RALPH NADER RADIO HOUR EPISODE 460 TRANSCRIPT

Steve Skrovan: Welcome to the *Ralph Nader Radio Hour*. My name is Steve Skrovan along with my cohost, David Feldman. Hello, David.

David Feldman: Good morning.

Steve Skrovan: And we have the man of the hour, Ralph Nader. Hello, Ralph.

Ralph Nader: Hello, everybody.

Steve Skrovan: We hope everyone is having a healthy and happy holiday season. And, in that spirit, our featured guest today is Dr. James Kahn. Dr. Kahn is emeritus professor of health policy, epidemiology and global health at the University of California, San Francisco School of Medicine. And he also works in the area of medical economy. Dr. Khan has developed a calculator in his home state of California where you can plug in some numbers, compare what you're paying for private healthcare insurance versus what you'd pay for in a Medicare for All system. And he's pushing this specifically in California because that's where he lives. And for instance, according to his calculator, someone making, say, around $79,000 would save over $16,000 every year under a Medicare for All system.

That's why Dr. Khan is part of coalition of groups both nationally and in California pushing for a more efficient and cost-effective Medicare for All system. We've talked about this a lot on the show, but he's got a way to throw some numbers at it. He's going to explain all of that and also comment on one of our bête noire, the further privatization of Medicare known as Medicare Advantage, which we of course have branded Medicare Disadvantage.

And that leads us directly into the second half of the program. We have done a lot on the subject of Medicare Disadvantage and our listeners have responded with comments and questions. So we reached out to a couple of experts to directly respond to those comments and questions. I spoke to Dr. Fred Hyde, who has appeared in the program in the past, and he's a consultant to hospitals, medical schools, and physicians as well as the unions and community groups and others interested in health of hospitals, healthcare facilities and organizations. And I also spoke to Kip Sullivan who has also been on the show. He is the healthcare advisor with Healthcare for All Minnesota.

So look forward to having both of these experts answer your most pressing questions on this really important topic that just doesn't get covered much of anywhere else. As always, somewhere in the middle, we'll check in with our corporate crime reporter, Russell Mokhiber, for the very latest on the white-collar crime beat. But first, let's calculate what you'd save with Medicare for All. David?

David Feldman: Dr. James Kahn is an expert in policy modeling and healthcare cost-effectiveness analysis, and evidence-based medicine. He’s an emeritus professor of health policy at the University of California, San Francisco. He’s also past president of the California chapter of Physicians for a National Health Program. Welcome to the *Ralph Nader Radio Hour*, Dr. James Kahn.

Dr. James Kahn: Happy to be here.

Ralph Nader: Welcome indeed. We've talked a lot about single payer in this series of programs, but we've never got down to the level of your expertise, which is how much does it save people in addition to saving lives, reducing needless complexity, anxiety, dread, and fear. So I saw in one article written on your research where you say, "Taxpayers already foot the bill for over 70% of our state's healthcare," referring to California. "The savings we can achieve by cutting the waste in private health insurance will allow us to guarantee improved healthcare services for all Californians while also lowering costs." And you've come up with something called the calculator. It was very intriguing. Tell our listeners about the calculator.

Dr. James Kahn: Sure. There have been quite a few studies over the years which have shown that single payer saves money overall by getting rid of the administrative waste and the profits and the high drug prices we can cover everyone with excellent insurance, excellent access to care, and still save money overall. And recently a healthcare reform commission in California found the same thing and they estimated how much we could save. But none of these analyses looked at this from the standpoint of individual households. For example, how people with job-based insurance and earning $70,000 a year do in the transition to single-payer? So, we decided to create what we call a household cost calculator and put it online. We built into that how much people are currently spending, say, on premiums, deductibles, and copays. And based on their income, what they would have to contribute to finance single-payer. And we let the people completing the calculator find out whether they would save money under single-payer or whether they would pay more. We built into this a progressive tax plan and what we found is that 90% of the thousands of people who completed the online calculator would save money with single-payer. Their increase in taxes to support the single-payer program would be much less than what they're currently spending on premiums, deductibles, and co-pays—all of which would go away. The average savings were about $6,000 per year. So basically, what it means is financially the typical household will do really well with single-payer, and as you point out, will also get rid of the worry about insurance because people will get all of the care that they need with comprehensive coverage.

Ralph Nader: Now presently in comparison with Canada, the administrative costs of running our corporate dominated healthcare system are enormous. I've seen different estimates. What is your estimate? The entire healthcare bill is estimated this year to be about $3.6 trillion. If that's in the ballpark, Dr. Kahn, how much of that is administrative?

Dr. James Kahn: Yeah. The wasted administration, the part that we really shouldn't be spending, is about $500 billion out of that $3.6 trillion to $4 trillion that you're referring to for total spending. So half a trillion dollars in waste. Some of that is insurance company profits; some of it is tasks that the insurance companies do that we wouldn't have to do under single-payer. And a lot of it is administrative burdens imposed on providers—doctors, hospitals, etc., in order to juggle these complex insurance arrangements. When you add up all those pieces, it's $500 billion a year in waste or excess administrative costs. So of course, if you take that money and put it into patient care, you can accomplish a huge amount of very important patient care.

