Pirates of the Medicaribbean

How insurance companies have plundered Medicare
Today’s topics:

• Comparing Traditional Medicare (TM) to Medicare Advantage (MA) (for-profit insurance)

• Rick’s story

• How Medicare Advantage and other for profit programs risk depleting the Medicare Trust Fund

• Actions you can take!
Comparing the choices

Traditional Medicare

Medicare Advantage (for-profit insurance)

Medicare Part C plans and Medicare Advantage plans are the same thing.
Essential Parts of Medicare Health Plans

• Part A – Hospitalization & related costs – no premium – paid from Trust Fund from monies you paid through payroll contributions

• Part B – Physician visits, outpatient procedures, lab and other diagnostics

• Part C – Now called Medicare Advantage

• Part D – Prescription drugs supplemental

• MediGap plans – (G, K, L, M, N)- supplemental plans to offset the 20% copay for Traditional Medicare
**Comparing: COVERAGE**

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<tr>
<th>Traditional Medicare:</th>
<th>Medicare Advantage (for-profit insurance)</th>
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<tr>
<td>• Choice of primary care &amp; specialist physicians</td>
<td>• Network restrictions</td>
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<tr>
<td>• Preauthorization <em>rarely required</em></td>
<td>• Varying copays &amp; deductibles</td>
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<td>• No part D (prescription)</td>
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Comparing: COST

Traditional Medicare:

• Part B premium ($165/mo)
• Copay (20% after deductible)
• Supplemental insurance (MediGap and/or Part D (prescription) – average premium $200/mo)
• No out-of-pocket cap on expenses

Medicare Advantage (for-profit insurance)

• Part B premium ($165/mo) +/- additional premium
• Cap on out-of-pocket expenses (varies, up to $8300/year)
No Out-of-Pocket Cap (TM) - The Inflation Reduction Act includes

- Beginning in 2025 - $2000 out of pocket cap on Part D(prescription)
  - Beneficiaries still pay Part A & B (20% without MediGap)

- Beginning in 2026 – Drug cost negotiation
  - Only 10 drugs are being negotiated
  - Low-income seniors will still be paying a significant portion of their income for health care
One of the main reasons beneficiaries state for choosing MA is the Supplemental Benefits available to them.....

Vision, dental, hearing

• Not available to TM beneficiaries (without additional cost)
• In 2021 MA beneficiaries had access to >$2,350 in added benefits – with network and geographic restrictions
TM vs. MA: Cost vs. Choice

- **TM has a higher initial cost**
  - Higher copays or premiums for supplemental and prescription plans vs. *varying copays & deductibles*
  - No OOP cap expenses

- **MA restricts choice**
  - Lower initial costs
  - Limited networks (may not incl your current provider) vs. *choice of primary care & specialty providers*
  - Referral and *prior authorization* requirements are common vs. *rarely required*
  - After 1 year in a MA program, no guaranteed issuance of supplemental insurance
  - Many seniors with limited income are forced to choose MA
Rick’s story

Why select Medicare Advantage?

Seemed like a bargain

Not much information available at that time (2016)

Recommended by insurance agent at an “informational seminar”
Why do many insurance salespeople recommend Medicare Advantage?

• They have an incentive

• The commission for selling Med Adv is much more than for a Medigap policy

• Commission continues as long as the beneficiary signs up for Med Adv

• Commission for Medigap dwindles; then disappears after 5 years
Medicare Advantage companies have a huge advertising budget. Traditional Medicare has none.

Barrage of advertising by MA companies – TV, telemarketing & mail flyers.

Seems like a good deal.
Rick’s experience with Medicare Advantage

Denial
(Limited and changing network)

Delay
(The wait for “Prior authorization” allowed small lump to grow into an aggressive, malignant tumor)

Unexpected costs
Growing medical debt
Due to delay, tumor had enlarged, become more aggressive
• Requiring
  • Major surgery
  • Immunotherapy (1 year)
• With potential recurrence
• And possible severe adverse effects from immunotherapy
• Follow up CT’s every 6 months for 2 years, and annually for 3 more years
There’s more....

