This document tells the truth as best we can determine based on what insurance companies reveal to the public. PNHP-WV and other like-minded organizations (a few examples are at the bottom of our About page on this website) have mined publications from insurance companies and the Federal government in our effort to know what the truth is. Disclaimer: Sometimes we come to the wrong conclusion. If you detect an error below, please bring it to our attention by emailing us at PNHP.WV@gmail.com. Together we can investigate the source, and, if we are wrong, we will correct our reporting.

What is an organism that derives its nutrition from another species without giving anything in return? The answer is, of course, a parasite. The United States healthcare system is parasitic. For-profit insurance, and others in the healthcare industry, are parasites feeding off the suffering of our population.

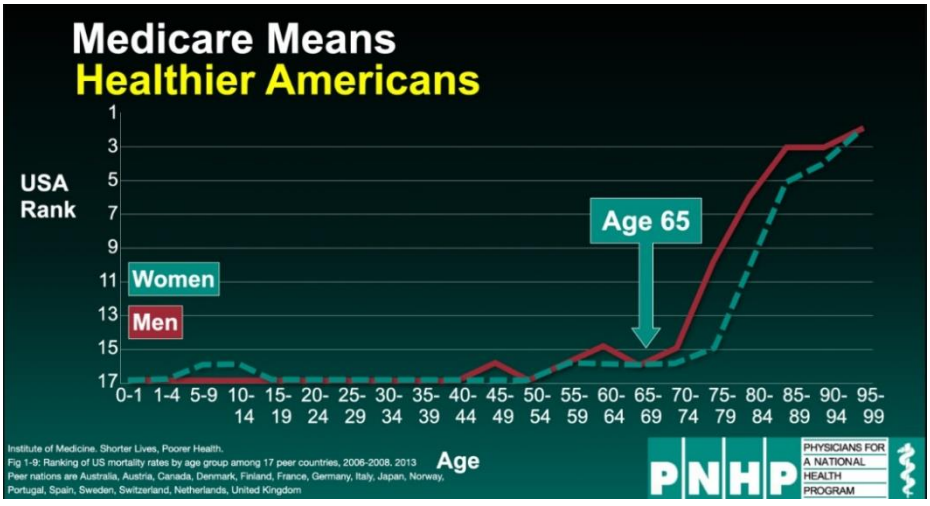
It is well documented that all wealthy countries, except Germany, spend less than half as much per person on health care than our country. Germany is slightly over half as much, but still far less than the amount paid by the United States.

How about the quality of health care in these other nations? How does the US quality of health care stack up against other nations in a word?

Not well according to healthcare indices such as longevity, infant mortality, and maternal mortality. The US does not even score in the top 10! The only area where the US consistently scores well is in innovation, but what good does it do to have all these high-tech solutions if patients cannot afford them and if health insurance refuses to pay for them.

Even though the United States spends more on health care, $5 trillion each year, than any other nation, our quality indicators are poor. We do not even rank in the top ten! What is the United States doing with all that money?

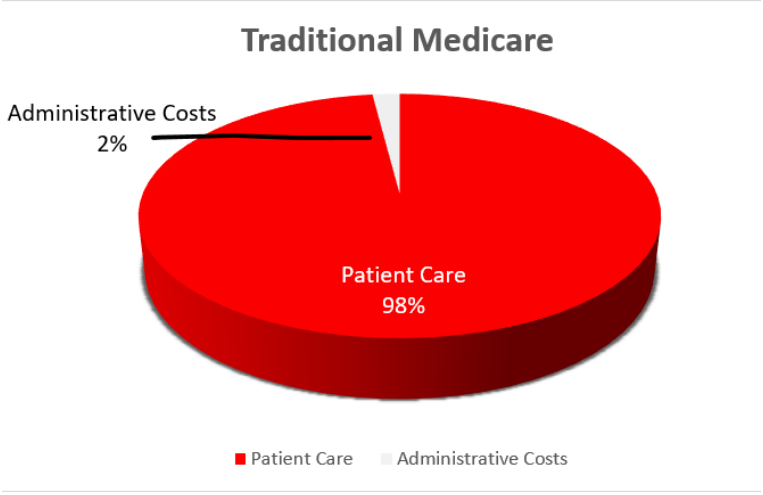
Let's compare Traditional Medicare versus Medicare Advantage to illustrate how our for-profit system is eating senior health funding.