Ralph Nader: Well, in Canada, the people I know say they get medical care, and they hardly ever see a bill. In our country, we see reams of computer billings in inscrutable code or

abbreviations. And that leads to all kinds of collection problems and cross collections, and apparently it takes about one clerical person for every practicing physician just to handle all the paperwork. Isn't that where a lot of administrative costs emerge from?

Dr. James Kahn: Absolutely. The best estimate I've seen was a few years ago showed doctors' offices spending about $80,000 a year per physician in the office for clerical assistance. And also, some of that is attributable to doctors having to do this extra paperwork. So, yeah, that's more than a person per doctor to take care of this. And if you go to a Canadian doctor's office, they're spending three quarters less than that. So, a quarter of a person to handle the billing. There it's night and day. It's a an efficient, effective, lean system. Doctors get paid quickly in Canada whereas in here in the United States, it's tremendously time consuming. And part of what makes it so bad is that the insurance companies are looking for every opportunity to deny or reduce the payment and then that has to be appealed. And this goes on and on until the end of the year when the doctors throw up their hands and just accept some small settlement from the insurance company and dive into the next year. It's painful and it's costly.

Ralph Nader: As one doctor said, "I want to practice medicine, not bookkeeping." Just for people who don't know what single-payer means, it's really government health insurance like Medicare with all its gaps, unfortunately. There's nothing particularly unique except that this would be universal, and it would be accessible. Everybody in, nobody out. You don't have to worry about changing jobs and affecting your health insurance. And also, it's much simpler. The Medicare legislation in Canada was 13 pages. Just the Obamacare statute and regulations are over 1000 pages. So the difference between complexity and simplicity hits the pocketbook real hard. Now, can you give us a figure on how much is taxpayer paid for the whole country? You said 70% in California. What is it for the whole country? Is it in that ballpark?

Dr. James Kahn: I can absolutely give that figure. I just wanted to add to your superb description of single-payer that many of us refer to this as improved Medicare for All. As you said, it would cover everyone. There are some gaps in Medicare. Some cost sharing, some services that aren't covered and those would be remedied with single-payer. So improved Medicare for All. In terms of your question--what portion is coming from the taxpayer--start with the cost of the public programs; that would be Medicare, which is a federal program, Medicaid, which is a federal/state combined program plus the federal Veterans Administration. There are literally scores of different public programs and they're all on budgets. And so, when you add those up, it's a big piece of our overall healthcare spending. Then if you add that onto what government agencies pay to get private insurance for their employees, i.e., what the federal government, state county and local governments pay to private insurers, and finally, add into the mix the tax subsidies provided by the government for private companies to pay for health insurance for their employees, It amounts to more than two thirds of all healthcare spending in the United States. It's about 70%.

Recently, the number has gone up even further with the growth of the Medicare Advantage program in which the federal government gives money to private insurers to administer a public benefit program. So all of that, as I said, comes up to about 70%. If you compare 70% of our healthcare spending to total healthcare spending in any other wealthy country around the world, we're already spending more in public money than any other country spends in total. We're already paying for universal healthcare; we're just not getting it.

Ralph Nader: Per capita, you're talking about.

Dr. James Kahn: Right. Thank you. This is all adjusted to per capita. Of course, in absolute terms, there's a stunning number that my colleague at WHO [World Health Organization] calculated. 40% of all global health spending is in the United States.

Ralph Nader: Well, in Canada they cover everybody from cradle to grave for about 10% of the GDP [gross domestic product]. In our country, we spend on healthcare about 19% of GDP and there are about 28 million people without any coverage and another 60/70 million, significantly under-covered. So that's the comparison per capita.

Dr. James Kahn: Exactly.

Ralph Nader: And people say, well, why would all this taxpayer money suddenly become more efficient than it is now? So the answer is it wouldn't filter through all these hundreds of insurance companies, some of which have administrative costs of 20%/25%, huge executive salaries, profits, and waste. Waste to them is a way of getting more income over diagnosis and over prescriptions, for example. The whole system is designed for waste. And so that's the answer why it would be more efficient. There would be no more private health insurance companies period. Is that correct?

Dr. James Kahn: Yes. Now I've looked at about 30 other wealthy countries around the world that are members of the Organization for Economic Co-operation and Development [OECD]; these are our peer countries. And I looked at all of their health systems. One of the absolutely consistent findings was that all of these other countries have a comprehensive, universal insurance package or benefit package that does not involve for-profit insurers. Most countries use a single government payer. And the ones that use private insurers like Switzerland, Germany, and the Netherlands, for example, those private insurance companies are not-for-profit and are highly regulated and all sell exactly the same health insurance package, not every possible variation of health insurance.

And that's the critical thing. You don't want profit in the mix. And you want absolute uniformity in that everyone has the same excellent insurance. Instead of this myth that somehow people want to choose between different insurance products. People don't want to choose between different substandard insurance products. They want to choose their doctors. And with a system where everyone is well covered, that's exactly the choice that they'll get.

Ralph Nader: Well, this is a good segue into Medicare Disadvantage as we call it on this program. You've been critical of Medicare Advantage, which is the corporatization and hollowing out of traditional Medicare and which engaged in wild and crazy reckless promotion in the last few weeks during the Medicare enrollment program. I mean, I cannot believe how much TV ads, postal handouts, all kinds of cards, and telephone calls occurred. They even solicited people who've been deceased for 25 years. That's how aggressive companies like Aetna, Cigna, and UnitedHealthcare were in trying to get more of the traditional elderly beneficiaries out of traditional Medicare.

