Delays, denials & death:
The Medicare Advantage Scam

"One academic study found that if the government canceled its contracts with the 5% Medicare Advantage plans that are the worst performing, it would save 10,000 lives a year." ***– Diane Archer***

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!** How do Medicare Advantage plans use pre-authorizations and claim denials to maximize their profits at the expense of senior citizen's lives? And how are corporate health insurers getting away with this? To find out, 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. Ms. Archer is the past chair of the Board of Consumer Reports. The longtime health advocate is also a board member of the **Center for Health and Democracy**. This is the first episode of a two-part series.

Welcome back to Code WACK! Diane. It's great to see you again.

Archer: It's great to be back with you.

Q: Lately, we're hearing more and more about pre-authorizations and claims denials. Can you explain to us what they are and how are they different?

Archer: Okay. Yes, this can get very confusing very quickly, but let's start maybe with a little bit of an explanation between traditional Medicare and the corporate health insurers that offer people what are now called Medicare Advantage plans – and they're very, very different. The fundamental difference is that with traditional Medicare, the government is paying doctors directly for the cost of their services and paying hospitals directly and other healthcare providers directly and if the healthcare provider says that the service is reasonable and necessary, there's a very high likelihood that the government is going to pay for your care. With the corporate health insurers offering Medicare Advantage plans, it's a very, very different story because what happens is the government pays them upfront regardless of the actual amount of money they're paying on your care so the less they spend on your care, the more they pocket, the higher their profits.

And so as any health corporation or any corporation that wants to get ahead will do, they're going to try to figure out every which way possible to effectively and efficiently hold on to the money that the government has given them and they can do that a few different ways. They do that in Medicare Advantage by restricting your access to healthcare providers, to doctors and hospitals. That's why in many Medicare Advantage plans, it's hard to find top quality specialists, top quality hospitals, cancer centers of excellence in the network. They also can profit more by having, as you just mentioned, a pre-authorization or prior authorization process for approving care before it's delivered. And basically, all Medicare Advantage plans use this process. You don't find this process in traditional Medicare except in a few very, very unique situations. And as a result, if you need care, if for example, you go to the doctor and the doctor sees something suspicious, thinks it's cancerous, and wants to get you that PET scan right away, well, you probably are going to have to wait because the doctor is going to have to get prior authorization from the Medicare Advantage plan to allow that doctor to provide you with the service.

Without the prior authorization, the Medicare Advantage plan will not cover your care. And so people in Medicare Advantage who urgently need care can suffer enormously waiting for their Medicare Advantage plan to decide whether or not it's going to pay for the care.

That's terrible.

Archer: And we've uncovered many stories of people with serious conditions whose doctors say they need particular services, whether it's oncology services or PET scans or other urgently needed care. And they end up having to wait a long time to get approval from their insurance company offering Medicare Advantage. And in many instances, they don't even get the approval initially. And that's because the insurers have an incentive to not approve care, because when they don't approve care, they profit more. Even when care is approved, if it's delayed, it can really harm patients so the prior authorization process allows the insurers one more time now to both hold on to their money that they've gotten up front from the government for a longer period of time, and to keep that money and not spend it if they can find a reason to deny care.

Q: Wow, that's horrible. And I want to go back for a second and talk about the delays. Do you know how long this process can take to get a pre-authorization?

Archer: Good question. So the good news is that a bipartisan group of senators recently sent a letter to the Centers for Medicare and Medicaid Services saying, you know what? It's time that these prior authorization requirements be completely electronic and real time and transparent. There's no reason to have people wait. In fact, it's inefficient to have people wait on both the insurer side and the patient side and the provider side. So we do now have a lot of congressional support to change the process, but the bad news is that the insurers can and do wait, as you know, I don't know, we don't know. I don't know what the average time is, but it can easily be two or three weeks that it takes to determine whether to authorize care. I don't know if that's usual, but it happens and it could be because the insurer says the provider ... hasn't provided all the necessary information. But what's also happening, and this is even scarier, is that the insurance companies are using AI, artificial intelligence, to do across-the-board denials.

I was just reading that – I think it was Cigna was doing 300,000 denials in two months just across the board without looking at the specific situation of the individuals needing care.

But going back now to how long can it take for the prior authorization, I think one of the bigger problems with this entire way we pay Medicare Advantage plans and allow them to operate is that not only do they have this very powerful financial incentive to delay approval of care and to deny approval of care, even when traditional Medicare would pay for the services and when they're required to pay

for the services. But it's very, very hard, very costly and difficult for the federal government to oversee them and know when they're acting wrongly and then for reasons that I find impossible to understand, the government will not punish them appropriately, even when it does find that they are routinely engaged in inappropriate delays and denials of care and coverage.

Q: Earlier, you mentioned to me a study by a Yale researcher involving the number of deaths estimated with Medicare Advantage plans. Can you tell us about that?

Yeah, so we've been talking a lot about inappropriate delays and denials of care in these insurer run Medicare Advantage plans. And that obviously has consequences for enrollees and their health. And again, we can't measure those consequences because we don't have the data. But one academic study in the **National Bureau of Economic [Research]** that was published a few years ago, found that if the government canceled its contracts with the 5% of Medicare Advantage plans that are the worst performing, it would save 10,000 lives a year.

