

# **Privatizing Medicare:** *How Privatization Really Works and Why It is Happening!*

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**April 2022**

# **Introduction: The corporatization and financialization of American health care**

- Everywhere, hospital systems are purchasing medical practices, becoming multi-billion dollar corporate giants.**
- Private equity is taking over parts of the health care system.**
- In this context, the battle to protect Medicare has become the front line in the fight for the soul of American medicine.**

*That's why many physicians and others are pressing Congress and the Biden Administration to end the growing privatization of Medicare.*

# **Evidence-based Policymaking?**

- I will show that fee-for-service is not a problem, but attacking it is being used to take over public Medicare.**
- Physicians are taught to practice evidence-based medicine.**
- Government policy makers don't seem to believe they have to practice evidence-based policymaking.**
- The evidence shows their diagnosis of Medicare economics is wrong, and their treatment is harmful!**
- Their plans are allowing private capital to take over the Medicare program, regardless of the evidence...**

**Q. What do we mean by privatization?**

**A. Privatization occurs when access to care in a publicly-funded insurance program – like Medicare -- is controlled by a private entity which can make money by limiting access to care.**

**Q. Why is privatization occurring?**

**A. The federal government asserts that**

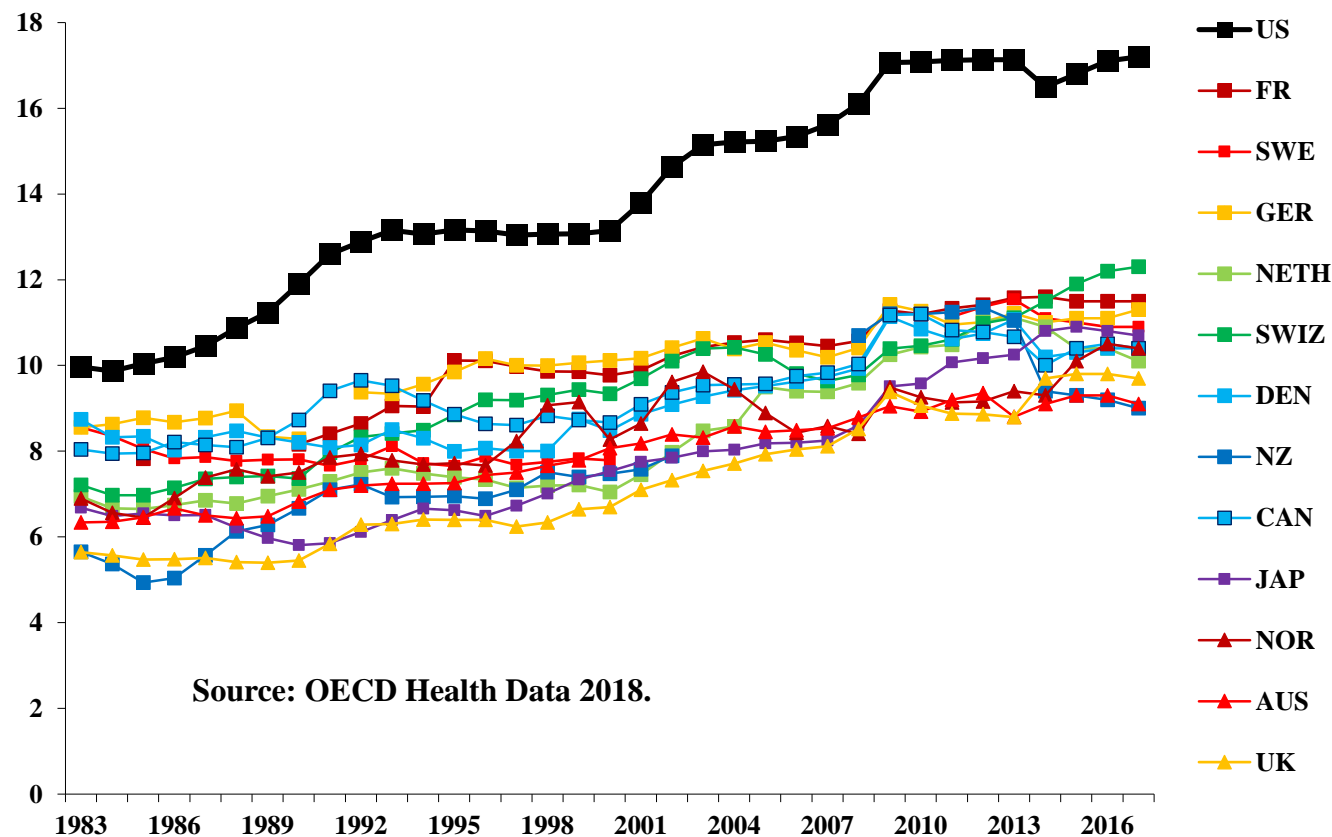
**(1) The fee-for-service system is responsible for the high cost of the US health care system, and**

**(2) Costs can be controlled through privatization and “alternate payment models” like capitation.**

# The US is the Exception!

Every other country covers all their residents and spends half what we do!

Percent GDP Health Care Spending as a Percentage of GDP, 1980–2017

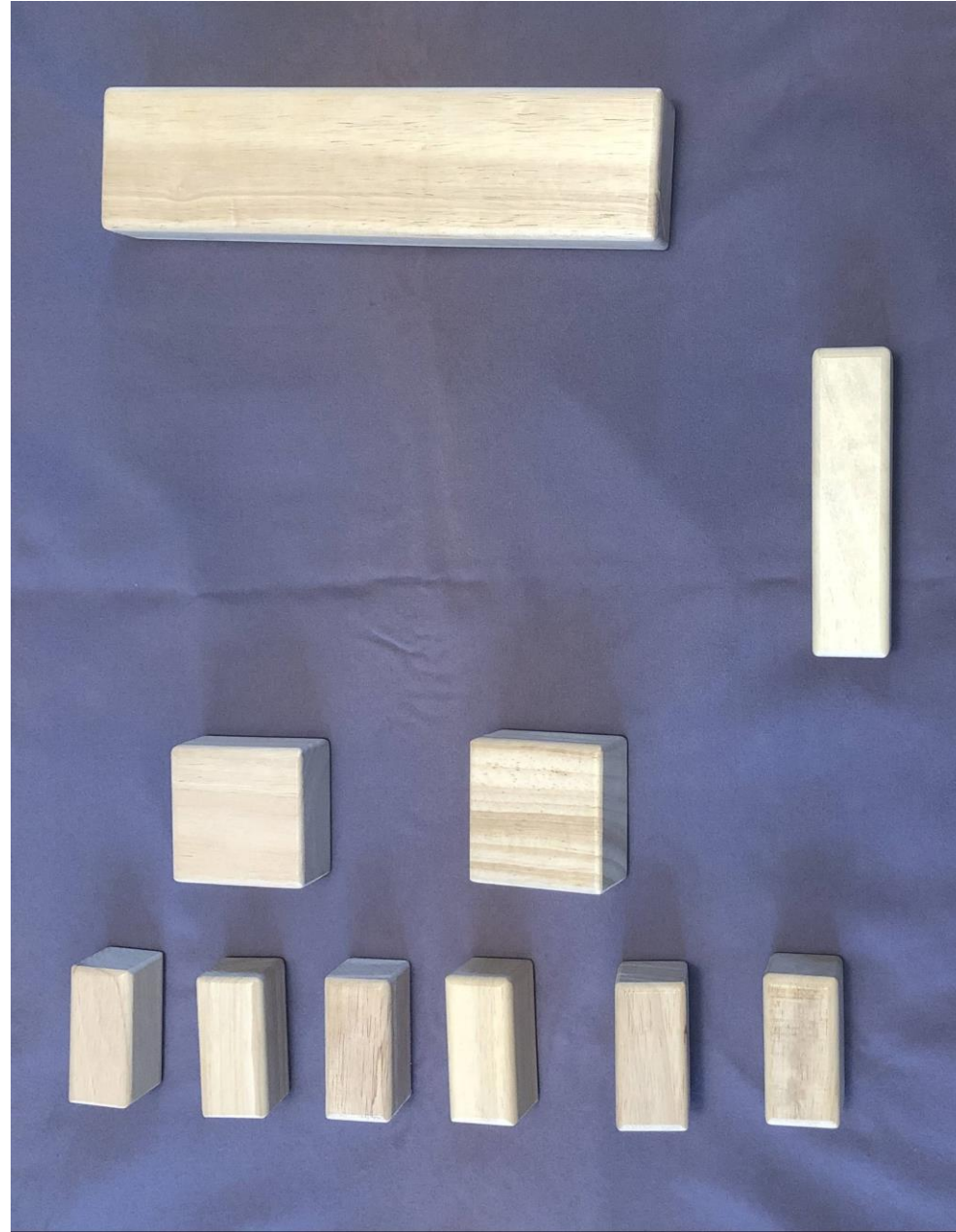


# **Evolution of US Health Insurance**

- 1930s-1940s — Employer-based hospital and medical insurance from a private non-profit company (Blue Cross)**
- 1950s — For-profit health insurance (Aetna, etc.)**
- 1965 — Medicare and Medicaid public insurance**
- 1985 — Private Medicare plans (paid 5% < public Medicare)**
- 2003 — Medicare Advantage plans (and Part D drug plans)**
- 2010 — Affordable Care Act (Obamacare)**

# Traditional Medicare

**Blocking out  
how Medicare  
works  
*It's child's play  
(children's  
blocks on an  
infant blanket)***



# Traditional Medicare

The payer  
(pays 80%) →

Medicare - CMS

← The supplemental insurer (They pay the extra 20%)

M  
e  
d  
i  
g  
a  
p

Primary care practice →

PCP

Spec &  
Hosp

← Specialists and Hospitals

Patients →

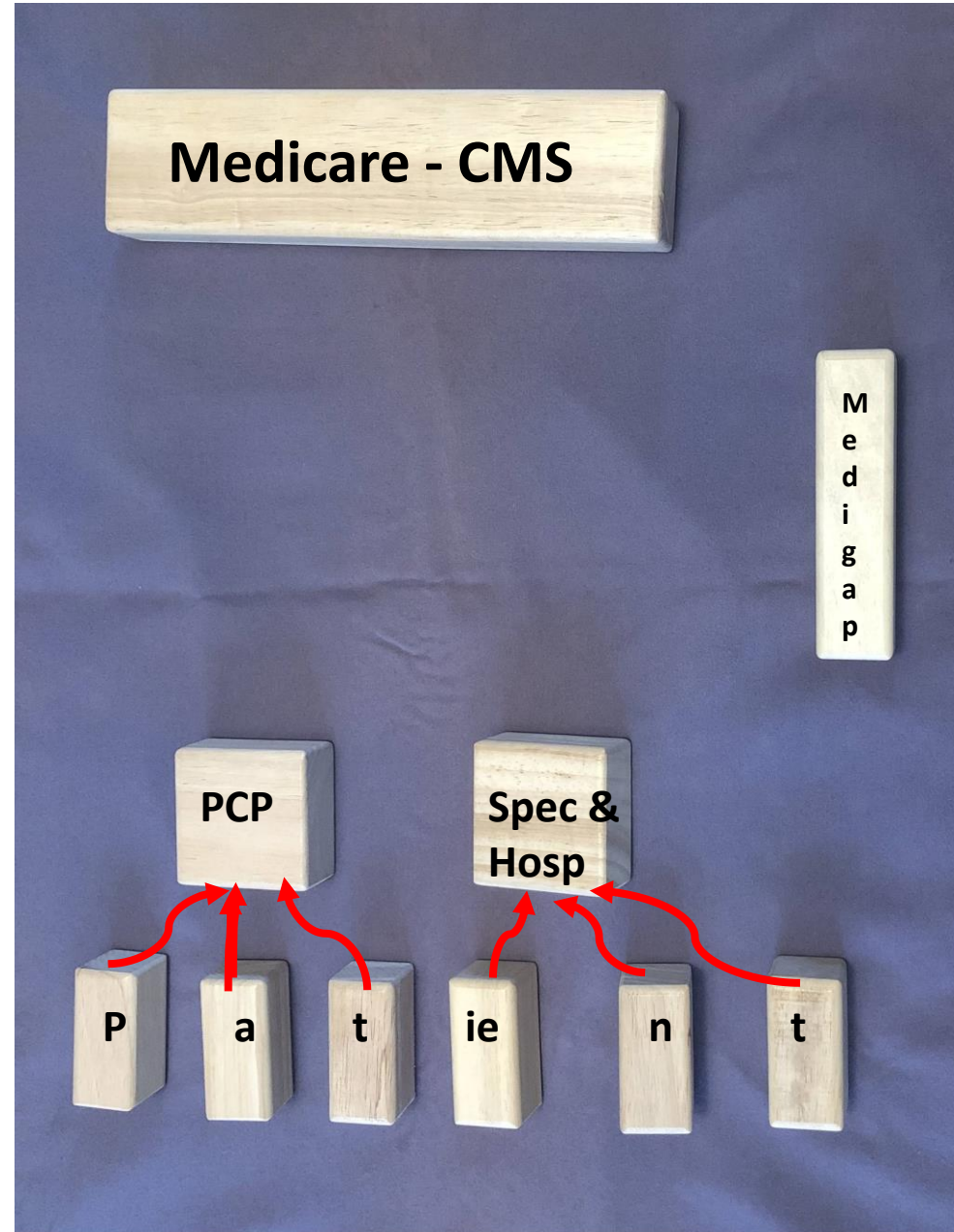
P a t i e n t

# Traditional Medicare

So how does Medicare work?

