



Physicians for a National  
Health Program

# taking advantage

HOW CORPORATE  
HEALTH INSURERS  
HARM AMERICA'S SENIORS

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# Executive Summary

Medicare Advantage (MA), the privately-administered version of Traditional Medicare (TM), is causing significant harm to America's patients, providers, and health care system. The insurers who run MA plans claim that they lead to better patient care and outcomes while saving money, but this is far from the truth.

Patients who sign up for Medicare Advantage are forced to deal with narrow networks which heavily restrict their access to physicians and hospitals, and are often misled about the size of these networks through inaccurate listings. They must seek prior authorization for many of the tests, treatments, and other procedures ordered by their doctor, often waiting days or weeks just to be inappropriately denied approval for necessary health care. These delays can have serious consequences for a patient's health, even sometimes resulting in death.

MA plans aggressively advertise their supplemental perks, particularly their offering of dental, vision, and hearing benefits. However, plan benefits are often highly limited and do not come close to meeting the needs of enrollees. Even worse, patients in MA who become seriously ill or develop chronic conditions end up paying thousands of dollars for their care, often struggling to afford treatment and incurring medical debt in the process. These issues often have a disproportionate impact on the most vulnerable communities, reinforcing inequities in health care access and outcomes.

When patients encounter these issues in MA and wish to switch back to Traditional Medicare, they often find that they are unable to do so. In all but four states, regulations allow insurers to deny Medigap coverage to patients who have been in MA for more than a year. Without a Medigap policy to cover additional costs, Traditional Medicare is not an affordable option for many seniors who are then forced to remain in MA despite its many flaws.

MA doesn't just hurt patients. Physicians, nurses, and other health care workers face serious barriers to caring for patients as a result of the excessive administrative burden placed on them by MA insurers. These workers must spend hours filling out authorization forms and fighting with insurers to get necessary care approved, limiting the time they can spend on their actual jobs. MA plans also frequently delay payments for the care of enrollees, or even refuse to pay altogether, causing serious financial harm to hospitals and medical practices that have limited resources to begin with.

Medicare was created to serve the people, and MA betrays that promise. We must rein in the abuses of MA insurers, eliminate profit-seeking in Medicare and beyond, and put an end to these egregious harms.



# By the Numbers

**11.1-20.5  
million**

**Hours per year wasted by medical practices** on Medicare Advantage prior authorization requests (i-iii)

**11.7  
million**

Number of **MA beneficiaries in a “narrow network” plan** that excludes more than 70% of physicians in their county, based on 2017 KFF study (iv) and STAT estimate of 2024 enrollment (v)

**7.3 million**

Number of **MA beneficiaries who are underinsured** based on their reporting of high health care costs, based on 2023 Commonwealth Fund study (vi) and STAT estimate of 2024 enrollment (vii)

**36**

Number of **studies cited in this paper** collectively finding negative outcomes for patients and providers in MA

**2x**

**Increased likelihood of death** after pancreatic surgery in cancer patients with MA, based on study in the Journal of Clinical Oncology (viii)



# Introduction

Insurance corporations in the privatized Medicare Advantage program are harming millions of America's most vulnerable, while costing the Medicare Trust Fund tens of billions more than if those people enrolled in Traditional Medicare. These insurers force patients and health care workers alike to deal with unjustifiable prior authorization requirements, limited networks, endless denials of care, and inadequate coverage, severely disrupting care in the name of financial gain. This report will summarize, through a review of relevant academic literature, research, journalism, and original interviews conducted by PNHP, the many ways in which corporate-run Medicare harms both patients and health care workers.

Medicare Advantage, also known as MA or Medicare Part C, is a privately administered insurance program that uses a capitated payment structure, as opposed to the largely fee-for-service (FFS) structure of Traditional Medicare or TM. Instead of paying directly for the health care of beneficiaries, the federal government gives a lump sum of money to a third party (usually a commercial insurer) to "manage" patient care.

"Managed care" has promised two benefits: to save money, and to improve patient outcomes. Advocates of the insurance industry assert that private insurers, by dint of their profit incentive, will do a better job at preventing unnecessary expenses and promoting efficient spending. However, as we detailed in a previous report, MA has failed to realize any true savings, and in fact transfers tens of billions of dollars from taxpayers to corporations each year. (1) But what of the second measure? Even if Medicare Advantage is more expensive than Traditional Medicare, does it provide better care?

