The Middlemen Making Money Off Medicaid

(Episode 322)

"Having just graduated college and working as an intern for a nonprofit, I didn't have access to health insurance. So my first thought after [the accident] was not to the trauma I just faced or my own health, it was really just fear and guilt about the financial burden that I was now placing in my family's lap." – *Dr. Alankrita Olson*

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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.**

(music)

This time on **Code WACK!** Why are there middlemen in Medicaid—and what are they doing to our most vulnerable patients and physicians? How are these private insurance intermediaries putting profits ahead of patients?

To find out, we spoke with **Dr. Alankrita Olson,** a public health physician and advocate for a universal single-payer system. She serves on the board of Physicians for a National Health Program and works to protect and expand healthcare access for all Americans.

Welcome to Code WACK! Dr. Olson!

Olson: Thank you for having me.

Q: So tell us briefly about yourself. Who are you and how did you become an advocate for healthcare reform?

Olson: Yeah, thank you Brenda. I'm a preventive medicine physician and I'm a board member of the Physicians for National Health Program, PNHP. And I've always been passionate about improving access to care and I think it really comes from growing up as an immigrant. You know, my family did not have health insurance and this had a real impact on our life. You know, my parents were always stressed about any health emergency, meaning financial ruin. They put off taking care of their own health and you know, relying on safety net institutions meant traveling far, they had to take a whole day off to be able to get anything addressed. And that fear was really realized. When I was 21, I was hit by a car crossing the street and I was uninsured and having just graduated college and working as an intern for a nonprofit, I didn't have access to health insurance.

So my first thought after that was not to the trauma I just faced or my own health, it was really just fear and guilt about the financial burden that I was now placing in my family's lap. And so I refused the ambulance. I waited for my mother to pick me up and take me to the ED, the emergency department, where I learned that I had damaged my knee and would need surgery. And it's crazy to say, but I was lucky because the driver had stopped. So we were able to hire a lawyer to utilize his car insurance and he had the minimum liability insurance in the state to pay for healthcare providers that the lawyer had on retainer to cover my ED bill and you know, have some even for himself as a fee. So at the end of the day, I didn't end up in medical debt.

But this is a situation that millions of Americans face daily and sometimes they're not that lucky. Their life is ruined, even if their health is preserved, they're in medical debt and they face a lot of challenges because of that. So when I started

medical school and came across students for a national health program, our student arm of PNHP, I was sold <laugh>.

I didn't know, and I never even thought that it was possible to have a different system. But in learning about single payer from PNHP and learning about other healthcare systems in other countries and seeing the possibility that we could build a system that prioritizes people and health was just eye-opening. And since then I've been a staunch advocate and yeah, I'm really happy to be able to continue that work and continue to work on improving access to care for people.

Q: Wow. I'm so sorry first of all that you were hit by a car and how sad and poignant that the first thought was the burden that this would place on your family. And that's very relatable, I think for so many people in America.

Olson: Mm-Hmm <affirmative>. Yeah. I think it's very known for a lot of people, even if they've never had interactions with the healthcare system, they've had friends, they've had family that have had that. So the stories are everywhere. People are very, very, very aware of the fact that it's costly and even if you have insurance, you can still end up in debt, lose your home, lose other assets. It's crazy. Yeah. It should not be this way.

Q: Completely agree. PNHP recently published a report, "Removing the Middleman from Medicaid." For listeners who don't live in the health policy world, what exactly do you mean by middleman in Medicaid and how do they affect physicians and other providers like therapists for example?

Olson: Yeah, I think you're right. A lot of people don't know about these middlemen in Medicaid. The Managed Care Organizations or MCOs as I will refer to them. But 70% of Medicaid beneficiaries are covered under a managed care organization, MCO, and this is essentially a private insurance company. So your Aetna, your UnitedHealthcare who receive the Medicaid funding from the government to administer your Medicaid benefits to you.

So it's private management of our public Medicaid. And these MCOs are paid an amount per enrollee upfront and, you know, to be able to keep as much of that money as possible, they're incentivized to spend as little as possible on people's

health care. So you can see that the system is really set up with the wrong priority. You know, it prioritizes profit for these private insurance middlemen and doesn't prioritize actually helping people get the care they need and keeping people healthy.

