Taking Advantage

Stories from the Front Lines of the Privatization of Medicare

HEALTHCARE-NOW

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Medicare Advantage: Beyond the Ads

The Medicare Advantage program ("Medicare Part C") originated in 1997 with the stated goal of providing "greater choice" to Medicare recipients by introducing insurance plans that would be funded by public Medicare dollars but administrated by private companies. Since then, each year has brought an increasingly torrential flood of advertising for Medicare Advantage plans into our homes via TV, radio, sales calls, and now social media. The commercials feature happy, active seniors and tout low or zero-premium plans with the same coverage as traditional Medicare, plus "extra benefits" like dental and vision care, prescription drug coverage, transportation assistance, and even home-delivered meals.

Unfortunately, because the priority of insurance companies is always to cut costs and increase revenue, the reality of having a Medicare Advantage plan often fails to live up to the marketing, and many customers are left with high costs and much less care than promised.

As if that weren't enough, according to a recent *New York Times* report, insurance companies have gone to extreme lengths to maximize their profits, with several facing fraud charges and federal investigators declaring that 8 of the 10 largest Medicare Advantage insurers had regularly overbilled Medicare for new enrollees.[1]

Amid this high-level controversy surrounding the executives whose exorbitant salaries and bonuses depend on Medicare Advantage, we at Healthcare-NOW wanted to better understand the impact of the program on people whose actual lives depend on Medicare Advantage. **We invited our members who are or were enrolled in these plans to tell us their stories, which resulted in over 100 responses encompassing a wide range of experiences and a few concerning trends.**

It is worth noting that just over 25% of those who submitted their stories had positive experiences with their Medicare Advantage plans, citing low premiums as the most significant incentive of Medicare Advantage over traditional

[1] Abelson, Reed, and Margot Sanger-Katz. " The Cash Monster Was Insatiable : How Insurers Exploited Medicare for Billions." *New York Times*, 8 Oct. 2022.

Medicare. However, many of those respondents who liked their plans also pointed to the fact that they hadn't required much care so far. As Myra in Oregon put it, "My husband and I are fairly healthy and don't have any big health problems. Maybe if I had lots of healthcare expenses, I would have a different opinion about the advantage plans."

While Medicare Advantage worked for some, the majority of our respondents had negative experiences with their Medicare Advantage plans. Overall, they reported that although their premiums may have been lower, the drawbacks were significant – often leading to higher costs and sometimes to health crises. Despite differences in geography and social and economic status, respondents frequently returned to the same issues with their plans:

- **Limited networks of providers** who accept their coverage and **limited prescription drugs covered** by their plans, making needed care difficult to find even if it would be covered
- **High co-pays, deductibles, and fees** that enrollees were not aware of in advance, leading to sometimes catastrophic out-of-pocket costs when they actually need intensive care
- **Pre-authorization denials and denials of claims for care received,** sometimes requiring drawn-out appeals or legal threats, sometimes leaving patients with unaffordable bills for tests or procedures they assumed would be covered
- **Upcoding,** which is an industry practice in which patients are assigned more severe diagnoses in an attempt to overbill Medicare for their care
- **Delays and bureaucracy in approving coverage**, which may sound like an inconvenience, but for those suffering from painful or life-limiting conditions, can have devastating impacts on physical and mental health

In addition, patients spoke of feeling duped by aggressive telemarketers and ads making false promises. Jim, in Colorado, expressed a common frustration, writing, **"The 'extra coverage' advertised by my provider turns out to be nearly worthless, due to severe restrictions."** Several respondents pointed to the fact that the term "Medicare Advantage" was itself confusing for patients. Edward Falcone in NY wrote, "It shouldn't be allowed to be called Medicare anything except Medicare replacement; this is misleading because it is not Medicare but private insurance funded by Medicare.'