Insurers will tell you that the answer is a clear "yes," using the same logic as when speaking about savings. After all, it's taken for granted that companies must satisfy their customers in order to stay competitive and stay in business. This logic is both deceptively simple and deeply flawed. The literature comparing quality and outcomes of care between MA and TM challenges the claims of insurers. The Medicare Payment Advisory Commission (MedPAC), the most authoritative source of data and analysis on the Medicare program, has found no consistent pattern of better performance or outcomes under MA, despite its higher costs. (2) What's more, the agency notes that the practice of "favorable selection" may skew quality and outcomes data in favor of MA. (3) By signing up less costly and thus generally healthier patients, insurers make it seem as though they do a better job of keeping patients healthy. (4) Even with this leg up, there is no persuasive evidence that MA outperforms TM on the whole. Insurers do not report much of the data that could help answer open questions about care in MA, further calling into question their claims about increased quality. (5)



Contrary to what insurers say, quality of care is often not the reason that beneficiaries enroll in an MA plan. They may be drawn in by misleading and aggressive marketing, as 17% of seniors have reported that advertisements led them to believe something about an MA plan that they later found out was not true. (6) They may sign up out of financial necessity, if they are unable to afford monthly TM premiums plus a supplemental Medigap policy. Their employer may only pay retiree benefits to an MA plan, a practice that has caused controversy around the country. (7) Or, most insidiously, they may be unhappy with their MA coverage but unable to switch to TM due to regulations detailed later in this paper. MA plans keep their customers through captive practices, not superior service. They make money not by providing the best medical services, but by withholding them. Ultimately, the effect of enrolling in MA on the care of millions of patients is decidedly negative. The existing evidence demonstrates that MA is not doing what it promised to do, and what its participating insurers are overpaid billions to do; far from improving quality of care or outcomes, Medicare Advantage is leaving beneficiaries, health care workers, and our health care system worse off, all in the name of profit.



# Patient Harms: Restricting Access Through Networks

To examine the harm that MA does to patients, it is logical to begin with the act of seeking care from a physician or other provider. A key feature of Traditional Medicare, one which is both widely known and widely beloved, is that beneficiaries can access care at nearly any hospital or doctor in the country. The vast majority of practitioners and physicians in the U.S. participate in the program, and receive additional benefits to do so. (8) With TM, there are no out-of-network fees or differences in payments between providers. This is not the case in MA.

Medicare Advantage insurers employ networks just the same as nearly any other commercial insurance policy. Over half of MA plans are health maintenance organizations (HMOs), which tend to be more restrictive than other plans, featuring smaller networks, little out-of-network coverage, and referral requirements for specialist care. (9) These HMOs also enroll the greatest number of MA beneficiaries—around 62% of the total beneficiary population based on estimates from 2021. (10)

For most insurance plans, the ostensible goal of establishing a network is to negotiate lower payment rates with a smaller set of providers. (11) However, when it comes to MA, payment rates are largely set near or at those of Traditional Medicare, so rate negotiations are less of an incentive. Instead, narrow networks are formed with health systems that have lower utilization rates, as a means of saving money for the insurer. (12) In addition, insurers try to form networks using providers who can help them to achieve high star ratings in MA's quality bonus program, as the ensuing reimbursement bonuses translate into extra profits for the insurer. (13) It is worth noting that the quality bonus program itself is highly flawed, and high star rating plans do not necessarily deliver better care to MA beneficiaries. (14)

The consequence of these financial incentives is that narrow physician networks are very common in Medicare Advantage. A study from KFF found that a little over one in three MA plans (35%) had a "narrow" physician network, meaning one that excluded more than 70% of physicians in a given county. (15) A further 43% of plans had "medium" networks, with anywhere from 30-69% of physicians included.



Only 22% of plans had “broad” networks that included more than 70% of physicians in the county area. On average, plans excluded over half of physicians in a county. (16) Although percentages of narrow networks for hospitals are lower, on average MA plans still only cover just over half (51%) of hospitals in a county. (17) Predictably, MA insurers often fail to meet the network adequacy standards that are set for them by the Centers for Medicare and Medicaid Services (CMS). (18)

These narrow networks persist across a variety of different specialties and categories of care. Multiple studies have found that psychiatrists are some of the most heavily restricted specialists in MA networks, with nearly two-thirds of plans covering less than 25% of psychiatrists in the network service area. (19) According to KFF’s physician study, 36% of assessed plans were even more narrow, with less than 10% of psychiatrists in the county included. (20) KFF also found that close to one-fifth of MA plans included less than five cardiothoracic surgeons, less than five neurosurgeons, less than five plastic surgeons, and less than five radiation oncologists. (21)

Evidence shows that patient demographics affect network size as well. Physicians who care for the greatest number of patients who are dual-eligible for Medicare and Medicaid (meaning patients who are both elderly/disabled and also struggling financially) have been found to have a lower chance of being included in MA plan networks. (22) The same is true for physicians who treat patients with higher levels of medical risk, which tracks with indications that MA plans actively seek to avoid such patients. (23) Patients in rural areas are also more likely to face restrictive networks across a number of specialties. (24)

Narrow networks compromise access to the best quality of care for the sickest individuals. Cancer care, already a nightmare to navigate for anyone regardless of their insurance, is especially bad for MA patients in terms of network inclusion. MA patients are much less likely than TM patients to be able to access cancer care at teaching hospitals, Commission on Cancer-accredited hospitals, or National Cancer Institute-designated centers. (25) MA patients are also less likely to have access to high-volume hospitals with more experience doing complex, high-risk surgery for cancers of the lung, esophagus, stomach, liver, pancreas, or rectum. This lack of access, largely a result of narrow networks as well as delays in receiving care, was found to have likely contributed to higher 30-day mortality rates for liver, pancreas, and stomach cancer surgeries. In other words, narrow networks are killing cancer patients. (26)



