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10 Things Medicare Won't Tell You

The government's massive entitlement program is full of costly glitches.

By CATEY HILL

1. "We fork over millions for unproven procedures."

Medicare spends millions of dollars each year on treatments that many medical experts deem unnecessary. One example: Digital mammograms. These are often more expensive than traditional mammograms but not necessarily better for older women. A five-year clinical trial conducted by the National Cancer Institute found that digital mammograms were no more effective in finding cancers in women 50 and older than traditional mammograms. But the number of digital mammograms that Medicare paid for has risen from 426,000 in 2003 to nearly 6 million in 2008 -- a jump that increased the cost of breast cancer screening by more than $350 million, according to an analysis by The Center for Public Integrity, a nonprofit investigative news organization.

Medicare also often pays significantly more for liquid-based cytology, a screen for cervical cancer, than it does for routine pap smears, even though a large 2009 study found that the expensive test is no more effective than the traditional procedure when it comes to detecting cancer. Using the newer, more expnsive test costs Medicare an extra $90 million since 2003, according to The Center for Public Integrity. Another point of contention is that Medicare pays for screening colonoscopies for people over 75 despite the fact that the United States Preventative Task Force "recommends against routine screening for colorectal cancer in adults age 76 to 85 years."

Medical experts argue that testing shouldn't always come down to cost. "One person's 'unnecessary' care is another person's necessary," says Joe Baker, president of the Medicare Rights Center. "Medicare pays for most tests or procedures that a doctor

orders." Still, there are many unnecessary procedures that Medicare pays for each year that are outside or clinical guidelines, some of which could be eliminated with better doctor and consumers education, he adds. A spokesman for the Center for Medicare and Medicaid Services (CMS) says that it "pays for services that are reasonable and necessary" though it does try to "provide physicians as much flexibility as possible in using their judgment to design a treatment plan that meets the patient's needs."

2. "Think Social Security is broke? Just look at Medicare."

With the debate raging over the astronomical cost of entitlement programs, experts say it's easy to forget that Medicare and Social Security are two different programs with different financial strains. In the short-term, at least some parts of Medicare are worse off than Social Security, according to a 2011 report by the Social Security Administration. The report concludes that the Medicare Hospital Insurance Fund or Medicare Part A, which pays for hospital insurance, "faces a more immediate funding shortfall" because it is projected to run out of money in 2024, compared to 2036 for Social Security. (Note that Medicare Part B and Part D, although expensive, "remain adequately financed into the indefinite future because current law automatically provides financing each year to meet the next year's expected costs," the report says.)

It's easy to see why Medicare is in such bad shape, experts say. Consider an average couple, both earning an average $43,500 per year. Upon retiring in 2011, they would have paid $119,000 in Medicare payroll taxes during their careers, but they can expect to receive medical services worth $357,000, according to an analysis by the Urban Institute, a research institute that educates Americans on social and economic issues. What the average person puts into Social Security versus what he or she gets out is more balanced. The same couple would have paid $598,000 in Social Security taxes and received an estimated $556,000 in benefits.

The picture doesn't look much better going forward. In 2010, Medicare costs represented 3.6% of gross domestic product for the United States. That number is expected to jump to 5.6% in 2035 and 6.2% in 2085 -- the result of "continuing growth in the volume and intensity of services provided per beneficiary," according to the CMS, the government agency that administers Medicare.

Baby boomers are a big part of that growth. In the last year alone, more than 7,000 boomers turned 65 every single day a total of 2.5 million in 2011, according to AARP. It's this rapid aging of the boomer population that contributes to the fact that the Medicare-eligible population will more than double by 2050, according to projections from the Census Bureau. A spokesman for CMS says that thanks to the Affordable Care Act --

which was signed into law last year and designed to make health care more affordable and expansive for Americans and hold insurers accountable -- CMS is "implementing many initiatives that will help reduce long-term costs while improving the quality of care that a patient receives."

3. "We pay for dead people."

It's not just for the living. In 2010, the Center for Medicare and Medicaid Services paid more than $3.6 million for Medicare Part D (the prescription drug benefit) to deceased beneficiaries, according to testimony from Daniel Levinson, the inspector general of the U.S. Department of Health & Human Services. Between 2004 and 2008, CMS paid for 142,000 procedures at 2,119 hospitals or clinics on nearly 5,000 dead patients, at a cost of roughly $33 million, according to an analysis by PearlDiver, a medical database management company. In 2008, the Senate Permanent Subcommittee on Investigations found that Medicare had paid tens of millions of dollars to suppliers who were using the identification numbers of dead doctors when filing claims. The total amount paid for these claims is estimated to be between $60 million and $92 million, according to the subcommittee report.