And so they do this in terms of, you know, trying to decrease the amount of money they have to spend. They do this by imposing administrative hurdles for physicians, for patients and you know, for example, as a physician having to deal with prior authorization, so you're usually required to request authorization to be able to get a diagnostic test like an MRI for a patient or a specific type of treatment like chemotherapy for someone. And you know, there's no guarantee that it is approved just because it's evidence-based, it can be denied and that leaves the patient unable to get care. So in this way, they're essentially making clinical decisions rather than care decisions being between the patient and the doctor. They're in the middle of us being able to actually provide care and in the middle of patients being able to actually get care that they need.

So that's why we have termed them the middlemen and it also demonstrates how unnecessary they are because once you remove them, the actual purpose of the system to provide care for patients, for patients to get the care they need and be healthy is still in place. So it definitely affects physicians in having to deal with these administrative hurdles day in and day out. We waste hours and hours trying to figure out who is a specialist my patient can see, who's in the network, we waste hours on the phone with insurance companies trying to fight denials and trying to understand what is covered or not trying to fight for reimbursement, you know, services that we've already done and have been rendered not being paid for. So it definitely affects physicians and their ability to do their duty and their job in providing care.

Q: Hmmm. Wow. And Medicaid beneficiaries are among our most vulnerable people. They are generally poor, they might have multiple health issues going on. And many have to deal with these middlemen who are trying to prevent them from getting care in many cases. Is that fair to say?

Olson: Medicaid is essential. It covers 71 million people including pregnant women. The majority of children I think in most states are under Medicaid. So it

definitely provides care for children, families, people with disabilities and the elderly because they provide funding for safety net and rural hospitals as well as long-term care facilities. So Medicaid is essential. It is a way that we stabilize our healthcare system so that communities have access to care and without it, it would just cause chaos.

Q: Right. So the report also states that states could save roughly 10 to 17% by removing these managed care organizations or these middlemen from Medicaid. That's a huge amount of money. Where is that money currently going?

Olson: Yes. So by law, these managed care companies are allowed to spend about 15% and they do, they get 14%, 15% of the Medicaid funding that is given to them, they spend on administrative overhead. So this is everyone that the company actually has hired, right? Staff reviewing claims staff that is negotiating rates with hospitals and providers to the CEO and their ridiculous large salary. And you can't forget shareholder profits, right? So all of the administrative aspect of running that company is done through our Medicaid funding and that is a waste because it's not money that's going to providing care. And then on the state side, they have to manage these MCOs. They have to provide oversight, hound them to actually report on things and provide transparency about the decisions that they're making and the money that they're spending. And when you look at our like public health insurance schemes, Medicaid and Medicare, when you look at traditional Medicare, Medicaid, so beneficiaries, enrollees that are not under a managed care company, when we have to administer care for them, cover their costs, that is about two to 3% of the budget. So states can really get away with administering the program themselves and only spending 3% of the budget. So losing that 11%, 12% to administrative waste that's not paying for care -- and we're essentially using our taxpayer money to create a barrier between doctors and patients.

Q: Yeah, that's really interesting too, how much money states could save if they did this on their own and managed it themselves. What does Medicaid managed care look like from a patient's perspective? Can you walk us through how it affects someone trying to get care?

Olson: Definitely from the very beginning, from just even getting enrolled into Medicaid, it's much more complex. With managed care companies, they have much more daunting forms and processes to even get enrolled. And then patients have to figure out what doctors are actually within their network. You know, what practitioners can they see who is contracted with their MCO and actually available for them to see is that person near, are they far? And most of the time that list is not even up to date <laugh>. And so you could try to be making an appointment with your own doctor, the one you've always had, only to realize they don't take your insurance. Or if you're coming to a new doctor, having to call 10 different places before you finally find one that says, 'oh yeah, we do take that insurance.'

So it's a lot of wasted time, you know, time wasted on on the phone trying to understand your coverage, figure out who you can go to, but also time wasted on the phone, fighting bills that they might get for something that was approved, but then retroactively they're told 'it's not,' and now they have to pay for that service – fighting the insurance company for denials of care.

So you know, your doctor put in a prior [authorization], it's not covered, and you wanna know why or you're requesting an x-ray or this or that and it's not covered and you wanna know why. And you know, overall it's just a lot of stress for the patient. It's a lot of time that is wasted on bureaucracy that doesn't serve any purpose. And all of this then delays the care that they should be getting, which means that their condition could be getting worse, their cancer could be caught at a later state and that means that when they do get care, there could be less that could be done for them. And as a result they're looking at, you know, complications, poor quality of life and early death from not being able to get care. So all of this has a bearing not just on physicians and the health system, but also on patients.