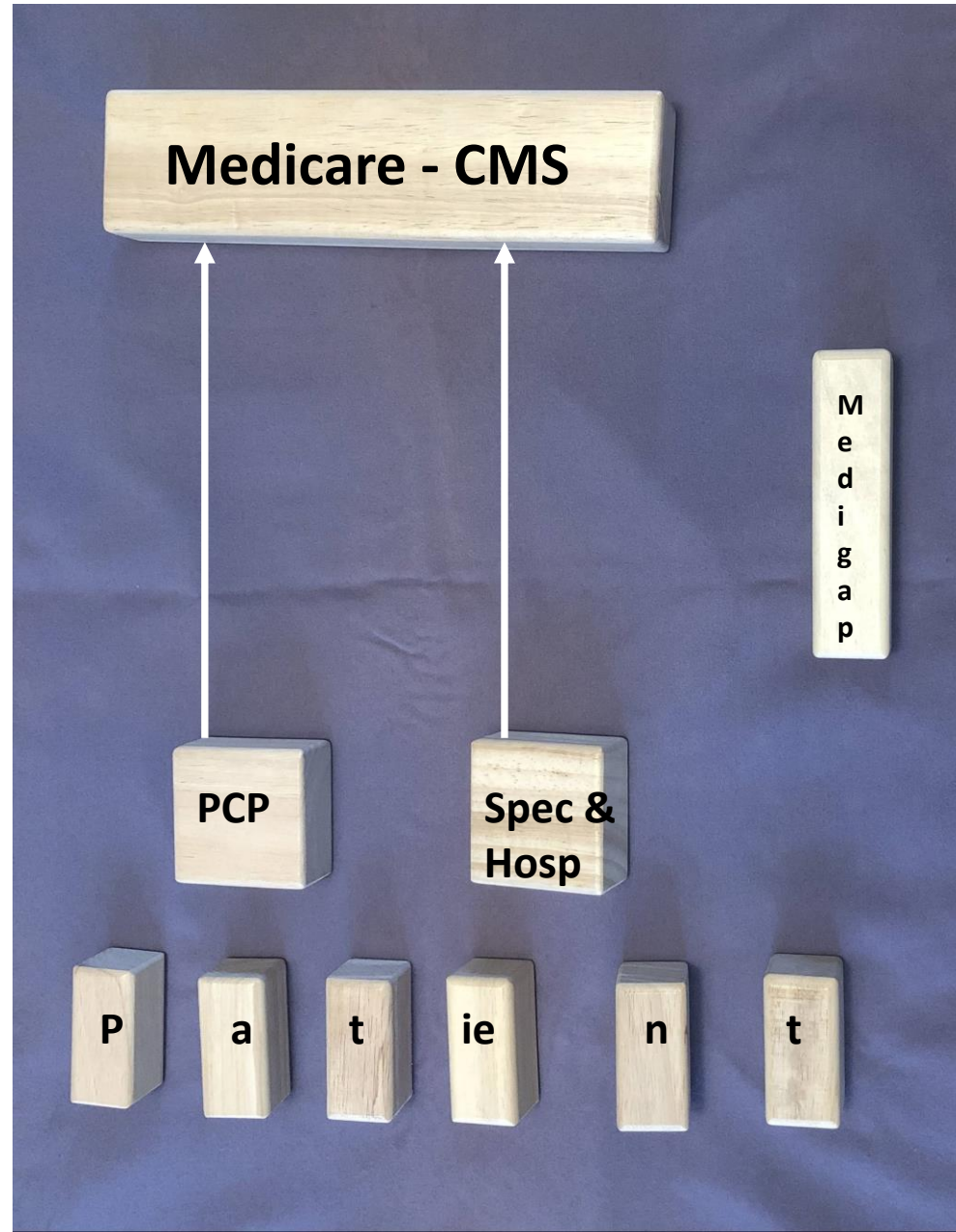
It uses a fee-for-service system.

Patients with illnesses see their doctors.



# Traditional Medicare

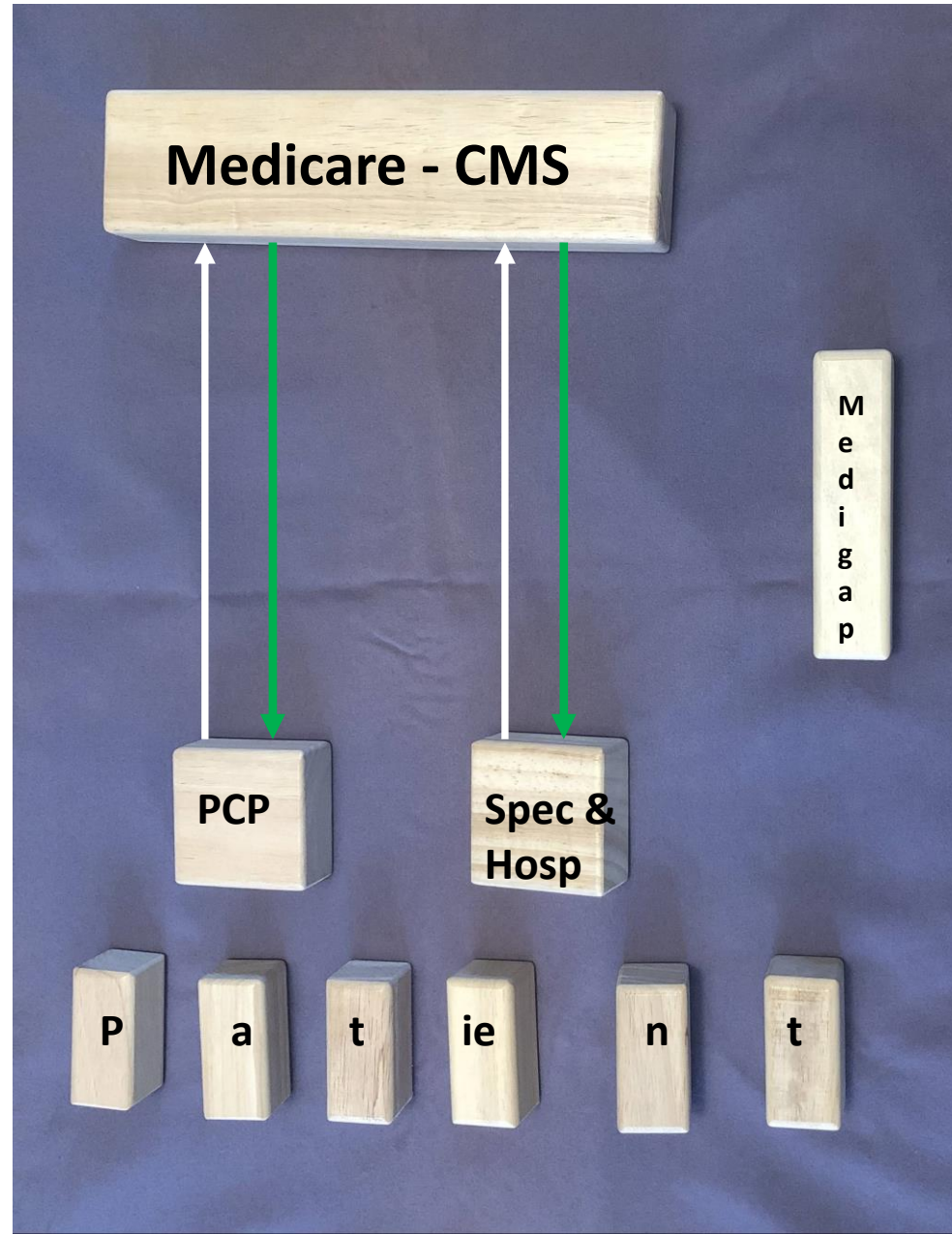
Doctors (and hospitals) file a claim with Medicare



# Traditional Medicare

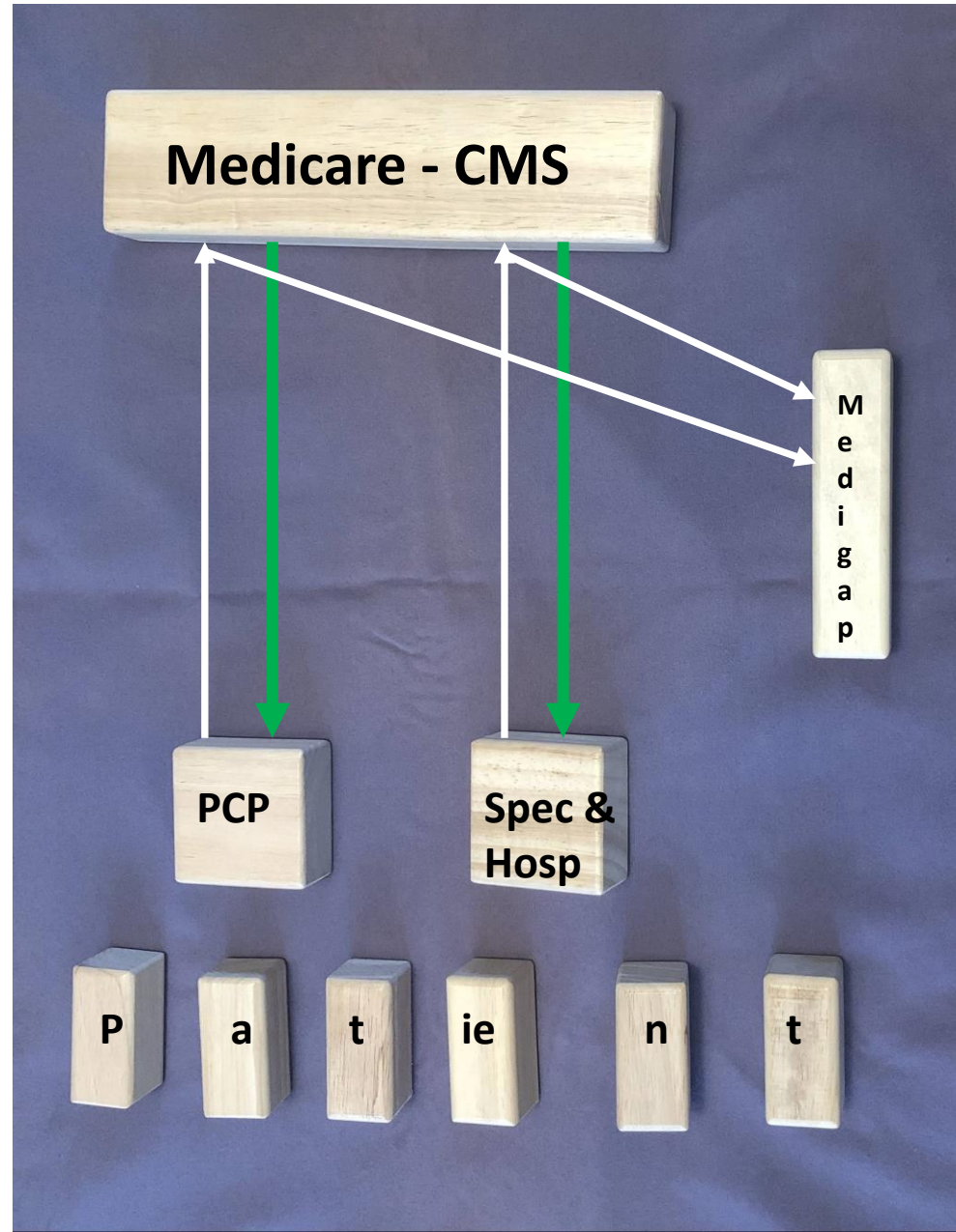
**Medicare pays  
80%\* of their bill.**

**\* This is somewhat  
simplified: there are  
deductibles, and hospital  
payments are more  
complicated.**



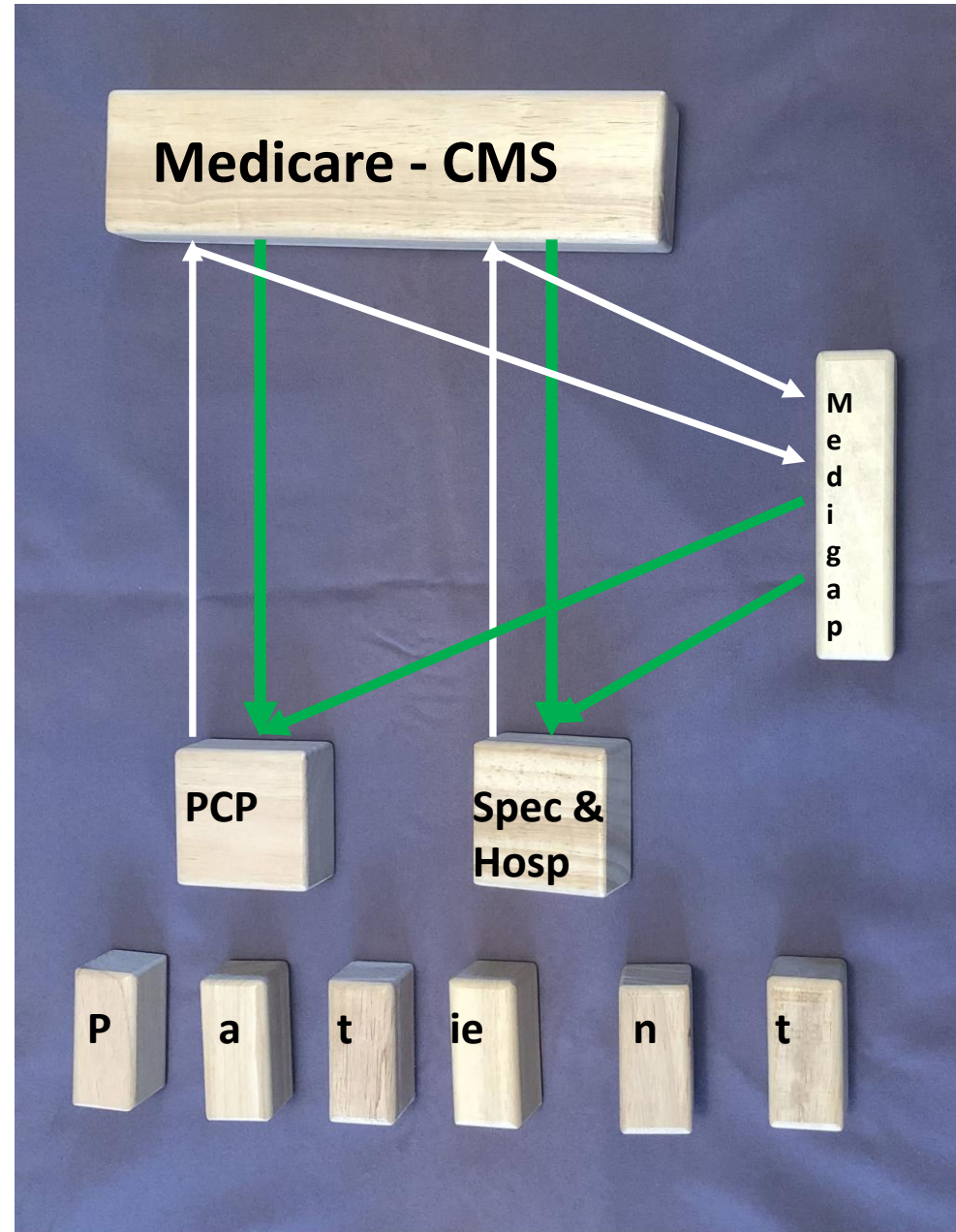
# Traditional Medicare

Medicare forwards the claim to the supplemental (secondary or Medigap) carrier, for those patients who have one.