Now single-payer gives you free choice of doctor and hospital. That's a great advantage over these corporate health insurance narrow networks that say you can only go to the specified

doctors and hospitals that are on our list. You can't go to any better doctors and hospitals. In Canada, you have your free choice of doctor and hospital under their single-payer system. Can you enlighten our listeners about Medicare Advantage and is there anything being done in the government or in any sector to stop it? Because it's now about 50% going for the whole ballgame in the coming years.

Dr. James Kahn: Well, that is a good description. The business model for Medicare Advantage —and I use the phrase "business model" intentionally. It is a business model, it's not a medical care model. It's a business model wherein these private insurers get paid a certain amount every month even before the care is delivered--a capitation payment based on the estimated risk of their enrollees. And then they have, as you say, a network of providers. They've negotiated relatively low reimbursement rates. They also oversee care and may deny an authorization request for care more so than in traditional Medicare. Overall, they push down the utilization of care by about 10% making it harder to get care and making it especially hard for people who are sick to get care. So when people get really sick, they tend to shift from Medicare Advantage into traditional Medicare to have better access to care.

Even though they push down overall utilization that's not quite enough for them, so they do this thing called diagnostic upcoding, which means that they find diagnoses for their enrollee that were missed or are equivocal or don't exist. So they may fraudulently create these diagnoses. And when these diagnoses are added, their capitation payment and their profits go up. And CMS [Centers for Medicare & Medicaid Services] knows about this upcoding thing, but don't fully correct for it. In 2020 it is estimated that CMS overpaid Medicare Advantage programs by $12 billion. And the estimate looking forward is that over the 2023 to 2032 10-year-period, we can expect to see as much as $500 billion in overpayments to Medicare Advantage because of this diagnostic upcoding gaming.

Basically, Medicare Advantage is taking money from CMS, which means from the taxpayers, and putting it into profits while making it harder and harder to get care. The Kaiser Family Foundation did a survey of Medicare participants and what they found is that people in Medicare Advantage who were in fair or poor health had a very high probability of skipping or delaying care because of financial barriers to care. So the people in Medicare Advantage who are healthy do fine. The people in Medicare Advantage who are in fair or poor health have real financial problems. And so, bottom line, CMS, in allowing the Medicare Advantage program to operate as it does, is padding the pockets of shareholders while denying care to the people who really need it.

Ralph Nader: And these health insurance giants are making staggering profits on the Medicare Advantage section of their business. What's stunning for us in Washington, D.C. is why there isn't more opposition to this in Congress, extensive public hearings, and why the [Joe] Biden administration has embraced Donald Trump's latest gimmick, which is coercive beyond belief called the ACOs [REACH], where they force in these pilot projects traditional Medicare beneficiaries into a kind of Medicare Advantage. Could you explain this ACO and why the Biden regime is supporting this?

Dr. James Kahn: Right. So, a few years ago, CMS started something called direct contracting. This is in the traditional Medicare portion, not the Medicare Advantage part, but the other part.

And they started this direct contracting, which was a mechanism to insert private equity and other businesses in between CMS and the traditional Medicare beneficiary. And then they transformed this, at least in name, to something called ACO REACH. And ACO REACH, again, has this direct contracting. It means that these corporate intermediaries are accepting capitation payments just like in Medicare Advantage. And if they keep the utilization down, keep their costs down for what's called the medical loss ratio, that is the medical care that's delivered, they keep all of the profits up to 25%, 25 cents on the dollar, and even beyond that.

They have this huge incentive just like the Medicare Advantage plans do to reduce utilization and to pocket the profit. So this is basically the privatization of the still public part of Medicare. and lots of people are fighting that. I wrote about this quite a few times in my blog, which I edit and I'm the chief blogger, called *Health Justice Monitor*. I encourage your listeners to check out healthjusticemonitor.org. I've written about ACO REACH and how it is basically a scheme to privatize the public part of Medicare, bringing with it all of the same problems that we have seen with Medicare Advantage, probably without the restricted networks, but every other trick they can do to suppress utilization and make it harder to get care.

In *Health Justice Monitor* I showed just how profitable private insurance is for the insurers. They talk about Medicare Advantage; they say they have a 5% profit margin because mostly they're just moving money around; turns out their profit margins are 35 to 40%. It's an astounding extortion amount of profit built on basically denying people care.

Ralph Nader: Listeners, especially Congress Club members, tell your senators and representatives to look up *Health Justice Monitor* and get educated and get moving here. You see the nefarious effect, listeners, of corporate complexity. Corporate complexity is another phrase for corporate control over your healthcare lives and your pocketbook and denying benefits and restricting your choice of doctors and hospitals and compared to the simplicity in Canada, where when you go to a hospital, they don't ask, what's your insurance situation. They ask "What is your health situation?" And you give them that Medicare card and that's the end of it. You're not going to get billed. You're not going to get harassed. You're not going to get complicated. You're not going to get induced into anxiety, dread, and fear. Why the American people do not wake up and demand that their members of Congress come to their town meetings back home, run by the people, where they talk all about this healthcare shenanigans and they send the senators and representatives back to Washington with instructions to support the kind of single-payer that was illustrated in HR 676 two years ago and replaced with a weaker one by Representative [Pramila] Jayapal. HR 676 is the gold standard, and it should be reintroduced in the next Congress so that people can rally around it.