In any healthcare program, there are bound to be individuals with positive and negative experiences, but, among our respondents, the negative outweighed the

positive. What is even more disturbing than the volume of serious issues they raised, was the way in which they described a shift in their experiences once they developed an illness that required treatment. **They found that once they became sick, accessing care through Medicare Advantage became an onerous ordeal of appeals, hidden charges, and compromises to the quality of their care.**

Those experiences make perfect sense within the business model of Medicare Advantage, where profit is the bottom line. Like private insurers in all areas of healthcare, the major players in Medicare Advantage advertise comprehensive care at low costs, but they benefit from denying and delaying care and pushing those who require the company to lay out large sums of money for care off their books and back onto the publicly administered Medicare system. However, that shell game takes a dangerous toll on people who are already struggling to meet their basic healthcare costs. Customers who can't afford the premiums for traditional Medicare are forced to gamble on their health, hoping that they will stay well enough that they won't need care and knowing that if they do, they will likely face financial and bureaucratic obstacles. Given that Medicare-eligible patients (seniors and some people with chronic conditions) have less ability to pay out-of-pocket costs and greater health needs, that gamble can be deadly.

It is clear that as long as we continue to allow private insurers to profit from programs like Medicare Advantage, they will continue not only to exploit their customers, but to line their own pockets with taxpayer money, putting additional strain on the finances of the entire Medicare program.

We hope that the following stories will demonstrate to you, as they have to us, that while we continue to fight to expand Medicare to everyone, we also need to fight harder than ever to protect Medicare from privatization and corporate greed.

“Stripped of His Dignity”

Anonymous, CA

My 86-year-old uncle was admitted to a rehab center after a fall. He did not sustain any injuries. He was just going for physical therapy to monitor his ambulation and stability. **He was given 10 days of physical therapy, and then the [Medicare Advantage] insurance was stopped, stating he reached his maximum.** He needed more physical therapy. Instead, he was allowed to lay in bed, no physical therapy. After nine months of being in a nursing home, he has now lost strength in his legs. This is a man who just prior to the fall was very independent. He lived alone. He did his own cooking, house cleaning, grocery shopping, paid his own bills. Hopped on the bus when he needed to go somewhere. **If he would have been given more sessions of physical therapy, he would be living independently. Instead, he lays in a nursing home, stripped of his dignity!** This is not right!

“I Hope That God Will Take Us Home Soon”

Cheryl, IN

My elderly father, now deceased, had a series of strokes. Then, he had a worse stroke. It was determined that chips of plaque were coming loose in his carotid and moving up to the brain, and a procedure was done to clean the carotid. **His Medicare Advantage Plan had a $5,600 out of pocket maximum,** and by the time the procedure was done, he owed that much. This, we understood, as that was the terms of the plan.

However, I was very distressed about what came after. The hospital said that he needed a period in skilled nursing during recovery from the stroke and the surgery, which we could clearly see. He could not even drink without choking unless someone was pinching the straw. He could not walk at all without two assistants, and he could hardly sit up in a chair. His speech was very affected (before the procedure), and he was still struggling to speak. The hospital said that the Medicare Advantage Plan had denied the stroke rehabilitation facility they

suggested, but they gave us some other options. We chose the one that was closest to our home, so that we could at least visit often.

Within days, we got a letter that the insurance would not pay for his rehabilitation. My elderly mother was very upset, and it almost made her sick. They said he did not even need physical or occupational therapy. We were shocked. He could not even scoot up to a comfortable position in his bed at the facility when we were ready to leave for the night without my husband and I pulling him up. I could clearly see, by the wording of their denial, that this was a robo-denial, and that they had not even looked at his recent medical records.

I had to file an appeal, but the deadlines were very tight, and they were slow in mailing us the paperwork. This was a complicated process, and my Dad could not sign his name in a way that looked like his normal signature. We had to take a notary with us to witness his signature […] After we mailed in the appeal, they requested that even more paperwork be sent in, again, needing a signature, and again, with a tight deadline. We had to get a notary again to go with us to witness his signature, and he was still barely able to do more than scribble.

