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Another consideration when choosing Medicare Advantage Plans: denials

It is open enrollment time for Medicare until December 7, 2018, and Medicare beneficiaries are, or should be, looking at various factors when choosing their 2019 coverage. A recent federal report, highlighted in an article in the *Pittsburgh Post-Gazette* on October 31 indicates that beneficiaries with a Medicare Advantage plan should consider another factor, that is, the risk that an insurer will deny claims. (http://www.post-gazette.com/business/healthcare-business/2018/10/31/Medicare-Advantage-insurer-denied-claims-appeal-health-coverage-2019/stories/201810290013).

Medicare Advantage plans are administered by private insurers such as Humana, Keystone and Aetna. An estimated 20 million members nationwide have chosen these plans over traditional Medicare with a supplement. These plans receive a monthly per-member fee from the Centers for Medicare and Medicaid Services (CMS). If the fee exceeds the cost of providing care, the insurer keeps the difference. Therefore, there is a financial incentive to keep members healthy and out of the hospital. These plans often also come with the added benefits of gym memberships and routine dental, vision and hearing care. They also appear to be less expensive than Medicare "medigap" or supplements. And that is often true for younger, healthier beneficiaries.

The report from the U.S. Department of Health and Human Services inspector general mentions an additional incentive to Medicare Advantage plans, that is, "the potential incentive for insurers to inappropriately deny access to services and payment to increase their profits." The report states that between 2014 and 2016, Medicare Advantage insurers subsequently approved patients' previously denied claims 75 percent of the time. However, that raises the issue that many Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. Furthermore, it was found that beneficiaries appealed the original rejections only one percent of the time, leaving open the question as to how many payments were denied and never subsequently approved. The HHS inspector general says that advocacy groups indicate that beneficiaries may be reluctant to navigate a process that is "often confusing and overwhelming for beneficiaries, particularly those struggling with critical medical issues."

Denial of payment does not just adversely affect beneficiaries, but also the relationship with the physicians who need to tell the patient that the care was not covered, as it is usually denied after the fact rather than as a failure to pre-authorize care. The article quotes a physician who says that doctors just want to be doctors, not fight with insurance companies.

There seems to be a pervasive misunderstanding about Medicare in general. Traditional Medicare and the supplement plans are overseen by the federal government. If a beneficiary chooses an Advantage plan (sometimes known as Part C plans) they should carefully research the differences between Original Medicare and the Advantage plans other than just the obvious price differences. Advantage plans, by their very nature as private plans, usually HMOs or PPOs, are dedicated to keeping costs down. The beneficiary must choose an in-network provider or providers, and generally are responsible for co-payments for physicians, especially specialists, and for hospital stays. The plans are often geographically specific, and are far less generous in paying for rehab days in a skilled care. The Part D prescription plan is usually included but the flexibility of formulary choice may suffer as compared to the variety of formularies on a stand-alone plan. It is helpful to look at both options to see which may be more cost effective overall. Consider contacting an area APPRISE counselor (through the County Office of Aging office) to discuss your options.