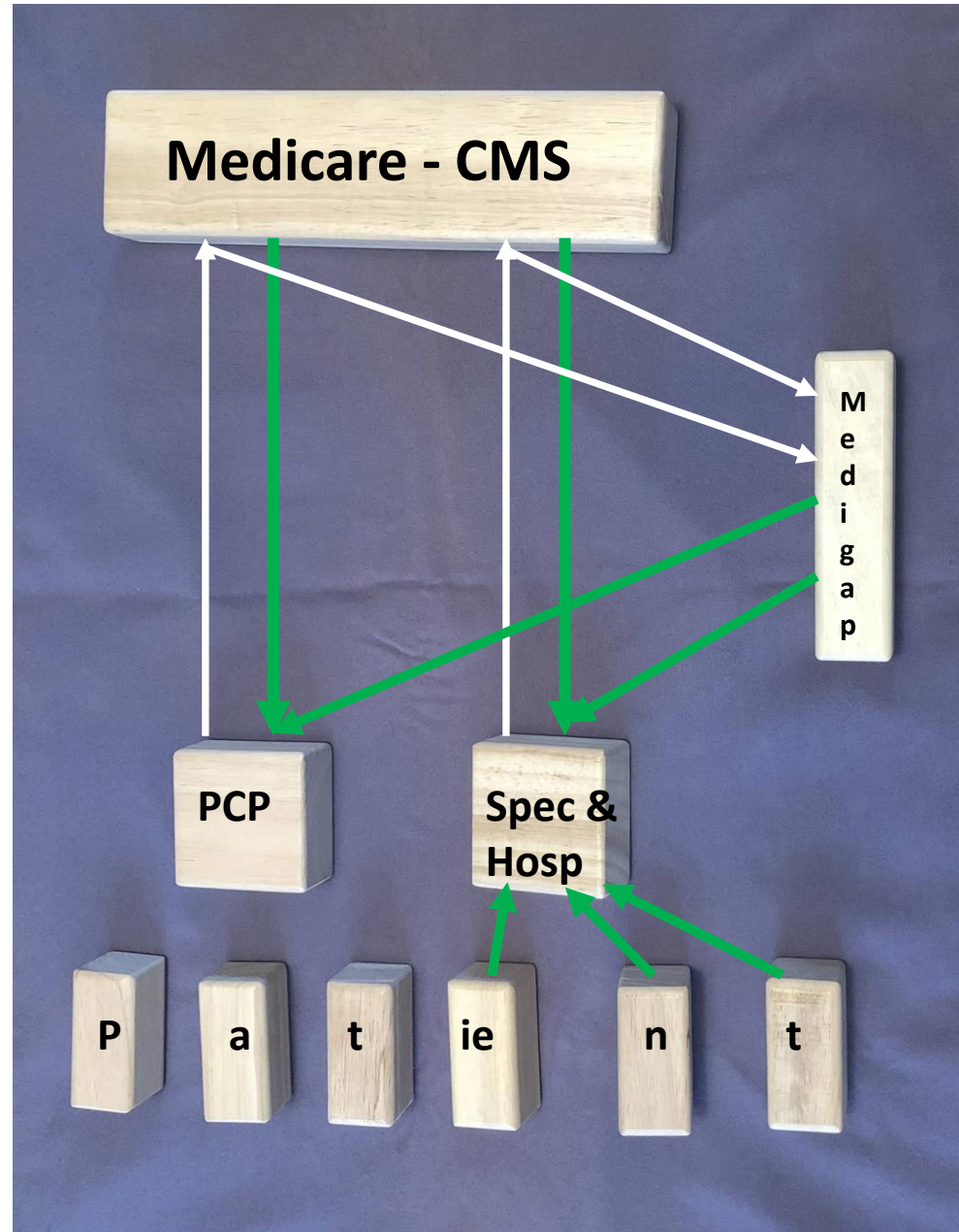
# Traditional Medicare

The secondary carrier pays the rest of the bill...

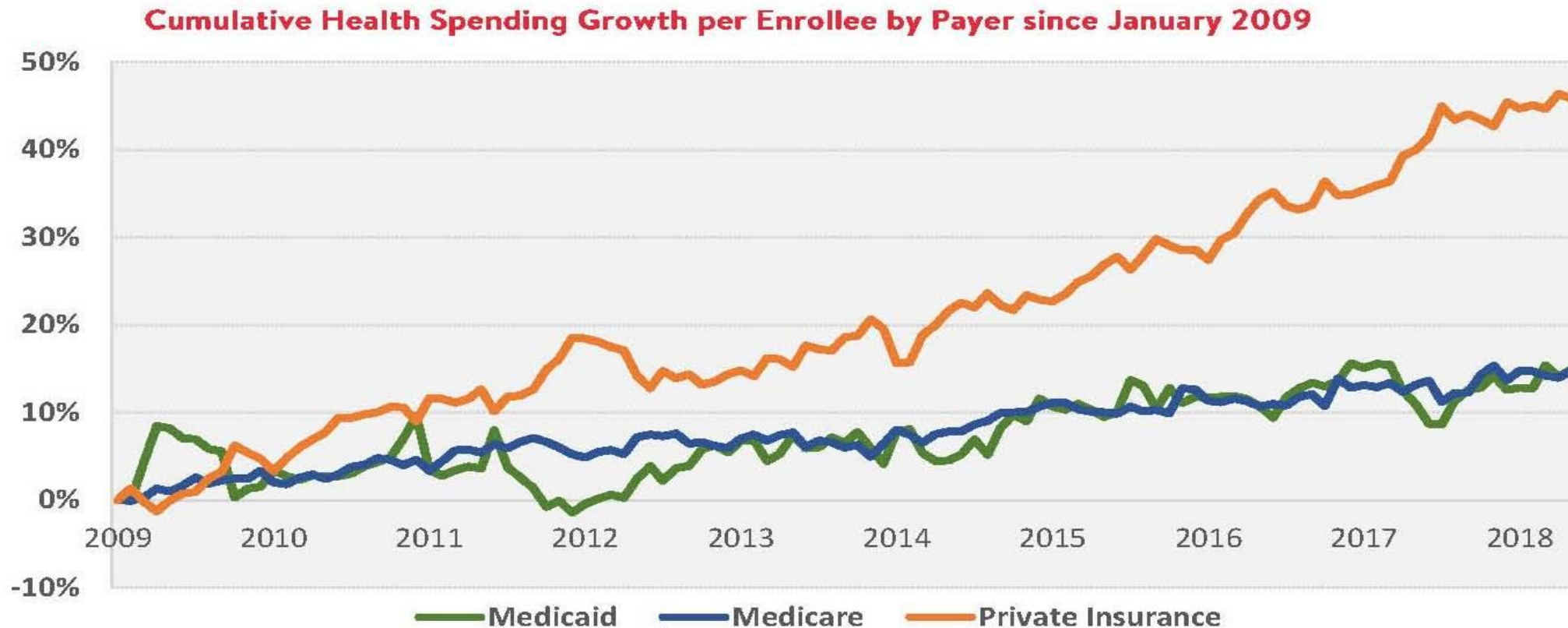


# Traditional Medicare

...except for what the patients may have to pay as copays.



# How is Medicare doing? Better than private insurance!



Source: "Growth in Spending on Privately Insurance Drives Much of US Health Spending Growth in 2017 and Early 2018", Altarum Institute, [https://altarum.org/sites/default/files/uploaded-related-files/Public Private Brief\\_final.pdf](https://altarum.org/sites/default/files/uploaded-related-files/Public%20Private%20Brief_final.pdf)

**Medicare sets reimbursement rates. Private insurance cannot.**

# The result is a huge discrepancy between what Medicare pays and what private insurers pay

## Private Health Plans in the U.S. Pay Hospitals 247% of What Medicare Would Pay

### FOR RELEASE

Friday

September 18, 2020

Prices paid to hospitals nationally during 2018 by privately insured patients averaged 247% of what Medicare would have paid, with wide variation in prices among states, according to a new RAND Corporation [study](#).

Some states (Arkansas, Michigan, and Rhode Island) had relative prices under 200% of Medicare, while other states (Florida, Tennessee, Alaska, West Virginia, and South Carolina) had relative prices that were above 325% of Medicare.

The study notes a steady increase in hospital prices, rising to the 2018 average level from an average of 224% of Medicare costs in 2016 and

### Media Resources

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### Researcher Spotlight

#### Christopher M. Whaley

Policy Researcher



Christopher Whaley is a policy researcher at the RAND Corporation and professor at the

# **There are many problems with Traditional Public Medicare**

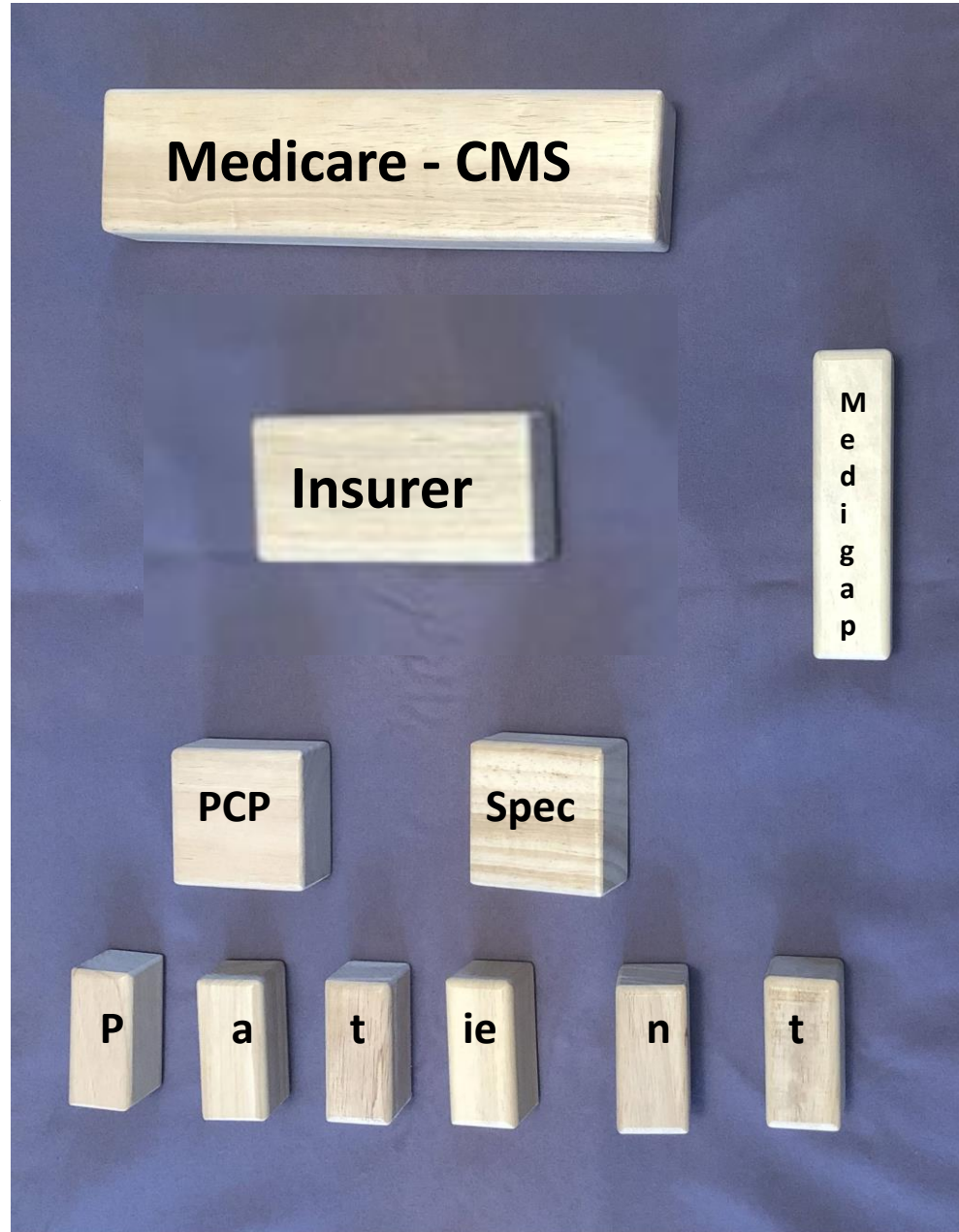
- It doesn't cover dental, hearing, or vision care.**
  - It has costly deductibles and copays.**
  - It has no limit on out-of-pocket expenses.**
  - As a result, the average Medicare recipient spends more than \$6,000 per year on health care.**
  - Since it only covers seniors, the inflation in non-Medicare (private) spending raises Medicare's costs.**
- This makes it vulnerable to attacks from the  
private sector.**