A short time after the appeal process was completed, I received a phone call at work. I don't even know how they got my number. The Medicare Advantage Plan representative was asking me to send an email to withdraw the appeal, because he said the denial did not refer to the facility where he was taken, but only referred to the hospital recommended facility that they had already said they were not agreeing to. I was having a busy day at work and was uncomfortable receiving that type of calls at my workplace. I told him I would have to go back and look at the original denial. When I looked at it again, it was as I remembered; it mentioned nothing about any particular facility. **It simply gave all kinds of inaccurate information about why rehabilitative services were not needed.**

I called the insurance back and told the person that had called that I could not withdraw the appeal because no particular facility was mentioned and because the denial made all types of statements about his medical condition that were not true. **He then told me that the insurance was not going to cover this, anyway, because it did not get pre-certified.** The hospital had told us that this facility would be okay, so we thought that had already been taken care of. I was so upset, I thought I was going to have a stroke of my own. My Dad was going to need at least 2 months of in-facility rehabilitation, so I knew that the bill would likely be about $20,000.00. I had to go to the clinic where I worked to have my blood pressure checked, as I felt like I was about to pass out.

I struggled with this Medicare Advantage plan for months. Every vacation day that year was for the purpose of calling the insurance. Finally, after constant effort, I got the rehabilitation facility bill paid.

After he was released, he needed some outpatient therapy. I never got a letter of denial for that, so I thought it was all okay. After almost a year, I got an email at work from the rehabilitation facility. Again, I was caught off guard, and I felt like I was going to be sick. **It was actually around $3,000.00 that they were saying he owed**. […] We never did get the insurance to pay that bill, but because my husband ardently complained that they had not filed proof that it had been pre-certified, the facility finally agreed to write off the $3,000.00.

A short time after that, we got notice that this Medicare Advantage Plan was being pulled from the market. We took that letter to a local insurance broker to try to figure out what to do, as both of my parents had pre-existing conditions. We were told that the notice was their "get out of jail free card." It enabled us to put them in a Plan F Medicare supplement without a pre-existing condition review, which we would not have been able to do otherwise.

After that, we never had trouble with the Plan F, because the law requires that they pay their 20% of whatever Medicare designates as the total cost. At their age, Plan F was expensive, but it was worth it. […]

My husband and I decided we never wanted Medicare Advantage. We also planned to choose Plan F when we became eligible. We knew that old people often get too confused to deal with deductibles, etc., and end up paying things they don't owe because of billing errors they don't catch.

My husband became disabled and had to go on Medicare early, but in Indiana, Medicare Advantage was his only option before the age of 65. I was so afraid of Medicare Advantage, I kept him on my workplace insurance, which was chopping the heck out of my paycheck, but which still had a high deductible and a high maximum out of pocket. After the experience with my father, I was afraid to deal with a Medicare Advantage plan again.

My husband has had a lot of health problems, so I have struggled with private, for-profit insurance my whole life. […] **If we get stuck on Medicare Advantage or some other type of private insurance for the rest of our lives, I hope that God will take us home soon, rather than leaving us here to spend the whole remainder of our lives fighting with insurance. I don't know that I can do this**

when I get really old, and my husband is already incapable of dealing with these types of phone calls, computer navigation, and paperwork.

"She Died the Next Day"

Anonymous, CA

I am a now-retired health care provider (clinical psychologist). I worked for a managed care system that offered Medicare Advantage. We providers always called it 'Medicare Disadvantage' or, in the days I worked there, "Senior Disadvantage". **Profit almost always seemed to take precedence over quality care.** The ratio of nursing staff to patients was inadequate. In far too many instances, patients or their families had to fight to get referrals to specialists.

Expensive procedures were often delayed. A ninety-year-old woman I knew who had broken her hip had to wait more than four days for surgery while going without food because they "couldn't feed her and they didn't know when a surgery suite would be available, so she had to be ready."

The wait caused her health to deteriorate significantly. **The wife of an elderly patient of mine who was a brittle diabetic was released to her home before her sugar levels were under control. She died the next day.**

A patient of mine became suicidal because she had been waiting months for surgery to control symptoms of her Parkinson's disease and she had given up hope she would ever get it. She finally did get it after **the family's attorney called management and threatened to both sue and go to the press if it wasn't scheduled immediately.**

What I saw convinced me to never, ever sign up for a Medicare Advantage plan with my former employer or with anyone else. […] I do not believe that decent care is possible under any private, for-profit health care system.

