Replace the failure of Medicare Advantage with ‘Medicare Part F’

By Steve CohenNov. 15, 2022

Adobe

Medicare Advantage began life as a brilliant idea: a public-private partnership to keep older people healthier and reduce costs.

At the time in 1992, both President George H.W. Bush and his challenger, Bill Clinton, supported it. An editorial in The New York Times declared, "The debate over health care reform is over. Managed competition has won." What finally emerged in 1997 — Medicare Choice, now known as Medicare Advantage — was hailed as a win-win-win for patients, providers, and payers.

Twenty-five years later, a different consensus is clear: Medicare Advantage (MA) is a failure for seniors, who receive worse care than they do under traditional Medicare; for doctors, who must negotiate costly and dangerous prior authorizations for their patients; and for the federal government, which spends more per capita on MA than on traditional Medicare. Further, eight of the ten largest insurance companies offering Medicare Advantage plans are currently defendants in False Claims Act lawsuits brought by whistleblowers or the Department of Justice.

But it's been a winner for employers, unions, and states that have pension and health care obligations to their retirees. They push hard to get people off traditional Medicare and onto MA plans. That's because retiree benefits often include supplemental or Medigap policies that former employers pay for, while Medicare Advantage plans are almost entirely paid for by the federal government. Medicare Advantage plans are also winners for the private insurance companies that offer and administer them. Their gross margins are typically two to three times greater than other insurance plans.

Medicare is simple in theory but mind-bogglingly complex in practice. Part A covers hospital care and Part B covers doctors; in each part, Medicare pays only 80% of the bills. The remaining 20% is paid for either by the individual or by supplemental insurance. All of Part A is funded by

the federal government, as is most of Part B, except for a sliding-scale contribution of up to $170 per month based on an individual's income.

Medicare Advantage — almost entirely paid for by the federal government — includes Parts A and B, and sometimes Part D, which covers prescription drugs. (Ordinarily, Part D plans must be bought on the open market.)

Confused? Most people are. Few seniors understand the difference between supplemental and Advantage plans, or can figure out which drugs are paid for under Part D or when that part kicks in. To make matters worse, they are inundated with often misleading mailers and TV commercials with aging but familiar pitchmen like Joe Namath, Jimmie Walker, and William Shatner urging them to sign up for low-cost, all-inclusive Medicare Advantage plans. As a result, nearly 50% of Medicare-eligible seniors are enrolled in Advantage plans.

How did such a promising idea grow so large and then go off the rails? Enamored with the 1990s promise of managed care — and prompted by then-First Lady Hillary Clinton's health care task force — a novel idea emerged: take the money the federal government was spending on Parts A and B, about $1,000 per person per month, and give it to private insurance companies. The insurance companies would be responsible for covering all hospital and doctor bills, and could charge people additional modest premiums for certain benefits, such as lower deductibles, or eye care, or more robust drug formularies. And if they kept people healthy — and out of the hospital — they would make more money.

Medicare Advantage was born from the belief that the market would serve the varying needs of individuals and spur innovation. That would help lead to smarter lifestyle choices, more preventive care, and better health outcomes.

But that was all based on two assumptions. First, the private sector would do what it does best (at least in theory): innovate. Second, insurers would be able to successfully persuade seniors to eat better, lose weight, exercise, and get regular check-ups in order to lead healthier (and less costly) lives.

The *concept* was great. But it was a disaster in practice. Habits of a lifetime are difficult to change. So insurance companies found an easier way to make money: they began denying medical services. To do this, they aggressively adopted prior authorization and utilization review practices. These protocols require a doctor to secure an insurer's approval that a test, treatment or medication is "medically necessary" before the doctor can administer it to the patient. In essence, the insurance company is not controlling payment but second-guessing doctors' professional judgment from afar.

Disguised as perfectly reasonable tools to root out waste and fraud, prior authorization and utilization review allow insurers to insert themselves between doctors and patients to decide what is medically necessary — often with deadly results.