We should have one day in the spring, where people from all over the country summon formally their senators and representatives to town meetings back in the districts, where all these issues can be aired and where the citizens will be enough informed that they can't be sweet talked by the senators and representatives, who will be there to listen for a change and not to choreograph their own town meetings. What do you think of that idea, Dr. Kahn?

Dr. James Kahn: Oh, I think that's fantastic. There have been quite a few municipalities around the country in recent years that have adopted pro Medicare for All or pro single-payer ballot initiatives. There's really a growth in that. There's a real understanding on the ground that our

current system is simply not working. Obviously, lots of uninsured. There're so many people who are underinsured. They have deductibles that run to thousands of dollars. So even though they're insured, they can't afford to get care. Let me say that again. Even though they're insured, they cannot afford to get care. It's a terrible state and people recognize it. And if you look at polling support for a government guarantee of health insurance, it's now up to about 70%. So, it's incredible to see that there's a growing support for what is the obvious solution. As you say, it's about simplicity. We want simplicity. I like to say that the complexity in our current system isn't a bug; it's a feature. It's something that the insurance companies, pharmaceutical companies with their pharmaceutical benefit managers, everyone who's making money off this system, wants it to be complex because it's so hard to understand what's going on and it's impossible to fix it. We need simplicity. And I agree if it's brought to the town square, people will insist on that simplicity. So, I think that's a great idea.

Ralph Nader: And also, the left-right voters will support initiatives just the way the left-right supporters have supported initiatives to raise the minimum wage in conservative states like Arkansas and Florida and other conservative states. So, listeners, there are two ways here. The statewide initiative if you live in a state that has the initiative referendum recall. And the second one is to summon formally your senators and representatives.

Some of you may say, "Well, they won't come." Well, here's my best estimate. If you get 500 clear signatures on a petition, they're legible and they give their occupation and their email, you'll get a member of the House of Representatives coming to a town meeting. If you get 1,000 or 1,500 in a fairly large state, you'll get the senator coming because they'd never seen such organizational demands. It'll be astounding, especially if you let them know that you can double a number of signatures if they so insist on getting a higher reading of the demand from back home. So imagine these town meetings at town halls or school auditoriums where the people are on the stage and the senators and representatives are sitting in a front row listening and then sending them back to Washington with their instructions. It's one of the greatest left-right conservative-liberal support issues in America today.

Dr. James Kahn: I couldn't agree more. And I think you're raising an important connection, and that is between healthcare reform and democracy. As you and all your listeners know, we still face extreme challenges to our democratic system with division and many participants denying the legitimacy of the processes we've set up. And I think that advancing to true healthcare reform with single-payer has the really huge potential to reduce the tension and bring us back together. For example, a lot of people on the right as well as the left are highly anxious about their inadequate health insurance. They're worried, if I get sick, how will I pay the doctor? How will I pay the hospital? Imagine how much anxiety would be reduced if everyone knew that all of their medical care was going to be fully covered under a single-payer system. And so that anxiety, which currently causes a lot of division and tension, would go away. I think there are many other ways as well that true universal coverage with a single-payer, simple and effective, would really benefit our democratic system.

Ralph Nader: It affects the whole quality of life. I've been to Canada many times. I have relatives in Canada who've used the healthcare system and I was persuaded to write an article a few years ago called "25 Ways Life is Better in Canada than Obamacare," because of their system of full Medicare for All and our poorest corrupt system that's so discriminatory and

avaricious. And that is up listeners on singlepayeraction.org. You can get "25 Ways Canadian Healthcare is Better than Obamacare." One of the ways, by the way, as you probably have read, there are some people so desperate for healthcare that they'll commit minor crimes to be put in jail so they can get healthcare in the US, land of the free.

Dr. James Kahn: That is the definition of perverse incentive. That's just horrendous. I can't say that I'm surprised. People are desperate; that's terrible.

Ralph Nader: On that note, before we close, Dr. Jim Kahn, give the website for the household calculator for people to use and advance their own civic demands.

Dr. James Kahn: So, the website for the calculator is best found by going to Google and typing California single payer household calculator and look for Healthy California Now. It'll be the first or second hit. And the other website I want to just remind people of is healthjusticemonitor.org, where we cover the ACO REACH issue, Medicare Advantage, and of course lots and lots on single-payer. And if you want to get a free email from the website every two to three days, just sign up online.

Ralph Nader: Well, thank you. On that note, thank you very much, Dr. Jim Kahn. To be continued. This is not a subject that's going to go away. Thank you very much.

Dr. James Kahn: Thanks for having me.

Steve Skrovan: We've been speaking with Dr. James Kahn. We will link to his work and his calculator at ralphnaderradiohour.com. Up next, healthcare consultants, Dr. Fred Hyde and Kip Sullivan, respond directly to your feedback about Medicare Disadvantage. But first, let's go to *Corporate Crime Reporter*, Russell Mokhiber.

Russell Mokhiber: From the National Press Building in Washington, D.C., this is your *Corporate Crime Reporter "*Morning Minute" for Friday, December 30, 2022, I'm Russell Mokhiber.

