Patients Not Profits:
A Language Analysis On Medicare and Medicare Advantage[1]

Introduction

We all want to believe ourselves creatures of reason, swayed chiefly by the facts before us. But much of the cognitive process we use to formulate judgments is beyond our conscious awareness and thus outside our deliberate control. We can know only what we *think* that we think; evidence shows that a turn of phrase or the ordering of an argument alters what we deem "true" and what we desire in terms of public policy.[2]

So, how should advocates fighting to eliminate Medicare Advantage and protect Medicare from corporate greed make their case? How do we move from reacting to the frames and disinformation pushed by our opposition to crafting an enticing narrative that has audiences desire and take action to establish government-provided healthcare for all?

To begin to answer these questions, we've explored how people make sense of and come to judgments about MEDICARE, MEDICARE ADVANTAGE[3] and related notions. These findings emerge from analysis of discourse from advocacy, opposition, social media and news media in the U.S., and an elicitation call with advocates. The present data set is made up of over 700 tokens — unique constructions attesting to reasoning. Also included in this analysis are previous explorations into persuasion and perception.

We proceed from the assumption that our task is to improve the conceptual terrain from which our audiences will hear arguments about our issue. As such, we're not exploring how to advocate for a specific policy intervention. Instead, this is a look at how our core arguments can be worded to most effectively prime positive associations and tamp down undesirable ones within our target audiences.

We start our exploration diving into a familiar messaging mis-step: shielding the culprits for problems from view. After examining this and offering correctives where possible, we move onto how advocates hinder their efficacy by arguing from their opposition's frames. Next, we examine the overall Medicare storyline offered, and what's profiled and eclipsed from view.

This document is admittedly heavy on diagnosis and light on cure – an inherent aspect of analyzing present-day discourse, but one that allows next for crafting and empirically testing new approaches.

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[1] Thanks to Liz Brown for her work cataloging tokens.
[2] Daniel Kahneman, *Thinking Fast and Slow*. (New York: Farrar, Straus and Giroux, 2011).
[3] SMALL CAPS signals a concept or frame rather than the word's meaning in commonplace usage.

Methodology

Using a variety of techniques from *cognitive linguistics*, a field dedicated to how people process information and communicate, we've examined how people reason, formulate judgments and come to conclusions about social and economic matters.

Principally, these conclusions emerge from *metaphor analysis*. This involves cataloging the common non-literal phrases in discourse. Noting patterns in these expressions reveals how people automatically and unconsciously make sense of complexity.[4] Each metaphor brings with it *entailments*, or a set of notions it highlights as "true" about a concept. Priming people with varying metaphors has been shown to alter not just how they speak but the ways they decide, unconsciously, what "ought" to be done about a given topic. We judge a metaphor's efficacy on how well it advances and amplifies what advocates wish the public would get about an issue.

For example, researchers at Stanford University showed that individuals primed with a metaphor of CRIME AS DISEASE (*plaguing* our communities, *spreading* around) came up with preventative solutions for crime such as after school programs and preschool for all. Conversely, subjects exposed to the frame of CRIME AS OPPONENT (*fight* crime, *beat back* homicide) thought harsher punishments were the answer.[5] For those working for criminal justice reform, these results suggest it best to liken CRIME to a DISEASE and avoid OPPONENT evocations. A three-strikes advocate would want to do the opposite.

Even single words can make a detectable difference in audience responses. In another experiment, ASO, alongside pollsters and other experts, found phrasing a policy demand for "people seeking asylum" yielded an eight-point advantage over one voiced on behalf of "asylum seekers" among a representative sample of 1200 Australians. Further, respondents were inclined toward a harsher stance when we addressed them "as Australians" than when we referred to them "as caring people." The words we use shape what's true for our audiences.

Findings

We turn now to what applying these aforementioned tools to this particular language data tells us. Here, we find some common messaging missteps — visible across issue areas — and explore how these manifest and can be corrected in this particular issue context. Specifically, we begin with an exploration of over-reliance on passive constructions.

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[4] George Lakoff and Mark Johnson, *Metaphors We Live By, 2nd ed.* (Chicago: University of Chicago Press, 2003).

[5] Paul Thibodeau and Lera Boroditsky, "Metaphors We Think With: The Role of Metaphor in Reasoning." *PloS One, February 23, 2011.*

Who does what to whom?

