US Medicare “open enrollment” period highlights attacks on health care

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The Medicare open enrollment period in the US, which runs from October 15 through December 7, is the time when current Medicare recipients—including retirees and others over the age of 65—can change the plans through which they receive benefits.

Many, especially outside the US, may be under the misapprehension that, while the for-profit US health care system is a scandal that leaves millions uninsured and with inadequate medical care, at least retirees enjoy good coverage under the system that was denounced as “socialized medicine” when it was enacted in 1965.

That is definitely not the case, however. What began as a limited reform—although far from socialized medicine—has been increasingly undermined in recent decades. In particular, so-called Medicare Advantage plans, administered by private insurers, have led to the semi-privatization of original Medicare. These plans, now covering about 16 million of the 54 million Medicare beneficiaries, are supposedly regulated by the federal Centers for Medicare and Medicaid Services (CMS). In fact, the profit interests of such giant insurers as Blue Cross Blue Shield, Aetna and others often lead to problems for patients and their families.

Much attention has correctly been focused on cutbacks in Medicare spending that will especially affect future beneficiaries. At the same time, current recipients have also felt the impact of the continuing attempts to cut funding and privatize Medicare. Retirees face increasing difficulty in finding doctors who will treat Medicare patients. And many patients, even when they do find doctors, deal with indifference and inadequate care.

As the *New York Times* reported last month, federal officials have been forced to admit that many if not most of privatized Medicare plans were guilty of “noncompliance” with Medicare regulations. In more than half of audits recently conducted by the CMS, denials of coverage were not adequately or accurately explained. In 61 percent of the audits, prescription drug claims were incorrectly rejected.

Capital BlueCross, operating in Pennsylvania, was faulted for delays and denials in providing prescription drugs, as well as denials of payment for emergency services. CalOptima, in Orange County, California, was found to have committed numerous violations, in its case especially affecting poorer beneficiaries.

These were only some examples of the errors and malpractice found by auditors. At the same time, however, the civil penalties imposed on the billion dollar insurers were no more than a slap on the wrist. Aetna, for instance, received penalties of about $500,000, while Tufts Health Plan in Massachusetts, accused of eight “serious violations,” paid a penalty of $137,000. These and other insurers professed agreement with criticisms and said problems had been or were being corrected. Clearly penalties of even half a million dollars amount to no more than the cost of doing business for firms dealing with hundreds of thousands of Medicare recipients.

The first step for those turning 65 is to choose how they will receive their Medicare benefits. Monthly deductions, currently about $105, are taken from their Social Security benefits for Medicare Part B, covering medical as opposed to hospital insurance. Each year they are confronted with the decision of whether they will remain with their current plan or choose another. Some go online to compare various plans, others ask family or friends for recommendations, and some go to brokers licensed by the CMS for advice.

Medicare Advantage plans had their origin in the 1980s, and their role was significantly expanded after legislation in 1997. In addition, in 2003, during the

Bush administration, bipartisan legislation led to prescription drug coverage, in what was another boondoggle for the private insurers and the massive pharmaceutical companies.

In the guise of providing expanded coverage for hard-pressed senior citizens, this new plan, Part D of the Medicare program, funneled millions of new customers to the big drug firms. This is typical of the kind of "public-private partnerships" that have come to dominate the health care system in the US, with public money going to enrich for-profit insurers, hospitals and pharmaceutical businesses.

The cost of prescription drugs, like that of other medical services under Medicare, is only partially covered. In most but not all cases working people are protected from financial catastrophe, but remain liable for hundreds if not thousands of dollars in bills in the form of co-payments and other costs.

Denials of coverage and delays in payments are only part of the story. As the end of the current calendar year approaches, and with it arrival of the open enrollment period for Medicare, beneficiaries are receiving phone calls and letters informing them of increased co-payments that will be due next year. In many cases one or more of a beneficiary's doctors are being dropped from the approved network of providers in the HMO (health maintenance organization) plans, and drastic increases in the cost of prescription drugs, including generic drugs, are also being imposed.

In recent years, as certain drugs such as statins, used for the lowering of cholesterol, have lost patent protection, the prices of the generic alternatives have soared. In one example, for instance, a Medicare Advantage plan in New York announced it was increasing the cost to the patient of a 90-day supply of a popular generic drug for the treatment of peripheral neuropathy from $18 to $120. Many co-payments for generic drugs have doubled or tripled, at the very least.

Medicare recipients enroll in the various Advantage plans, which generally have low or in some cases zero monthly premiums in addition to the uniform Part B premium, because they seek protection from unforeseen bills, with Medicare covering on average only about 50 percent of medical charges. For additional protection they can consider various supplemental plans, but these will cost them an additional $2,000-$3,000 annually, if not more.

The task of wading through the various private Medicare plans and comparing costs and benefits can consume much of the time between mid-October and early December, the open enrollment period. Many retirees, living on fixed incomes and already having to cut spending even for necessities, find it difficult to navigate the book-length government Medicare handbook and other publications, as well as online sources.

Defenders of health care for profit, Democrat and Republican alike, often point to alleged bureaucratic waste and mismanagement in any government system. The reality is that the alleged magic of the market translates into far more waste. The private insurers send out a veritable blizzard of often repetitive and unnecessary monthly statements to beneficiaries.

Those who have already paid into the Medicare system are forced, in an effort to lower their out-of-pocket costs, to shop around among plans whose differences are often difficult to understand. Health care for older Americans is not treated as a basic social right. It has in effect already been divided into three or more tiers, with the wealthy of course bypassing the waits, inadequate treatment and various indignities of Medicare.