

TESTIMONY BEFORE THE NY STATE PARTNERSHIP FOR COVERAGE

November 2, 2007

My name is Meyer Braiterman. I am testifying on behalf of Brooklyn-Wide Interagency Council of the Aging. Although most of us are on Medicare, We are very concerned for our children and grandchildren as well as younger friends. Vocationally I am a New York licensed insurance agent and I am bombarded daily with complaints about the HMO insurance companies.

At a recent meeting of about sixty insurance agents who, like myself, sell medical insurance, half would just as soon not have their business clients needing medical insurance. They could make better commissions if employers' money were used to buy disability, dental, and life insurance. They don't need the hassles of dealing with the problems that employees and employers have with HMO insurance companies.

Some agents feel guilt when an employee is hurt because of the insurance they have sold. Let me give you an example. An employee who was two years free of cancer after a mastectomy noticed a lump on another part of her body. Her oncologist referred her to a surgeon for a biopsy. When she got to the surgeon's office she was not seen as she had not gotten a referral by her HMO company. The oncologist does not have the greatest staff - she is in a group setting - and the patient could not get through on the phone. It was just before a holiday weekend. It was two months later, when she had gone from a commercial insurer to Medicare as a disabled person that she got the biopsy which turned out to be positive for cancer. Treatment could begin only a few weeks later due to holidays, etc. By this time the lump had become two lumps. She is still in treatment and I wonder whether the delay will make a difference in the outcome.

The bottom line is that we don't need HMOs or insurance companies in our system of health care. They make a profit by managing care B by refusing or even delaying care. Managing care once meant appropriate treatment coordination and careful and complete primary care. Now it means refusing or delaying care or claim payments. Some insurance companies have deleted the requirement for referrals but seem to have made up for that by tightening their definition of medically necessary care. This is then appealed and the appeal usually wins when it goes to external appeal. In the meantime the HMO has had a float on their cash for a couple months. By their nature they are too costly and their rules can cost lives. We need health care coverage that does not depend on HMOs or insurance companies.

Thank you.