Altering descriptions of events influence how audiences assess culpability and determine what they believe a fair outcome will be. In particular, varying verb forms between agentive and non-agentive can create significant changes to audiences' judgments about real world events. In one experiment, using the infamous "wardrobe malfunction" during the Super Bowl Halftime Show in 2004, researchers found that respondents who read that a named agent (Justin Timberlake) "tore" another's (Janet Jackson's) clothing attributed blame and sought to levy at least 30 percent more in indecency fines than those who read a description that said "the clothing was torn." This is especially telling because all the participants first watched the same video footage, which clearly shows Timberlake ripping Jackson's clothing.[6]

This research and its antecedents bring into focus a major challenge any social justice-seeking organization faces in communication: defining the problem it seeks to solve.

Obscuring the origins of problems

Across the progressive landscape there's a tendency to describe problems without naming how they came to be. Here are some of the countless examples[7] from the present data on MEDICARE ADVANTAGE and HEALTH INSURANCE:

> Our system **is hopelessly fragmented**, and staggering sums of money **are wasted** on costs other than providing necessary health care.
>
> To add insult to injury, these private plans **are subsidized** with taxpayer dollars through Medicare.
>
> Medical debt **can happen to** almost anyone in the United States, but this debt **is most pronounced** among people who are already struggling with poor health, financial insecurity, or both.
>
> Our constituents continue **to be crushed** by the costs of healthcare and prescription drugs.
>
> Medicare **is rapidly becoming** a privatized, heavily subsidized public health insurance program through the use of private insurers in the Medicare Advantage (MA) program.
>
> American wages **are still being eaten up** by private health insurance premium increases.

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[6] Caitlin Fausey and Lera Borodtisky, Subtle linguistic cues influence perceived blame and financial liability, *Psychonomic Bulletin and Review, September 2010.*

[7] Throughout this document, sources are deliberately not cited and potentially distinguishing details are omitted. This is to ensure that examples are read as attesting to a wide-spread pattern rather than impugning any author or organization.

A major obstacle advocates have in explaining why people face all the difficulties they do is **frequent use of non-agentive constructions.** In the examples above, there is never a single culprit or even an actor named – suggesting no obvious means to change conditions. Sometimes advocates will bring those responsible for harm into view, but still use non-agentive constructions that obscure solutions. Take this example: "We cannot continue to allow Medicare Advantage to be a source of profit for greedy companies and a source of suffering for seniors." While the villain, "greedy companies," is named in this sentence, they are merely passively benefiting from a problem of unnamed origin, rather than actively creating the problem that needs to be solved.

Fortunately, we can remedy this form of non-agentive construction with relative ease, as demonstrated here using the first two examples:

> Our system **is hopelessly fragmented**, and staggering sums of money **are wasted** on costs other than providing necessary health care.
> *Corporate insurance and pharma lobbyists have fragmented our healthcare system so they can funnel staggering sums of money into their own pockets rather than providing necessary health care.*

> To add insult to injury, these private plans **are subsidized** with taxpayer dollars through Medicare.
> *To add insult to injury, these private insurance corporations profit off these scams by taking the money we put aside for Medicare.*

The importance of naming the actors responsible becomes especially clear in reviewing opposition rhetoric. Of the following examples, two come from advocates making the case for Medicare for All, and the remainder come from industry opposition pushing increased privatization as a solution:[8]

> [I]t is a necessary first step to address **the racial health disparities that plague** the South and our entire country.

> America **is facing an affordability crisis** when it comes to our health care.

> Americans aren't just paying more: they are paying more for poorer health.

> The longer we simply stare at it -- or pretend it doesn't exist -- the longer **the healthcare crisis will continue**.

> COVID-19 and the **disproportionate impact it has had** on Black and Brown communities has shown us that the time to fix inequities in our health care system is now.

[8] The two advocate examples are the first and fourth sentences.

Here, advocate and opposition descriptions of the problems plaguing healthcare are nearly indistinguishable. In their lobbying for Medicare Advantage, the industry has successfully coopted and weaponized advocate language around disparities, "social determinants of health," and even achieving a "more affordable and equitable health care system for all." In fact, part of the industry's pitch for Medicare Advantage is that, with perks like gym memberships, transportation support and other benefits unrelated to healthcare, it allows a more "holistic" approach to health that recognizes and contends with deeper social issues.

