The tricks and traps of Medicare 'Disadvantage' plans

"We really find out how good our insurance plan is when we get sick. 'Oh, I got diagnosed with cancer and then I found out what was not good about my plan and what it didn't cover and what I really needed.'" – *Dr. Diljeet Singh*

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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.

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This time on **Code WACK!** Why are seniors in between a rock and a hard place when choosing between various Medicare options? How do private Medicare plans, known as Medicare Advantage, limit patients' options and why are they considered riskier than traditional Medicare? To find out, we spoke to **Dr. Diljeet Singh,** the incoming president of **Physicians for a National Health Program.**

Welcome back to Code WACK! Dr. Singh, and congrats on being the incoming president of Physicians for National Health Program, a single-payer advocacy group. For Americans on Medicare, open enrollment just ended on Dec. 7. And for Americans on Medicare Advantage, open enrollment is between Jan. 1 and March 31 of 2025. These private plans can be cheaper upfront than traditional Medicare and they also sometimes offer freebies like gym memberships and basic dental, hearing and vision coverage. Yet you and other physicians have urged caution. Tell us why.

Singh: I think it is very challenging for seniors to make decisions because I do think seniors are in a rock and a hard place situation. What are the good things about traditional Medicare? No. 1, people are going to have the widest range of access to hospitals and physicians and specialists, and they're less likely to have problems getting prior authorizations and we don't see those kinds of denials. But traditional Medicare is 80-20, 80% of outpatient things are covered, 20% is not and so patients often have to get additional insurance, something called Medigap to cover the extra and dental and vision and hearing is not covered. People who can't afford a Medigap plan will find themselves forced. So I wouldn't say Medicare Advantage is more popular. Many people have no choice. They have to go with Medicare Advantage plans and a lot of people are calling them 'Medicare disadvantage' plans now because they have no choice financially.

The tricky part is so many of the things that these plans promise people are not accurate, so people will think that they're getting vision coverage, but it's a relatively often very small financial limitation. I want to say maybe around $200 or something, which most people easily spend on a pair of glasses. Not to mention the optometry check and everything else.

Oh, I didn't realize that.

Singh: Or for a lot of people, they'll say, 'I thought I had dental coverage, but there's only one dentist and that dentist is an hour and a half away and I have to drive to get there.' Meanwhile, there's a dentist 10 minutes from my house that I can't go to 'cause they're not part of the plan and sometimes people will get a Silver Sneakers or a gym membership and there's something insidious about that.

Q: How so?

Singh: No. 1, a lot of people don't use their gym memberships, but it is another way that those private Medicare plans are able to get healthier people. If you're healthy enough to be able to use a gym membership, it means inherently you're probably younger, you probably don't have certain kinds of limitations, you probably don't have home healthcare needs. You probably don't have certain things. And so it's a way that these Medicare private plans mostly get healthy people.

Q: That's kind of sneaky. What else is problematic about these Medicare Advantage plans?

Singh: Most Medicare private plans have limited networks and I think about 50% of the physicians and the specialists in the area are not part of that network. And for me, when I work in Virginia, it was so challenging trying to get people in to see a cardiologist and endocrinologist, hormone diabetes specialist or to get them into certain kinds of surgeons, cardiothoracic surgery, neurosurgery, like these less common specialties. Often these private plans don't cover most of the docs in the area. And [for] me as an oncologist, and I'm a gynecologic oncologist, and so I take care of women with ovary, endometrial, cervical cancer, and often cancer centers, National Comprehensive Cancer Network, or NCI-designated cancer centers are not part of these private plans and so if patients have something uncommon, if they have something rare, they don't have access and there is research showing that for uncommon cancers like stomach cancer or liver cancer, that actually patients are more likely to die around the time of surgery, mostly because they have surgery at a hospital that isn't used to doing these kinds of complex cancer surgeries.

Q: So Medicare Advantage patients with rare cancers may be at higher risk?

Singh: So right in those private Medicare plans, I'm just so resistant to saying Medicare Advantage 'cause it's such a falsehood. Patients in those private Medicare plans are more likely to die and of course these are the extremes, right? And I think the other thing that patients don't realize when they're signing up is there's this concept of prior authorization and you can argue about it in multiple ways. One argument is corporations have a lot of power in America and they lobbied our legislators and got them to do it. And there's probably some truth in that. But there was also this idea that, 'oh, these corporations, their main goal is making money and being profitable, so they're going to help make our healthcare system more efficient and they're going to have better outcomes because they're more efficient.'