A final issue with MA networks is the prevalence of “ghost” networks. These networks claim to include providers who are not actually in the network, and sometimes no longer even exist. A study by the U.S. Senate Committee on Finance found that over 80% of identified listings for mental health providers in studied MA plans were inaccurate or unavailable. Of 120 provider listings who were contacted, researchers only succeeded in setting up an appointment with 22. (27)

Another study of dermatologists in MA networks found that more than half of the dermatologists listed had incorrect contact information, were deceased, retired, had moved, were not accepting new patients, did not accept the insurance plan, or were subspecialized. (28) Ghost networks present a huge transparency issue for MA beneficiaries, who may select a plan based on the appearance of a robust network only to find there are far fewer available providers than initially shown.

It is also worth noting that hospital networks in MA may be shrinking as health systems continue to opt out of accepting Medicare Advantage due to low reimbursement rates and the administrative burden of insurer practices like prior authorization. Dozens of hospitals, including large and well-known systems like Scripps Health and Mayo Clinic, have indicated that they will no longer take most or all MA plans because of these issues. (29) Patients, especially those in rural areas or places with few options for medical care, suffer greatly from these closures, which further decrease access to care for everyone in the community. (30)





# Patient Narrative: Restricting Cancer Care



Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“In 2021, my wife became very seriously ill very suddenly, within a matter of 3 or 4 days, and she was diagnosed on the 5th or 6th day with category 4 brain cancer, glioblastoma, inoperable. Pretty much from that point in time, it was always a fight with insurance. Which hospital could we be in? Could we coordinate benefits between hospitals? Some services might only be covered in one hospital and other services in another hospital. What kind of treatment could she get approved for as she got progressively worse? Would she be able to be admitted to hospice? I wouldn't wish it on anybody. It was absolutely horrible.”

- Husband of MA patient, New York



# Patient Narrative: Restrictive Networks



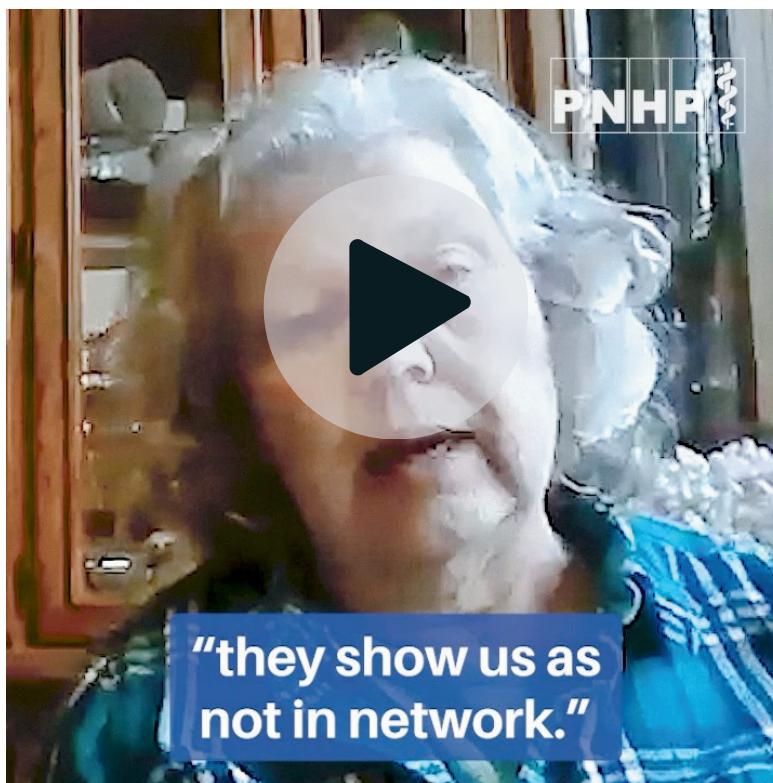
Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“Trying to find a dentist on my Blue Cross plan was virtually impossible. They were not accepting new patients, at least not when I told them I was a Medicare Advantage patient. After a lot of searching, I finally found a dentist, and now, what I have to do is take a ferry from my home, then drive about 20 miles into another town, and there is the only dentist I can go to. All of the travel combined takes about an hour to an hour and a half each way, when there are dentists who won’t accept Medicare Advantage patients ten minutes from my house.”

- MA patient, Washington



# Provider Narrative: Ghost Networks



Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“When Medicare Advantage plans were taking off in our area some years ago, Coventry Health, which later became a part of Aetna, sold a Medicare Advantage plan in the area that listed us as a network provider—but we weren’t. The first patient that showed up with this plan, I had to look it up and tell them we weren’t in-network, and they were furious, because this plan was sold to them on this presumption. This was bad enough and they sold this plan to enough people that I reported them to CMS for contracting issues, and they had to change their network.”

