Profits over people?
There's an algorithm for that.

"We want to make sure that nobody is signing up for a Medicare Advantage plan that endangers their health and wellbeing or puts their life at risk." ***- 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 are corporate health insurers using Artificial Intelligence to step up their claims' denials? And what's being done to out some of the bad actors in Medicare Advantage? 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. Miss Archer is the past chair of the Board of Consumer Reports, currently serves as a senior advisor at **Social Security Works** and is a member of the board of the **Center for Health and Democracy.** This is the second episode in a two-part series.

Welcome back to Code WACK! Diane!

Q: ***In our last episode, we discussed the dangers of Medicare Advantage plans, in which health insurers are incentivized to spend as little money as possible on***

patients' care. How easy would it be for the government to increase its oversight of these plans?

Archer: Well, it has to start with paying these plans in a different way in order to eliminate the incentive for these plans to deny people care. But you can also do what other wealthy countries do with private insurers, which is (to) set the terms of coverage much more strictly. So, for example, traditional Medicare has a whole data system for approving care, and it works with insurers who are intermediaries to process claims. Why don't the Medicare Advantage plans have to use that same system so that they were all paying for services when Medicare pays for services and all doing the same, using the same system to pay for care. That's how it works in other wealthy countries.

And under Medicare laws and rules, insurers are required to cover all medically necessary care that traditional Medicare covers. So if they are required to do so, why don't we have them follow and use the same tools that traditional Medicare uses to decide when care is covered and when it's not covered?

Right. That makes so much sense.

Archer: Right now, again, what you'll read in the Medicare new handbook and what the insurers will say is you get all the benefits of Medicare in a corporate health insurance Medicare Advantage plan, and in theory you do. But in practice, because these insurers don't have to use the same software that traditional Medicare uses to process claims, you allegedly get the same benefits, but you may face a lot of inappropriate delays and denials of care.

Right. It seems like such an easy fix to me.

Archer: Doesn't it? It seems like such an easy fix to me, but in this country, we allow corporations to make decisions on their own that are inexplicable. Even when we see that the results are dangerous to people.

Yeah, until the people rise up.

Archer: Until the people rise up. Exactly.

Q: So here we have insurance companies dictating what treatments and medicines we can have with Medicare Advantage plans. How is it that they can overrule a doctor's orders? Is that even legal?

Archer: It is legal for them to overrule the doctor if the doctor is prescribing a treatment that is actually not reasonable and necessary. But the question is, are

they overruling doctors when the treatment is reasonable and necessary? And the answer seems to be that in a large number of instances, that's exactly what they're doing.

It may be that you have some kind of a pain and the doctor prescribes an MRI when it's perfectly appropriate for you to have an X-ray first. I'm not a doctor, but in some instances, as I understand it, a lesser cost treatment, a lower level of treatment is completely warranted. But in many, many instances, that's not the case. And you have to trust the treating physician or … if you're going to question a treating physician, then you better know exactly the situation the patient is in and treat the individual based on the individual's particular needs, not on some algorithm as is currently happening now in Medicare Advantage.

Q: So is it a doctor that's looking at all the records saying 'I don't think this is medically necessary?' Or who is it that's making that decision? Is it now mostly an algorithm?

Archer: The insurers say no, but recent reports out of Stat News and other media outlets is that in fact that there are these sweeping denials that the insurers are making with no review by a doctor and so that is cause for terrific concern because again it is in the insurance company's interest to make these sweeping denials and then maybe to approve care if somebody appeals. But since most people don't appeal, they end up able to keep a ton of money by not paying first go-around when doctors are saying patients need care.

Q: So it seems like things are getting worse with health insurers stepping up their claims denial game using AI or artificial intelligence?

Archer: Yeah. Things are getting much worse with the use of artificial intelligence, also with the incentive system. If the insurers weren't paid upfront, and if their payments were actually based on the amount of money they spent on care, we'd have a different situation. But right now, the way they're paid is just a mistake from the perspective of the needs of the patient.

Q: Wow. Talk to us, Diane, about the class-action lawsuit against Cigna for using computer software to deny payments in batches in California. What's the significance of this?

Archer: It's an important case because it lays out how Cigna has been making across-the-board denials of care for their members who actually need care. In that case, I believe former employees of NaviHealth, which is the company that has the artificial intelligence that's used to deny services, say that there are no second-level reviews before claims are denied, that it's just across the board denials based on an

algorithm without any focus on the particular needs of the patients. And then under California law, it is required for insurers to review claims based on the particular needs of their members and so that lawsuit is designed to challenge the insurer's practices on the ground that they're not looking at the individual needs of their members.

Q: I wonder if that's the case in other states as well?

Archer: I am sure it's the case in every state. We'll see more lawsuits in the future. You know, that if Cigna's doing it, so is every other big health insurer. And if you know that if they're doing it in California, they're doing it everywhere else, right? I mean, it's in their economic interest and so long as they can do it, "why not?" is, I think, a fair reading of how they think about it.

Q: Hmm. What does this practice with AI reveal about our broken and callous healthcare system in America?