Everyone purports to agree that our current system is deeply flawed. But this actually doesn't help us. By continually diagnosing problems without exposing and impugning the people who created those problems, advocates leave room for the very people responsible to seem like trustworthy stewards of the solution.

Approaching agency

Even when advocates do name or suggest deliberate causes to problems observed, they too often assign culpability to Medicare Advantage plans themselves, not to the greedy corporate insurance executives who peddle and profit from them:

> **Medicare Advantage plans typically cover** 25 percent fewer services than traditional Medicare because **they take** a narrow view of what care is medically necessary and profit more the less care they cover.
>
> **MA plans have imposed** ever greater barriers to care for their enrollees, in part due to the growing use of algorithmic or artificial intelligence.
>
> **Medicare Advantage plans profit** from delaying and denying care, and the government does not have the tools or resources to hold them accountable when they are bad actors.
>
> **Medicare (Dis)Advantage plans defraud** taxpayers and fail to provide the care patients deserve.
>
> The less money a **Medicare Advantage plan spends** on your care, the more money the **Medicare Advantage plan has** for its shareholders.
>
> **Medicare Advantage can tell you** which hospitals you can and can't go to.

This convention of personifying Medicare Advantage plans, attributing actions and even motives to these abstract and inanimate products, is so common that we could provide dozens more examples from the present language data set alone. By making "plans" the agent in a sentence, advocates shield the human beings who are responsible for and profiting off of those plans from view. Even more insidiously, this tendency risks tarnishing the brand of Medicare itself. As suggested by advocates' repeated public

insistence that "Medicare Advantage is NOT traditional Medicare," the difference between these two programs – or even the fact that there is a distinction – is not generally well-known or understood.

In fact, insurance corporations work hard to elide their role in Medicare Advantage, presenting it merely as a flavor or extension of the beloved government program. Take the following examples from insurance marketing materials:

> It's easier than ever to get more for your Medicare dollar.
>
> Consider purchasing a Medicare Advantage plan for coverage that offers all Medicare Part A and Part B benefits while generally including some additional services, such as wellness programs, hearing aids and vision services.
>
> When it comes to Medicare, one size does not fit all.
>
> Medicare is a federal health plan.
>
> These plans include all the coverage of Original Medicare (Parts A and B) along with extra benefits you won't get with Medicare alone.

Insurance executives know that Medicare is popular – and that the corporations they run are not. By continually naming Medicare Advantage plans as the problem, rather than foregrounding the corporations that craft and market them, advocates unintentionally play into health insurance corporations' strategy.

To be sure, we do see examples of sentences from advocates that either conform or get admirably close to what we shorthand as the *people do things* rule:

> Greedy **private health insurance corporations** are choking Medicare.
>
> **Hold corporations accountable** by ending rampant profiteering, kicking the **bad actors** out and mandating transparency in Medicare advantage *[sic]* plans.
>
> CMS should meaningfully hold the bad Medicare Advantage actors to account, cancelling *[sic]* their contracts when necessary to protect people with Medicare.
>
> **For-profit insurance companies** are denying care to seniors and people with disabilities using AI algorithms.
>
> **Giant insurance companies** have free rein to **scam millions of seniors** in Medigap, offering agents lavish vacations to steer unknowing beneficiaries into more expensive plans.
>
> Americans are demanding relief from skyrocketing out-of-pocket costs and drug prices from **ruthless for-profit companies** who make billions off their suffering while paying their **CEOs** tens of millions a year in compensation.

In contrast to the prior examples that attribute harms to Medicare Advantage or insurance plans as actors in themselves, these examples expose the human beings and groups exploiting Medicare for profit. Notably, three of these examples include a call to action that demonstrates strategic thinking – once we name the people or groups of people responsible, the path towards redress becomes clear. However, advocates employ the kinds of constructions above infrequently. These rare examples are thus insufficient rejoinder to the prevailing sense that today's terrible healthcare conditions are of origins unknown while calls for desirable changes are similarly unsourced.

Impugning the good guy

At times, advocates will use active language but do so in a way that inadvertently impugns government, the very entity we ask people to trust for solutions, as the agents taking actions that create bad outcomes:

> **The government now spends** nearly as much on Medicare Advantage's 29 million beneficiaries as on the Army and Navy combined.
>
> **The U.S. wastes** more on health care bureaucracy than it would cost to provide health care to all of the uninsured.