Q: Yeah, that's very unfortunate. And the reality of too many people, so many people assume private insurance companies are more efficient than government programs. What did you find about that assumption?

Olson: Yeah, the myth is so pervasive and it's really an ongoing legacy from the eighties, from the Reagan era when we started to turn over our public services and goods to private control, MCOs, you know, are supposed to assume the

financial risk of Medicaid costs. So the state in just paying a lump sum is trying to avoid any additional spending that'll come from taking care of patients, right? So there's, so the MCOs, assuming the financial risks of all of the costs that will come from people actually getting care. And in doing this, in continuing to have, you know, the ability to negotiate with doctors and hospitals and pharmaceutical companies and device companies to set lower rates, they're supposed to be able to reduce spending. But the reality is far different. So the state still covers costs for the sickest beneficiaries that MCOs leave out. So most states -- very few actually have all their Medicaid beneficiaries under a managed care company, there's always 10 to 15% that are left out.

And these tend to be the sickest individuals, the ones that need the most care. And so the state is still on the hook for the costs of the Medicaid services provided to this population, while the MCOs get to enjoy being able to provide care for people that might not need care that much. So they're getting that payment for someone that might not even go to the doctor, you know, someone healthy that just needs insurance for anything that it might happen. And when it comes to the reduced spending, you know, we see healthcare costs have ever increasing. They're supposed to be negotiating with hospitals about how much things cost. They're supposed to be negotiating with pharmaceuticals about how much a drug costs, but these costs just keep going up and it's because it's in the benefit of both of them for it to increase so that they can continue to get more money to administer this program, to cover these costs, but ultimately end up with more in their pocket each year. So that's why when you look year over year, you see their profits rising. So it's obvious that they actually don't reduce spending. They're not saving us money at all. So this myth of private insurance companies being more efficient is definitely unfounded.

Q: Wow. Thank you so much for speaking to that. If they paid providers directly instead of going through insurers, how would the experience change for doctors, nurses, and clinics on the ground?

Olson: Oh, it would be absolutely transformative. I think healthcare for the state would definitely improve. And we don't even have to speculate. So in our report we talk about Connecticut, who was one of the first to remove managed care

organizations back in 2012, and they saw an immediate 33% increase in physician participation within their Medicaid program, right? So physicians were like, 'oh, if I don't have to deal with all this administrative hurdles and I can just take care of patients and easily be able to coordinate their care, get reimbursed, sign me up, I wanna be able to take care of patients.'

And recently their Medicaid program saw a 97% satisfaction rating from physicians. So 14 years later, and they're still doing so well in their Medicaid program. So it means that, you know, doctors are able to coordinate care better, get streamlined quicker reimbursement, so that they can focus more on their job and not have to waste so much time fighting the administrative hurdles that MCOs have put in place and it can really transform access to care for patients.

So when you have Medicaid as just one program and everyone that takes Medicaid is in one network, you have a much larger choice of doctors. You don't have to travel as far for someone in network if you have a doctor down the street that you can go to that takes Medicaid. So it makes it much easier for patients to access care. And if they go to physicians that take Medicaid, they can stay with that physician for as long as they continue to take Medicaid. Sometimes contracts that physicians have, that hospitals have with managed care organizations, they change every year. And that's part of that administrative waste. They're wasting time sitting in a room negotiating these contracts year in and year out, and hospital changes their policy. They don't take that insurance anymore. You know, a physician group doesn't take this insurance anymore and suddenly you can't go to your doctor.

So when patients are able to keep their doctor for a long time, you see much better health outcomes. And, you know, doctors want to be able to take care of patients long term too, especially primary care physicians. They want to be able to actually work with you to improve your health, and that takes time. And so a couple visits here or there, and then suddenly you're off to another insurance, another hospital, another doctor, you're not able to get effective care because they have to learn about you all over again. They have to see what's been done, they got their own process, et cetera. So it would definitely improve physician satisfaction with Medicaid, with their jobs, and it would improve access to care.

Thank you, Dr. Alankrita Olson of Physicians for a National Health Program. Stay tuned for next time when we take a deeper dive into privatized Medicaid, and what we can do to fix it.

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