# Privatization: Step 1

**Under pressure to create a private alternative to Medicare, the Congress created a private insurance option which, in the 2003 legislation, it called *Medicare Advantage*.**

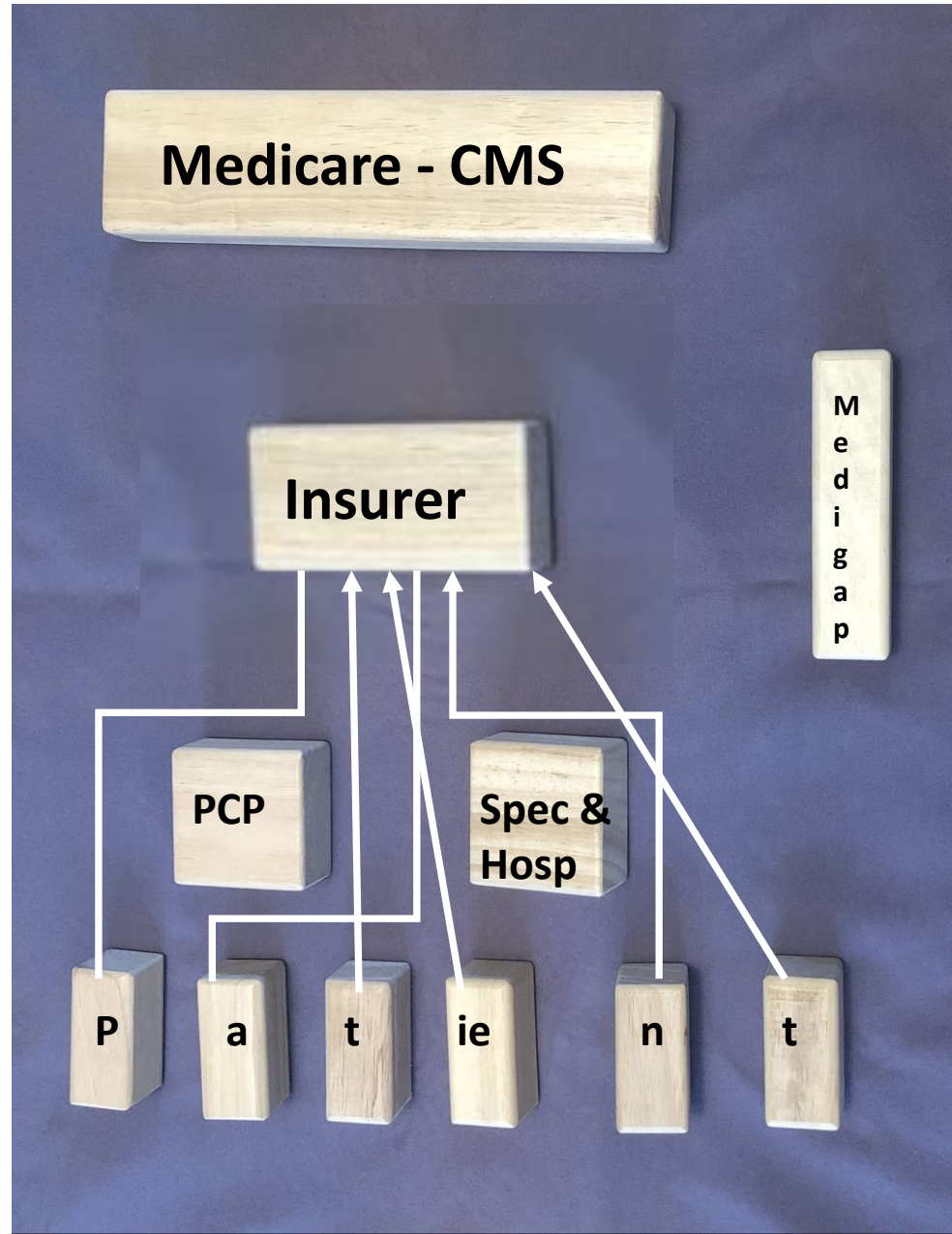
# Medicare Advantage

Private insurance company inserted in the middle, between Medicare and the doctors and their patients →



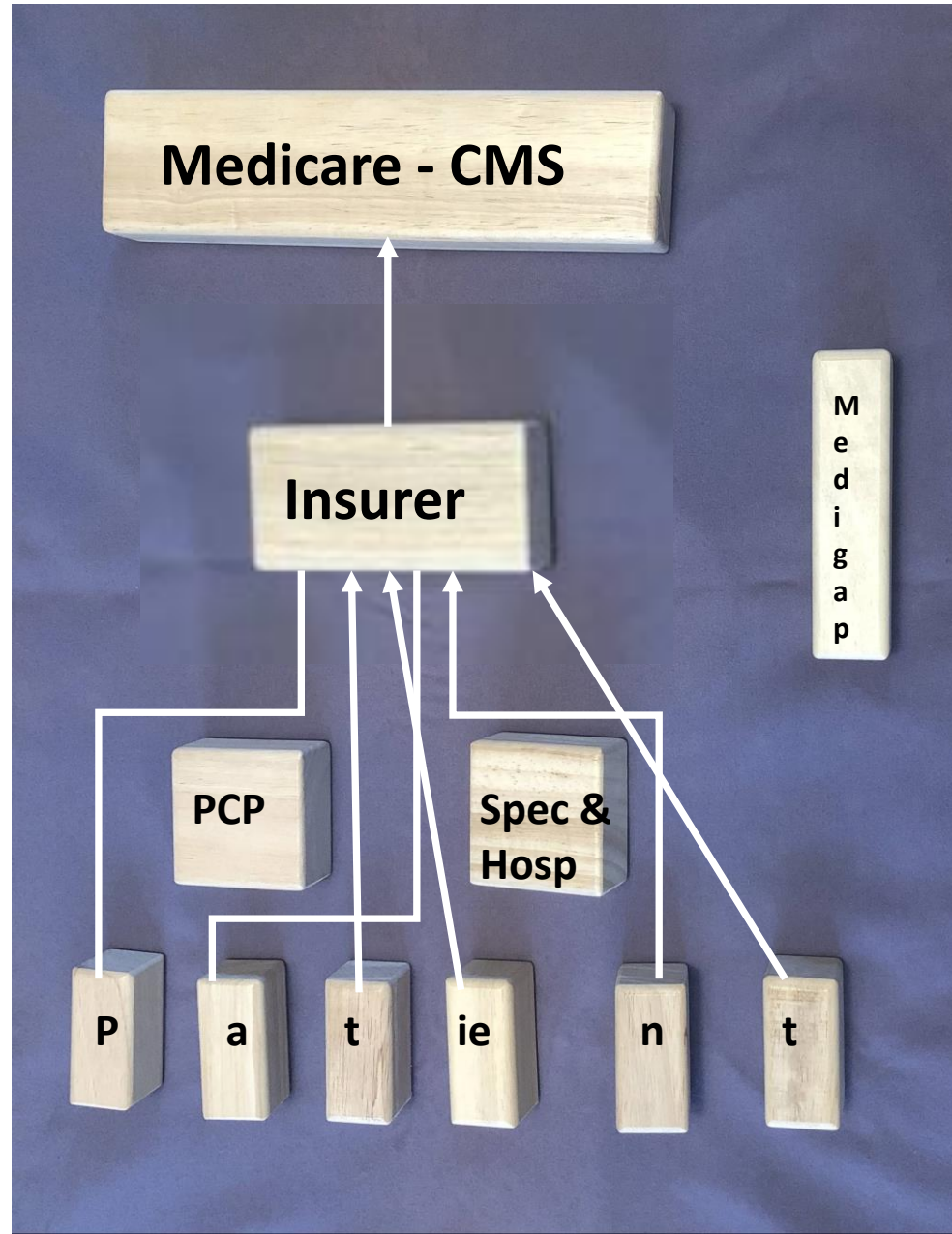
# Medicare Advantage

**Patients sign up with the insurer, believing it's a better deal than Traditional Medicare.**



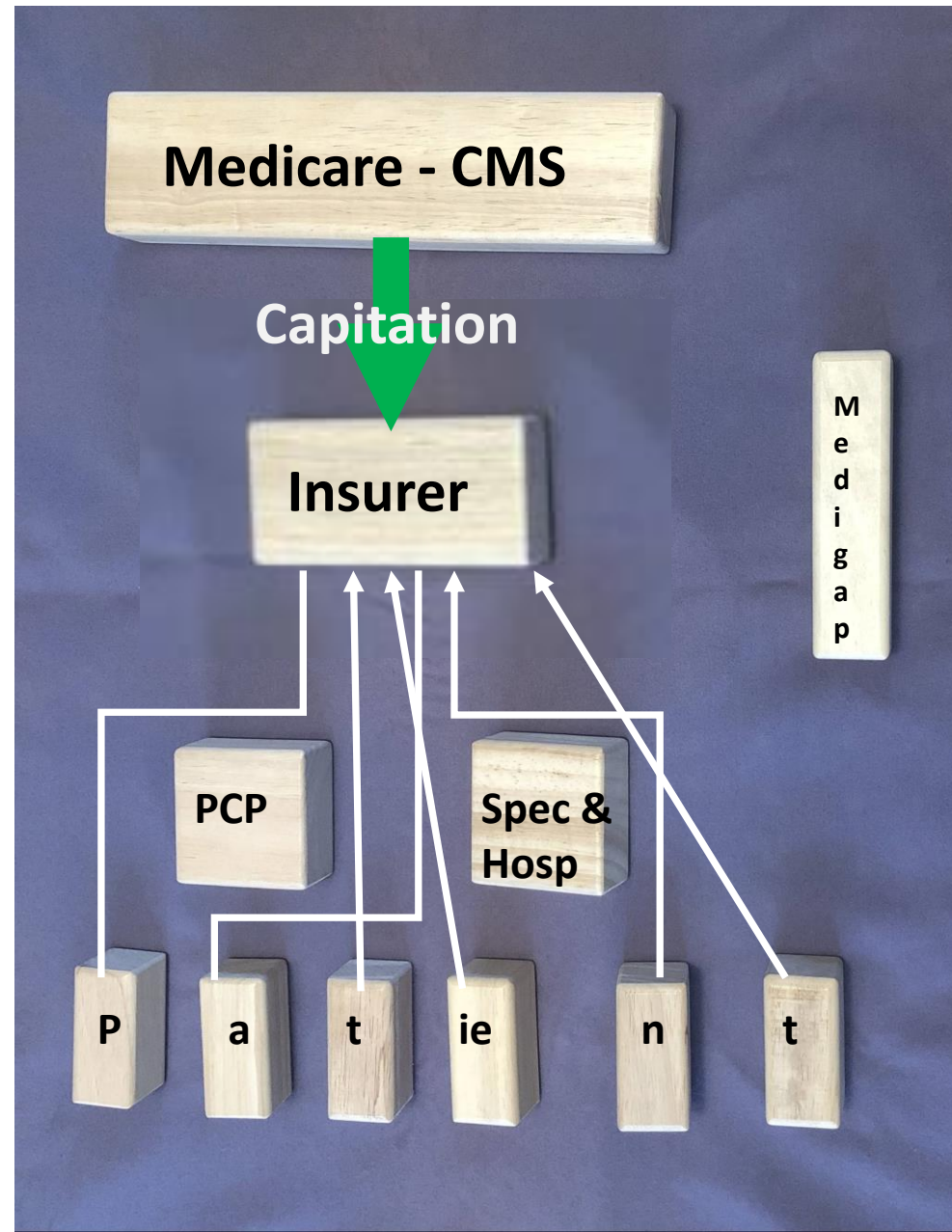
# Medicare Advantage

The insurer notifies Medicare of their new member.



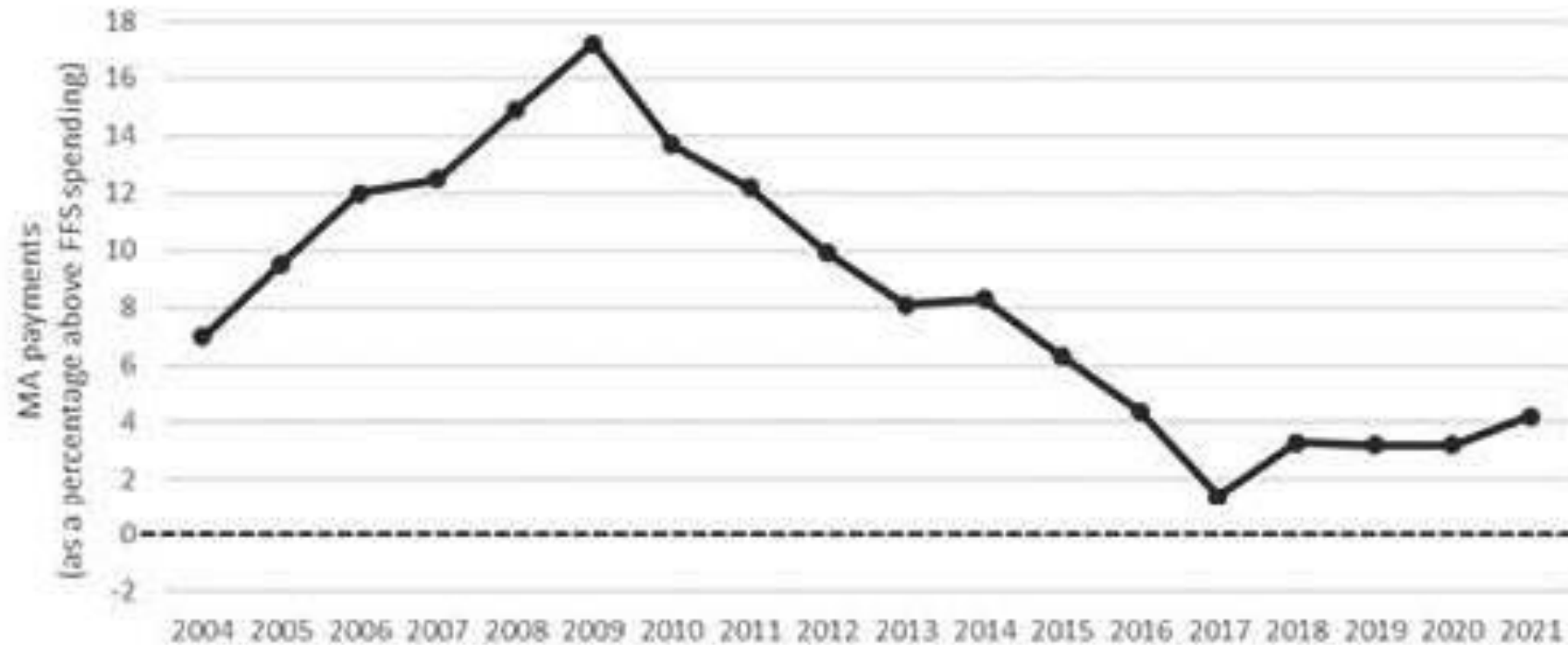
# Medicare Advantage

Medicare/CMS sends the insurer a monthly payment to cover the average member's costs.