Unfortunately, that is completely untrue. The profit making part of it, how these health insurance companies have ended up making their profits is not by being more efficient or using better preventive care. It's become by just spending less money on health care and by denying care and so these things called prior authorization, the thought was maybe we're ordering too many MRIs or maybe we're getting too many PET scans as healthcare professionals, as physicians and so maybe we need some ways to set this up.

Q: Can you give us an example?

Singh: Medical societies came up with guidelines. If somebody has cervical cancer, they need an MRI of their pelvis, they need a PET scan, they should get a referral

to radiation oncology if that's appropriate, right? Medical societies and specialty groups came up with guidelines and we thought that was a way to do it. Meanwhile, these insurance companies were like, 'no, we'll set up our own authorizations and we'll help.' And what we see with these private Medicare disadvantage plans is prior authorizations are just so burdensome, burdensome to hospitals and physicians and physicians' offices. So you end up hiring all these other people and one of the studies that Physicians for National Health Plan said that hospitals and doctors' offices spend somewhere between 11 million and 20 million hours getting these prior authorizations, right? Not providing care, not counseling patients, not helping people deal with side effects of their treatment. No, just getting prior authorizations.

And a lot of those prior authorizations, like they just don't make sense, right? If the National Comprehensive Cancer Network says, 'if you have this cancer, then you need this test,' why wouldn't it just be approved? And most often, it's just a time delay process. One of the things I know as an oncologist is that the shorter the time between someone finding out they have cancer and getting started on their treatment, someone's chances of being cured of cancer are better. We think it's about four weeks for breast cancer where the most research is. We think it's ideally in that two-to-four week window that you get your diagnosis and you get started. Let's throw a wrench into everything with prior authorization. Right?

Right. I see what you mean.

Singh: Somebody comes to see me. She's having bleeding. She's postmenopausal, I do an exam, I look at the cervix, I see a cancer. I've been doing this 26 years, cancers look pretty obvious. I know it's there. I take a biopsy because we want details on exactly what kind of cancer it is, but I already know a whole bunch of stuff. If they have one of these private Medicare Disadvantage plans, we can't do any of the above until the pathology report comes back and confirms cancer because an oncologist seeing a cancer is not good enough. No, we need a pathology report. So we wait. That pathology report might take five days, might take seven days, it might take longer. We get the pathology report back and then I order a PET scan and then my team has to call and get it authorized and that can take anywhere from three to five days to seven to 10 days.

And then in a lot of parts of our country, we don't have a ton of PET scan machines and not every site of getting a PET scan is covered by a private Medicare plan. So then you're adding another week or two weeks or whatever, and really it doesn't make sense to see a radiation oncologist until you have the PET scan result 'cause then they can make their best recommendations. So everything's getting delayed. And then that radiation doctor has to get any treatment plan

approved. So then they have to go through the prior authorization process. There's no way somebody's starting treatment in two weeks. If we're doing something crazy or costly or if somebody has something rare, okay, maybe then it would make sense to talk it through. But 90% of the time, the prior authorizations, if I end up needing to call somebody and get coverage for something, I'm not talking to an oncologist.

A lot of times I'm talking to a family practice doctor who doesn't know one tenth of what I know about cancer. The idea that they're somehow gonna be better at making decisions for what tests are right, again, just doesn't make any sense. Yeah. So people just don't know, they don't know what it means to have one of these private Medicare plans or like I said before, their hands are tied. They can't afford a Medigap policy and so they go with the cheapest option or their retirement plan was connected to this. So it's not like somebody actually chose it or they've had it for a certain number of years and then they can't get out of it. They can't go back.

Once you've been in one of these private plans and you didn't get that Medigap, later on in most states in the country, you can't get one of those Medigap plans the same way. Right? We know in most parts of health care, we've eliminated pre-existing conditions except for this one little window. If you were in a Medicare private plan and now you want to get traditional Medicare, you want to get one of those Medigap plans to cover that 20% or whenever the deductibles might be. Now they can do pre-existing conditions on you for that Medigap plan now for your whole insurance, but for that to cover the extra thing. So a lot of people can't afford it.

Yes, let's take a sec to clarify the Medigap trap because if you're in Medicare Advantage and you decide you want to switch to traditional, original Medicare, the supplemental policy, the Medigap policy, they can actually look at your preexisting conditions and say, 'you have this condition, we don't want to cover you.'

Singh: Yeah, you can be denied coverage or you can be charged a lot more for it.

