Health care or rent? The Medicare Advantage dilemma

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!**, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on Code WACK! Health insurers in the Medicare Advantage market are under heavy fire!

In a letter this month to the head of Centers for Medicare & Medicaid services, the American Medical Association decried the "burdens" of prior authorizations -- which requires doctors to get approval from a health insurer before performing a procedure -- and how we're all paying more as a result.

Just weeks ago, at the end of February, 2023, the Biden-Harris Administration announced that it will "start recovering improper payments made to insurance companies in Medicare Advantage ... and returning this money to the Medicare Trust Funds."

And progressive lawmakers in Congress introduced a bill banning corporate health insurers from using the word "Medicare" in their plan names. Why? Because they undermine the original Medicare program by leaving "patients without the benefits they need while overcharging the federal government for corporate profit."

Can you imagine how bad this must be for patients?

Today we're focusing on common business practices of Medicare Advantage insurers. What hurdles do people on Medicare Advantage plans face when it comes to accessing the care they need, and what should be done about it?

To get the consumer perspective, we spoke to **Diane Archer**, founder and president of **Just Care USA,** an independent digital media hub covering health and financial issues facing boomers and their families. Miss Archer is the past chair of the Board of Consumer Reports and is a member of the board of the Center for Health and Democracy.

Welcome back to Code WACK! Diane.

Q: So you've talked about prior authorizations with Medicare Advantage. Tell us how that impedes care for someone who's really sick, for example.

Archer: Medicare Advantage is supposed to deliver all the benefits that you would receive in traditional Medicare. But again, what the (Health and Human Services') Office of the Inspector General has found is that most Medicare Advantage plans, if not all, are not delivering the benefits that you would get in traditional Medicare and part of the reason they're not is because they're using prior authorization requirements and putting in place rules about what care is medically reasonable and necessary that are more restrictive than the rules in traditional Medicare.

So again, if a doctor says, 'I see signs of cancer, I want to give you a PET scan to see if it has spread,' it is not, as I understand it, uncommon for a Medicare Advantage plan to say, 'before you get a PET scan, you're going to need to get an X-ray or a CAT scan and we won't pay for that PET scan until you've gone through these other hoops' or if they are willing to pay for the PET scan, you might have to wait three weeks or a month in order to get it and by that time, your cancer could have spread.

Q: Right. Wow, that's very disheartening.

Archer: It's really concerning and I think here the big issue is that each plan is allowed to have its own prior authorization rules, right? So the physicians and the hospitals complain because they're going through different hoops with each different plan. But the other reality is that nobody is actually looking at the rules

that each plan has in place and whether they are actually in sync with standard medical practice or out of sync so it might be appropriate for a Medicare Advantage plan to say, 'you shouldn't be getting an MRI for your back right now. It's totally appropriate for you to go through some other steps before we give you an MRI' but it would be potentially inappropriate for them to deny you access to a PET scan when there are signs of cancer.

But we don't know, because it's all proprietary. They're allowed to have their own proprietary rules, which create roadblocks both for the providers and for the patients and even when it's the provider, the doctor or the hospital who's having to go through these hoops, it becomes a burden on the patient because the doctors don't want to deal with these Medicare Advantage plans. It takes up too much of their time, and that makes it harder for patients in Medicare Advantage to get the care they need from the doctors they want to use.

Q: Is it similar, Diane, to an HMO? I know HMOs often times require you to get preauthorizations, right? Or am I mistaken?

Archer: You're exactly right. In fact, Medicare Advantage, I should have explained, can be an HMO, just an HMO that has a contract with the federal government or a PPO where you're allowed to go out of network and part of your care will be covered, but not all of it. So yes, it's exactly like an HMO.

Q: Right. Wow, and then what about referrals and out-of-pocket costs? What are those like?

Archer: So in a Medicare Advantage HMO and most Medicare Advantage plans are HMOs, the majority of them, you usually need a referral from your primary care doctor before you can see a specialist so that's another hurdle because as we all know, accessing a primary care doctor can take weeks, right? They're just not enough primary care doctors and they don't have the time to schedule you quickly as a general rule. So in a Medicare Advantage plan HMO, you could be waiting weeks to see a specialist because you need the primary care physician first to approve that specialty care.

Wow.

Archer: So we talked about the cost of supplemental insurance and traditional Medicare, and it is about $2,500 a year, but once you've paid that, you can sleep at

night knowing that if you need to go to the emergency room, if you need to see a doctor, whoever you need to see, your care is going to be either fully covered or almost entirely covered.

You're going to have virtually no out-of-pocket costs. With Medicare Advantage plans, there is no supplemental coverage so you are responsible out of pocket for thousands of dollars in costs, and that's each time you go to the doctor or hospital, you're responsible up to the out-of-pocket limit for in-network care – so up to as much as $7,550 so if you think you need to go to the emergency room, you're saying to yourself, do I want to spend $1,000 or $2,000? I don't know what this is going to cost me, or do I want to pray this isn't an emergency and stay home? So I think what happens all too often in Medicare Advantage is that people are making tradeoffs between their health care and other basic needs in order to avoid paying high out-of-pocket costs in Medicare Advantage.

Mm-Hmm. <Affirmative>

Archer: And that's a travesty.

Right.

Archer: The Kaiser Family Foundation issued a report showing that out of pocket costs were a particular barrier to care for people with low incomes and people with complex conditions and people of color and people in rural communities and huge health inequities are the consequence of these out of pocket costs.

