20 REASONS FOR ENDING MEDICARE ADVANTAGE PLANS

Medicare Advantage (MA, Medicare Part C) was authorized by Congress in 2003 to encourage the private health insurance sector to develop innovative ways to provide seniors better care at lower cost. However, neither goal has been met, and serious concerns have arisen with the program.

The Medicare Payment Advisory Commission (MedPAC) stated that many policies governing MA are flawed and that with those policies, MA enrollment continues to grow, threatening Original Medicare's fiscal sustainability. The Commission concluded that that Congress and the HHS Secretary must correct these flawed policies.[1]

A recent study concluded that "Redeploying MA overpayments to improve Original Medicare coverage would better serve seniors and impede the accretion of medical resources by investors whose profit seeking too often overrides patient care priorities." [2]

Here are 20 of the main reasons why MA plans should be terminated. There are many more.

MA Plans Waste Taxpayers' Money

- After being paid **104% per capita** of what Original Medicare spends, MA plans further manipulate the system through favorable enrollee selection, questionably legal upcoding of medical conditions, and a flawed system of benchmarks, quality ratings, and bonuses to **overcharge the government between $88-104B per year.** [3]
- Tens of billions of dollars are thus transferred from taxpayers to **multi-million-dollar executive salaries and billion-dollar profits for private insurance companies with no public benefit**. Many of the largest plans have been charged with **fraud and overbilling** by the U.S. government, Inspector General, and insider whistleblowers.[4]
- Administrative **overhead and profits of MA plans average 17%**, in contrast to Original Medicare's overhead of 1.3%, further wasting taxpayer dollars.[5]
- More than half (54% of 61.2M) of eligible Medicare beneficiaries are enrolled in MA plans. Insurers are drawn to the MA market due to high profitability, **threatening the Medicare Trust Fund**.

MA Plans Limit and Restrict Care, Imposing Challenges for Patients and Healthcare Providers

- Their aggressive **marketing misleads enrollees** into believing the plans are free and equivalent to Original Medicare, only to be hit with surprise out-of-pocket costs with substantial co-pays and deductibles in addition to frequent denials of care.
- The plans **restrict patients' freedom of choice** of physicians, hospitals, and other providers by having limited provider networks and requiring large out-of-pocket payments for using out-of-network care. Plans include only 51% of hospitals in the country. Mayo Clinic and Vanderbilt are among many systems that no longer accept MA enrollees.[6]
- As those restrictive networks include fewer NCI-designated cancer centers, MA enrollees have a **higher risk of death** due to inadequate access to the highest quality cancer care.[7]

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[1] MedPAC report to Congress 2022
[2] AJMC, 6/24, 2024
[3] PNHP, 10/4/23, KFF 1/19/23
[4] NYT 10/8/22
[5] KFF 1/19/23
[6] KFF 6/20/16, Becker's Hospital Review, 8/16/23
[7] KFF 6/20/16, Journal of Clinical Oncology 11/10/22

- Many plans have **"ghost networks**," especially for mental healthcare, with listings of non-existent or unavailable providers or providers with inaccurate contact information, misleading enrollees to believe that networks are more comprehensive than they actually are.[8]
- Many essential specialists are underrepresented in MA networks, specifically psychiatrists, cardiothoracic surgeons, neurosurgeons, plastic surgeons, and radiation oncologists.

MA Plans Do Not Deliver Promised Health Outcome

- A pillar of their business model is to generate much of their profits by **imposing delays and denials of care**, often using AI rather than human agents to make these decisions, and even when the requests meet Medicare coverage rules. [9]
- These delays and denials result in **millions of provider hours spent** filling out forms and fighting insurance companies for coverage, which is almost always eventually granted.
- Most MA enrollees are **too intimidated** to take on larger insurers, even though most denials are for care that would not have been challenged by Original Medicare. Those with the energy to appeal denials also spend myriad hours submitting and fighting them.
- Many MA enrollees **die, develop complications**, or their **conditions worsen during delays** and denials.
- Their coverage of dental, vision, and hearing care is **extremely limited**, such that out-of-pocket payments and cost restrictions to accessing such care are very similar to those of Original Medicare enrollees
- Other benefits like Silver Sneakers gym memberships are used by fewer than 10% of enrollees and are primarily used to market the plans in the guise of preventive health to a younger and healthier population, aka **"cherry-picking."**
- MA plans "**disenroll**" their **sickest and most vulnerable enrollees** who are not profitable, aka "lemon-dropping." [10]

MA Weakens Our Public Health Systems

- Many sick and elderly enrollees leave or are kicked off their MA plan and return to Original Medicare after facing delays and denials of care, thereby **imposing more costs on the public program** and generating more profits for the MA insurers. [11]
- After being on a MA plan for 12 months, enrollees in all but 4 states (CT, ME, MA, NY) no longer have guaranteed issue for private supplemental Medicare policies (Medigap) and can be refused or charged higher premiums for pre-existing conditions, thus **trapping them in MA**.
- Many retirees are **forced into undesired MA plans** by their employers, who save money at taxpayers' expense by not paying for Medigap plans.
- MA plans threaten the **viability of rural hospitals**, with an older and sicker patient base, with denials and delayed payments. [12]

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[8] The Guardian 11/4/24
[9] US HHS OIG 4/27/22
[10] HEALTH CARE Un-covered, 8/8/24
[11] WSJ 11/11/24
[12] KFF Health News 10/17/23; Axios 8/21/23