“Overnight, I Became a Diabetic”

Ginny, CA

I got tricked into signing up for a Medicare Advantage plan by the Health Insurance Counseling and Advocacy Program counselor that my federally funded health care clinic told me I needed to see. I am a college graduate and comfortable with medical terminology and concepts. I was misled about Medicare Advantage – not even told about other options – and not told any of the downside. Basically, it was a bait-and-switch deal. **I found out the hard way that I have to fight and pay for really basic Medicare-covered preventive care.** I am furious and have come to understand that Medicare Advantage is a profit-driven, insurance company-backed ruse which is going to be the death of me.

The TV ads are a lie – those “extra benefits” aren't benefits if you can't use them! The 'covered' dentists and optometrists are big chains that give substandard care to Medicare Advantage patients and ‘upsell' when they think they can get away with it. I went to the “covered” dentist and was lied to by them about what needed doing and what they were doing. I had to pay $150 to get an “out of network” dentist to give me a truthful exam. […] And when I couldn't see out of the glasses I got from the “covered” eyeglass provider chain because the lenses were made with such cheap plastic they made everything blurry, I went to another provider and got glasses with the same prescription (from a non-network provider) and paid $200 out-of-pocket instead of the $400 the “in-network” chain charged me for my share of the useless glasses**. I went into debt but at least now I can see.**

I have had bi-annual mammograms denied by my Medicare Advantage plan. I've had to wait 6 months to see any specialist my primary care referred me to and struggled to find one that would see me, I believe because of my Medicare Advantage coverage. I had to wait almost a year to get a colonoscopy because of my lousy coverage, but at least I finally was able to get it. Now, I am waiting to see an oncologist. My primary care doctor at the federally qualified health clinic asks me why I have such bad insurance. My only option is to return to standard Medicare, as I have been told I am blocked from any other supplemental plan.

As soon as I signed up for Medicare Advantage, downgraded health metrics appeared on my records at the federally funded health clinic. Even though my weight hadn't changed for the past 20 years, I went from being overweight to

"morbidly obese." Overnight, I became a diabetic with cardiovascular problems and severe asthma, and my primary care doctor couldn't explain why. I was stunned and incensed. **That is how I found out about up-coding, which means that my Medicare Advantage plan bills Medicare something like $32,000 for my care every year, even though I am not being provided care for any of these "severe ailments" and struggle to get basic preventive care.** Medicare privatization is a crime that is intended to bankrupt Medicare and deny seniors healthcare.

"Their Own Set of Rules"

Anonymous, CA

I am a 71-year old woman in Santa Monica, California with a Blue Shield Inspire (HMO) Medicare plan. I am writing because I am not being provided with all the benefits outlined in the Evidence of Coverage (EOC). **Blue Shield is refusing to take any responsibility and when I file a complaint, they basically ignore what I'm saying and twist it around and say I can re-apply.**

One of the covered benefits as stated in the Evidence of Coverage for 2022 is eyecare and glasses, specifically "An eye exam every 12 months at no cost if in network provider; One pair of lenses, no matter the strength or size valued up to $200 every 12 months from network provider." If it costs more then I pay the difference.

Blue Shield contracts with VSP [a vision care insurance company] for eye services. On Feb 22, 2022, I went to Ocean Park Optometry, a VSP provider who I have used once before, both times for an eye exam/prescription and lenses in my own frames that I bought elsewhere. They charged me $255 because they said I needed thinner lenses, UV, and a protective coating. They never called when the glasses were ready so I didn't know I should pick them up until April 2022.

In June 2022 I was reading through the EOC and saw that it very clearly stated that I got a free exam, $200 towards lenses, and $200 towards frames. When I called Ocean Park Optometry on June 29, 2022, and asked why they weren't going by the EOC, they said to call VSP. They also said I hadn't asked at the time

so there was nothing they could do. **I called VSP and they said those were their prices and that was that.**

I called Blue Shield on June 29, and VSP told them I had a “different benefit,” although no one knew what that meant. Blue Shield refused to do anything, so I filed a grievance on the EOC not being correct and an appeal for payment of the $200 benefit. On July 11 **Blue Shield sent a letter quoting their EOC benefits that give me $200 towards lenses, but they would not refund me the $200! '**

On Friday, August 5, 2022, a Health Care Advocate with the Health Insurance Counseling and Advocacy Program (HICAP) program at the Center for Health Care Rights in Los Angeles, called Blue Shield with me on the line to inquire if there had been a denial of service and the reason why - and why Blue Shield was not covering items in the EOC.