- Primary care practice office manager, Missouri



# Patient Harms:

## Prior Authorization

Even if patients are able to obtain an appointment, the challenges do not end there. Like other insurance plans, MA plans practice “utilization management,” requiring prior authorization (PA) for most tests, procedures, and medications. Ostensibly, the purpose of this practice is to prevent unnecessary use of medical services; in practice, it is often a way for insurers to delay paying for necessary care in the hopes that patients will abandon their efforts to receive it. By contrast, beneficiaries in Traditional Medicare are only required to obtain prior authorization for a small set of services, meaning delays in care due to denial are much rarer.

When it comes to its effect on patient care, prior authorization is almost universally hated by health care providers. A survey of physicians conducted in 2022 by the American Medical Association (AMA) found that 94% of physicians reported that PA caused delays in care for their patients, with 80% saying that this delay led to treatment abandonment at least some of the time. (31) 89% of physicians said that PA has a negative effect on patient treatment, with 25% of physicians even reporting that delays in treatment due to PA led to a patient’s hospitalization. (32) Although the AMA’s survey was about PA in general and not specific to PA in Medicare Advantage, the organization cited this data in an open letter to the Centers for Medicare and Medicaid Services (CMS) calling for the agency to crack down on the abuse of PA in the MA program. (33)

Many problems have been reported with the use of prior authorization in Medicare Advantage. According to KFF, in 2021, more than 35 million prior authorization requests were submitted to MA plans, of which about 2 million or 6% were fully or partially denied. (34) It is important to remember that these denials do not account for delays in approval, which can take weeks and still result in profound negative consequences for patients (nor do these statistics reflect the number of requests physicians never submit because of the anticipated hassle of approval). The appeal process for denied requests also demonstrates the true harm of this process: just 11% of the 2 million denied requests were appealed, but in those appeals, 82% of denials were overturned. (35) These findings were echoed in a report by the U.S. Department of Health and Human Services’ (HHS) Office of the Inspector General (OIG), which found that from 2014-2016, just 1% of payment or service denials in Medicare Advantage Organizations (MAOs) were appealed, but 75% of appeals overturned the initial decision. (36)



In effect, these statistics suggest that denials are often entirely arbitrary, as even one attempt to question their use results in the request's approval in the vast majority of cases. The inpatient denial rate in MA is also higher than in other programs, with a survey by the American Hospital Association (AHA) finding that 19.1% of inpatient prior authorization requests in MA were denied, compared with 15.5% for Medicaid Managed Care patients and 11.4% for commercial insurance patients. (37) Here, too, the overturn rate on appeal was high, with 69% of MA appeals resulting in a reversal of the initial decision. (38)

Indeed, studies and reporting have demonstrated some of the magnitude and characteristics of inappropriate denials in MA. Despite statutory requirements for MA to cover all the same services as TM (and consistent claims by CMS and insurers that plans do so), an HHS OIG report from 2022 found that 13% of denials in MA, close to 1 in 7, would have been approved in TM. (39) 18% of denied requests, or close to 1 in 5, met both Medicare coverage rules and MA billing rules, meaning their denial was most charitably the result of human or system error. (40) An investigation by STAT News revealed that, contrary to claims of careful review by medical experts, insurers were using unregulated AI algorithms designed to cut off care as soon as possible based on training data, without adequate regard for the individual circumstances of the patient. (41) Another STAT investigation also revealed that the insurer UnitedHealth developed secret criteria used to deny care to patients in rehabilitation care without explanation. (42)

MA beneficiaries are aware of and concerned by the excessive delays and denials of their care as a result of prior authorization. A survey by the Commonwealth Fund found that 22% of patients on MA reported delays in care due to need for approval, compared with just 13% of TM patients. (43)



# Provider Narrative: Prior Authorization



*Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)*

“I had a patient with several chronic diseases who was very sick and had just survived major abdominal surgery, almost miraculously. In the aftermath, she desperately needed to go to acute rehab, which is the most intensive rehab – we found a facility, she liked it, her family liked it, and then her MA plan looked at the place and said ‘No, she’s healthy enough to not go to acute rehab, we won’t authorize it.’ This was after our PM&R specialist, physical therapist, and 3 MDs on our team had told her she needed acute rehab, and that it was the only thing that would keep her out of the hospital again. And this insurer, without anyone ever looking at her, rejected that conclusion. And we knew that on Traditional Medicare this never would’ve happened.”

- Internal medicine resident, Illinois



# Patient Harms:

## Limited Coverage

Besides delaying and denying care through prior authorization, MA plans also explicitly restrict care ahead of time via the use of limits on benefits and coverage. These restrictions may, for example, set an upper bound on the number of days a patient can be admitted for an inpatient treatment, or determine what drugs will be included on a formulary.

Medicare Advantage insurers are known for aggressively advertising “supplemental benefits” such as dental, vision, and hearing. These benefits are not covered by Traditional Medicare, and thus patients on TM generally require supplemental coverage to access these services. An analysis of MA television ads found that 92% mentioned supplemental benefits as a perk of the plans, compared with just 22% touting better access to physicians. (44) What these ads fail to describe are the significant limits applied to these benefits.