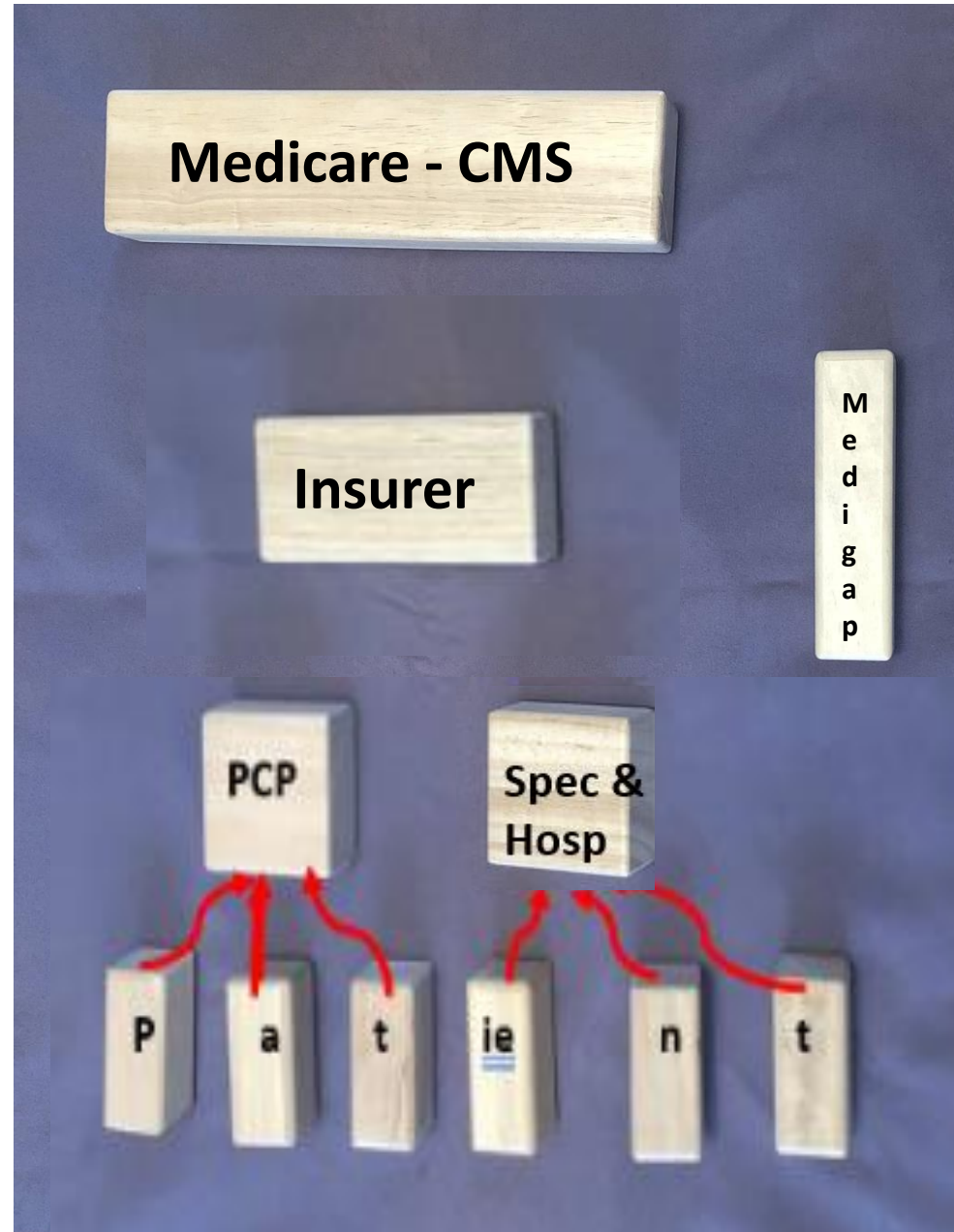
# Private Medicare Advantage costs Medicare more!

Figure 1. Medicare has paid more to MA plans than FFS Medicare spending would have been for the same enrollees, 2004–2021



Source: <https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/>

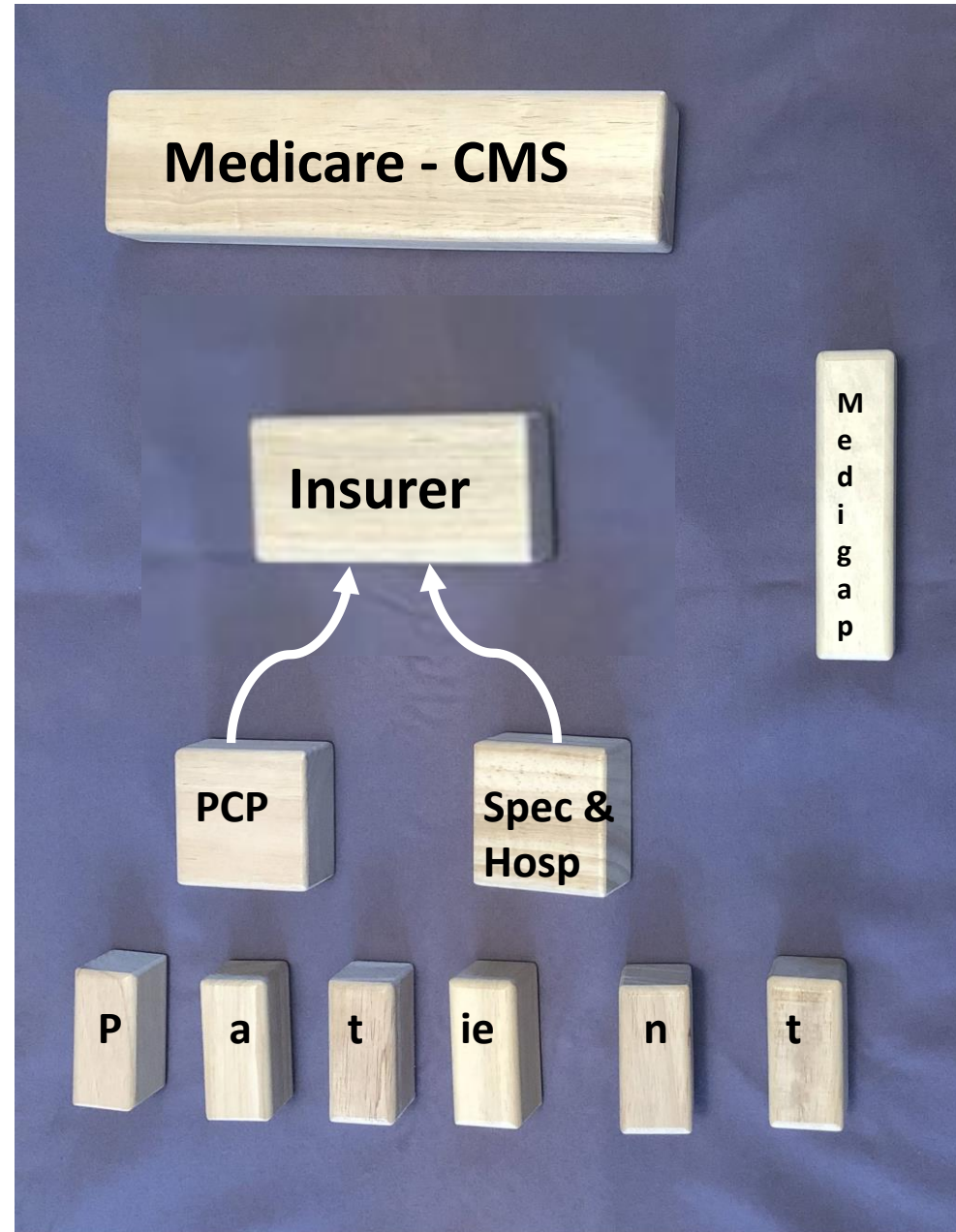
# Medicare Advantage



Now what happens when the patients with illnesses see their doctors?

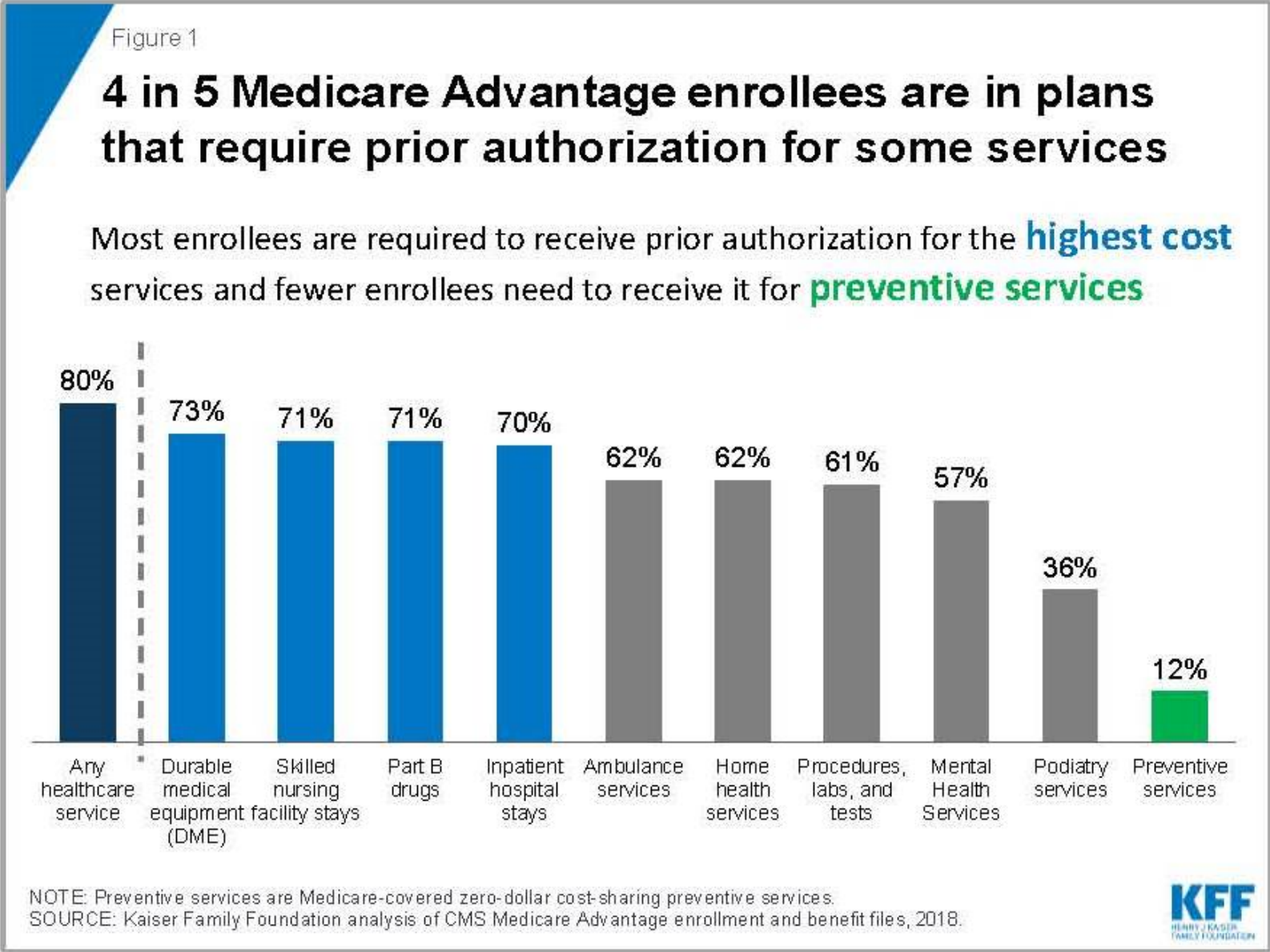
# Medicare Advantage

The doctors seek approval from the insurer for tests or treatments they want performed. This is required “prior authorization”. *This is how the insurers “manage care”!*



**Note: Traditional Medicare does not require prior authorization for any medical procedures. What the doctor orders gets done!**

# And such prior authorization is common in MA plans



# Here's prior authorization in NYC's MA Plus



Questions about prior authorization?  
Here's what you need to know.

## What does prior authorization mean?

Some types of care require your provider to get an approval from us before you receive care. This is called prior authorization.

## Why is prior authorization needed?

Prior authorization helps ensure you get proper care. It helps us work with your doctor to evaluate services for medical necessity before you receive treatment or services.

## What is medical necessity?

Medical necessity means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. We use medical

Your NYC Medicare Advantage Plus Plan will generally cover care as long as it is medically necessary and the service is included in your *Evidence of Coverage* and benefits charts.

## How do I know if I need prior authorization before I receive care?

It is the provider's responsibility to ask for prior authorization from Empire BlueCross BlueShield (Empire). **You aren't responsible for asking for it when you see a provider that accepts NYC Medicare Advantage Plus.** We've provided a list on the pages that follow of some common services to help you know when to ask.