What's going on here? Sometimes it's fraud -- the doctor, hospital, medical group or supplier knowingly uses a deceased person or doctor's identification number -- and sometimes it's a mistake, experts say. However, it's usually clerical error on the part of Medicare that they actually pay these claims, says Ben Young, president of PearlDiver. "It's hard for [CMS] to manage its large database effectively."

A May 2011 report from the Office of the Inspector General regarding the $3.6 million in improper Part D payments comes to a similar conclusion: "CMS's systems categorized these enrollees as alive or as having different dates of death than those listed in the SSA death master file," the report says. This happened because "its systems did not always identify and prevent improper payments."

With regards to the $3.6 million in payments to dead beneficiaries, a spokesman for CMS says the organization has now "recouped the entire amount of improper payments." In addition, it says that it "has installed modifications to its data systems to further reduce the likelihood of improper payments."

4. "Don't expect a five-star plan."

Medicare's Five-Star Quality Rating System is designed to rank Medicare sold by private insurers. Often called Medicare Advantage plans, these policies offer Medicare Part A (hospital insurance) and Part B (medical insurance) coverage and sometimes extras like

vision and dental coverage. They also often come with prescription drug coverage, or Medicare Part D. The star system is designed to recognize the best private policies with five stars. You can switch to a five-star plan at any time during the year.

But that's if you can find one of these policies in your area. "There are not a lot of these to choose from," says Adrienne Muralidharan, the senior Medicare specialist at Allsup, a site that provides Medicare resources. In fact, as of Nov. 30, five-star Medicare Advantage plans were available in just 10 states, according to an analysis by Allsup. The reason: It's hard to earn five stars. Plans are graded on several counts including customer service, how many doctors are in your network and prescription drug coverage.

A spokesman for CMS offers a similar explanation saying that "achieving a 5-star rating is Medicare's highest mark of excellence, and can only be obtained by those plans that are truly providing the highest quality care to beneficiaries."

Despite that fact that there aren't many five star plans now, Medicare is now creating new incentives and systems to increase the number of higher rated plans, says Baker of the Medicare Rights Center. "You see how consumers flock to cars that Consumer Reports rates highly," he says. "The expectation is that will happen in the Medicare Advantage market as well."

5. "We're not popular with many doctors."

Many doctors limit the number of Medicare patients they will treat, according to a new study. Roughly one in five physicians across all disciplines restrict the number of Medicare patients they will take on at a given time, according to a 2010 study by the American Medical Association. For primary care physicians, this number jumps to 31%.

These doctors often restrict the number of Medicare patients they will accept because they feel Medicare payment rates are too low (85% of overall physicians and 83% of primary care physicians, according to the study) and that the "ongoing threat of future payment cuts makes Medicare an unreliable payer" (78% and 82%, respectively), the AMA study showed. "A lot of doctors are just sick of hearing about these rate cuts," says Muralidharan. "They figure it's not worth it."

But despite the restrictions, Baker points out that most doctors do take Medicare. Typically doctors who won't accept Medicare are concentrated in specialties like neurology. And, they are often located in urban areas like New York and San Francisco, where a large number of consumers can afford to pay medical bills out of pocket. "Some doctors leave, but it's often the same doctors who stop taking insurance entirely," Baker says. "We

haven't seen a significant number of doctors across the board stop taking Medicare entirely." A spokesperson for CMS says that "the number of doctors currently participating in the Medicare program is at an all-time high."

6. "We get ripped off a lot."

Last year, the Centers for Medicare and Medicaid Service saw "improper payments" for Medicare totaling $47.9 billion, according to testimony by Daniel R. Levinson, the inspector general of the U.S. Department of Health and Human Services. True many of these mistakes are due to clerical snafus such as eligibility errors and miscoded claims. But there is a growing body of evidence that shows fraud is a major contributor. The National Health Care Anti-Fraud Association estimates that at least 3 percent of the total spending on health care -- or more than $60 billion each year -- is lost to fraud. "Although it is not possible to measure precisely the extent of fraud in Medicare and Medicaid, everywhere it looks the Office of the Inspector General continues to find fraud against these programs," Levinson said in his testimony.

Medicare fraud takes many forms. Some of the most common include health-care providers manipulating payment codes to inflate reimbursement amounts or to bill for unnecessary or never-performed services. One of the costliest Medicare rip-offs involves pharmaceutical or medical technology companies "knowingly selling unsafe or ineffective pharmaceuticals, medical equipment, devices and other technologies," says Ken Nolan, a partner at Nolan & Auerbach, a health-care fraud law firm with offices in three states. "Medicare is susceptible to fraud not only because of its size and complexity, but because the system itself makes it easy to defraud the government," says Nolan. "Most of the scrutiny, if any, is made after payment is made -- not before as in traditional business transactions."

A spokesman from CMS says that the "Administration is doing a great deal to fight fraud and errors" and notes that this week the Department of Justice announced that it has recovered more than $2.9 billion from health-care fraud.