Though somewhat trickier than the non-agentive examples above, these can still be rewritten to shift blame to the corporations or at the very least societal conditions forcing these outcomes. The first example, for illustration, can become: "insurance corporations profit obscenely and often fraudulently off of Medicare Advantage, inflating costs to the point where they drain nearly as much of our money through that program as we spend on the Army and Navy combined."

At times, advocates even make patients the actors whose decisions cause harm:

> [Patients] are more likely to end up in emergency rooms or hospitals because **they are delaying** more appropriate preventive care.
>
> A recent NBER study found that more than 20 percent of **people with Medicare drop all their prescriptions**–including life-saving medicines–when they face a copay increase of as little as $10.40. As a result, thousands die.
>
> **People who elect Medicare Advantage** must gamble on whether they will get the care they need.

Even though advocates intend in these examples to call out the difficult position insurance corporations put patients in, the sentence structure itself places blame with the patients. Attributing bad health decisions to individual patients undermines the call for systemic solutions and, more broadly, the case for patient protection and empowerment at the heart of Medicare advocacy.

A subtler but even more common way advocates attribute agency to the wrong party is through use of the phrase "Medicare overpayments." This data set is rife with laments about how much money Medicare "pays" or "overpays" to Medicare Advantage plans:

> Medicare overpayments to MA plans will ultimately cost Medicare beneficiaries $145 billion in increased premiums over the next eight years.
>
> The Medicare program cannot afford this magnitude of continued overpayments to Medicare Advantage plans, which undermine the affordability and sustainability of the Medicare program.

This formulation places the onus on Medicare, making insurance corporations the passive beneficiaries of Medicare's generosity or incompetence. Instead, advocates should always flip the emphasis to "corporate overbilling" or "overcharging," or even "corporate defrauding of Medicare."

Fighting on our opposition's turf

In addition to making current problems seem to emerge from the ether or be the blame of government and patients, we find another common message misstep in this discourse: reinforcing our opposition's arguments while trying to make the case for our own. At times, advocates unintentionally hamper their efficacy by walking onto the other side's field and trying to fight for hearts and minds from there.

Giving our opposition more air time

In this data, we find a familiar tendency to hand our opponents precious airtime. In its simplest form, this occurs through negation. Here is a sampling, followed by revisions for each example. Note, corrections go beyond addressing simple negation to also contend with other messaging issues:

> The right-wing extremists in the House are blaming President Biden for **"cuts to Medicare." No cuts to Medicare have been made!** A smaller increase than what the health insurance industry hacks want **is not a cut**.
> *Right-wing politicians and the CEOs who pay them are spreading lies about President Biden in an attempt to stop him from ensuring our Medicare dollars go to patient care, not corporate profits.*
>
> They **are not in this to invest in health care** and create sustainable care providers or organizations. They are here to gain outsized returns and exit.
> *They are here to gain outsized returns and exit. We need reliable health care with sustainable care providers and organizations.*

Negation need not always follow the simplest "not" before a false claim format. More sophisticated formulations still repeat the opposition's lies, rebutting them with wordier explanations, as seen in the examples – and corrected in the rewrites – below:

> Organized interest groups representing insurance companies that offer Medicare Advantage plans have misleadingly claimed that **the administration's proposed changes will result in substantial benefit cuts for beneficiaries**, but the evidence suggests this is unlikely.
> *Corporate insurance lobbyists who profit by lying to patients about Medicare Advantage are now lying about the administration's efforts to combat their fraud.*

> Calling for a universal care system in the United States is often painted as a quixotic pursuit because of incessant fear-mongering by conservatives about the supposed **evils of a "government takeover" of health care**.
> *A handful of conservative politicians fear-monger and divide us so that we won't join together to demand a universal healthcare system that works for all of our families instead of for their corporate donors.*

When we repeat our opponents, in a laudable effort to discredit them, we risk cementing their false claims. Indeed, research demonstrates that after hearing such assertions, people recall the claim and have trouble remembering whether it was true or false.