Wells Fargo's mistreatment of its customers has resulted in yet another record-breaking fine and a warning that more restrictions on its ability to do business could soon follow. The bank will pay $1.7 billion in penalties and another $2 billion in damages to settle claims that it engaged in an array of banking violations over the last decade that harmed millions of consumers. That's according to a report in the *New York Times*. The latest developments contribute to a picture, years in the making, of Wells Fargo as one of America's worst-run big banks. For decades, the 170-year-old bank has struggled to fix its practices despite run-ins with regulators, even as employees and customers continued to identify new problems. For the *Corporate Crime Reporter*, I'm Russell Mokhiber.

Steve Skrovan: Thank you, Russell. Welcome back to the *Ralph Nader Radio Hour*. My name is Steve Skrovan and Ralph wanted me to reach out to two healthcare experts we've had on the program to respond to your questions and comments in order to clarify and expand upon our take on the terrible program we call Medicare (dis)Advantage. Here are those two interviews. Listen closely. Your name may come up.

So, thank you, Dr. Fred Hyde, for joining us today on the *Ralph Nader Radio Hour*. This special segment where we're going to deal with some questions our listeners had about Medicare Advantage. How are you today, sir?

Dr. Fred Hyde: I'm fine. Thank you, Steve. How are you?

Steve Skrovan: Very good. Very good. Better that you're here now too because Ralph wanted you to answer some of these questions that we've been getting on the segments we've done about Medicare Advantage, that he would rather have you, the expert, answer because he's getting his information from you, anyway.

So here we go. And our first question is from a listener named Beedy Parker and she's thanking us for hammering on Medicare Advantage. And she says, "My late husband tried to keep us off it, but we felt we had to have Part D coverage. After he died, it kept getting more and more expensive, which scared me. So, I gave up and got Medicare Advantage, which included it. It hasn't been awful for me, but I understand it scams Medicare, so would rather have plain Medicare. Assume the Part D barrier is still there though. What can I do?

Dr. Fred Hyde: Well, Ms. Parker is correct. She would need drug coverage one way or the other. Medicare Advantage people have successfully packaged the different pieces of Medicare and it becomes easier, if you will, for the Medicare beneficiary to sign up for one plan rather than to chase down traditional Medicare, Medigap plans, Part D pharmacy plans, and to put it all together. And of course, the Part B premium also has to be paid there for outpatients. So, she's correct. It's easier to sign up for Medicare Advantage that has a pharmacy plan than it is to assemble, if you will, the different component parts, which understandably come from the history of Medicare, which was passed originally 1965. The outpatient pharmaceutical benefit didn't come along until the early part of this century. So, we have 65 years' worth of f history, if you will, to assemble pieces and the Medicare Advantage people have undertaken to make that assembly easier. Traditional Medicare frankly doesn't make it easier.

Steve Skrovan: So, it's the complexity of the actual Medicare plan because it was put together piecemeal over the years that makes Medicare Advantage seem so convenient to people.

Dr. Fred Hyde: That's exactly right. You put your finger on a problem, which is quite aside from the extraordinary cost of our medical care system, and that's its complexity. I'm not surprised that your listeners have questions. I have questions and I've been in the field 50 years. I teach graduate students in hospital operations and healthcare finance, and trust me, everyone has questions when it comes especially to their own coverage. What do I do about these specific facts and these specific circumstances that characterize what I need as opposed to what somebody else has assembled? So, you're right, complexity is itself an issue. And once again, we live in a society where there is a good deal of middlemen who undertake to smooth over the complexity of our society and make a buck doing so.

Steve Skrovan: So how would you answer Ms. Parker's question about what do I do? Is there some clearinghouse other than the *Ralph Nader Radio Hour* where somebody could walk her through the complexity of Medicare if she doesn't want to do Medicare Advantage?

Dr. Fred Hyde: The very first thing is that if you're in possession of a telephone or computer, you can find good advice from 1-800-MEDICARE or from medicare.gov. And you can also find a booklet which is itself a weighty tone. Every year Medicare publishes *Medicare & You* and there's a 2023 addition of that. So, if you call 1-800-MEDICARE or log onto medicare.gov and ask for the booklet *Medicare & You*, you're frankly 50% there. You've got objective resources that are not trying to sell you anything, but rather are trying to respond to questions, which have come from a half century worth of Medicare beneficiaries.

Steve Skrovan: All right, thank you for that. So, Dr. Hyde, we have another question from a listener whose name is Brenda Reid, and it's rather a long question. So, I'm just going to compact it a little bit into the three short paragraphs here. And she says, "Someone asked about the 20%, which Medicare doesn't cover, or some such supplemental, and I don't think Ralph really answered the question other than to agree that yes, it shouldn't be this way." I think the person was asking, what's the better choice if you can't afford the 20%, would you still say in traditional Medicare and scramble to pay the 20% even though Medicare Advantage fraudulently offers to cover your entire bill?

And she says, "I've been wondering about the question myself for a while now because it's not even just the 20%. There are also deductibles and plenty of other restrictions and time limits and whatnots that Medicare doesn't cover, especially when you get really sick, though of course you can always go broke and hope Medicaid would pick up the tab." And finally, she says, "By the time you add Medicare and Medigap's premiums, you could be out of pocket $500 a month per individual, $1,000 for a couple. Lots of retirees simply can't afford that. Never mind that it's an outrageous amount of money and kind of a tax essentially in old people. What kind of country is this?" So how would you respond to that, Dr. Hyde?