We talked with [a Blue Shield customer service representative], who said if I wasn't satisfied, I could file another complaint. […] He decided to “escalate” the call after 50 minutes to [another customer service representative], who said “I don't see there are exceptions listed in the EOC, but it doesn't mean there aren't any.” […] [The representatives] from Blue Shield said they would confirm our conversation in writing, but there has been no letter or other communication from Blue Shield. […]

VSP is refusing to give us the benefits clearly stated in the EOC. Conversely, if there are exceptions to what is written in the EOC, the EOC is not stating any of them.

I can't be the only senior who believes what is written in the EOC while VSP tells their contractors to do something else. **This seems very, very unethical of Blue Shield of California to let VSP use their own set of rules and not provide the benefits in the EOC.**

“Not Right!”

Carmen, NJ

In the beginning, last year, it seemed pretty good. But this year after my husband got sick with small cell lung cancer, Medicare Advantage denied some of his claims. We tried to do anything possible to save him, but we could not.

We spent thousands of dollars on alternative treatments, and at this point it looks like the money is lost. Premiums are too high and medication is unaffordable. Not right!

"The Insurance Company Will Not Cover It"

Anonymous, FL

My husband and I have been relatively happy with Medicare Advantage over a number of years. However, this year has not been as good as previous years. We changed doctors (not the Medicare Advantage company) this year because we needed to find a doctor nearer to our home. Thus far, we have not been pleased with our experience. […]

I have developed a problem with my eyelids and have to have surgery on them. The insurance company will not cover the surgery. I love to read and am unable to read for more than 30 minutes because of my drooping lids. The insurance company will not cover it because the eyelids are not completely covering the iris. **My husband and I are paying for the surgery -- $3,000.**

"Providers Warn Me Ahead of Time"

Adrianne, CA

It is Medicare DISAdvantage! **I'm constantly paying for everything out of pocket!** Providers warn me ahead of time & apologize to me for the high co-pays with Medicare "Advantage." I needed a 5 year colonoscopy: It cost me $370! And just the lousy bowel prep solution cost $116.88! My previous one was completely paid by Medicare and my medi-gap coverage.

People living on social security cannot afford Medicare DISadvantage co-pays!

“Slowly Turning Into a ‘Bad Deal’”

Milo Trak, VA

I've been with Medicare C for last 10 or so years. **What started as being a "good deal" is slowly turning into a "bad deal.”** The thing is that the insurance (in our case UHC [United Healthcare]) is shifting more and more costs on us in terms of co-insurance, co-pay, etc. I truly believe that this is a step for the insurance to prepare for privatizing Medicare.

“Can’t Trust Them”

Maria, TX

I'm a widowed grandmother raising a grandson alone on my retirement. I can't afford much. **I got an Advantage program thinking it would provide the services it claimed: free medical transportation, covering specialist fees, medications, and other items. It didn't!**

When I realized the program was lying, and it was owned by an insurance company and not by Medicare, I cancelled immediately. I don't trust companies that lie to me. Can't trust them. And when the only purpose is to privatize Medicare, I am furious!

“Immoral and Fiscally Ruinous”

Jan, OK

My late mother had trigeminal neuralgia a number of years ago. She was in desperate need of surgery. We found a surgeon at the Mayo Clinic in AZ. **Through some weird paperwork snafu that our convoluted and obscenely expensive system engenders, it was not noticed until surgery was eminent that she had United Health Care instead of Medicare. The Mayo Clinic didn't accept advantage plans!** That's when I knew such plans weren't good for practitioner nor patient. The Mayo worked some sort of humane magic and Ma got her successful surgery. Every time I see those advantage care commercials

on tv I want to scream! They are so self-serving and make Medicare seem to be the bad choice. Shame on the American for-profit system! It's immoral and fiscally ruinous and is weakening our country.