Feeding what we fight

Negation as seen above is relatively easy to correct. But we also find another, subtler way advocates reinforce opposition thinking: basing our argument in the conservative frame of what is "good for the economy" rather than what is good and just for people. Frequently, this comes in the form of a process or hypocrisy argument where advocates repeat opponents' promise that Medicare Advantage will deliver cost savings, then point out that the program actually costs taxpayers more.

At other times, advocates take on the mantle of fiscal responsibility for themselves:

> People in traditional Medicare **cost taxpayers much less**.

> Medicare Advantage has always **cost more** than traditional Medicare.

> In short, Medicare Advantage **costs the Medicare program and taxpayers more**, but provides beneficiaries less when they really need care.

> The program **is more costly** than traditional Medicare, not more efficient.

> Contrary to the image painted by critics, Medicare-for-All would increase access to care and **grow the economy.**

In these examples and countless others, advocates cede the moral high ground by emphasizing conservative values of fiscal responsibility and efficiency over human lives. We do not seek to provide healthcare for all in this country because it's the cheap thing to do. Moreover, regardless of the actual facts, our opposition has the brand advantage when it comes to "growing the economy" or lowering costs for taxpayers. By locating our case in what will save taxpayers the most money, we are agreeing to have our opposition's debate – at which point we have already lost.

What is Medicare really?

While advocates and opposition will discuss Medicare using somewhat similar terms, they tend to activate very different underlying frameworks for understanding what, precisely, it is.

National Treasure and the Protection Catch-22

Advocates frequently present Medicare as a rare, precious, and fragile entity in need of our protection:

> We're fighting to **protect and expand** Social Security, Medicare, and Medicaid.
>
> [We want people to believe that] **Medicare is sacred** and so fundamental to our futures **you wouldn't dare touch it**.
>
> For more than two decades, health insurance corporations have been privatizing our **cherished Medicare program.** Now, I'm worried that once they **have it** we may never **get it back**.
>
> We need to fight to **protect and strengthen Medicare**.
>
> Act to **preserve traditional Medicare** the way we'd act to engage any **national treasure**.
>
> Medicare is a massive money-making opportunity for the corporate sector. If corporations **can take control of traditional Medicare**, there are hundreds of billions of dollars to be made each year.

In these examples from advocate discourse, including the elicitation call, Medicare is something that can either be protected by us or taken away from us. The hashtag #ProtectMedicare exemplifies this approach towards the program. It is a thing of great value but also great vulnerability, which should not be touched except to strengthen or expand it.

While loss aversion is often an effective tool for mobilizing people to action, there are a few potential pitfalls with the PROTECTION frame. To start, PROTECTION is about preserving

the status quo. Unfortunately, the status quo today is not what it was ten or twenty years ago.

As one advocate notes, "Today Medicare looks more like a marketplace of private plans than a national public health program." A full half of Americans enrolled in Medicare now experience it *as* Medicare Advantage. Negation, as we have seen, does not serve us, so no matter how many times advocates insist that Medicare Advantage is **not** Medicare, that distinction is unlikely to break through on a large scale. With enrollment in Medicare Advantage equal to and poised to surpass enrollment in "traditional Medicare," MA will increasingly dominate people's understanding and experience of Medicare, continuing to erode its brand and muddying the picture of what, precisely, advocates are calling to protect.

This trajectory, of course, is precisely what insurance corporations intended, and their lobbyists have turned the PROTECTION frame right back on advocates. As advocates push to pass regulations that would combat profiteering off of Medicare, insurance corporations derail those efforts using the very same rallying cry of "protecting Medicare" – but protecting it in its current Medicare Advantage-tainted form:

> That is why health insurance providers join with policymakers committed to the **goal of strengthening and protecting MA**.
>
> Americans agree: **Medicare Advantage should be protected**.
>
> Not only do senior voters who choose Medicare Advantage report overwhelming satisfaction (93%) with their coverage, but 3 in 4 think it is important that the federal government **protect funding for Medicare Advantage**.

Even more nefariously, insurance corporations have used their success in targeting low-income Americans and Americans of color to shield themselves from criticism and even characterize progressive proposals as attacks on those communities:

> With **Black Americans and Hispanic Americans** experiencing higher levels of chronic conditions like diabetes and major depression, they **will be among those most impacted by the MA payment structure and diagnosis code changes** proposed in the Advance Notice.
>
> Medicare Advantage had a higher overall share of diverse populations (29%) compared to original Medicare (20%).
>
> Every American deserves affordable health coverage and access to high-quality care – including the more than 30 million seniors and people with disabilities who choose Medicare Advantage (MA).

