Advantage Plans – How can they be Free? What's the catch?

It's that time of the year again. Time for all the medical insurance experts on TV to tell you to get ALL YOU DESERVE by signing up with a Medicare Advantage Plan. You are flooded with possible additional benefits all at promised zero or low premium and depending on where you live, maybe get money back through a credit to your social security monthly pension. So, how can they do this?

Insurance companies contract with the Federal Government/Medicare to offer health insurance to senior citizens authorized to be covered by Medicare through the operation of Advantage Plans, otherwise known as Medicare Part C, policies. These policies must, at a minimum, provide the same coverage as Original Medicare and as the ads proclaim, can provide more coverage such as drugs, dental, vision, and services such as access to exercise facilities, transportation to medical appointments, etc, etc. Well, if your premium is zero, who pays for all of this? Other than the copays associated with Advantage Plans that are paid by the participant, it is Medicare who pays.

Each year, insurance companies submit bids based on their estimate of the average cost to provide Medicare Part A and Part B coverage for each enrollee. The bids are compared to a benchmark based on the average cost of claims for the area and if equal or below, the policy premium can be set to zero. Plans that bid below the benchmark receive rebates from Medicare to provide enrollees extra benefits. So if the revenue is fixed by the bid + rebate + participant copays, how do the insurance companies make money? Obviously they have to keep the expenditures per enrollee less than the revenue per enrollee which is fixed. To achieve this, Advantage Plans have been designed with the following features.

First, insurance companies control access to medical services covered under their plan through the implementation of what is called managed care. Access to medical specialties outside the Primary Care Physician's (PCP) office is controlled by the PCP through the referral process. Clearly the PCP must agree that a specialist is needed before a referral is made which becomes the first line of expense control.

Second, insurance companies exercise a high degree of control over the cost of services provided. Medical service providers must agree to the rate the insurance companies offer for the service provided to be on the referral list (in network).

Third, for plans that include prescription drug coverage (Medicare Part D), insurance companies have negotiated favorable contracts with a Pharmacy Benefit Manager or become their own PBM to deal directly with the drug manufacturers.

Finally, the insurances companies try to attract enrollees that are relatively healthy which accounts for the focus on all the extra benefits highlighted in their advertising.

Enrollees attracted to such services as Silver Sneakers for example, are probably in better health and will be using less of the expensive services such as those covered by Medicare Part A. In addition, the other “extra” benefits offered to attract more enrollees simply cost the insurance companies far less to cover than most anything covered by Medicare Part A & B.

So, if you have someone “managing” your health care, what’s the rub? The problem is the financial setup of the Advantage Plan. Since the revenue per enrollee is fixed, the only way to maximize profit is to minimize expense which puts the insurance representative in the middle of every discussion about your health. I have observed the operation of an Advantage Plan through the activities of a family member with very sad outcomes. These interactions varied from the just irritating such as being refused a flu shot at a local pharmacy to the very serious such as being released from a hospital to a poorly rated Skilled Nursing Facility (SNF) which was one of two “in network” with an available bed at the time only to have the family member catch Covid from the staff who at one point had a 50% infection rate and as a result of poor medical care be transported back to an ER with Covid pneumonia and dehydration. I have watched this family member wait a month for an inferior knee brace to come in from China rather than be able to wear the one fitted to her at the in-network orthopedic center at the time of her initial consultation because the center’s knee brace was not authorized (too expensive). I have watched this family member pay out-of-pocket for the only hearing aids that worked for their situation despite having the hearing benefit because the hearing aids were not of the type covered. I have watched this family member have a broken hip surgically repaired by an orthopedic team in a hospital only to never have a follow-up visit with the surgeon because that team was not in-network and did not accept any Advantage Plans….Original Medicare only. Advantage Plans are great for seniors who really don’t need health insurance but if you are flat on your back in a SNF and the physical therapist is recommending at least three more weeks of daily therapy, that’s not when you want the SNF to get a discharge order from your Advantage Plan for failure to progress. The choice is yours but perhaps Original Medicare + Medigap Plan N is a better relatively low-cost choice in the long term to keep the discussions about your health between you and the health service provider and not between the health service provider and the insurance company. Or you can save now and get into infuriating situations later…..

Meanwhile….

Humana raked in $696 million in profit for the second quarter of 2022, up nearly 20% year over year. In the second quarter of 2021, the insurer reported $588 million in profit for an increase of 18.4%, according to its earnings report released Wednesday. Humana also brought in $23.7 billion in revenue for the quarter, an increase of 14.6% from the $20.6 billion reported in the second quarter of 2021.

Profit and revenue are also up by double digits through the first half of the year, according to the report. The company posted $1.6 billion in profit through the first six months of 2022; an increase of 14.8% compared to the $1.4 billion earned in the first half of 2021. Revenues reached $47.6 billion in the first half of 2022, up 15.3% from $41.3 billion in the first half of 2021.

The results surpassed Wall Street analysts' expectations on both profit and revenue, according to Zacks Investment Research.