Medicare Advantage — Whose Advantage Is It?

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". . .my experience was that it was fine unless you get sick, in which case they severely limit your options, including getting a second opinion. I quit as soon as I could. Do not get this plan unless you know you'll never need any kind of serious medical care."—Eva, a former Medicare Advantage patient, expressing her frustration with the program.

At long last, election season is over. The shouting, screeching, wild claims and outright B.S. of non-stop political commercials are gone—at least for a short while.

But if you're somehow missing all of that, I have great news. You can still turn on your TV and hear a litany of monotonous, mind-numbing exaggerations. You can still go to your mailbox and find it stuffed full of slick marketing materials.

Of course I'm talking about Medicare Advantage. Just call our toll-free number.

As a physician and an Old Guy myself (I mean *really old*—I'm nearly 71, for God's sake!) I have a real concern about the future of Medicare. It's been around since 1965. Congress passed it so older Americans wouldn't have to choose between forgoing health care and getting crippled physically, or receiving health care and getting crippled financially.

Like most legislation, it was far from perfect. But it's still been a godsend for millions of older Americans. There's a whole chapter about Medicare in my book, if you're interested. For now, let's just look at a portion of Medicare. The part you constantly see on T.V.

The part that's threatening to bankrupt the entire Medicare program.

From the outset, private insurance companies have made money off Medicare. Private carriers have served as "intermediaries." That is, they got paid to process the claims submitted to Medicare.

They made plenty of money doing this. It just wasn't as much as they wanted.

So the insurance industry had to find another way to get at all of those Medicare bucks. In 1997—after intense lobbying—the industry convinced Congress to pass a plan that allowed older Americans to enroll in private programs, rather than Traditional Medicare. Instead of paying for an enrollee's medical expenses directly, Medicare would instead turn over a fixed sum of money to a private insurer to "manage" the patient's care. They called it Medicare Advantage.

From the outset, any rational person could have seen this was going to be an expensive boondoggle, but we're not talking about rational people here. We're talking about Congress. Traditional Medicare had run an overhead (even with the claims processing being outsourced) of around 2-3%. Private insurers exceeded 10%. Even by third grade arithmetic standards, the numbers didn't add up.

And they still don't. Today, Traditional Medicare runs a 2% overhead. Advantage plans combined overhead and profit checks in at over 12%. That difference represents taxpayer dollars that don't pay for health care. Instead, they're eaten up by TV ads, marketing, and corporate bottom lines.

But money buys influence, and the insurance industry has plenty of both. And since its passage, Advantage plans have been marketed non-stop. They've become a gold mine for private insurers, but a multi-billion dollar drain on the Medicare Trust Fund.

But how can Advantage plans offer all of those "extras" like gym memberships, etc. and still be so profitable? Through the twin processes of "upcoding" and "care management" (which really means denying referrals and refusing to pay for treatment). Both are endemic in the Advantage world.

Upcoding works like this. The money the Medicare Trust Fund pays an insurer is based on the diagnoses listed for an individual patient. The more diagnoses, the greater the payment, *whether the patient actually receives any care for those diagnoses or not.* Through aggressive data mining, seniors are suddenly assigned diagnoses they've never heard of, never been treated for, and likely never will. But it adds big bucks to the insurer.

How widespread is this? According to the Office of the Inspector General, 4 of the 5 largest Advantage insurers are guilty of overbilling. Three have been charged with outright fraud.

Multiple whistleblower complaints have uncovered a scale of fraud that's unprecedented. In addition to the quote at the beginning of this post, further evidence reveals seniors have been lied to about what the plan covers, whether their doctor is included, and what treatments are available. That's right—I said outright lies.

But they'll be so convincing when you call that toll free number.

Estimates of how much all of this costs Medicare run upwards to $25 billion per year—money that would otherwise actually pay for care in Traditional Medicare.

But upcoding is only part of the story. Because Advantage plans are basically managed care products (unlike Traditional Medicare), patients are only allowed to receive care through a specific insurance-designated network—and pay through the nose if they go out of network. Claiming you didn't know the providers were out of network won't help. You'll still pay.

Think staying "in network" sounds simple? Think again. Some hospitals might be in network, but most of the doctors aren't. Sometimes the laboratory testing will be in network, but not the radiologists reading the X-Rays. For those expenses, you'll have to cough up the money yourself. And you probably won't find out until you get the bill.

And even if you stay within the network, testing, treatments, referrals, and even some admissions must first be approved by the insurer, resulting in long delays in care and often outright denials. A recent audit found that 18% of those denials were for treatments that Medicare was supposed to cover. And in each instance, the care was ordered by the patient's physician. It was the Advantage insurer who denied it.

One of the added financial drains from Advantage insurers is the fact that each year older Americans can sign up for a different plan. That's where the TV adds, mailings, and repeated badgering phone calls come in. It's high stakes marketing that gets thrown at Seniors year in and year out. And it's extraordinarily expensive.

"Ditch your traditional Medicare for our Advantage plan!" "No, ditch their Advantage plan for *our* Advantage plan!" "But ours gives you these benefits!" "But we give you *these* benefits?"

Often these products are sold on a commission basis, where the incentive for sales reps to shade the truth to older Americans, or simply outright lie, is enormous. And every phone call, every advertisement, every come-on, is paid from one source. Your tax dollars. And not a penny of it goes to pay for health care.

But don't some of those Advantage programs say they'll also pay for dental care? And vision? And home meals? And rides to the doctor? And trips to Mars on Elon Musk's spaceship?

Some do, some don't. And nobody pays for all of it (listen closely when that commercial says "they told me I *might* qualify for. . .)"

But shouldn't I want dental coverage? Of course. What Medicare Advantage plans do is take some of the thousands of extra dollars they receive from the Trust Fund and buy a policy that is available to everyone for $10-25 a month. Then they pocket the rest.

Forget the fact that I'm a doctor. I'm also a patient. And as a patient, I really don't give a damn about the bells and whistles in an insurance plan. I'm interested in something else.

Can I see any doctor I want, or just someone in my network (who may not be in the network tomorrow)? Can I get the tests my doctor orders, or do I have to wait until the insurance company approves them? Can I get admitted for treatment, or have to wait for the company's OK? How much will I ultimately be stuck paying in copays and deductibles after I've paid the premium—regardless of how low the premium seems at first (remember, there's no free lunch)?

According to an investigation by the Kaiser Family Foundation, insurers are now reaping twice the profit from Advantage plans as from their non-Medicare products.

This was never the intention of the Medicare program. And if it continues, Medicare's future is in serious jeopardy. Through clever (and expensive) marketing, nearly half of all Medicare recipients have signed up for Advantage plans. They're wildly popular.

That doesn't change the fact that these plans are bleeding the Trust Fund dry.

And to be honest, I'm also concerned about something other than just my own health care. I want Medicare to be there for my children and grandchildren.

According to news sources, some in Congress are demanding cuts in Medicare and an increase in eligibility age, claiming both are necessary to sustain the program.

Fine. But I hope those Senators and Representatives also realize that there are far greater savings in the $25 billion currently being lost through Advantage overpayments. If Congress has the courage to act, these dollars could quickly be recouped by moving the program back to the far more efficient Traditional Medicare, where overbilling would cease and care placed back in the hands of health care providers.

That would go a long way toward stabilizing the Medicare program. It could even pay for those dental benefits for *all* Medicare recipients.

If that were to happen, it would be a *true* advantage for all Americans.