Q: Mmmm. So it's kind of exacerbating the huge inequities that our healthcare system already has.

Archer: Well put.

Q: Yeah. Wow. Do you have any stories that you can share with us, maybe people you've known that kind of just illustrate how dangerous or risky Medicare Advantage really is?

Archer: There's a story I recently read from the Texas Hospital Association involving a 93-year-old woman who presented at the hospital in serious shape, and the hospital was concerned that she had had a stroke and requested authorization from her Medicare Advantage plan to get her an MRI so that it could treat her properly. And the Medicare Advantage Plan denied the request and the hospital looking out for the best interest of this woman decided that they were going to send her to get that MRI notwithstanding the Medicare Advantage plan's decision to

deny her coverage for that MRI, and as it turned out, the hospital saved her life that she did have bleeding and she had had a stroke and it needed to be addressed.

Q: Wow, that is so interesting. I'm curious – did the Medicare Advantage plan end up paying the cost of that, or who did?

Archer: That's a really good question. I don't know the answer to that. If the hospital had to eat that cost or the Medicare Advantage plan ultimately paid, but recently the administration asked sort of the general public for how it could improve Medicare Advantage, and the American Hospital Association wrote a 40-something page response, and at the outset basically said that the Medicare Advantage plans were not paying them appropriately. We're basically negotiating low rates and then not even paying those rates and jeopardizing the ability of the smaller hospitals to stay afloat and putting patients at risk so it's interesting because it's taken a long time for the hospitals to get on board and speak out against Medicare Advantage, but they are doing so now.

That's encouraging, you know, that they're speaking out.

Archer: Yeah, I think some hospitals have become their own Medicare Advantage plans, so there's a tension here, but it's great that they are. I think it will be even better if Congress steps in and acts, and I think the first thing it would need to do is stop paying Medicare Advantage plans a flat fee, regardless of the amount they spend on care. The term “fee for service” has gotten a bad rap, and people think fee for service is the past, and paying a flat fee is the future. But what many people don't realize is that when we pay Medicare Advantage plans a flat fee, they're still paying their doctors and hospitals on “fee for service.” So all we're doing is adding another layer of payment and another layer of bureaucracy and another layer of cost to the process. We're not eliminating paying for the services that people get.

Q: Got it. So it sounds like one policy solution that you would support would be to not pay a flat fee and go to fee for service?

Archer: We need to cap payments overall, but we need to pay Medicare Advantage plans for the cost of the services that they cover, plus an administrative fee, and the total amount needs to be capped so that they're not running away with the store.

Q: Wonderful. Diane, what other policy recommendations do you recommend?

Archer: Where to go from here? You have my list, <laugh>. There are so many, I mean, with Medicare Advantage right now, people in the HMOs are limited to a very narrow network of doctors. As a general rule, we sanction having networks as a way to lower costs, but with Medicare Advantage, they're generally piggybacking off of Medicare rates and so there's no reason for them to be allowed to have a network and no financial reason, no cost reason for them to be allowed to have a network and keep people from seeing the doctors they need to see and they want to see. So I would argue for an open network if we're going to have Medicare Advantage so that people get access to the providers that they need to see.

Q: Mm-Hmm. <Affirmative>, right. If you could have your way, would you do away with Medicare Advantage completely?

Archer: If I could have my way, I would do away with Medicare Advantage completely. There's a lot of talk these days about “value-based care.” There is no value in value-based care if you understand value to mean quality and low cost. Because with Medicare Advantage, we have no, no, and I underline no, I capitalize no, no understanding of value because the data that we would need to understand value is not available and so it is incorrect to talk about Medicare Advantage offering anything of value because we don't have any idea about the quality of care they offer.

There's some indication that overall for their average person, Medicare Advantage could offer as good care as traditional Medicare, but what we also know is that it costs more than traditional Medicare meaning if the quality is the same and the costs are higher, it offers less value than traditional Medicare. So why would we continue to offer a lower value product when we have traditional Medicare, which is far more cost effective, and gives people access to the doctors they need to see.

What we really need to do is lower people's out-of-pocket costs in traditional Medicare. We need to make traditional Medicare more comprehensive and its coverage so that people don't need supplemental insurance, and that would not cost a lot of money. That's what we should be doing and then we need to add vision, hearing, and dental as well.

Q: Do you think Medicare for All would solve most of these issues that you've brought up with Medicare Advantage plans?

Archer: What we need is traditional Medicare with much more comprehensive coverage for everyone and that would give everybody a customized product. Sometimes Medicare for All is considered one size fits all, and you could say that's a fair description because it fits everyone. But what it allows for is for different sizes for everyone, because people need particular services. They'll get those services. If they need other services, they'll get those services. When you have Medicare Advantage and a lot of different choices offering different things, you have one size that may not fit the people who are enrolling in the Medicare Advantage plan, and that's the worst possible scenario. What you want is something that works for everyone in the ways they need care, and you want something that's cost effective. So I do think that building off of traditional Medicare is the way to go with a global cap.

This is what many other countries do. It would allow also for a much more robust public health system because one thing that traditional Medicare offers that we're losing as more people enroll in Medicare Advantage is a window into who's getting care, where, when, how. It's a window accessible only to the researchers but what it then allows us to do in a moment when we're in a pandemic is to see where are people being hospitalized? What are the needs of those hospitals? How can we better ensure that people are getting the care they need? Because we can see what's going on. Right now, again with Medicare Advantage, it's a big black box. We don't know what they're paying for or how, and so we're really at a loss.

Thank you, Diane Archer.

Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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