best coverage for your situation. Individuals seeking objective counseling should call the HIICAP (Health Insurance Information Counseling & Assistance Program) lines below. They are funded by federal, state, and city governments.

#### New York State Medicare Rights Center HIICAP

(800) 333-4114

Mon.-Thurs. 9:00am-3:00pm

<http://www.medicarerights.org/>

#### New York City Department for the Aging HIICAP

(212)333-5511

Mon.-Fri. 10:00am-4:00pm

<http://hiicap.state.ny.us/>

#### Institute for the Puerto Rican/Hispanic Elderly HIICAP

(Instituto Puertorriqueño/Hispano Para Personas Mayores)

(212) 677-4181

Mon.-Fri. 9:00am-5:00pm

#### New York City Managed Care Consumer Assistance Program

(Community Service Society of New York)

(212) 614-5400

Mon.-Fri. 9:00am-5:00pm

<http://www.nycmccap.org/>