"Every Refill Is a Hassle"

Anonymous, VA

I have Aetna Medicare Advantage with [prescription coverage]. They had to cover over $30,000 for an ICU stay for me in 2020 for a high blood pressure crisis. **Ever since, they have been nickeling and diming me about the pills I have to take for blood pressure.** Their clerks harass my specialists constantly wanting to "discuss alternative (cheaper) meds." Every refill is a hassle, not to mention the $90 copay for two of them. This is awful.

"Fine Unless You Get Sick"

Eva, DC

I was in Rhode Island when I was a member, and **my experience was that it is fine unless you get sick, in which case they severely limit your options, including getting second opinions.** I quit as soon as I could; do not get this plan unless you know you will never need any kind of serious medical care!

"Death Squads"

Anonymous, FL

My husband tried the Medicare Advantage program. There is a large medical facility [in our area] that only accepts Medicare Advantage programs because they also manage one.

My husband liked the doctor. However, there was a $5000-a-year deductible. He needed to have cataracts removed. **He was called by the eye specialist to hand over $2000 before they would schedule the surgery.** We knew that was

absolutely nuts. I had both of my cataracts removed and Medicare paid the entire bill. Cost me nothing.

We immediately made inquiries about how to get back on Medicare. It was an awful dragged-out experience. It took a couple of weeks to reverse our really bad decision. One person on the phone would tell us what to turn over to them in a mailed letter. Had to wait for a review. Then they needed something more and more. You get the picture. We were not giving up and did succeed.

The bad part [of Medicare Advantage] is that the deductibles and out of pocket are staggering. The first 3 days in a hospital are on the patient. The first 3 days are the most costly, with all of the tests, emergency ICU care, and possible surgeries. That alone will put people into bankruptcy. Plus, the company collects $9000 for just signing you up for their program. A real cash cow for medical groups. Those death squads that [Sarah] Palin use to talk about – they are real in Medicare Advantage programs.

"What's So Good About It?"

Valerie, OR

I have the Kaiser Medicare Advantage plan and have been having the hardest time getting access to the kind of care I want/need. When I broke my arm last year, I spent 7 torturous hours in the ER, waiting for help. I was finally bandaged up and told to make an appointment within the week with an arm specialist. The next day, I called Kaiser and they said I needed a referral from my PCP first. It took a week to get the referral and another week to be seen by a Kaiser specialist located in an inconvenient facility far from where I live. After x-rays and splinting, I was told to start occupational therapy right away. So I called [the department] and was told the first available appointment was 5 weeks later by video! I explained that in 5 weeks, my arm might heal awkwardly, and I wanted an in-person visit, but the scheduler said I could take it or leave it. I contacted the arm specialist again, and he said to ask for an out-of-network appointment because that was the only way Kaiser would give me the support I needed. He was right – I was given an OT appointment for a couple days later. **This is just a short summary – just the beginning of what became my 6-week ordeal. And this is just one unhappy incident in a series of terrible HMO responses.**

In contrast, on a family road-trip to Canada this summer, my grandson got a "crush injury" and we rushed him to the Canadian ER. They saw him in 10 minutes, took x-rays, cleaned and splinted his injury, and had him out of there in 2-1/2 hours. They even gave him popsicles during the discharge process. A few days later, my husband got too dizzy to stand so we ended up in another Canadian ER and this ER was also wonderful! They saw him in 10 min, did an array of blood tests and an EKG, and the doctor spent about 45 min asking questions and doing an array of physical movements of my husband's head and neck, etc. I was so impressed with his thoroughness! Each Canadian healthcare professional we interacted with was friendly, courteous, respectful, knowledgeable, and CARING! […] We were also surprised that the ER posted their fees so everyone would know up-front what their charges would be. It was a flat rate of about $1,000 for non-residents for everything, including the blood tests, x-rays, splinting, etc. Canadian residents were charged a flat rate of around $300. They didn't nickel and dime those who need care by charging for every little thing they did! **If Canada is an example of universal healthcare, what's so bad about it? And if the US is an example of "the best healthcare system in the world," what's so good about it?**

"Cut-Throat Cost Controls"