## How long does it take for my prior

## Select outpatient services

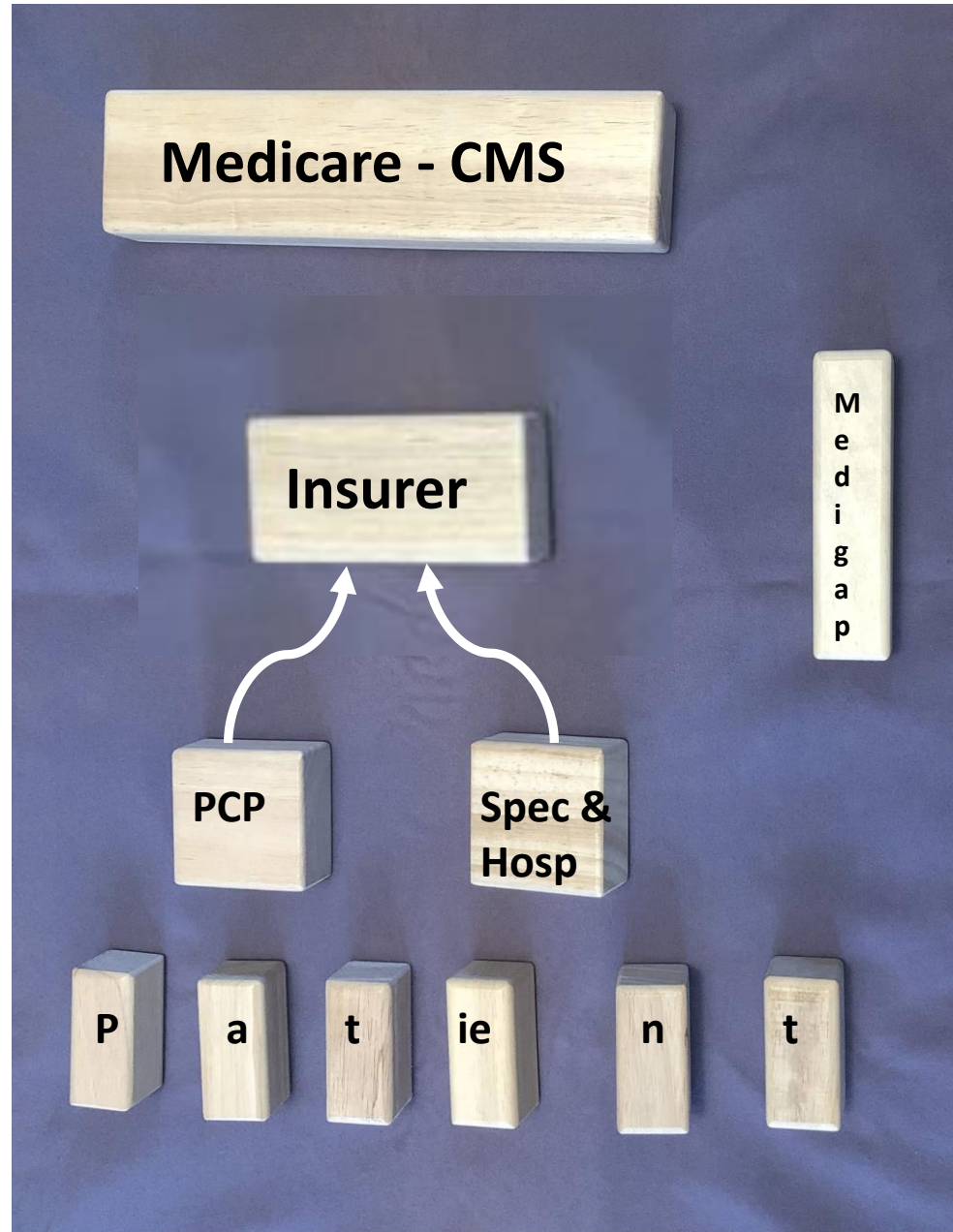
- Orthotics (performed primarily on ankle, back, foot, and knee)
- Elective inpatient surgery
- All potentially cosmetic surgeries
- Arthroscopies/arthroplasties
- Bariatric/gastric obesity surgery
- Breast reconstruction
- Cervical fusions
- Continuous glucose monitoring (CGM)
- Coronary artery bypass graft (CABG)
- Defibrillator/pacemaker insertion or replacement
- Genetic testing
- Endoscopies
- Epidermal growth factor receptor testing
- Home health
- Hyperbaric oxygen therapy
- Intracardiac electrophysiological studies (EPS) catheter ablation
- Knee and hip replacements
- Knee orthoses
- Laminectomies/laminotomies
- Laparoscopies
- Nerve destructions
- Nonemergency ground, air, and water transportation
- Occupational therapy
- Oncology (Breast), mRNA, gene expression profiling
- Pain management
- Physical therapy
- Sleep studies and sleep-study-related equipment and supplies
- Spinal orthoses
- Spinal procedures
- Tonsillectomy/adenoidectomy
- UPPP surgery (Uvulopalatopharyngoplasty - removal of excessive soft tissue in the back of the throat to relieve obstruction)
- Vascular angioplasty and stents
- Vascular embolization and occlusion services
- Vascular ultrasound

## Durable medical equipment (DME) and prosthetics

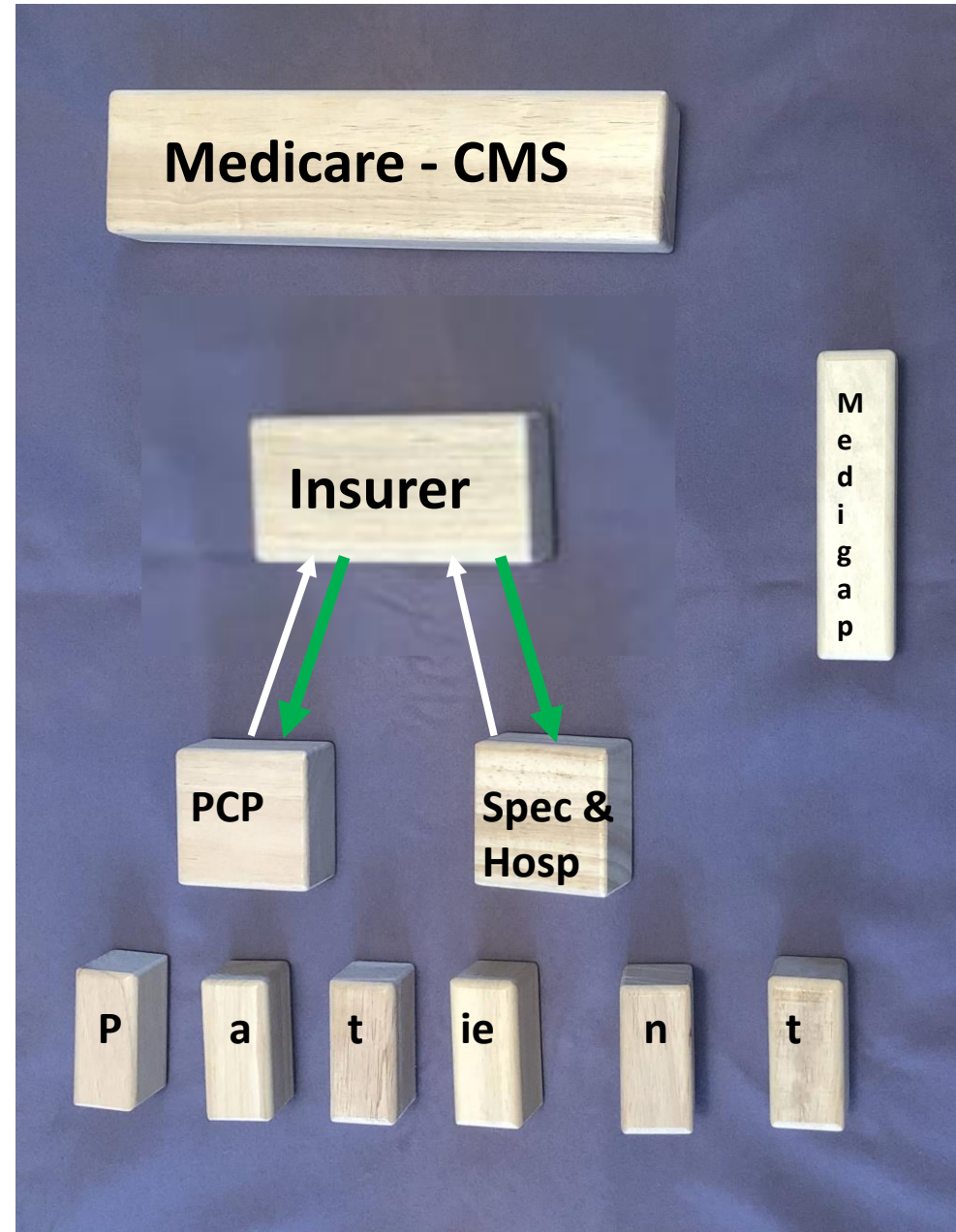
- Automated external defibrillators
- Bone stimulators
- Cochlear implants
- Cough assist (insufflator/exsufflator)
- High-frequency chest wall oscillator
- Insulin and infusion pumps
- Left ventricular assist device
- Nonstandard wheelchairs
- Nonstandard beds
- Pneumatic compression devices
- Power wheelchair repairs
- Power wheelchairs, accessories, and power-operated vehicles (POVs)
- Prosthetics, orthotics
- Sleep-study-related equipment and supplies
- Speech-generating devices and accessories
- Spinal cord stimulators

# Medicare Advantage

**What happens if the insurer says “No”. In most cases, the test or treatment is not performed. In a few cases, the doctor will appeal the denial on behalf of the patient, and the decision is reversed.**



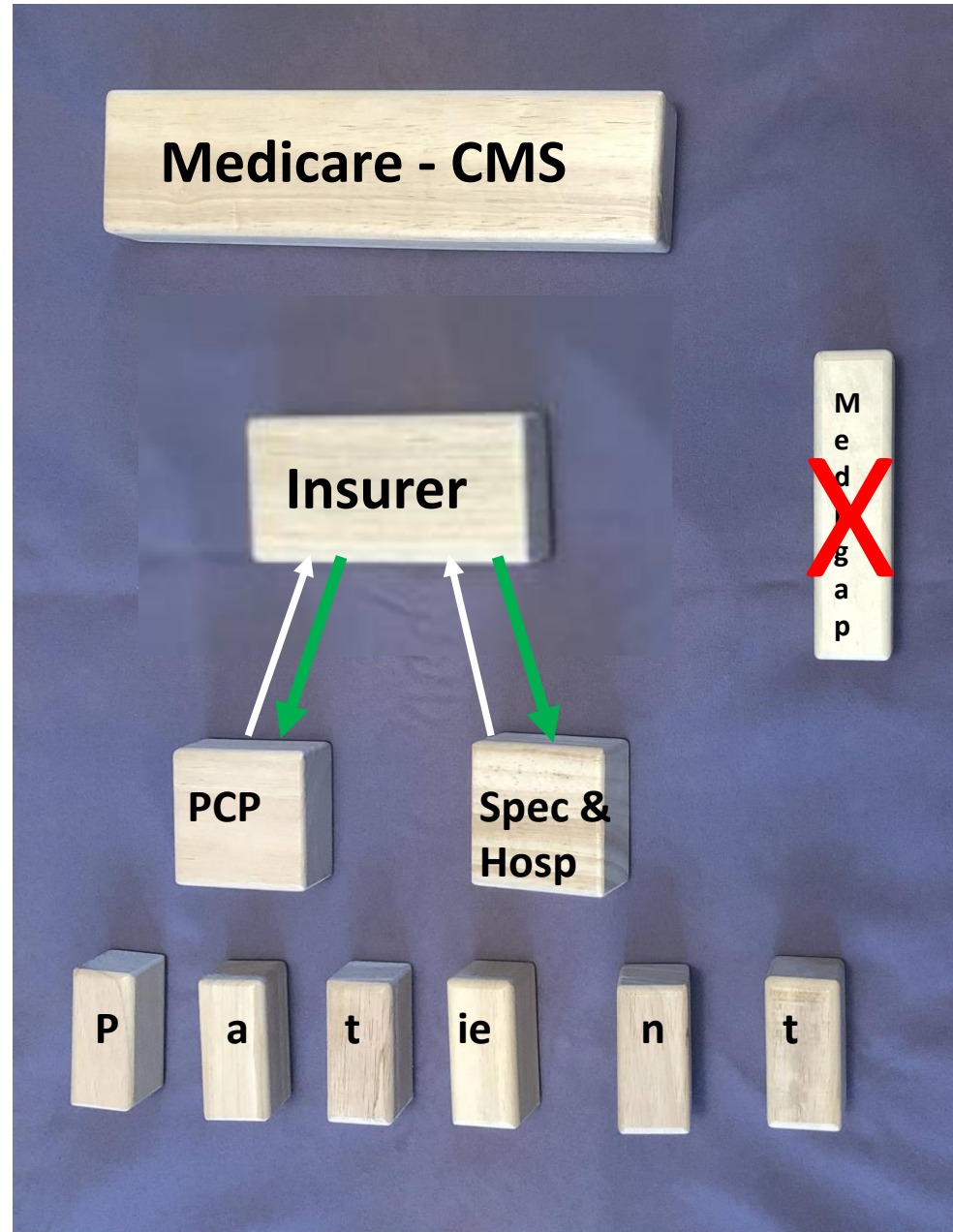
# Medicare Advantage



**If the insurer approves, the doctors send their bills to the insurer, not to Medicare, and the insurer pays them.**

# Medicare Advantage

What about the  
Medigap  
supplement?