Rick’s MA insurance company is now in contract negotiations with UW Medicine (including the Fred Hutch Cancer Center)

Both have advised patients they may need to switch providers

Medicare Advantage put patients’ care at the whim of the insurance company

PROFIT TAKES PRECEDENCE OVER PATIENT CARE
Rick is not alone

• More than one-third of physicians said that prior authorization had led to a “serious adverse event.”*

• 91% said that prior authorization had a “somewhat or significant negative impact on patients’ clinical outcomes.”*

• Being on a Medicare Advantage plan is a risk factor for having a medical debt

*2022 American Medical Association survey
One more thing... *guaranteed issuance*

- Once you are in a MA plan for a year, you are trapped.
- If you try to go back to TM, there is no guarantee that you will be able to obtain supplemental insurance.
- Only 4 states (New York, Massachusetts, Connecticut, Vermont) have “guaranteed issuance” – no underwriting allowed.
- Costs will go way up.
A basic difference between Traditional Medicare and Medicare Advantage: How they are paid!

• Traditional Medicare: Fee for service
  • Pretty simple: provider bills Medicare for services rendered
  • Concern: incentive to provide extra, unneeded services – No evidence to support this concern.

• Medicare Advantage: Capitation
  • A sum is paid to insurance company for each beneficiary enrolled
  • How the sum is determined is complex and has potential for fraud.
How does Medicare determine how much to pay Medicare Advantage plans? It’s complicated...

- Bids
- Rebates
- Benchmarks
- Quality Bonus
- Star Rating
The sum Medicare pays the Medicare Advantage plan depends on information supplied by the plan:

- How much the Medicare Advantage Plan says the medical care of the beneficiaries will cost (the bid)
- A rebate if it is less than the average cost of Traditional Medicare
- Demographic characteristics and medical conditions that plans report in the form of medical condition codes
- Bonuses for “star rating” and other nebulous quality metrics
- The Medicare Advantage plan can keep what is not spent (up to 15%)

This incentivizes Medicare Advantage plans to restrict services they pay for.
Medicare Advantage was intended to save Medicare money – it doesn’t!

- Costs 6% more per beneficiary than TM

*Amounts to $27 Billion in 2023* (MedPAC, 2023)

- Operating costs for MA = 15% vs 2% for TM

• Most recent CMS audits (2011-2013) of a sample of 18,000 patients (90 audits) showed $12 million overpayment to MA companies. A very small sample resulting in significant overpayment

• MedPAC (2021) estimated MA companies were overpaid by $140 BILLION during the previous 12 years
Something smells fishy!


8 of top 10 MA insurance companies submitted inflated bills; 4 of top 5 sued by department of Justice for fraud and the other is under investigation.
How has Medicare Advantage gotten away with this fraud?

- Medicare adjusts what it will pay the MA company based on the severity of beneficiaries’ health issues.
- Severity determined by risk score.
- Risk score determined by coding—a health condition code which is submitted by the Medicare Advantage company for each beneficiary.
- Higher risk score brings more money to the MA company.
How to game the system – upcoding

MA plans **add diagnostic codes** to a beneficiary’s record that make the patient appear sicker ("upcoding").

- Mining records
- Home health visits by nurses
- Making stuff up (ghost records)

The sicker the patient, the more money Medicare gives to the MA

*More codes = More profit*
Consequences of upcoding

Risk score:
- Basis for “risk adjustment” (increasing the $ going to the MA)
- 2021, MA Risk Scores were almost 5% higher than for TM beneficiaries, equivalent to overpayment to MA companies of $17 Billion
The Committee for A Responsible Federal Budget and MedPAC agree:

Over the next decade (2021-2030), policies to adjust MA payments more accurately for coding intensity could:

• Reduce net Medicare spending by a range of $198 to $355 billion, with just over half the savings accruing to the Medicare Part A Trust Fund

• Reduce premiums for Medicare beneficiaries by a range of $32 to $57 billion

• Reduce the federal budget deficit by a range of $207 to $372 billion
Upcoding is not the only issue:

Random sample by Office of the Inspector General of the HHS showed excessive denials and delays

13% of prior authorization denials and 18% of payment denials met Medicare coverage rules and should have been granted.