Whoah.

And what's really galling is not only is the government not canceling those contracts, but it's not even naming the Medicare Advantage plans with the high mortality rates so that people can avoid them. And we are working very hard to get the government to start naming those companies so that people don't choose a company with a high mortality (rate).

Q: Wow. Is there any way to know how many of these low performing plans there are?

Archer: There's really no way to know, I think I flip that question, though, and say, right now I can't point you to a Medicare Advantage plan that's high performing, because we have no data. So you can't assume that any of them are high performing until we have that data.

Q: Wow. Are certain types of policies more likely to require pre-authorizations? It sounds like there are. So who is most at risk and why?

Archer: You're in traditional Medicare, you're, it's very rare that you're ever going to have to deal with prior authorization. You're going to be able to go to your doctor, you're going to be able to go to the specialist that your doctor refers you to without

any prior authorization requirement. You'll go directly, easily, no barriers. The way that the Medicare Advantage program is set up, the government allows insurers to decide on their own when they're going to use prior authorization and when not. And there is no way for the public to understand whether they're using it judiciously -- appropriately -- when maybe you don't need care and they should be reviewing it and that's the rare instance I will say, because anytime the insurer is reviewing whether you need care, the insurer's second guessing the treating physician, coming between you and your doctor, and so is not really on top of what's going on.

But each insurer can do that differently. And as a result, if insurers are using prior authorization as a way to maximize their profits without regard to the particular needs of the patients who are enrolled in their plans, it's very hard for the government to know and for people to know and to avoid those plans. And when the government does know, as is sometimes the case it doesn't seem as if the government has the interest or the resources or the ability to take on those insurers and if not, cancel their contracts, punish them in a meaningful way for their bad acts.

This is a big problem and people do need to know directly which plans have high denial rates. We know from the Office of the Inspector General that some of these Medicare Advantage plans have super high denial rates, maybe as high as 30, 35, 40 percent denial rates. Well nobody should be signing up for those plans. But the Centers for Medicare and Medicaid Services have not disclosed which plans have these high denial rates yet.

Q: ***Yes. Interesting. Is anyone working on that?***

Archer: We're all working on that. We feel it's absolutely critical that nobody should be suggesting that people can choose a plan, a Medicare Advantage plan that's right for them without knowing this critical information. Because it could be a life or death characteristic of a plan. If you need to wait for care and you can't get it because of inappropriate denials, you should know that you may be at risk in a particular Medicare Advantage plan. So yes, we are working very hard on that.

Q: So let's talk more about Medicare Advantage. Are there specific kinds of treatment that typically require preauthorization?

Archer: A lot of specialty care often requires prior authorization, but again, it depends on the insurance company and the Medicare Advantage plan. And they're

all different. And that's why I should say now, if you can choose traditional Medicare over Medicare Advantage, you have much greater choice of providers and much better access to care in traditional Medicare than you will ever have in a Medicare Advantage plan and that could maybe change at some point, but at the moment, so long as you don't know whether a Medicare Advantage plan you're enrolling in has a high denial rate, you are really putting yourself at risk joining up with that plan.

So as for what kinds of treatments, the office of the (Health and Human Services') Inspector General talked a lot about rehab care, physical therapy as an inpatient, nursing home care as two areas that are very costly, where there are prior authorization requirements. There are lots of inappropriate denials of care and there are also what are called downgrades so it's sometimes the case that an insurance company will approve your care in a rehab facility, but your doctor will be asking for a hundred days of care and the insurance company will only approve five days of care. It wasn't a denial because you got your five days, but you're missing 95 days that Medicare would've paid for if you were in traditional Medicare that the insurance company has decided they don't want to pay for.

Q: So what happens when somebody is denied care? Do some people just give up?

Archer: Well, that's an excellent question and what happens typically is people go without care and they have no choice because the only way they can get the care is if they can afford to pay for it upfront and then they can challenge the insurance company's denial. But most people with Medicare live on small fixed incomes and they can't afford to pay upfront. And then most people with Medicare don't appeal the denial even though they should.

And here it's an excellent question because actually appealing is much easier than you would think it would be. If you simply send back a letter to the insurance committee that's denied your appeal, saying 'please review,' it helps to have a note from your doctor explaining why the service is medically reasonable and necessary. But 80% of the time that denial is overturned, but only about 1% or 3%, a very small percentage of people do appeal because they don't realize how easy it is and how likely it is that they will win on appeal.

Q: Wow, and how long does the appeal process take?

Archer: It can take several months, so people are going without care often while they're appealing but if they can afford to pay for their care, then they can get reimbursed afterwards. Still, the majority of people with Medicare can't afford to front the money for nursing care and rehab therapy. So it's a really terrible setup

right now with all the incentives aligned against the needs of patients and against the treating physician's opinion. So it used to be when – I don't know if you're old enough to remember the ads against the Clinton healthcare plan – it was Harry and Louise talking about a system where the insurance company would come between you and your doctor, and your doctor's will would be overridden. Well, that's exactly what we have with Medicare Advantage.

Thank you Diane Archer. Stay tuned next time when we dive deeper into the ways corporate health insurers are maximizing profit at the expense of seniors.

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