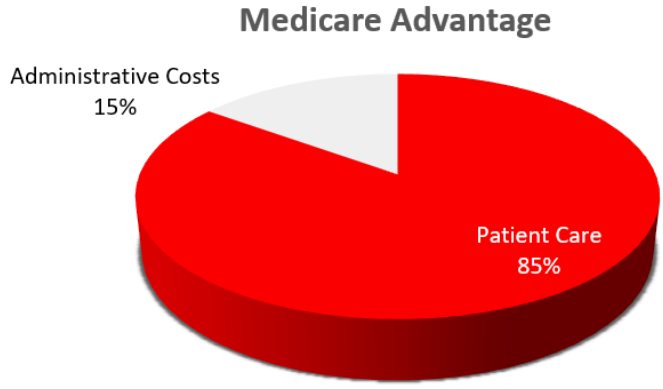
Traditional Medicare, run by the Federal government, was signed into law in 1995 by President Lyndon Johnson. Initially it consisted of two parts: Part A, covering hospital and nursing care, and Part B, covering outpatient and preventative health care, such as doctor visits, screenings and vaccinations, and some medical equipment. From a public health standpoint, it was a great success because it demonstrably improved the health of seniors aged 65 and over when they became eligible for health care coverage for the first time. (see above chart)

Medicare Advantage plans under Part C, run by for-profit insurance companies by Traditional Medicare, was signed into law by President George W. Bush in 2023. Medicare Advantage is not a great success and, indeed, is under scrutiny by Federal government for various allegations including **fraudulently extracting money from the Medicare Trust Fund**.

Traditional Medicare is a taxation-based system. Almost all Medicare dollars are used for patient care. Conversely, Medicare Advantage plans are for-profit companies—the public is blocked from viewing their ledgers.



This pie chart shows how much of each Traditional Medicare healthcare dollar is spent on patient care ($0.98) and on administrative overhead ($0.02).



The second pie chart shows how much of each health care dollar given to Medicare Advantage is spent on patient care ($0.85) and on administrative overhead ($0.15).

We know that much of the 15% administration costs are millions and tens of million dollars used to pay exorbitant salaries to CEOs and upper-level management, and pay dividends to stockholders. As substantial as those costs are, they are not the primary cause of Medicare Advantage plan's high administrative costs.

To keep their jobs and bloated salaries, and to keep stockholders happy Medicare Advantage insurance companies have devised ways to withhold treatment to increase profits. Pre-authorization is a tool to keep what Medicare pays for themselves by delaying or denying authorization for treatment, especially expensive treatment. Too many times a patient dies before an authorization is issued.

Other ways include up-coding (deeming patients more ill than they are equals more from Medicare), cherry picking (only accepting people in good health to join the plan), and lemon-dropping (refusing to renew policies for those that are too expensive).

Physicians who have worked in busy emergency rooms, or staffed a busy ward, or even worked in busy doctor's offices know about pre-authorization requirements. In each of these, additional staff is necessary to handle just pre-authorizations for lab work-ups, imagining studies, and referrals to specialists. They deal with questions such as, "Is this specialist to whom the patient is being referred currently with the panel of specialists mandated by each individual patient's insurance? Translation: Is the specialist within the patient's insurer network? With endless waits on the phone, the staff tries to work efficiently to no avail. It is common for non-medical staff members hanging on the phone for 20 to 30 minutes on a single call.

Does that bureaucracy result in better health care? Surely you jest! The costs saved by denying pre-authorizations means more money available to those 'other' administrative costs.

Unfortunately, Traditional Medicare has strayed from its beginning program. Seniors now incur co-pays and deductibles for care without a cap to limit their out-of-pocket expenses. These costs mount up fast and too many leads to personal bankruptcies. In fact, there are one-half million personal bankruptcies triggered by health care bills every year in America. Few other developed nations saddle their citizens with substantial health care debt, much less actual bankruptcies. Why is the United States an exception? Because the way other wealthy countries finance health differs significantly from ours. Is it because our system is more high-tech than theirs and, as a result, leads to better outcomes but at a higher cost? The answer is 'NO'.

To help seniors cover copays and deductibles, Medicare introduced the Medicare Supplement program, also called Medigap. However, these plans regulated by Medicare, are marketed by the same for-profit insurance companies that are pushing seniors into Medicare Advantage insurance, and they are not required to accept those with pre-existing conditions. Furthermore, insurance agents working on commission tend to promote Medicare Advantage plans over GAP plans because the commissions are better.

Medicare predicts that half of seniors will choose Traditional Medicare during this enrollment period and the other half will choose Medicare Advantage, approximately two equal groups.

Each year, because of misleading advertising the number choosing Medicare Advantage plans has been increasing.

Yes, Traditional Medicare needs to be tuned up. We must start by getting for-profit insurance out of the health care business. No other industrialized nations insert for-profit companies into their healthcare systems; common sense told them it would not work and, by gosh, it doesn't. Just by doing that out-of-pocket expenses could be eliminated again.

Nevertheless, most experts agree that despite its flaws traditional Medicare plus a GAP policy gives patients better protection than Medicare Advantage, especially if the patient contracts a serious illness.

CONCLUSION:

Our point is that Traditional Medicare should be used as a model for providing Universal Healthcare, cradle to grave, for everyone in America, at less cost than Medicare Advantage by avoiding the 13% administrative giveaway, and at less cost to non-seniors who have private for-profit insurance. After all, what do CEOs and stockholders bring to our actual healthcare? NOTHING.

The United States must reform health care by legislation creating a Non-Profit, Single-Payer, Universal, cradle-to-grave coverage system!