Dr. Fred Hyde: She's not wrong. And Ms. Reid has an excellent point, which is that the seniors who are the primary intended beneficiaries of Medicare are not receiving what was originally promised. Here's the original promise. You work, allow yourself to be taxed, put aside funds in the trust fund for Medicare, and when the time comes, you can retire without worrying about your medical coverage. Now, that isn't true. Why is it not true? Well, it's a complex question, but basically what Ms. Reid has found is what other Medicare beneficiaries find, and that is there are trade-offs. It's very presumptuous and I have to say this, and your listeners hopefully will understand this, to tell somebody else how they should assemble their health insurance coverage. Very presumptuous. We have more than—believe it or not—4,000 Medicare Advantage plans in the nation. And we have one traditional Medicare plan.

The 4,000 plans are busily presenting information to people who are not necessarily in possession of the same capacity to analyze that. It's an asymmetric warfare, if you will, in advertising. And some of these plans have very low premiums; some of them have no premiums. Some of them have very low deductibles; some of them have no deductibles. What's the trade-off? There is always a trade-off.

And Steve, the fundamental thing to remember is if you like managed care, especially as it was in the 1990s, where there were limits on doctors you could see, limits on what your doctor could do, limits on what your doctor could refer you for, and a lot of retroactive penalties. If you like managed care, you'll love Medicare Advantage. That's what it is. Medicare Advantage is

managed care as we came to know it in the late ‘80s and early ‘90s when it was a very raw trade-off. You can only go to these doctors in these hospitals and we're going to put paperwork on them that will be hidden to you. Let me give you an example. This will hopefully be of interest to your listeners. In one of the journals that many physicians look at every day called *MedPage Today*, there's a headline in a story this week, “Should Doctors Warn Patients About the Downsides of Medicare Advantage Plans?” It's a very interesting article. And the subtitle is: “Beneficiaries may not be aware of the plans' limited networks or prior authorization rules” In the health field, most of the time the doctors know which way is up because they have to wrestle with it. They have to wrestle with the bureaucracy and the approvals and so forth. One of the worst of these is something that happens in Medicare Advantage, but not in traditional Medicare called prior authorization.

Your doctor thinks you need a test. You need an expensive imaging test. In Medicare, you get the test. In Medicare Advantage, the doctor has to get a bureaucrat in the end of an 800 number to agree that you need a test. What kind of plan is that? You're really going for the lowest common denominator here, which is an 800 number box checker, second guessing your doctor. And of course, the doctors are furious about this, but they're also somewhat powerless. That's the type of thing that's an obstacle, and very difficult to explain to people who are looking only at the monthly out of pocket. So a way of summarizing my answer is if the monthly out of pocket is too much for you, frankly, do what you need to. If $500 a month is going to keep you from eating and staying at a shelter in which you're comfortable, well, for goodness’ sake, don't do that. But keep in mind that you've made a trade-off.

What's the solution? The solution is where it started, which is in Congress. Congress right now has at least two bills that would make Medicare Advantage fairer, but which would also make the whole process easier. One would standardize benefit plans. You know, these 4,000 Medicare Advantage plans come at you on the television, on the telephone, in your mail and at your door with different benefits. And the benefits are not always comparable. They're very, very difficult for the Medicare beneficiary to say, I'm going to have plan A and not plan B because plan A is otherwise equal but offers me something that I want. Very difficult. So, standardization of benefits is very important. The other congressional initiative, which seems to be getting some traction, is eliminating this prior authorization business. This is the devil. It really is just inserting a roadblock between a Medicare beneficiary and his or her physician and the hospital they want to be at and the specialist they want to see.

So just to summarize, if short-term financial impediments are the controlling instrument in your life right now, don't bankrupt yourself on the price of American healthcare. On the other hand, if you do have to choose Medicare Advantage because you can't afford not to and you can't afford a Medigap plan, and you can't afford a pharmacy plan... If you have to choose Medicare Advantage, don't give up on getting Congress to do the responsible thing and to have these plans shape up so that they treat consumers the way they should be treated when they are ill, when they're sick, when they need medical care.

Steve Skrovan: Thank you, Dr. Fred Hyde, for answering our listeners' questions.

Dr. Fred Hyde: Sure.

Steve Skrovan: We hope it shed a little bit more light on a very complex issue and given our listeners a more nuanced view of the whole project. Thank you, Dr. Fred Hyde.

Dr. Fred Hyde: All right, Steve. Very good. Take care.

Steve Skrovan: So, we're going to continue our conversation on Medicare, what we call Medicare Disadvantage, and we've invited back on Kip Sullivan, who did our show in October and got some very interesting feedback. Some of it a little strident, and from one listener in particular. And that listener is Mary Beth Heiter who said, "Too bad, someone who doesn't know what is going on in Medicare would be giving such false information. As a Medicare broker who educates beneficiaries in all the ways of getting their Medicare benefits, it does not matter to me what Medicare option a client gets. However, it is my job to give them all the details and advice based on their individual situation and health. How dare someone, who hasn't gone through all the licensing and training that an actual licensed broker has, give any type of advice as to what is best for the general public? He can join the ranks of Joe Namath and Jimmy JJ Walker. Shame on Nader for being part of the problem instead of the solution." What do you have to say to that, Kip?