Anonymous, FL

It was a pain for me and the provider. When I had rotator cuff surgery, my Medicare advantage did not pay a partial payment to hospital on my behalf. I appealed it, and eventually I was refunded hospital partial admission charge that I paid. This was through Humana. In fact, my orthopedic doctor provider desired for me to have outpatient surgery, but insurance insisted on hospital procedure only. I understand that most insurance companies would prefer outpatient, which is less costly, but not in this case. **Also, the doctor informed me he is considering terminating his contract with Medicare Advantage due to cut-throat cost controls that are hindering his managing realistic clinical costs.**

In addition, Medicare Advantage significantly delayed any MRI diagnosis and only preferred an X-ray, which would not show a tear. Then I was given direction to follow up with physical therapy, which was painful and not helping. Eventually, my orthopedic doctor was given authorization to use an MRI on my shoulder, which

showed a 75 % tear on my rotator cuff. **Then and only then, after insurance delayed my diagnosis, could surgery be authorized.**

When I had surgery finally, I was again ordered to have physical therapy treatments. **The physical therapy provider is also considering not accepting Medicare Advantage due to strict oversight by the insurance company hindering treatment progress, demanding additional monthly paperwork to verify ongoing need, and keeping costs low that are restricting realistic treatment costs for rotator cuff follow up.**

I was also learning that if I keep Medicare Advantage instead of Medicare when I retire, I might be subject to medical underwriting if I wait too long until I have major medical problems that Medicare advantage may not cover. I also became aware of networking that does not allow me to see my own internal medicine provider, so I had to lose my doctor to another doctor who is willing to accept Medicare advantage cost controls set by the insurance industry and not clinical best practices. It was a pain to use Medicare Advantage.

But fortunately, I applied for Medicare at 65 and have been on it, and thankfully I did not need medical under writing. I have friends over 65 that believe they are paying less for additional benefits under Medicare advantage and are not aware of service and claim denials and restrictive payments. However, I am also aware I am paying high premiums for Medicare supplemental coverage, but am assured doctor choice and covered services where I choose to go.

“Deductibles, Copays, and Denied Coverage”

Jim, CO

Medicare Advantage gives me minor coverage for routine medical office visits, at the expense of deductibles, copays, and denied coverage. **The "extra coverage" advertised by my provider turns out to be nearly worthless, due to severe restrictions on dental procedures and eye care coverage.** The subsidy paid by our federal tax dollars to Medicare Advantage providers ($8K+ per person, per year, depending on location) would be far-better-spent on low-overhead, federally administered Medicare F (Medicare for All), in my opinion. **And as a healthy senior, I would much rather see healthcare dollars I don't spend go to those with greater healthcare needs, rather than coverage-**

denial infrastructures, marketing budgets, executive bonuses, stock buybacks, and profit margins of giant, for-profit corporations.

"Taking Advantage of Clients and Providers"
Anonymous, CA

As a healthcare provider, I keep seeing clients having to pay way more with the advantage plans. **The advantage plans take the bulk of the money that would go to the provider if Medicare were the primary plan.** The private industry is taking advantage of clients and providers, which is unethical and so wrong. No wonder providers will not accept [Medicare Advantage] insurance payments.

"I Can Barely Afford the Medicare Premiums"
Jo-Ann, TN

Medicare should cover EVERYTHING – all government-recognized and regulated forms of medicine and treatment. This having to have different programs and insurance is INSANE. **I got a [Medicare Advantage] plan that costs me no money – thank God because I can barely afford the Medicare premiums – but I can't go to the hospital 3 miles from my house. I have to go over the mountain.** What kind of insanity is that? It doesn't cover any of the medications or therapies I need to keep moving. The only ones benefiting from this system are insurance companies.

"I Have to Keep Watching"
Bob Krasen, OH

I am a type 1 diabetic. Our Medicare Advantage Plan is an entity of a non-profit hospital conglomerate and supposed to be non-profit as well. However**, I have caught them upcoding my health care records with stuff that is extraneous.** I told the doc which ones I wanted removed. They did, but I have to keep watching.