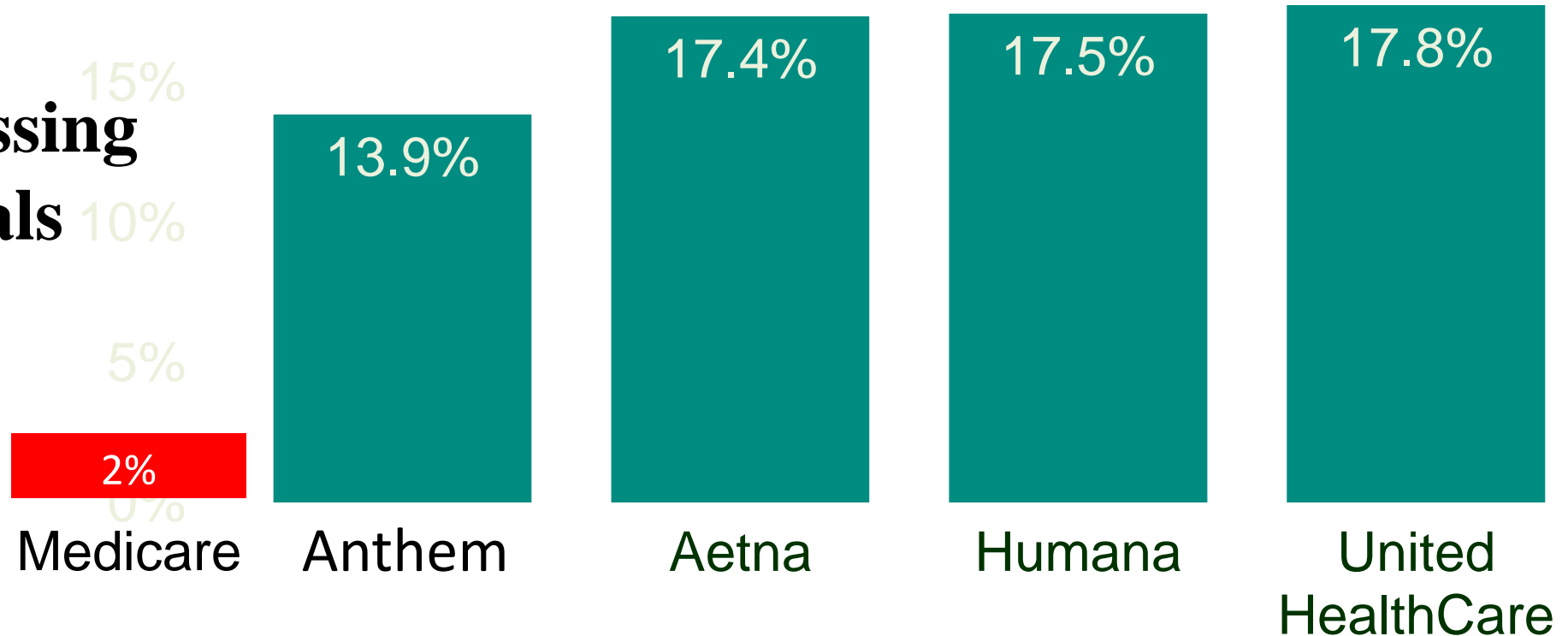
No supplemental  
insurance is  
allowed.

As a result, MA  
plans have less  
money to spend  
on health care.  
How much less?

# Private Insurance Overhead Costs\*



- ✓ **Claims processing**
- ✓ **Prior approvals**
- ✓ **Marketing**
- ✓ **CEO salaries**
- ✓ **Profits**

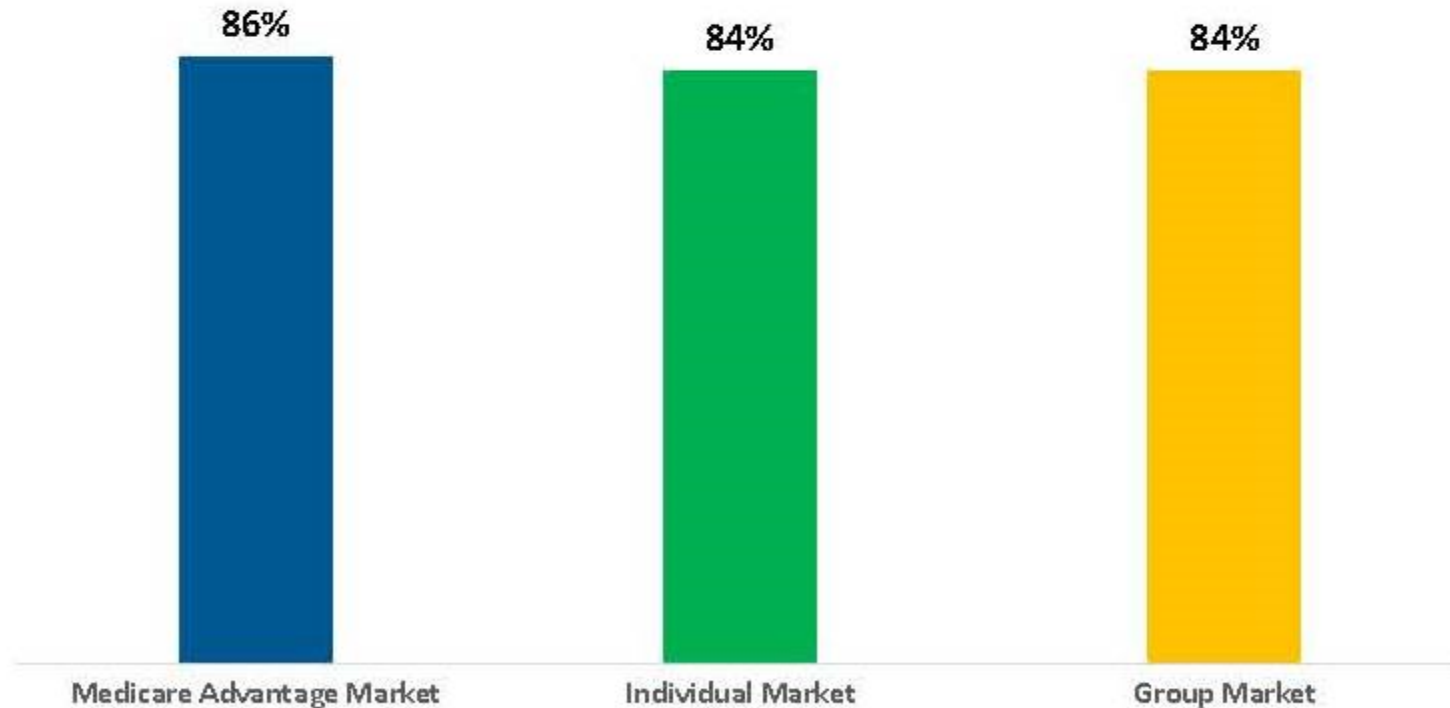


Source: SEC Filings/Reports to Shareholders. Data for Q1 or Q2 2017

# MA plans spend just 86¢ of every \$1 received.

Medical expenses as a percentage of premiums collected were similar across the three markets

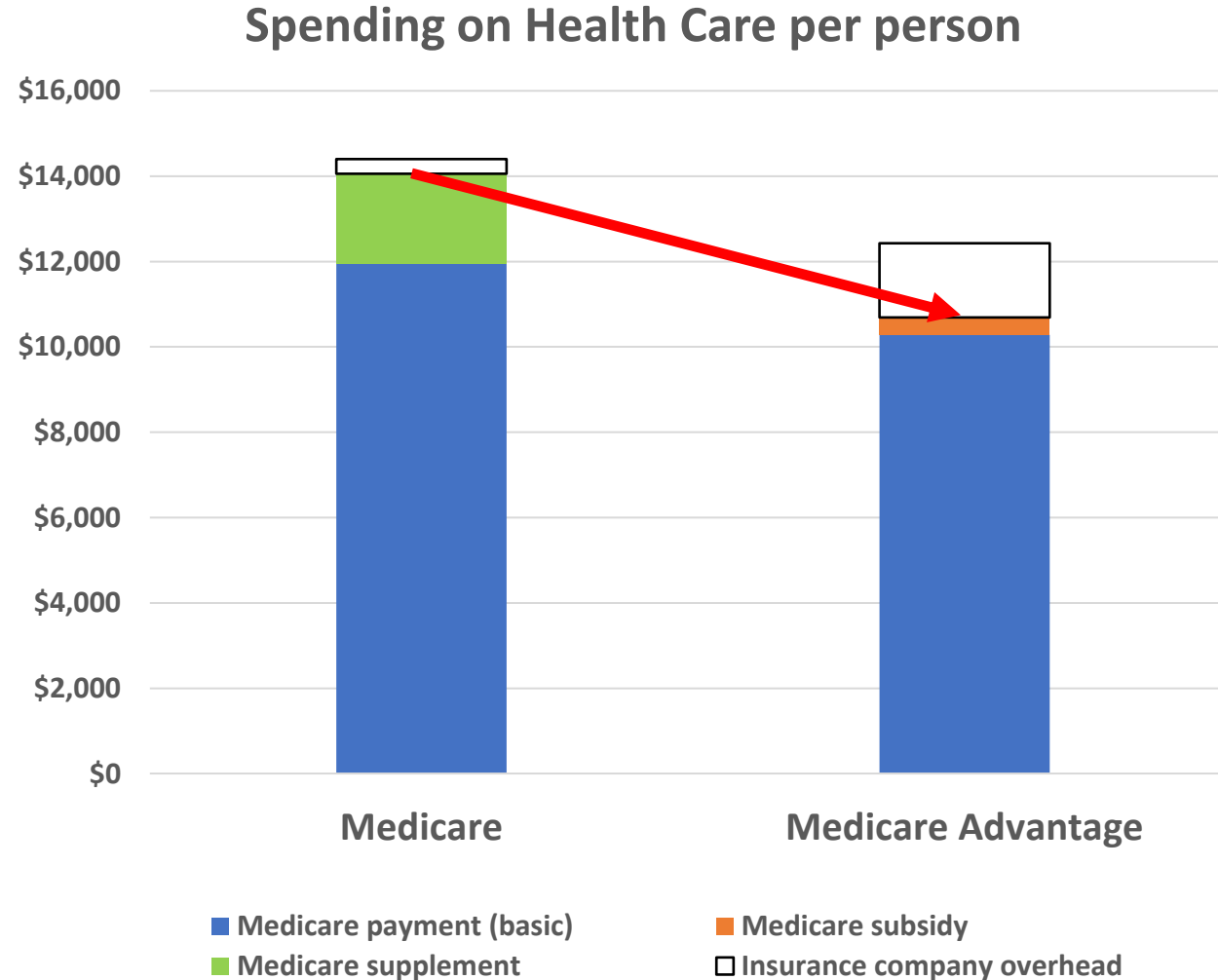
*Average Medical Expenses as a Share of Total Premiums, 2016-2018*



Note: The group market only includes fully-insured plans. Figures above represent claims divided by premiums, and are averaged across 2016, 2017, and 2018.

Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM.

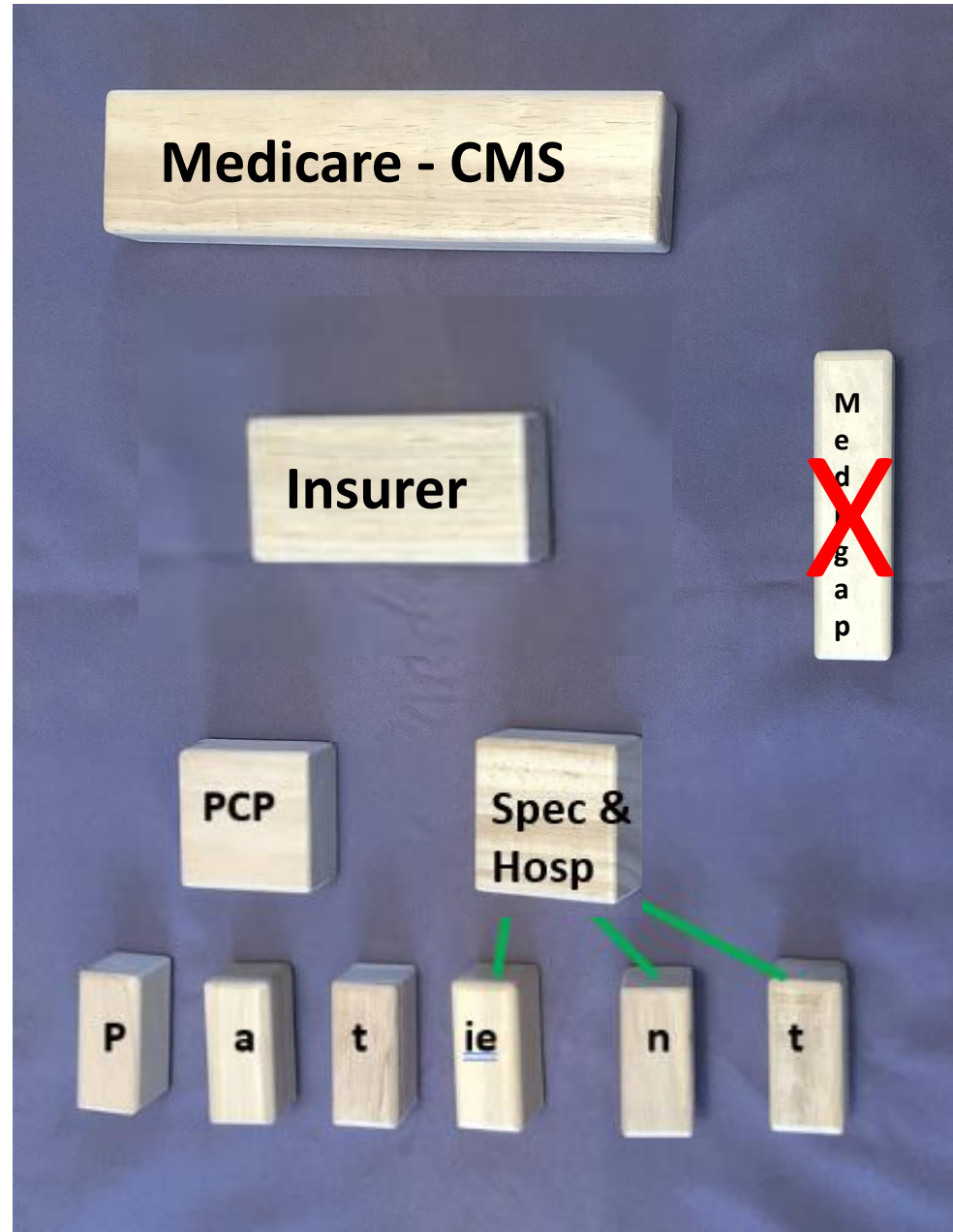
# Patients in Medicare Advantage plans get less care than in Traditional Medicare