Alert from the Office of the Inspector General HHS
Selecting TM will avoid all these MA issues, right?

Not necessarily

ACO REACH

Accountable Care Organizations Realizing Equity, Access and Community Health
ACO REACH

132 participating for-profit entities (insurance companies, investment firms, venture capitalists, etc.), WHO HAVE DECIDED THEY ARE MEDICAL EXPERTS, ARE GOING TO MANAGE THE HEALTH CARE OF BENEFICIARIES IN TRADITIONAL MEDICARE!

Each entity is assigned a geographic region and all TM beneficiaries whose primary care physician is in the region are automatically enrolled in the ACO REACH plan.
CMS keeps introducing new pilot programs involving for-profit entities in Medicare. None of them benefit Medicare! All of them benefit the for-profit entities!

Pauline Lappin with CMMI stated that, regarding payments to ACOs, “...cumulative spending over the four years of the model so far indicates net losses to the trust fund.”

**WHY DO THEY KEEP TRYING TO PRIVATIZE MEDICARE??**
Follow the money

• The insurance company lobbyists spent $14.4 million lobbying in 2022 and >$13.5 million on ads opposing the administrations’ feeble attempt to fix MA in 2023
• These companies spent millions on advertising to promote MA
• And major donations to political parties were donated from CEO’s, venture capitalists, and their families
Revolving door

- These insurance companies’ lobbying organization are populated with former CMS executives from the Obama, Trump and Biden administrations.

- Current CMS and CMMI directors come from the insurance companies and private equity firms, including the CMS administrator Brooks LaSure and CMMI administrator Fowler (who conceived and implemented ACO REACH).
The Big Steal

- Privatization diverts public funds to investors

  Patient care

  Overhead and profits

Traditional Medicare

- 98%

Medicare Advantage

- 85%

Medicare Supplemental

- 78%

Medicare REACH

- 75%

Traditional Medicare = Best Value
Medicare is not the only treasure the profiteering pirates are plundering...

The health care industry is looking very attractive to retail giants.
Why Is This Man Smiling?

Because Amazon bought One Medical (primary care) which owns Iora Health (ACO Contractor) and now has access to patients’ medical records.

Other retail giants who are seeking to profit from medical care include:

- Walmart Health (primary care centers)
- Walgreens Majority owner of Village MD (primary care)
- CVS owns Oak Street Health (ACO REACH) and Aetna (Medicare Advantage)

This is just a small sample.
Profiteering hurts us personally and threatens the entire Medicare program

- Rick’s story demonstrates harm to an individual
- MA delays and denials results in worse outcomes for patients
- Fraud threatens the demise of Medicare by depleting the Trust Fund, currently predicted to occur by 2031 according to MedPac 2023 (if no changes are made)
- Profit motive hurts many seniors and the most vulnerable
- TM has proven itself more efficient and effective in cost and patient care
Level the Playing Field

• Eliminate the diversion of Medicare funds to bonuses, rebates and extra benefits allotted to Medicare Advantage companies ($27 billion in 2023) *

• Take back money that the Medicare Trust Fund lost to fraud and abuse by Medicare Advantage plans. ($198 - $355 billion)**

• Expand Traditional Medicare to include vision, dental, and hearing; eliminate the 20% Medicare co-pays; and cap all out-of-pocket expenses

* MedPAC (2023)