59% of enrollees in an MA plan with dental coverage have a maximum benefit of \$1,000 or less, beyond which any dental services will not be covered. (45) This is despite the fact that 19% of Medicare beneficiaries have reported spending more than \$1,000 on dental care in out-of-pocket costs during a yearlong period. (46) Hearing services in MA are similarly restricted, as 91% of beneficiaries with hearing coverage face limits on the number of hearing aids they can receive in a given time period. (47) 32% of beneficiaries with hearing coverage have both frequency limits and a dollar limit applied to their benefit. (48) The average dollar limit for hearing coverage is \$960, despite the fact that an average pair of prescription hearing aids costs over \$4,000. (49) The dollar limits for vision coverage in MA are perhaps the most striking; 99% of beneficiaries receiving vision benefits have a dollar limit on coverage, and the average limit is just \$160 per year. (50)

Similar coverage restrictions are present in other aspects of care as well. About 60% of MA enrollees are in plans that do not cover out-of-network outpatient mental health or substance use disorder services, with a similar number of enrollees in plans that do not cover out-of-network mental health hospitalization or opioid treatment programs. (51) A study of prescription drug coverage among 4 large MA insurers found that of the 20 most common physician-administered drugs, 17 were subject to prior authorization and 10 were subject to step therapy by at least 1 insurer (step therapy refers to a practice wherein insurers require the use of alternative treatments, and only approve the requested treatment if those prove unsuccessful). (52)

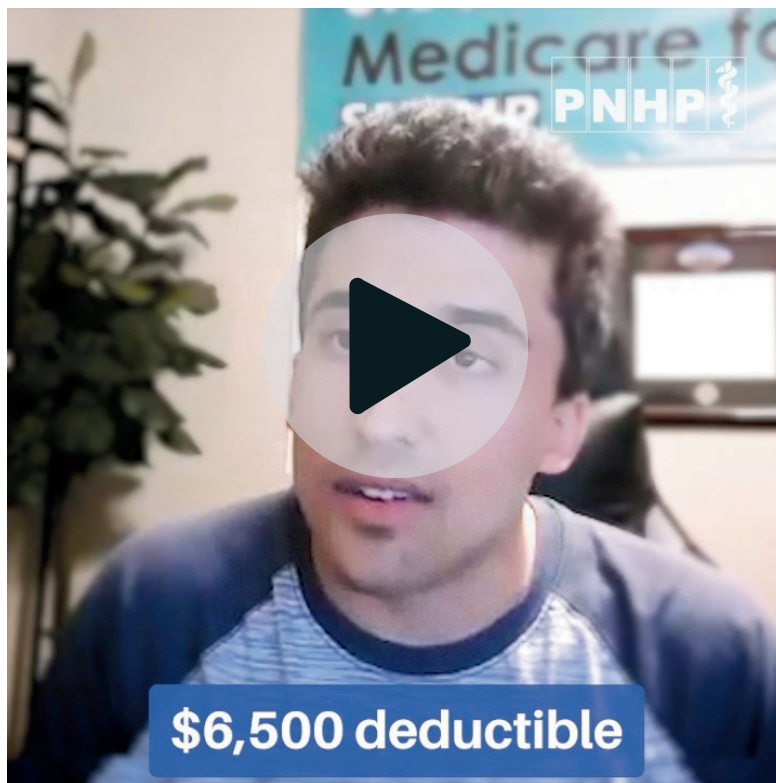


Over the period from 2018 to 2020, many of these drugs were also removed from all 4 MA-Part D (MA-PD) insurer formularies, meaning they would no longer be covered at all. Humana, for example, covered 14 of the 20 listed drugs on its Part D formulary in 2018, but by 2020 only included 4 of them. (53)





# Patient Narrative: Limited Coverage



Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“My grandfather, who has pancreatic cancer, has to pay thousands of dollars before he gets any real coverage. On top of that, he has copays and coinsurance he needs to pay as well. He even has had to pay out-of-pocket fees for emergency life flights he needed due to complications from his chemotherapy. I know those would’ve been covered fully under Traditional Medicare.”

- Grandson of MA patient, Pennsylvania



# Patient Harms:

## Excessive Costs

Even with insurance, cost-sharing for medical services is virtually unavoidable in the United States. Traditional Medicare, for all its benefits, generally covers only 80% of the cost for outpatient services, leaving patients responsible for the other 20% (usually covered by a Medigap plan). (54) However, cost-sharing in Medicare Advantage plans is often egregious, and can lead to serious affordability issues for beneficiaries.

In a survey conducted by the Commonwealth Fund, 22% of seniors on MA reported high health care costs in the previous year, compared with 13% of seniors on TM with a Medigap supplement. (55) 41% of MA enrollees said they had problems accessing care because of high costs, compared with 35% of those in Traditional Medicare plus Medigap. Finally, 21% of those on MA reported problems paying off medical bills or debt, compared to 14% of those on TM plus Medigap. (56) Another survey from KFF found that across white, Hispanic, and Black racial groups, higher percentages of beneficiaries reported cost-related problems in MA compared to TM with a Medigap supplement. The biggest difference was among Black beneficiaries; 32% reported cost-related problems on MA, while just 20% reported the same on TM with Medigap. (57) These gaps increased for beneficiaries reported to be in fair or poor health, lending more credence to the idea that MA is especially bad for those actively dealing with significant health issues. (58)