A few years ago, my insulin costs were sending me into the "doughnut hole" in July. I asked my Endocrinologist about it, and she said, "You should be getting your insulin through Part B of Medicare because you have a pump." At first, customer services at CVS Caremark said they couldn't do that, but I insisted and called the Pharmacy Manager at the Medicare Advantage office. He was able to help, and ever since, I have at least stayed out of the "doughnut hole," even though I am paying about the same for insulin as before – about $57 per vial.

Too bad Congress didn't vote to support the insulin cap of $35 per month. I guess too few of them have kids who face a lifetime dependency on insulin.

"More Help, Not Rip-Offs"

David, NY

I got a call from this guy from Wellcare who swore it was such a great thing. **No, it's just costing me money and it won't pay for the practitioners I want to use.** They have sent me a little payment booklet the last two years and it goes right in the trash. These people are garbage. Fortunately, I don't need medical care. Seniors should be getting more help, not rip-offs from our incredibly crooked insurance industry.

"This Is Why Seniors Don't Go to the Doctor"

Susan Baker, WA

I went in for my annual Medicare Wellness checkup and ended up paying $93.00. **I pay over $200.00 [per month] for the Advantage plan, and you would expect something good coming from that.** It's through United Health Care. I've also had Humana which wasn't any better. This is why seniors don't go to the doctor – we can't afford it!

“My Procedure Was Too Radical”

Cam, CA

I was diagnosed with cancer about two years ago. I found a great hospital here in Southern California. I called my Advantage plan, […] Anthem Blue Cross, where I was told my procedure was approved. The hospital also called to verify the approval, and “yes” was the answer. **About four weeks into my appointments, I received a letter telling me that my insurance company decided my procedure was too radical and that they would not cover my expenses.** Thank goodness the hospital agreed to just take my Medicare. I have been cancer free these past 30 months.

“It Was Denied”

Anonymous, WA

I requested a new obturator to replace one that is ill-fitting and 20yrs old. **It was denied because it was considered a “dental device.”** An obturator is a prosthesis that replaces the entire upper left quadrant of my mouth, which was removed in 1983 in order to take out a myxoma tumor. It is not a "dental device," but rather a necessary plug that fits in the hole in my scull so that I can eat without food entering my sinus cavity and also allows me to talk like a normal human being. Medicare covers 80% of the cost of a prosthesis, which, in this case, would cost over $4,000.

“Three ICU Nurses and the Credible Threat of Litigation”

Kenneth Kenegos, AZ

My parents were in a Medicare Advantage plan in 2010 when my father was accidentally struck by a golf cart. He sustained a fractured pelvis and internal injuries. He was transferred from the local hospital to the area level 1 trauma center about 25 miles away. Although it was not in his Medicare Advantage

network, it was the only hospital able to care for his severe injuries, so the Medicare Advantage plan had to pay for him to go there.

At the time of his accident, my father was a very active, healthy 89-year-old. He was in the trauma center ICU for over two weeks, most of that time on a ventilator. He had multiple surgeries. **When the ICU physician said he was ready to leave Intensive Care, the MA plan said that he would be transferred to their in-network rehab facility.**

My brother, sister-in-law and I were all ICU nurses and knew that the appropriate transfer after the ICU would be to a Step-Down unit, not Rehab. My brother and I both went to see the "Rehab" facility. It was a nursing home, permeated with the smell of urine. I asked to see the location for physical therapy and was shown a small room with its floor competed covered with walkers, wheelchair, and other equipment. It was obvious that no therapy was taking place there. **If my father were to be sent there, he surely would have died. I suspect that would have greatly favored the Medicare Advantage plan's bottom line.**

We called for a meeting with representative of the Medicare Advantage plan. My sister, who is an attorney, was also at that meeting. We made it clear that our father should not be transferred to their "Rehab." We would only accept transfer to an appropriate Step-Down unit and that legal action would be taken if they refused. **He was transferred to an in-network Step-Down unit only because we had the knowledge of three ICU nurses and the credible threat of litigation all in our family. How many others were not that fortunate?** As it turned out, he did have problems that were appropriately dealt with by the Step-Down staff. I doubt that the nursing home could have done the same. He went on to return home and live for another seven years. He died from an unrelated illness.