Given how successfully corporations have already been in privatizing much of Medicare, blocking much-needed improvements to "traditional Medicare," and

harnessing loss aversion themselves to keep profitable policies in place, there's a real question whether the PROTECTION frame – as opposed to a demand for something better – can accomplish what advocates need.

In lieu of the protection frame, since it basically accepts the broken and perverted Medicare we see today as given, we could consider something more ambitious. One route to this could be demanding a *re*turn to what once was prior to the plunder and privatization, which you can hear in examples like "Restore Medicare" "Reclaim Medicare," "Revive Medicare," or, most dramatically, "Resuscitate Medicare." Restore and reclaim both suggest Medicare is an inorganic object but differ in terms of the implied goal. Restore indicates setting it back to how it was; reclaim foregrounds taking possession but possibly without altering the makeup of the entity. Which of these verbs better suits the task is an empirical question beyond the bounds of this analysis.

In contrast, revive and resuscitate convey that Medicare is a living being. This may offer additional benefits given this issue exists inside the domain of human life and health. But, again, whether either of these articulations feel credible, animating and effective at persuading audiences to engage as you seek requires testing.

Returning back to the issues with the current discourse, presenting Medicare as an object in need of protection eclipses from view how the program actively benefits us. Our relationship to Medicare in these constructions is one-way, with the audience relegated to the role of wary defender of a weak and helpless public good. Instead of saving our lives, Medicare requires *us* to save *it*. A slight shift in the PROTECTION frame, to always make visible how by protecting Medicare we are also protecting ourselves and our own health, might alleviate this particular issue.

There are, of course, examples in the data where advocates describe Medicare or a larger vision for healthcare in terms of the positive impact on people's lives:

> Every American should be able to get the care they need when they need it.
>
> Whether you're rich or poor you should have the same quality of guaranteed health care.
>
> Everyone should have the care they need, no matter who they are, where they live, what job they have or whether they have a job at all.
>
> We will all benefit from living in a country where public health is a right, not a privilege.

These instances, though, are discouragingly rare and often veer back into more abstract language of, for example, healthcare as a human right rather than something that is tangibly felt in our day-to-day lives.

Freedom to Choose

Another framing device used on occasion by both advocates and opposition, though not as frequently as one might expect, is that of FREEDOM:

> Many people choose traditional Medicare because it affords them **the freedom to see the providers they want to see and to get the services they want and need**.
>
> Improve Medicare so that people have the **freedom to just choose Medicare**.
>
> Some Medicare Advantage plans may also allow you to see doctors and hospitals that are not in the plan's network, giving you additional **freedom to choose** your doctors.
>
> It's Medicare coverage that gives you the **freedom to choose**.

Though rendered here by both advocates and opposition as "freedom to choose," that phrase likely favors our opposition by suggesting there *should* be many different plans, with the patient holding the choice. Despite the paucity of examples in this data set, a broader FREEDOM frame – namely the freedom to see a doctor when you need and not get sick worrying about the bill – seems worth exploring on this issue given the resonance of freedom as a core value for Americans.

Your Medicare Journey

While the previous two frames appear in both advocacy and opposition discourse, there's a third frame embraced almost exclusively by the industry alone. Corporate marketing materials for Medicare Advantage regularly speak directly to their audience and to that audience's lived experience. Our opposition employs second person direct address to engage the reader and to convey that what they have to say concerns the listener personally:

> **Your** healthcare needs and budget are as unique as **you** are.
>
> Even if **you're** happy with **your** current Medicare coverage, **you** might want to take some time to see what new benefits may be available to **you** with a Medicare Advantage plan.
>
> It may give **you** peace of mind that **you're** covered in case unexpected medical expenses happen.
>
> After all, **you** need a plan that's going to be there for **you** whenever and wherever, without the hassle.

Unsurprisingly, corporate insurers position Medicare plans as products (a different kind of object from the fragile treasure that advocates guard) and slot beneficiaries into the role of savvy consumers:

Medicare Advantage (Part C) plans often have a low or $0 monthly premium. That sounds like a **good deal when you're on a budget**.