# Patient Narrative: Excessive Costs



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“Like a lot of people, I thought Medicare Advantage was cheaper, and it’s supposed to cover everything Medicare covers, right? That’s the way it’s supposed to work. I made the mistake of choosing a UnitedHealth MA plan, and it was about a year later I realized what kind of hell I was in when I ended up inpatient. I was looking at \$300+ dollars a night bills for being inpatient. And because of my health issues, I was ending up in the hospital nearly every six weeks, staying for a few days to a week and then coming out with these monstrous bills. As long as you’re not sick, Medicare Advantage is great - you’re spending less money! But when you do get sick, the co-pays, the co-insurance, out of pocket costs, they grow so fast, and you never hit the deductible.”

- MA patient, New Hampshire



# Patient Harms: Trapped in MA

One of the promises of free-market advocates in health care is the idea of “consumer choice.” The insurance industry will claim that the availability of a wide variety of plans allows beneficiaries to find one that suits their personal needs, and encourages competition among insurers that leads to better policies. However, this narrative elides the serious problems MA enrollees face in leaving the program if they find it unsuitable.

There is substantial evidence that many patients, especially those who are more ill or face high medical costs, tend to leave MA at high rates. A report by the Government Accountability Office (GAO) found that Medicare beneficiaries in their last year of life (when medical costs are generally very high) disenroll from MA back to TM at more than twice the rate of all other beneficiaries. (59) A similar study in Health Affairs found that the switching rates from MA to TM were generally higher than rates for the reverse among patients receiving high-cost services like long-term nursing home care (17% vs 3%), short-term nursing home care (9% vs 4%), and home health care (8% vs 3%). (60)

Not all enrollees have the option of leaving MA when things go wrong, though. When beneficiaries first become eligible for Medicare, they have the option of signing up for MA or TM. For their first six months of eligibility, these beneficiaries are protected by “guaranteed issue” requirements for supplemental Medigap plans. This means that Medigap insurers are not allowed to deny any senior a Medigap policy, nor can they engage in “medical underwriting” to potentially charge a higher premium based on health history or other factors. (61) This six month period is extended to twelve months when a beneficiary joins MA.

However, once this period is up, these protections disappear in all but four states. If an enrollee outside of these states signs up for MA during their initial open enrollment period, and then decides to switch to TM during the next year’s open enrollment period, they are no longer guaranteed to receive a Medigap policy, and can be denied on the basis of their medical history. Many seniors are unable to afford the 20% of costs covered by Medigap, meaning their only option is to stick with MA, even if they are unhappy with their coverage. (62) While more states do require “community rating,” wherein insurers must charge all recipients of a Medigap plan the same premiums, these protections mean little to those who are outright denied coverage to begin with. (63) Thus, MA plans get to keep many of their customers not on the basis of their high-quality services, but because they simply have nowhere else to go.



# Patient Narrative: Trapped in MA



*Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)*

“If my husband gets older and develops more serious problems, his access to a specialist may be restricted under his MA plan. So we would like to pull him out and get him on Traditional Medicare, and my worry is that now he’s being upcoded, he has a high risk health profile, so how much is Medigap going to cost if we can get it? Who knows about these kinds of problems until later on?”

- Wife of MA patient, North Carolina



# Provider Harms: Barriers to Patient Care and Administrative Burden

Thus far, we have discussed the myriad harms that MA inflicts upon patients. It is worth remembering, however, that MA is not only a problem for them. Medicare Advantage makes the jobs of physicians and health care workers substantially more difficult, contributing to stress, burnout, and moral injury, which refers to the psychological impacts of working in a system that forces providers to compromise their ethical commitment to patients due to the profit-driven nature of the health care system. (64)

As discussed earlier, limited networks and prior authorization are two techniques used by MA insurers to deprive patients of care as a means of saving money. Physicians are forced to contend with these practices daily, greatly hampering their ability to adequately care for patients. Limitations in networks mean that physicians often cannot refer patients to their preferred specialist or one that is convenient to the patient, making it harder to follow through on treatment plans and increasing the odds that patients will abandon treatment. These failures in treatment can weigh heavily on physicians, especially when they result in harm to a patient's health.

Even if patients are able to get an appointment and receive a diagnosis, the physician will often need to spend hours wrestling with the insurer to justify their desired course of action and receive prior authorization for it. These interactions can be highly frustrating; in the previously mentioned survey by the AMA, 31% of physicians reported that PA criteria rarely or never follow evidence-based guidelines approved by medical specialty societies. (65) In other words, many physicians believe that insurers are denying care based on faulty premises, rejecting the expertise of these physicians and established national guidelines in favor of their own dubious standards.