Archer: It reveals that the healthcare system is in need of a total overhaul. We need to take the profits out of health care. We need to focus first and foremost on patient needs. And so long as we have for-profit corporations competing with one another to maximize profits and combined with almost no data on who's doing what and whether any of these insurers are harming lots of people or helping lots of people, we are all at risk. So it's interesting because as we were thinking about sort of all the reasons why traditional Medicare is so much better than Medicare Advantage, which is run by the corporate health insurers because it does put patients' needs first, we also were thinking about how some people argue that traditional Medicare leads to overtreatment and that's why they think Medicare Advantage is a better system because it limits the amount of money that can be spent on care.

But what's curious is that to the extent they believe traditional Medicare is flawed because there's overtreatment, they support giving these health insurance companies in Medicare Advantage more money than we spend on people in traditional Medicare. So the system is just so flawed and so fraught even from a delivery system perspective. Because if the goal is to improve quality and reduce spending, traditional Medicare actually does a far better job than Medicare Advantage, as we've seen for the last, more than a decade, almost two decades now.

Q: And how do we know that to be true?

Archer: Well, we know from the data that every year since its inception traditional Medicare has cost less per person than Medicare Advantage. We know as well from

most recently the University of Southern California's Schafer Center that this year alone, we will be overpaying the Medicare Advantage plans $75 billion because of the way we've set up the payment system – $75 billion that could be spent on health care that's actually just going into the pockets of insurance companies. And then when it comes to quality, we have terrible data from the Medicare Advantage plans and so the first thought is, why are they hiding their data? It's probably showing that people with cancer and heart disease and other costly conditions are not faring as well as people in traditional Medicare with those conditions.

And otherwise they wouldn't be hiding the data, which they have been for years now, we haven't been able to see good data, but to the extent there's any data, it is showing access to poor quality hospitals, access to poor quality skilled nursing facilities, access to poor quality home health care in Medicare Advantage.

Q: This is unbelievable that the government can't even get that data and disclose it to the public?

Archer: Yeah. I mean, and especially in the context of they're supporting quote unquote "choice and competition" because if the choice is meaningless, the competition doesn't exist. And then what are we doing by having all these hundreds and thousands of Medicare Advantage plans in the country, other than spending a lot of money on corporate profits and administration that could better be spent on people's health care?

Q: Right. But I could see how the healthcare insurance industry would be fighting tooth and nail against any of that. Right? Like they want the least transparency possible to protect their profits.

Archer: I can see why they would fight against the transparency and my response is, great fight against it, and let's all go back to traditional Medicare and, and when you're ready to play a fair game and show us what you're really doing and show us that you're performing at lower cost and delivering better quality, you're in. But until then, don't put frail and vulnerable older adults and people with disabilities at risk.

Q: It's like the bar is so low for them to get in and do what they're doing, right?

Archer: The bar is so low. It's unconscionable how low it is.

Q: Okay. So what policies do you believe are needed to rein in corporate health insurance companies?

Archer: I think we have to overhaul the entire way that these insurance companies operate in Medicare. They have to be fully transparent. They have to be paid differently. They should be paid, I believe, in the same way that employers pay private insurers, large employers, which is on a cost-plus basis so they have an incentive to give people the care they need and get paid a small fee on top of that for managing people's care and then the amount of money we spend can be capped so that nobody's running away with the store, but the incentives are better aligned between insurers and patients and doctors.

Q: Right. So would Medicare for All eliminate some or all of these obstacles?

Archer: Yeah. Medicare for All is the ultimate solution here. Medicare for All would be based on a fee-for-service model where insurers were out of the picture altogether except to process claims and then people would not have out-of-pocket costs to get care. So it would be a much more equitable system than we have now where copays and deductibles present huge barriers to care for people. And more so in Medicare Advantage, I should add, than in traditional Medicare.

Because in Medicare Advantage, there is an out-of-pocket cap, but it is typically at least $5,000 a year, and it can be as high as $8,300 a year for in-network care alone. So that's at least $5,000 out of your own pocket in order to get needed care if you need a lot of care. Whereas in traditional Medicare if you have supplemental coverage, your out-of-pocket costs are very low and so costs are not a barrier to care, but you have to pay upfront for your supplemental coverage unless you have Medicaid.

Q: Unless you have Medicaid?

Archer: Yeah.

Q: Got it. So what is currently being done about all the problems with Medicare Advantage plans, like pre-authorizations and denials of care?

Archer: Yeah. We're focused heavily on outing the bad actors in Medicare Advantage, not knowing how many of them are bad actors, but knowing from the office of the Inspector General that there is this widespread and persistent inappropriate delays and denials of care in the Medicare Advantage program. We want the government to name names. We want escalating penalties for insurers that are engaged in these bad acts, culminating in the cancellation of their contracts. We want to make sure that nobody is signing up for a Medicare Advantage plan that endangers their health and wellbeing or puts their life at risk.

And right now we have every reason to believe that some if not the majority of Medicare Advantage plans are a risky proposition for people with Medicare.

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.

Don't forget to subscribe to Code WACK! wherever you find your podcasts. You can also find us on ProgressiveVoices.com and on Nurse Talk Media.

Code WACK! is powered by HEAL California, uplifting the voices of those fighting for healthcare reform around the country. I'm Brenda Gazzar.