You really need to know, like anything else in life, **what you're buying**. What's the **value of the product** you choose?

We understand that finding affordable insurance coverage is a priority, whether you're **shopping on a budget** or needing to manage a short-term health challenge.

Medicare Advantage plans can also **offer more value**.

Doing a little homework up front will help you be **an educated consumer** to make a good choice.

Our online search tools can help you compare our plans' costs and coverage with your current plan's to help you make sure you're **getting the most from your healthcare dollar.**

So they began **shopping around for another plan**. They switched to a different plan, but soon encountered the same obstacles.

As already evident in the last example in which the "shopping" couple "encountered [...] obstacles," insurance corporations frequently pair the consumer frame with a JOURNEY metaphor. Rather than presenting themselves as retailers of a good, insurers often cast themselves as a friend or helpful guide on your JOURNEY to selecting the best product that Medicare has to offer:

We can help you find a plan that's right for you.

As you **embark on your Medicare journey**, you'll want to be sure you understand the facts of the program. That way, you can better assess all of your options and more confidently choose the plan that's right for you.

The Chioccas are thrilled with their Medicare plan today. But they admit that their **journe**y to finding the right coverage **wasn't a straight path**.

Which path you take will determine how you get your medical care — and how much it costs.

Whew! That's a lot to consider. **We're here to break it down for you** into manageable parts.

Anthem is committed to **helping you** meet your healthcare needs, no matter where you are on **your personal health journey**.

> With complex terminology and many plans to choose from, Medicare can be confusing for newcomers. But **you don't have to do it alone. An insurance agent, also known as an insurance broker or adviser, can help.**

In these examples, insurers are not selling you a plan but rather helping you navigate the government's complicated system, overcome barriers, and discover the product that's right for you. To choose Medicare Advantage is to choose a friendly guide to help you along your way, rather than "leaving you to do more of the legwork" as one insurer puts it in describing "Original Medicare."

In insurance materials, your Medicare journey is merely one jaunt along your longer journey through life: "Over the years, you've reached several milestones: Birthdays, weddings, promotions, maybe even grandchildren. Turning 65 is another one of those moments to cherish." And in this leg of the journey, your destination is the goals that you set for your health and yourself. Insurance marketing imagery rarely includes doctors' visits, tests, or other care provision. Rather, insurers depict the life that medical care makes possible. Likewise, in choosing a plan, they encourage you to envision the life you want to live:

> We're here to support you as you explore Medicare plans that match your personal wellness goals.
>
> Do you want to speed-read your way through your favorite author's latest novel? Or are you dreaming of the moment you hear your granddaughter's first coos? You want to make sure nothing gets in the way of living each moment to its fullest. And that means protecting your vision, maintaining proper oral health and keeping track of any changes in your hearing.
>
> This is a busy time and you may be making a lot of changes in your life. Maybe your goal is to simplify things.
>
> Your PCP works with you to help you get the right care at the right time. So you can achieve your best health.
>
> In fact, the couple says their active lifestyles and the health care they receive through Aetna are what's helped them stay healthy all these years.

While advocates share impersonal statistics, solemn warnings, and systemic analyses, insurers hold your hand and ask you to imagine the best version of yourself. You just need to trust them to take you there.

With their endless profits to conduct research and develop marketing materials, it's no surprise these private corporations have arrived at this compellingly slick version of their sales pitch. But it does potentially lend itself to either mockery or an attempted frame flip.

As a first option, advocates could parody insurance corporations' Medicare Advantage claims by characterizing this program as a journey to hell, to nowhere, to poverty, to aggravation and so on. This is probably best done in meme or short digital ad form where the insurance corporation is personified as a guide leading an unsuspecting elderly couple down a dark path to pick their pockets.

A second approach, not mutually exclusive approach, is to ensure you have a concrete, repeated simplifying model for these corporations, their privatization schemes and thus Medicare Advantage. The most obvious one is of a leech or other parasite that feeds off of and harms its host.

Besides painting Medicare Advantage and insurance corporations in the correct – dangerous and deeply negative – light, a PARASITE metaphor suggests that Medicare itself or perhaps more broadly single payer healthcare is a BODY. An argument utilizing this frame could sound as follows:

Congress must restore Medicare to its full vitality - cutting off the private corporations leeching off of the healthcare program we the people created, funded and rely upon to fatten their own wallets. Reviving Medicare to its original full health is the only thing that can revive our health.