Prior authorization protocols create real health risks for seniors. Diagnostic tests and medical procedures are often delayed and occasionally denied. These dangers were underscored in a report issued in April 2022 by the Inspector General of the Department of Health and Human Services. This report showed that one in 10 treatments that had been denied and one in five denied payments would have been covered by traditional Medicare. In short, insurers were simply not following Medicare guidelines for care. The report also showed that fully 75% of all medical services that were denied via prior authorization were overturned upon appeal, resulting in unnecessary and dangerous delays in patients getting care.

For all of this, Medicare Advantage plans haven't saved the federal government any money. Although some 48% of eligible seniors are enrolled in Medicare Advantage plans, the insurance companies offering them are gobbling up 55% of total Medicare spending.

Time for a new approach

In my work as an attorney, I recently represented two groups of retirees — in Delaware and New York City — against their former employers. The state and the city were each trying to force these seniors and disabled first responders out of traditional Medicare and into Medicare Advantage plans. The reason was simple: money. As part of their retirement benefits, the former municipal workers were entitled to supplemental insurance paid for by their former employers. In New York City, for example, that meant the city was spending nearly $600 million a year for a plan that covered nearly 250,000 retired teachers, police officers, firefighters, nurses, and others. By shifting them to Medicare Advantage, that expense would disappear because the tab would be picked up by the federal budget.

In both cases, the seniors won in court. Now the battle is shifting to the political realm: New York City is trying to repeal the law that guaranteed retirees' health insurance. The lure of federal money is simply too tempting, even if the health care the replacement programs would provide is demonstrably worse.

That single factor — the lure of federal money — is both the problem and the potential solution.

As long as the federal government is willing to pick up the tab for Medicare Advantage, but not for other more-promising options, states, cities, companies, and unions that have retiree pension and health care obligations will chase that money. The solution is an alternative Medicare

plan that allows former employers to tap federal funds but doesn't suffer from the structural flaws that led Medicare Advantage astray.

I propose a new plan called Part F, for Medicare Future. It relies on the federal funds that are being used for Medicare Advantage plans, but prohibits insurance companies from imposing prior authorization or utilization review hurdles.

Compared to the current system, Part F is simple. It would cover all medical expenses, including Part D for prescription drugs, but would not allow insurance companies to impose hurdles like prior authorization. And, as with current Medicare Advantage plans, the federal government would pay a set capitated amount to insurance companies, which would design different configurations of plans — to meet people's varying needs — and then market and operate them.

In practice, Part F would operate much like the current supplemental/Medigap approach, which works incredibly well, but would be paid for by the federal government instead of by former employers or individuals. The government would control fraud the way it does with traditional Medicare, by approving claims up front then auditing them to uncover provider abuses.

Part F would give insurance companies a modest guaranteed profit margin and an incentive structure based on better health outcomes. Unable to deny services through prior authorization, insurance companies would need to actually innovate to boost profits. Part F would also offer insurance companies a huge incentive they have longed for: permission to market their plans nationally, not just state by state.

Part F is a way to give insurance companies one more chance to prove they can innovate and add real value to the health care system. Private

companies have done a lot to revolutionize other sectors of life and the economy: think Amazon in e-commerce and Netflix in entertainment. It could happen in health care as well if the incentives and consequences are right. But if the insurance industry can't or won't add real value, the forces for single-payer health care may push a recalcitrant industry into its own Blockbuster corner.

Does a Medicare Future approach have any chance in the current political or bureaucratically entrenched environment? Surprisingly, it does.

It was a very liberal friend who convinced me that private insurance companies need to be part of the mix in any future reform. And it was a conservative friend who reminded me that Republicans still have not proposed any viable alternative to the Affordable Care Act. More important, the mechanism for testing Part F plans already exists: The Center for Medicare & Medicaid Services has an innovation center looking for new public-private initiatives.

The shortcomings of the current Medicare system must be addressed ASAP. A good place to start is recognizing what hasn't worked — and why — in order to develop a revamped system of medical care that both effectively and economically serves the growing senior population.

Steve Cohen is an attorney at Pollock Cohen, a litigation-oriented law firm based in New York City.

About the Author

Steve Cohen

scohen@pollockcohen.com
linkedin.com/in/steve-cohen-17a9052/
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