What is Medicare Advantage? How is it different from Traditional Medicare?

Under Traditional Medicare, the federal government pays directly for the health care of seniors and adults with disabilities. Beneficiaries generally pay monthly premiums and need to meet a deductible, but patients have access to a wide range of doctors and hospitals across the country. Many patients also choose to enroll in a supplemental “Medigap” plan to limit their out-of-pocket costs.

Under Medicare Advantage (MA), the government pays a third party (often a commercial insurance company) to “manage” patients’ care. Premiums tend to be lower than they are in Traditional Medicare, but patients can face high out-of-pocket costs. They can also be stuck with much more restrictive networks and face the hassles of prior authorization.

How do Medicare Advantage companies make money?

Private companies participating in MA are paid a fixed amount per enrollee, an amount which is adjusted based on the “risk” of the individual (that is, the state of their overall health and any conditions which may require care). By restricting care through pre-authorizations, referral requirements, and limited networks, insurers keep their costs lower than the provided maximum payment from Medicare, and are allowed to keep a portion of the difference as profit.

Denying care also drives sicker beneficiaries to leave the program, which, when combined with marketing that targets healthier individuals, leads to a lower-risk patient pool and higher overall profits. Many MA insurers have also been accused of “upcoding” patients with a variety of illnesses and conditions that may be exaggerated or even non-existent in order to get a higher risk score and thus bigger payments from Medicare.

Why do people sign up for Medicare Advantage?

There are a number of reasons people sign up for MA instead of Traditional Medicare. Most significantly, premiums for MA plans are generally lower than those for Traditional Medicare, and in fact there is often no monthly premium for an Advantage plan. Insurers are able to offer these low premiums because they restrict care, take measures to keep only healthier individuals in their plan, and lobby for generous, and ever-increasing, payments from the federal government.

This largesse also allows Medicare Advantage to cover services that Traditional Medicare does not, such as vision and dental. Lastly, there is a limit on out-of-pocket costs in Advantage plans, meaning that beyond a certain level of spending 100% of costs will be covered by the insurer (provided care remains within the limited network). This out-of-pocket maximum is quite high—$7,550 for in-network services in 2022—but can be tempting for patients who cannot afford a Medigap supplemental plan.

With the REACH program allowing third-party middlemen to infiltrate Traditional Medicare, do I even have a choice any more to avoid profiteers?

While MA is rife with problems caused primarily by the greed of insurance companies, patients at least have the choice between an Advantage plan or Traditional Medicare. REACH takes away that choice by “aligning” Medicare beneficiaries with REACH entities without their full knowledge or consent. The only way for patients to leave the program (for now) is by finding a new primary care doctor. That’s why it’s crucial that we end REACH, to restore choice to Medicare beneficiaries.

These articles are written by physicians and covers most of the issues with M.A. I’ve also attached a couple more for your review to help understand the absurdity of M.A. plans: Secret rules, denials and fraud.