The administrative burdens of prior authorization are significant. 88% of physicians describe the burden of PA as high or extremely high. (66) 35% of physicians surveyed reported that they have needed to hire staff members to work exclusively on prior authorization. (67)



In a survey of practices conducted by the Medical Group Management Association (MGMA), groups were asked to name the type of policy most burdensome for obtaining prior authorization: 46% of groups said Medicare Advantage, compared with 32% naming commercial plans and just 4% naming Traditional Medicare. (68) 84% of practices also reported that PA requirements for MA had increased in the last 12 months. (69) When asked if the clinician hired by the insurer to review an authorization held relevant expertise to the treatment in question, 72% of groups said they did not. (70) And perhaps most strikingly, an overwhelming 97% of practices said their patients had experienced delays and denials of necessary care due to prior authorization. (71)

The AMA's physician survey found that practices spend an average of 14 hours each week processing 45 prior authorization requests, for a mean time of about 19 minutes per request. (72) Taking this figure as a global average (keeping in mind that practices rate prior authorization in MA as more burdensome than other types), the 35 million requests KFF reported were made in 2021 would result in roughly 11.1 million hours spent just on prior authorization for Medicare Advantage. Using a higher reported average time of 35 minutes per request from the MGMA survey, this number increases to 20.5 million hours. That is just over 1200 years at a minimum, and over 2300 years at maximum—or, in health care terms, anywhere from 35 to 65 million average patient visits. (73)

Prior authorization is not the only aspect of MA that results in administrative burden to physicians. In another survey from the MGMA, roughly 86% of medical group practices reported MA chart audits as being at least moderately burdensome to the practice, with 62% reporting that audits were very or extremely burdensome. (74) Because these chart audits are often used by MA insurers to inappropriately extract more money from the Medicare fund via upcoding, this also means that physicians are incurring a significant time and resource burden for the financial benefit of insurers. This is yet another example of MA contributing to moral injury among physicians. (75)



# Provider Narrative: Barriers to Patient Care



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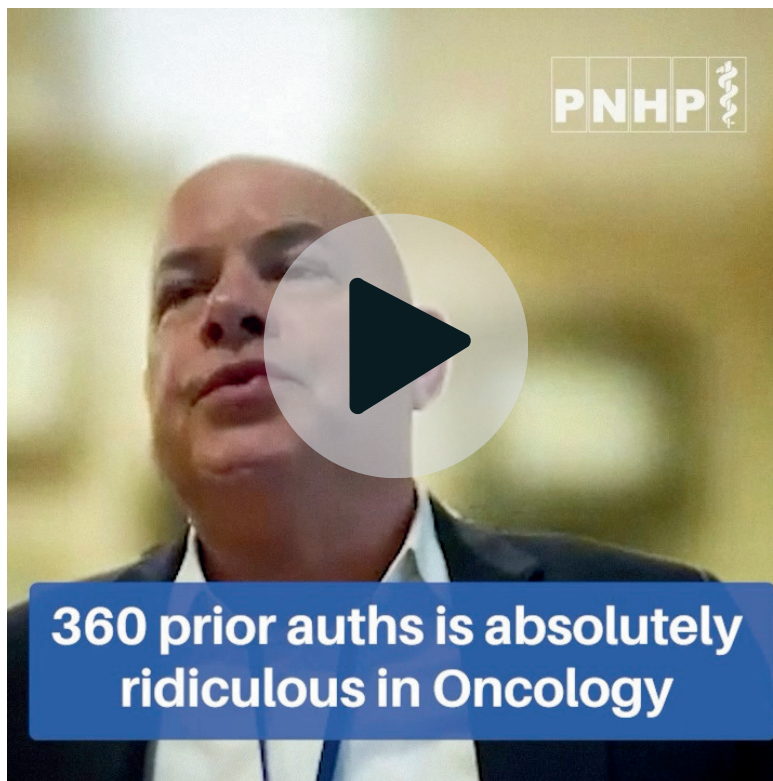
“We had a patient recommended for acute rehab. He was medically ready, but insurance denied him. We had to do an appeal, and we’re waiting on the results of the appeal, but he’s been here for 20 days, and 10 of those days have been us fighting with the insurance. In that time he’s developed pneumonia.”

- Nurse and case manager, Illinois





# Provider Narrative: Administrative Burden



Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“In one month, the staff for our two oncologists did 360 prior authorizations for their patient population—so much so that I’ve had to add another full-time equivalent employee just to do prior authorizations in the oncology unit. And every request in there is urgent.”

- CEO of health system, Connecticut



# Provider Harms:

## Corporatization of Medicine

In a general sense, physicians are increasingly under the thumb of large corporations or other entities that interfere with the practice of medicine. Approximately 74% of physicians are now employed by a hospital, health system, health insurer, private equity firm, or other corporate entity. Over a three year period from 2019-2021, the percentage of corporate-owned medical practices increased an astonishing 39%. (76) In 30% of metropolitan statistical areas (MSAs) in the United States, one private equity firm owned more than 30% of physician practices in a given specialty; in 13% of MSAs, one private equity firm owned more than 50% of practices. (77)