Kip Sullivan: Oh, my first reaction is I think it's strange that anybody would assert that the average American citizen is incapable of deciding whether the traditional Medicare program or the Medicare Advantage program--whether one is better than the other. The idea this is somehow esoteric knowledge that can only be known to brokers who have gone through training is just flat out bogus. Just to recap, my recollection is that the question that I was responding to came at the very end of the interview and there was somebody who wrote in, and Steve, I think you read the question. And this was somebody who had just turned 65 or was about to turn 65 and was just asking, "Do I have any advice about whether about what to do?" And I said, I'd give you the same advice I'd give you to my mother, which is, don't enroll in Medicare Advantage. I can't recall—we didn't have much time to talk about why. I believe I said something to the effect that you run a higher risk of having your health be harmed if you enroll in Medicare Advantage than in traditional Medicare and/or paying a lot of money out of pocket because Medicare Advantage plans deny services. And that's still my answer. And we've got a little time now we can elaborate on the problem.

The main reason Ms. Heiter's question is misleading is she's implying that it's possible for a broker or anybody to sit down with an individual and ask such questions as: Do you have asthma? What's your income? Where you live? And then somehow come up with the best Medicare Advantage plan for that person. That's false. And the reason is you don't know what you're buying when you enroll in a Medicare Advantage plan. And they have names that everybody recognizes--Humana, UnitedHealthcare. And there're two reasons why you don't know what you're buying when you enroll in a Medicare Advantage plan. The most important one is that Medicare Advantage plans make extensive use of what's called prior authorization. You and your doctor are no longer in control of what services will be paid for and how quickly you'll get them.

Just to give you some idea how often insurance companies interfere in doctor decision patient making, consider these numbers from a study published by the Kaiser Family Foundation. They reported that 98% of all Medicare Advantage enrollees have to receive prior authorization for

admission to a skilled nursing facility or to a hospital. Similarly, 93% of all Medicare Advantage enrollees have to play Captain, May I with their insurance company to get diagnostic procedures, labs, and tests. 92% have to go hand in hand to their insurance company for permission to get home health services. 85% of people who have diabetes have to ask permission of their health insurance company for diabetic supplies. 60% have to get permission to see a specialist.

So the problem we face in advising anybody about whether to enroll in Medicare Advantage, and if so, which plan, is you can compare the premiums upfront and you can find out what the deductible is, but that's it. And you can see what the insurance company claims they will cover, but you don't know what they'll cover until you need it. And that's a little bit locked by in a car and not knowing if the brakes will work until you're out on the road and you put your foot on the brake to see if it works. That's the major reason. It's extremely misleading to tell people that if you sat down with a broker, the broker could help you figure out what plan is right for you. You don't know what plan is right for you because you don't know what you're buying because of the extensive use of prior authorization.

The second reason, and less important reason you don't know what you're buying, is that all of these Medicare Advantage plans limit your choice of doctor and hospital. Now, it's possible if you do some research ahead of time to find out if your primary care doc is in the Medicare Advantage network, but it's very difficult to look down the road with your perfect 20/20 vision into the future, and say, well, someday I might get cancer or fall out of a tree, and I'll need specialists. You don't know if the specialists you want are in the Medicare Advantage Plan. But to repeat, the main problem is extensive use of prior authorization.

Steve Skrovan: Well, that's a theme that all the experts we've talked to in this area have talked about is this. We just talked to Dr. Fred Hyde who said, “It's not what you pay, it's what you get.” And this leads me into the next question, which does have to do with cost, which we're discussing when we talk about medical issues. This is from listener John Glascock who said, “I wish you had covered the following things even for two minutes in your talk--a comparison--what's it cost just for Medicare alone? I pay $170 a month out of my Social Security. What are the benefits and limitations of Medicare alone? How much extra do you pay for Medicare Advantage? Is it the same for everyone? And how much is it for Medicare with Medigap? I wish that you'd cover that even for two minutes in your talk,” he says. He says, “I hate health insurance companies. We really need a single-payer system. But at the same time, I think you and Ralph need to disclose the difference with and without advantage--what it costs, and more about Medigap policies. Just as Ms. Heiter mentioned in her comments, just changing over without knowing the risk could be financially devastating if someone blows off the Advantage program without thoroughly checking on exactly what is covered and what isn't. Should they need ER, or a hospital stay could easily wipe them out financially. With Blue Shield, a couple years ago, for two-and-a-half-day hospital stay, I paid maybe $150. If I had Medicare only, I'm assuming that would've paid 80% and the balance would've been close to $5,000. I don't know what it would've been with Medigap or even if that’s the difference from what I have already.” He says, “Please set me straight if I'm wrong or misunderstood something. But that's my concern.” And so, he wants the little cost breakdown here.

Kip Sullivan: My recollection is, we didn't have much time at the end of the October interview to get into this. Now we're getting into it. And my answer to Mr. Glascock is the same as my

answer to Ms. Heiter, which is, it is impossible to give you a dollars and cents comparison of the cost of Medicare Advantage with either Medicare alone or Medicare with supplemental coverage. And the reason it's impossible is you don't know what you bought from Medicare Advantage until you need it. It is often the case that people who paid $500 less per year in premiums by enrolling in a Medicare Advantage plan than they would've paid if they had gone with traditional Medicare and supplemental coverage. But all you have to do is have the insurance company refuse to pay for a thousand dollars service and you're out of money.