"Traditional Medicare" vs. Medicare Advantage

Advocates, opposition, and media use varying terminology for the different types of Medicare. When distinguishing it from its for-profit counterpart, advocates tend to use the term "Traditional Medicare" for our publicly run program, while insurers are more likely to call it "Original Medicare." Almost everyone, however, accepts "Medicare Advantage" as the label for privatized Medicare.

While these names might seem neutral on the surface, they ultimately work against advocates by positioning Medicare Advantage as, essentially, an evolution of Medicare, a sort of Medicare 2.0. The "original" or "traditional" flavor might be fine, but, in our novelty-driven culture, the next generation of a product is generally the more desirable one. Insurance corporations certainly play into this dynamic in their marketing materials:

> While **Original Medicare may seem safe and easy**, you may find yourself **missing out on some pretty valuable options** only available through Medicare Advantage.
>
> MA delivers affordable coverage by reducing Medicare's cost sharing, and **offering additional benefits that traditional Medicare doesn't cover,** such as integrated vision, hearing, and dental benefits, a cap on out-of-pocket costs, wellness programs, in-home caregiver support, and innovative telehealth options.
>
> Medicare Advantage Plans may include plan **extras not found in Original Medicare**.

> Under Medicare Advantage, you will get all the services you are eligible for under original Medicare. In addition, some **MA plans offer care not covered by the original option**.

The current terminology simply does not serve advocates. There are a handful of examples in which advocates use "Medicare (Dis)Advantage," which, though an improvement on accepting the industry name, still falls short of drawing the proper contrast. Advocates need a name for Medicare Advantage that not only conveys its flaws, but foregrounds the bad actors behind it and their motivations. And since Medicare Advantage has already muddied the Medicare brand, we ideally would also have a clear and positive designation for what we now call "traditional Medicare."

One option would be labeling Medicare Advantage "for-profit Medicare" or "for-profit Medicare Advantage" in contrast to "for-patient Medicare" or "non-profit Medicare." There might also be a way to play with something like "MediCon Advantage" or "MediScam Advantage," but that would require testing to ensure that these attempts to impugn Medicare Advantage do not further tarnish the overall Medicare brand. A third approach worth considering and, again ideally testing, would be to bring the corporations behind the plunder into view in the name. This could sound like, "Medicorporations Take Advantage."

Concluding Thoughts

Taken as a whole, there is a stark and disconcerting imbalance between advocate and opposition rhetoric. Advocates focus on policy or, at best, on harms to "seniors and people with disabilities." Insurers focus on YOU. Medical care and therefore Medicare is personal – not just for those who are currently on it, but for *all* Americans at some point in their lives (should advocates succeed, at least). Yet our language rarely evokes a sense of personal stake and connection.

In order to capture the hearts and minds of our audiences, we need to articulate what we're fighting **for**. We need to underscore what a world where respect for the rights and needs of all people and our families is made real looks like. And it's here that we find advocates with little to say.

Perhaps more than in most fights, our opposition is very successfully selling people a beautiful vision for what their lives can be. Against that seductive mirage, advocates' dire warnings and calls to protect an abstract (though beloved) object are not likely to break through. Beyond just the names for these programs, this analysis suggests a more profound rethinking in how we make the case for the Medicare we want and need.

Sustained participation in mass movements requires an opportunity to create something good, not merely diminish something harmful. Or, in pithier terms, there must be a *dream* not merely a series of (absolutely justified) complaints.

We've seen, for example, in previous work that a shift from "ending poverty" to *creating shared prosperity* or *ensuring people's welfare* has measurable impacts on audience's desire to get involved. Similarly, "prevent all forms of violence" proves more effective when rendered *ensure all people live in peace*. Even seemingly small tweaks from, for example "reform our broken immigration system" to *create a fair immigration process* have measurable impacts on public perception.

This language analysis represents a kind of "you are here" dot. This is the range of ways people currently reason. The work of advocacy is, of course, to act as a thermostat not a thermometer. We are here to *change* the temperature, not to take it. Thus, we have offered some directions to explore in future research, which should focus not on where people are but where they're capable of going – and the messaging and advocacy that can get them there.