**Committee for Responsible Budget & MedPAC (2021)
What we wanted you to learn today:
Privatization has no place in health care

• Focusing on profit leads to worse health outcomes
• Focusing on profit leads to fraud and theft of the Medicare Trust Fund
• Focusing on profit depersonalizes health care – deprives beneficiaries of choice in doctor, treatment
• Economic inequality forces many seniors and disabled beneficiaries into MA and locks them out of options

Privatization and its programs (MA, ACO REACH) are killing Medicare
What can be done

- Stay informed
- Spread the word and encourage others to get involved
- Join PSARA & build our coalition
- Contact legislators
Call to action – NOW!

Make the calls – “Stop fleecing Medicare”

1. Eliminate excessive administrative costs and profits in the Medicare Advantage plans and,

2. Take back money that the Medicare Trust Fund lost to fraud and abuse by MA plan, and,

3. Adding benefits to TM – vision, dental, hearing, eliminate the 20% copays, cap OOP expenses.

4. Thank you, Senator/Representative __________. I am counting on you to end the profiteering in Medicare.
Do you have a story like Rick’s about unpleasant experiences with Medicare Advantage?

• If you are willing to share that story with PSARA, we will combine it with other stories to help convince our legislators that Medicare Advantage is a bad deal for Medicare beneficiaries

• Follow the directions on the handout to contact Be A Hero (BAH), a PSARA partner working to protect Medicare

• Any questions, contact Rick (rptimmins@gmail.com) or Ellen (menshewmom@gmail.com)
Questions???????
1. 2022 AMA Prior Authorization (PA) Physician Survey
   (This survey highlights the negative impact on health care of patients due to prior authorization requirements.)

   https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html?unlocked_article_code=U6-qVA6Rm8bYpKD_dVGH9tI53ruH5KP1Mahmk7-SkyWEZhG_Ck4l3HyseNoT0YqRbFUsvVZdMMg2YsWfWC-3Z-R2I9gfenM0pFc02iAbCKCMhbSASPUnxr0A8Nm0pofPsUWCzhwNmtQcURjh
   (Investigative article exposing fraud, upcoding, denials and delays by MA companies.)

3. Frank RG, Milhaupt C. Profits, medical loss ratios, and ownership structure of Medicare Advantage plans. USC-Brookings Schaefer On Health Policy, July 2022
   (This is a description of the complex way MA plans profit from Medicare.)

https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/?utm_campaign=KFF-2021-Medicare&utm_medium=email&_hsenc=p2ANqtz-8BiHUivL9XGPO5rcNTOwfNtRb3dubTE4dagw9aNAE3cnxd8ykjE0i03zDvodPpujBW2QbpZoWfF687S4cYar17PfUdA&utm_content=2&utm_source=hs_email

(This explains how the higher payments for Medicare Advantage — $321 more per person — have led to higher federal spending than would have occurred under traditional Medicare and higher Medicare Part B premiums paid by all beneficiaries, including those in traditional Medicare.)


(Discusses inappropriate denials of prior authorization by MA companies.)

(These yearly reports assess the efficacy and efficiency of Medicare Advantage programs. Reports in 2021 and 2022 and 2023 confirm overpayments and fraudulent behavior such as upcoding by MA companies.)


(This article describes reports from the Office of the Inspector General of Health and Human Servics (HHS), whose investigations reveal inappropriate and harmful denials of requests for prior authorization and payment by Medicare Advantage insurance companies. There are also links in the article expanding on the extent of fraud by Medicare Advantage companies.)

https://www.npr.org/sections/health-shots/2022/12/12/1141926550/medicare-advantage-plans-overcharged-taxpayers-dodged-auditors

(Insurance companies were found guilty of upcoding and ghost records.)

9. 2023 Summary of the Annual Reports – Social Security and Medicare Board of Trustees


(This summary report describes the outlook for both the Social Security and Medicare programs and the projected actuarial status of the trust funds that finance them.)