Now Let's talk about denials in these Medicare Advantage plans.

Singh: Okay. My radiation oncologist for my patient came up with a plan to treat her cervical cancer. They deny it. We can't do that. We don't want to cover the internal radiation or we don't want to cover this. Now is that because there's a specialty oncologist sitting back there over there? No. Often it's some AI-driven algorithm that's just saying deny a certain percentage. And the problem with

denials is most people don't push back on denials. When we push back on denials, the numbers are somewhere between 70% and 80% of the time. Denials get overturned.

Oh wow, I didn't realize that percentage was so high.

Singh: Somebody comes to see me, she was having vaginal bleeding and she went to see an OB/GYN. The OB/GYN said, I think you need a biopsy of the lining of your uterus to find out if there's something precancerous or cancerous there. And they tried to do a biopsy in the office, but it was uncomfortable. They couldn't get the right cells. So the OB/GYN recommended a DNC and a DNC means when we give someone anesthesia, sometimes it's just medicine through an IV that they're relaxed enough with some numbing medicine in the cervix, sometimes it's a stronger anesthesia than that depending on what someone needs. But regardless, we do it in an operating room. I think she'd had it for four or five years and she'd had the same plan and she lived in a part of the country where these private plans, they would come to her house and bring her a bag of groceries once a year, and they would send her a Christmas card and they would do a lot of these kind of private company things.

And the OB/GYN she ended up seeing, she didn't know that doctor. She had never met her before. She actually hadn't seen an OB/GYN since her youngest son was born – this patient was now like in her late sixties. And so the insurance company denied the DNC and this patient's response to the denial was, 'I guess I don't need it. I've known this insurance company for five years. I just met that doctor. Maybe I just don't need it. And lo and behold, she waited and then the bleeding got heavier. And so almost a year after that initial visit to the OB/GYN, she went to an emergency room, had a lot heavier bleeding. They sent her directly to me as a cancer specialist and when she saw me in the office, I was able to do a biopsy. And she said to me, 'so that just proves that OB/GYN didn't know what she was doing, right, cause she couldn't do a biopsy.' And I said, 'it's a year later and the cancer's bigger and that's making it easier to do a biopsy now.'

And she ended up needing radiation that maybe if we had caught the cancer earlier, we could have just done surgery and cured her cancer and the radiation caught some irritation to her rectal area that then she had trouble with that caused side effects. Fingers crossed, likely this person is cured of her cancer. So she doesn't get an exciting story on the evening news, but does that mean that the right thing happened to her? Absolutely not.

She probably suffered a lot more because of those delays.

Singh: Absolutely. She suffered with the bleeding for that whole extra year. She needed a blood transfusion that we could have avoided. She had surgery and then radiation. Radiation took six weeks where she had to go Monday through Friday. Then like I mentioned, she had this irritation to her rectum, where she had some rectal bleeding from radiation. You can't even quantify. Plus the worry right? The earlier your cancer stages, the more reassured you are that cancer's gone forever. Now we're telling her you had a stage two cancer, so there's a higher chance of it coming back. So the worry factor comes in. So many things were challenging about it, but I especially really struggled with the idea that this insurance company, we call it predatory, right? By giving her a bag of groceries once a year and meeting her, they established like this sense of connection and trust.

Meanwhile, they did wrong by her. They denied something that she really needed, but that's not how she saw it, because she felt like she knew them. I think that's like the tricky, sneaky hard part about medicine. There's less and less specialists, there's less OBGYNs willing to practice in certain parts of the country. So there's a lot of turnover so she didn't know her doctor for years and it's really challenging, like I said, to be a senior sitting down and meanwhile, I don't know, Joe Namath and you name it, a famous guy is like doing advertisements for these like companies and making it sound like they're trustworthy and reasonable and have great benefits. I think it's really hard. And the other part that's hard is you don't know what you need until you get sick and fingers crossed people never get cancer, right? But we know one out of two men and one out of every three women will get diagnosed with cancer over their years.

And again, I focus on cancer. I'm sure if there's a cardiologist, they would focus on heart disease. Most of the time we feel pretty good. Most of the time we're healthy. We just need to do our prevention, get our cholesterol check to get our mammograms, and we're okay. But we really find out how good our insurance plan is when we get sick. ‘Oh, I got diagnosed with cancer and then I found out what was not good about my plan and what it didn't cover and what I really needed and by then I was sick and I was in the middle of it and I couldn't change things.’

Thank you, Dr. Diljeet Singh, of Physicians for a National Health Program.

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