Medicare Advantage Plans:
Unpopular with Medical Providers

Created a few years ago with the goal of improving efficiency, care and overall cost, Medicare Advantage plans (part C) claim uneven success. While enrollment is higher in some parts of the country, efforts at increasing the number of subscribers have been met with obstacles, such as a low number of contracted providers, or difficult access to care.

Before blaming the cause on medical providers' greed or lack of caring, let's look at things from their perspective:

1. Straight Medicare is great

Consider "regular Medicare": render service, send a bill, get paid. Follow well published, simple instructions, and your payment will make its way into your bank account within 14 days.
Advantage plans are less transparent, more complex and obstructive. More resources, time and manpower are needed for the same payment...in 30 days... maybe.

Disputed claims, in general, are a minor reason for rejecting Medicare Advantage patients. But there is no doubt that for each single appeal made to Medicare, there are dozens made to Part C carriers.

Even if the payment is eventually similar, the cost of the added paperwork, stress, processes, appeals, calls and staff time bites through any profit, quickly throwing a practice into losing money territory.

2. It's complicated

The tedious and often-delayed authorization process remains a major drain on resources and staff time. Losing money (and patience!) on that end is common.

Fee for Service or PPO (a misnomer as patients think providers are contracted with Medicare when in fact it is with a specific plan administrator) plans are more widely accepted. Less resources or staff time are required.

HMO plans are disliked throughout. Any service, visit, treatment requires prior authorization. This routinely takes 3 to 5 days (if no emergency) and the patient must return to receive care. Schedules are burdened, diagnoses and treatments delayed, frustration rampant. The exceptions are autonomous and self-contained plans like Kaiser.

Because of cost and unrelated contract requirements, simple tests or labs must often be performed by an outside provider. An authorization must be requested, paperwork sent to the lab (for example), blood drawn, reports sent to the office, before the patient can be notified of results which may have taken a few minutes otherwise. This waste of time causes hardship and anxiety for patients, while the added office administrative costs are not reimbursed.

I worked with cancer patients whose HMO plan forced them to receive chemotherapy at home. With no way of supervising the treatment, the stress on staff, doctors and patients was crushing. Saving a relatively small amount of $ seemed the only reason for the insurance to impose such a risky and potentially disastrous decision.

3. Unpaid patient balances

Another element has become important in the decision-making process of medical practices: straight MCR patients usually have a secondary insurance. Patient liability, though growing in recent years, remains low and easily collected.

Medicare Advantage policies often come with much higher deductible and out-of-pocket costs. Some plans have no patient limit for certain items (chemo drugs for example), causing patients to either forgo treatment altogether or drain their savings. Without secondary insurance, many cannot afford to pay their bills.

4. Unclear policies

Straight Medicare offers a vast range of guidelines, policies, webinars, educational materials and contact methods to help offices determine whether a specific item or treatment is covered, under what conditions, and at what price.

Commercial carriers, the administrators of Part C plans, must offer equivalent coverage. But they may impose which treatment to order (cheaper, non-surgical or less drastic first), which drugs to prescribe (generic only), where and how patients get treated, etc. Pre-authorization requirements vary, so calls must be made before any treatment or service can be recommended or prescribed.

5. Patient Responsibility

If an office bills incorrectly, or provides a non-covered service to a straight Medicare patient, it must absorb the loss. Not always so with part C. Patients are more likely to be hit with unpaid balances, especially if they see a non-contracted provider or receive non-pre-approved care.

In Conclusion:

Seniors are caught in the middle. Between restricted access to medical providers, billing surprises, treatment delays, widespread confusion and impositions of all sorts, they are too often left to fend for themselves, with no way to change their plan until the following January.

If you are a Medicare Advantage patient, check and double check. Not doing so could lead to bad and expensive surprises!