7. "We don't cover a lot of the care seniors need most."

If your aging mother needs full-time care in a nursing home or a significant amount of home health care, she will have to meet some strict criteria to make it happen. For the most part, Medicare doesn't pay for nursing home care except for people who were hospitalized for at least three days within the previous 30 days and require "skilled" care, which is care that only a medical professional like a registered nurse could provide. Even then, it only covers up to 100 days per benefit period.

Qualifying to get reimbursement for home health care is also difficult, as you must meet all of following criteria: Be homebound (which means that a doctor has advised you not to leave home due to your condition, that leaving home takes considerable effort or you need help like special transportation to leave home); require skilled nursing care, physical therapy, speech-language pathology services or continued occupation therapy; and be getting regular services from your doctor under a plan of care that he or she has ordered. Medicare does not cover meals delivered to a home, cleaning and laundry services or, in most cases, personal care like help bathing, dressing and using the bathroom. "A lot of people don't realize it but these kinds of care are very limited," says Muralidharan. A spokesperson for CMS notes that the organization wants to engage with members of Congress, aging/disabled community members and experts to "explore solutions to the nation's long term care needs."

This gap in Medicare coverage can be financially devastating for many families. The average nursing home, for example, costs about $77,000 per year, according to a study by the MetLife Mature Market Institute. Home health care is also expensive, with rates ranging from about $17 to almost $30 per hour, according to the American Association for Long-Term Care Insurance, significantly more for a trained nurse or therapist.

8. "Paws off that cash, grandpa: Your settlement is ours."

Let's say something goes terrible wrong, you sue your doctor for malpractice and you win. Don't go counting the money just yet. If Medicare paid some of your doctor bills, it has a claim against any damages for expenses, says Joan Robert, a partner at elder law firm Kassoff, Robert & Lerner. (Medicare only gets money for what it paid, not a percentage of punitive damages, she says.) A spokesperson for CMS says that claims are handled in this manner "in order to protect the Medicare trust funds when other sources of payment are available."

Most people don't realize this is the way it works, says Robert. What's more, Medicare often doesn't collect its share of a payout until months or even years later, Baker says. At that point, many people have already spent that money on other things. To prevent this, "ask your lawyers to build this into what they're asking for in the settlement and make sure your lawyer understands the Medicare recovery process," Baker says.

9. "Complain all you want ..."

The Center of Medicare and Medicaid Services is supposed to notify the group that that accredits hospitals, typically the Joint Commission, of all complaints they receive concerning hospitals. But according to an October 2011 report by the Office of the Inspector General, CMS rarely does so. CMS regional offices notified accreditors of only

28 of the 88 sampled complaints against hospitals," according to the report. That's fewer than one third. The lack of reporting "compromises Medicare's quality oversight system," says the Office of the Inspector General.

Non action also impedes the ability of accreditors to respond to complaints that may be related to adverse events or other problems at hospitals they oversee, the report says. "This in turn can deprive overseers important information when deciding whether to renew a hospital's accreditation." Bottom line: If the accreditors don't know about all of the complaints that a hospital receives, they may continue approve a facility where significant errors occur. A spokesperson for CMS says that they are now "clarifying the existing policy for ROs [regional offices] and are working with them to enhance compliance."

10. "Want Your Way? Just ask."

When Medicare denies a claim, experts say often the recipient will simply pay out of pocket, even if they can't afford it. That's the wrong strategy. Oftentimes, it's better to appeal, says Judith Stein, the executive director of the Center for Medicare Advocacy. "People are denied Medicare like any other kind of insurance," she says. "Insurance wants your money and doesn't want to give it back." Only 1% to 2% of people with denied claims appeal, but of those that do, more than half either receive more care or get a higher payment, according to research from the Medicare Rights Center. "If you appeal, you may very well get your claim approved," says Stein.

Filing an appeal is oftentimes pretty easy, experts say. For those who have original Medicare, they only need to fill out a Redetermination Request Form, and send it to their Medicare administrator within 120 days of the date of getting their Medicare Summary Notice (the form that Medicare sends when it pays or denies a claim). Those in a Medicare plan administered by private organizations need to read the materials the plan sends you each year to learn how to appeal. Another strategy, say advisers: Call the plan directly for this information. You may also want to contact your doctor's billing staff for help with your appeal. A spokesman for CMS notes that when a denied claim in appealed, in 44% of the cases those denials were overturned.

Corrections & Amplifications

An earlier version of the story said that people could switch to a five-star Medicare plan through February 14th. You can actually switch at any time during the year. See more here.

NEXT

2. "Think Social Security is broke? Just look at Medicare."

FINANCIAL GLOSSARY

Words used in this article: SSA, gross domestic product, CMS, Part B, management company