So that second request is impossible to address for the same reason the first one was. Medicare Advantage plans are black boxes. And so if you want, you can go to medicare.gov and spend a lot of time going through their tables trying to compare this insurance company to that insurance company. And you may find that you've got an insurance company with a lower premium than another insurance company. But in the end, you don't know the value of what you bought until you need it. That's the fundamental problem we're facing.

Steve Skrovan: So, you're saying it's a roll of the dice with Medicare Advantage. You may be saving on some premiums in the short term, but if you get really sick, you may find out you're not covered.

Kip Sullivan: Yes, and we have statistics that demonstrate that. Let me just give you a couple of numbers here. Kaiser Family Foundation reported that 19% of all Medicare Advantage enrollees report cost-related problems in the previous 12 months. What's the percent amongst traditional Medicare with supplemental? 12%. Your odds of having bills you can't pay or being denied are 50% higher if you enroll in Medicare Advantage. It's even worse for Black people and for people in poor health. Here's the statistics for Black people: 50% of Black people in fair or poor health reported cost-related problems versus 27% in traditional Medicare. Obviously neither program is with supplemental coverage. Obviously neither program is perfect, but you're far more likely to run up against unpaid bills and denial of services if you enroll in Medicare Advantage. And it's worse if you're poor; it's worse if you're already in poor health. And you know darn well, I assume most brokers are not telling people this. Otherwise, they wouldn't sign up.

Steve Skrovan: Right. Exactly.

Kip Sullivan: Now this is something, this is information that's available on the internet. You don't have to be a trained broker; you don't have to have a PhD in anything to look it up.

Steve Skrovan: Let's go to one last question. This comes from Evan Levine. And he says, "Great show," about the Medicare Advantage programs, "but you didn't answer the 20% question. If you have Medicare and cannot afford the 20% or supplemental, then what?"

Kip Sullivan: That's a problem. If you can't afford either--you can't afford the premium to buy into a Medicare Advantage plan or the premium for supplemental--you really are exposed to some big bills. We desperately need legislation in Congress to eliminate that problem. But it's not a new problem. I mean, in this country, people who are low-income wind up having to make bad deals all the time. If you're low-income, you wind up buying cheap cars that break down on you on your way to work. I'd like to say to everybody, don't buy cheap cars that break down on the way to work. Buy one that that functions. I'd like to say to everybody, don't go naked. Don't

go without some kind of supplemental coverage, either supplemental coverage and traditional Medicare or Medicare Advantage. If for some reason, Medicare Advantage is your only option, I don't know why it would be, by all means enroll in Medicare Advantage as opposed to going without some kind of supplemental coverage. It's just way too risky.

Steve Skrovan: That's what Dr. Hyde told us too. And I guess one of the problems is, is that Medicare itself, because it's been sort of put together/things have been added to it over the years, is a very complicated thing in and of itself. Would you agree with that?

Kip Sullivan: I wouldn't. I don't think the traditional Medicare program is complicated. I just think it's insufficient. We shouldn't ma making people buy supplemental coverage, but it's the closest thing we have to universal health insurance in this country. The problem is that Republicans and Democrats for the last 50 years have been persuaded that somehow Medicare would save money if insurance companies were stuck in the middle. People need to remember this. The reason we passed Medicare in 1965 is the health insurance industry didn't want the elderly, right? They didn't want the poor. And so how the heck is it that they're falling all over themselves paying Joe Namath to advertise like crazy that we need insurance companies in Medicare? Answer: We're blowing enormous amounts of money on these insurance companies. They're overpaid and they use the money to offer slightly lower premiums and a few extra services and to pay Joe Namath to blabber at us all day long in the fall.

Steve Skrovan: Well, thank you once again, Kip Sullivan, for responding to our listeners. We hope that's satisfying to our listeners. Keep those comments and questions coming,

Kip Sullivan: And thank you for having me and thank you for the questions. I'm glad we had a chance to talk about them.

Steve Skrovan: I want to thank our guests again, Doctors James Kahn and Fred Hyde, plus healthcare consultant Kip Sullivan. For those of you listening on the radio, that's our show. For you, podcast listeners, go to our Substack page at ralphnaderradiohour.com for bonus material we call “The Wrap Up.” A transcript of this program will appear on the *Ralph Nader Radio Hour* website soon after the episode's posted.

David Feldman: Subscribe to us on our *Ralph Nader Radio Hour* YouTube channel. And for Ralph's weekly column, it’s free, go to nader.org. For more from Russell Mokhiber, go to corporatecrimereporter.com.

Steve Skrovan: The American Museum of Tort Law has gone virtual. Go to tortmuseum.org to explore the exhibit, take a virtual tour, and learn about iconic tort cases from history.

David Feldman: To order your copy of the *Capitol Hill Citizen “Democracy Dies in Broad Daylight,”* go to capitolhillcitizen.com. The producers of the *Ralph Nader Radio Hour* are Jimmy Lee Wirt and Matthew Marran. Our executive producer is Alan Minsky.

Steve Skrovan: Our theme music, *Stand Up, Rise Up*, was written and performed by Kemp Harris. Our proofreader is Elisabeth Solomon. Our associate producer is Hannah Feldman. Our social media manager is Steven Wendt.

David Feldman: Join us next week on the *Ralph Nader Radio Hour*. Thank you, Ralph.

Ralph Nader: Thank you, everybody.