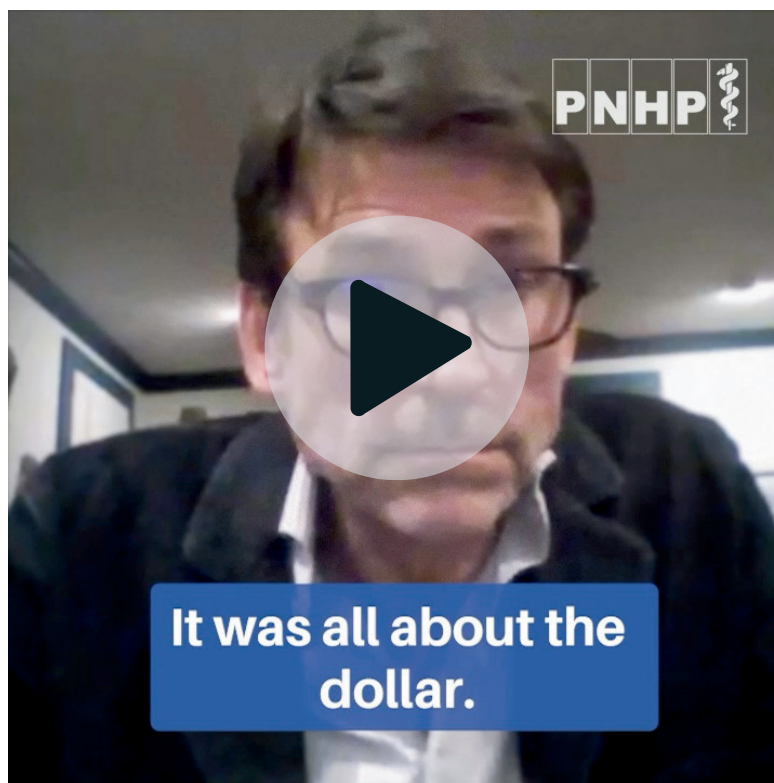
One significant motive for this rapid increase in corporate control of medicine is the massive profit machine that is Medicare Advantage. (78) Health insurers and private equity groups seek to control providers, encouraging them to upcode diagnoses and carefully managing the amount of care that their employees are allowed to give to beneficiaries. In one reported instance, the combined health system and insurer Kaiser Permanente called physicians during lunch breaks and after work to ask them to add more diagnoses to the charts of their patients, even offering bonuses and bottles of champagne as a reward for doing so. (79)

Another method of compelling doctors to participate in the financialization of care is through the use of “full-risk” or “global risk” models, in which physicians assume the financial risk of caring for patients and only make money if they can stay under a certain budget. MA plans have increasingly adopted such models in contracts with physician groups and health systems, leading some to fear that doctors will have to decide between providing the necessary amount of care for a patient, or meeting their budget in order to stay afloat. (80)

By placing financial concerns in the hands of physicians, MA plans subject them to moral injury. To consider profit in the determination of a patient’s care goes against the most important ethical standards that health care providers set for themselves; however, the reality is that physicians in the United States must already do this as a result of the constraints placed upon them by insurers like those in Medicare Advantage. When a physician has to prescribe a less effective medication because it is the only one covered by the patient’s plan, or when a patient must wait 3 months for a surgery that will allow them to walk without pain, profit motives have already infected the standard of care. The overt corporatization of medicine and the placing of financial incentives explicitly into the hands of physicians are simply the next logical steps in this process.



# Provider Narrative: Corporatization of Medicine



Watch this story at [pnhp.org/HarmsReportVideos](https://pnhp.org/HarmsReportVideos)

“My patient was told by an MA plan that they would no longer cover a particular calcium channel blocker, and that the patient needed to be on a different one. The cost difference here could not have been significant, but they switched the coverage, and encouraged the patient to get their drugs by mail. In the wake of all this shuffling around without my involvement, the patient got confused, and was taking both medications. They came in profoundly hypotensive, and we had to keep them on IV fluids all day to avoid a hospitalization. All this came from the effort of trying to pinch a penny, but what I really noticed was this was a pulling apart of what is most important in medicine - the doctor-patient relationship, and the pharmacist-patient relationship. It was all about the dollar.”

- Primary care physician, South Carolina



# Conclusion

Medicare Advantage represents the worst of private insurance coming to take over the best system of health care that America has to offer. Insurers in MA prey on some of the most vulnerable among us, luring them in with false promises of superior coverage and low costs only to make every effort possible to prevent them from accessing necessary health care, all while siphoning billions of dollars from taxpayers. The more MA is allowed to expand, the more harm will come to patients, physicians, hospitals, and the health care system writ large. More patients will die waiting for care to be approved, more doctors will face tremendous burdens trying to prevent this outcome, and more hospitals in areas of critical need will close as MA plans refuse to pay for their services.

The money that goes to profit-driven insurers in MA should instead be used to improve Traditional Medicare, including by adding dental, vision, and hearing coverage as well as establishing an out-of-pocket spending cap. Traditional Medicare follows the original spirit of the program, one that was created to serve *all* Americans without the perverse incentives that come from a profit motive. This is the model we should be following in our health system, instead of devoting more dollars to the failed experiments of managed care. We must eliminate out-of-control profit seeking in Medicare and beyond, both by reining in the abuses of insurers via executive action and legislation, and by greatly expanding our public health insurance programs. It's time to take Medicare back for the people.



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# By the Numbers Notes

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