Source: <https://www.pnhpnymetro.org/city-s-plan-will-reduce-retiree-health-care-by-24>

# Medicare Advantage

**There is one other source of funding in MA plans: Patient copays**



**This benefits the insurer in two ways: It reduces what they pay the provider, and it discourages patients from seeking care – and remember, the insurer has already been paid, whether they provide care or not.**

# Here are the copays in the NYC MA Plus plan

## Plan Design Comparison: General

Provision	Senior Care (Today)	Alliance Medicare Advantage Plan
Annual Deductible	\$253	\$253
Ann. Retiree Out-Of-Pocket Max*	No Limit / Protection	\$1,470
PCP Visit	No Copay	\$0 Copay
Specialist Visit	No Copay	\$15 Copay
Diagnostic Tests (X-rays, lab, radiology, etc.)	No Copay	\$15 Copay
Mental Health / Substance Use Disorder	No Copay	\$15 Copay
Urgent Care Center	No Copay	\$15 Copay
Preventive Services	No Copay	No Copay
Rehab. Services	No Copay	\$15 Copay

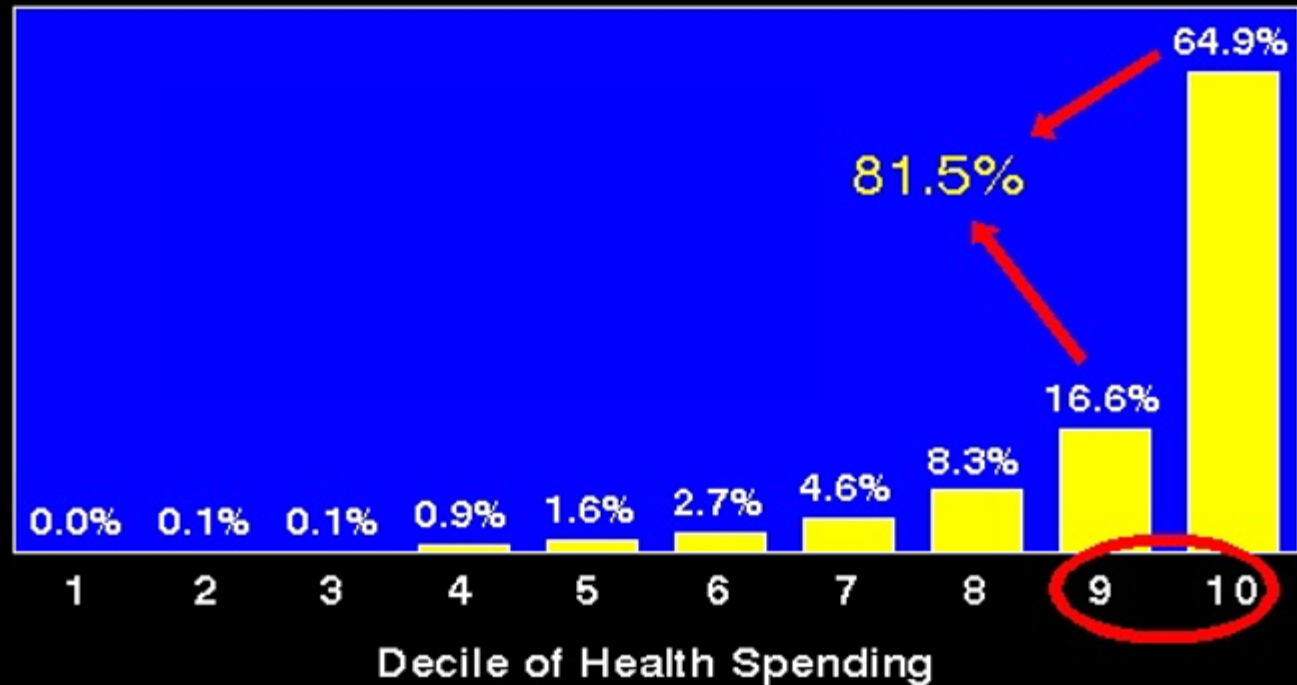
# Surveys say people like their MA plan

Here's why:  
most of them  
don't use it!

## The 80-20 Rule

Percent of Total Spending for Each Decile Among  
Non-Institutionalized Americans

% of total health spending accounted for by decile



Source: JAMA 2016;316:1348

# **When MA members get sick, they leave for Medicare**

Medicare & Medicaid Research Review

2012: Volume 2, Number 4

## **Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for- Service**

*Gerald F. Riley*

Centers for Medicare & Medicaid Services

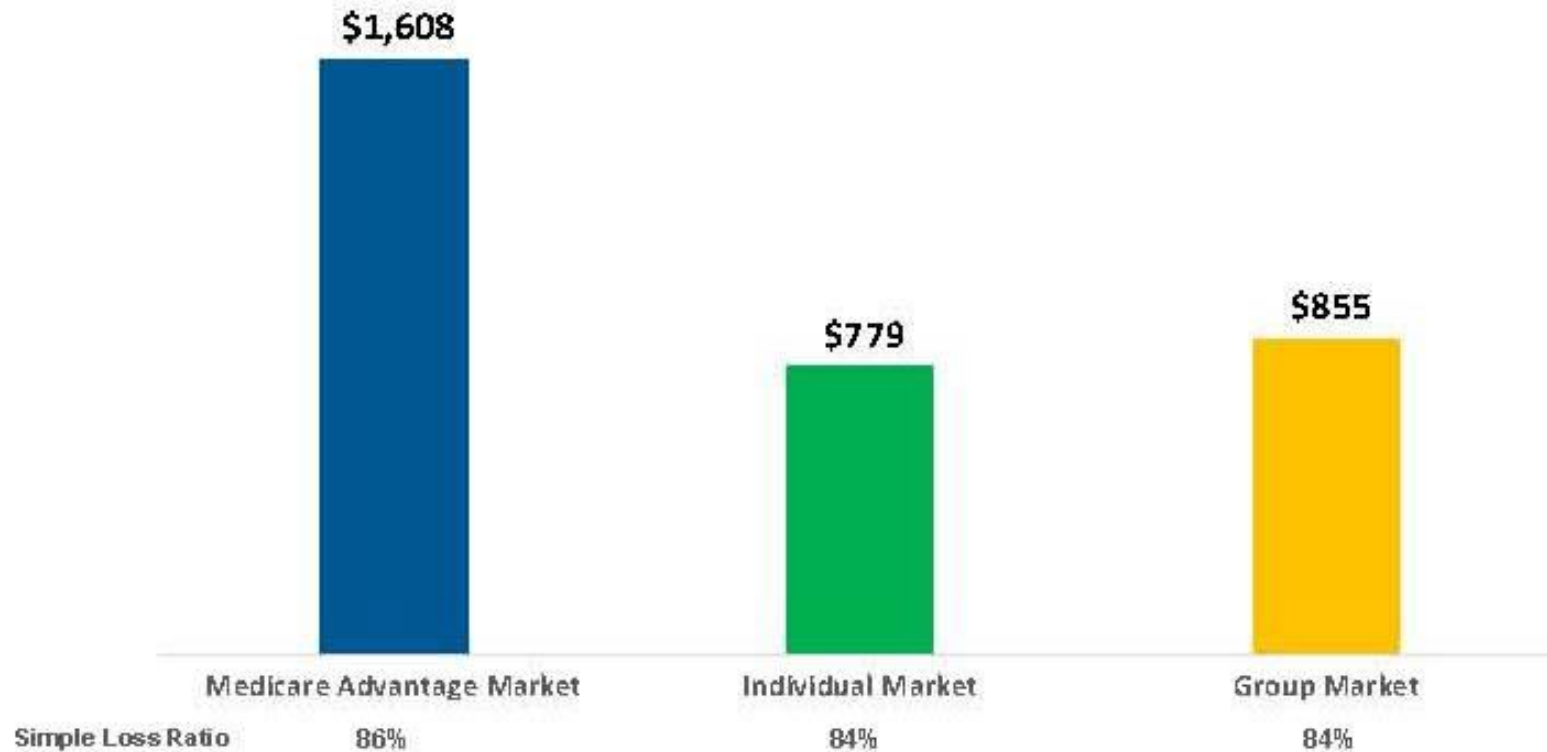
**Background: Medicare managed care enrollees who disenroll to fee-for-service (FFS) historically have worse health and higher costs than continuing enrollees and beneficiaries remaining in FFS.**

# Medicare Advantage is Very Lucrative

E.S. Figure

Annual gross margins in the Medicare Advantage market were about double the margins in the individual and group markets

*Average Gross Margins per Covered Person per Year, 2016-2018*



Note: The group market only includes fully-insured plans. Figures are averaged across 2016, 2017, and 2018.  
Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM.

# **The Bottom Line: Medicare Advantage...**

- Costs the government more than public Medicare**
- Gives less care to those who need it most.**
- Since insurers receive per-person (capitation) payments that don't depend on what they spend, the less care they give, the more money they make.**

# Privatization: Step 2

After a decade of attempting to find ways of paying for health care that will save money – e.g., ACOs and value-based payment, CMS has created a new “model”:

*Direct Contracting, now rebranded ACO REACH.*

They have big plans for it:

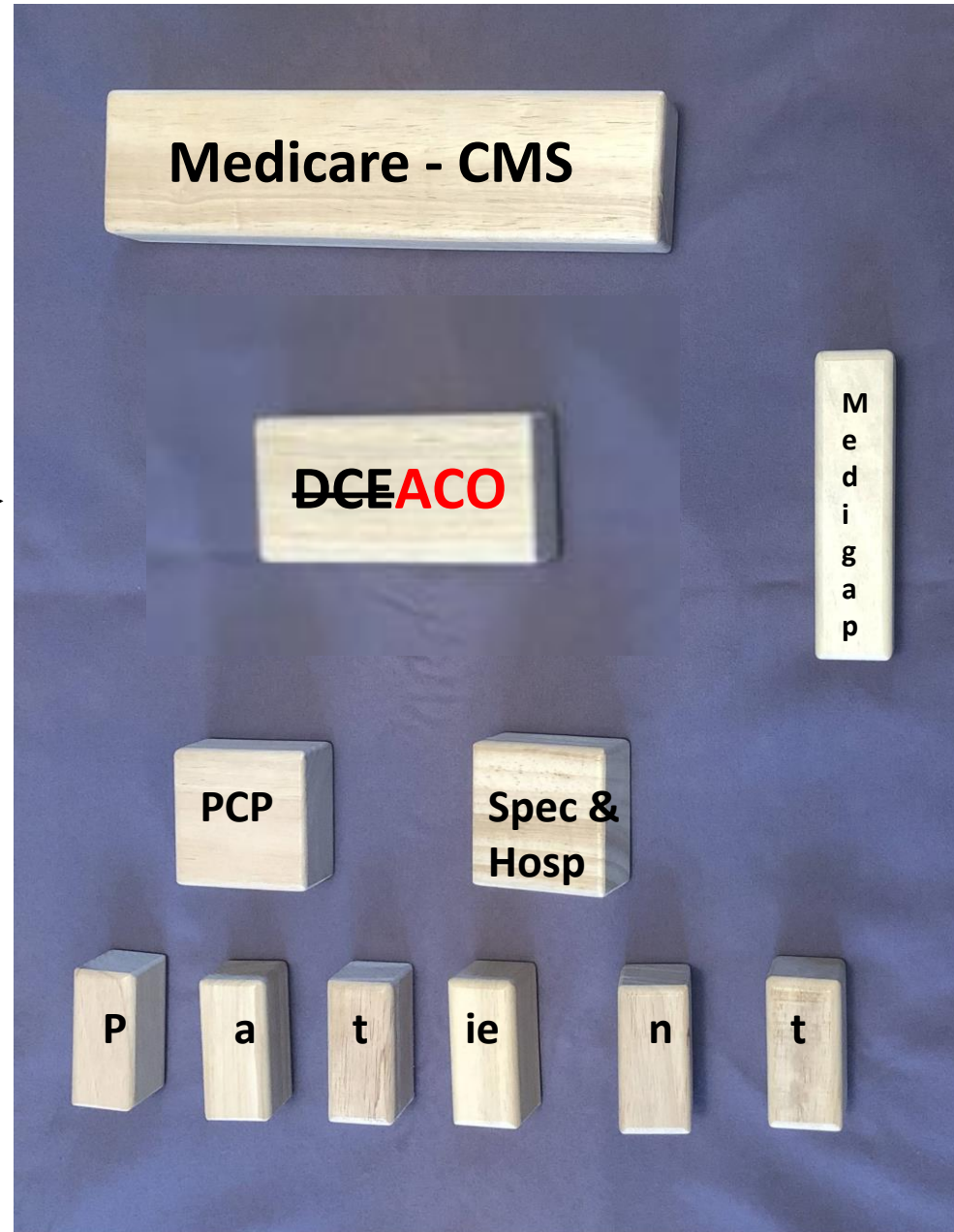
*“CMS is committed to the shared goal of moving away from fee-for-service .. our goal of moving 100% of traditional Medicare beneficiaries into [accountable care] relationships by 2030 .”*

-- Liz Fowler, Director, Center for Medicare and Medicaid Innovation, CMS.

<https://www.medpagetoday.com/practicemanagement/reimbursement/96497>

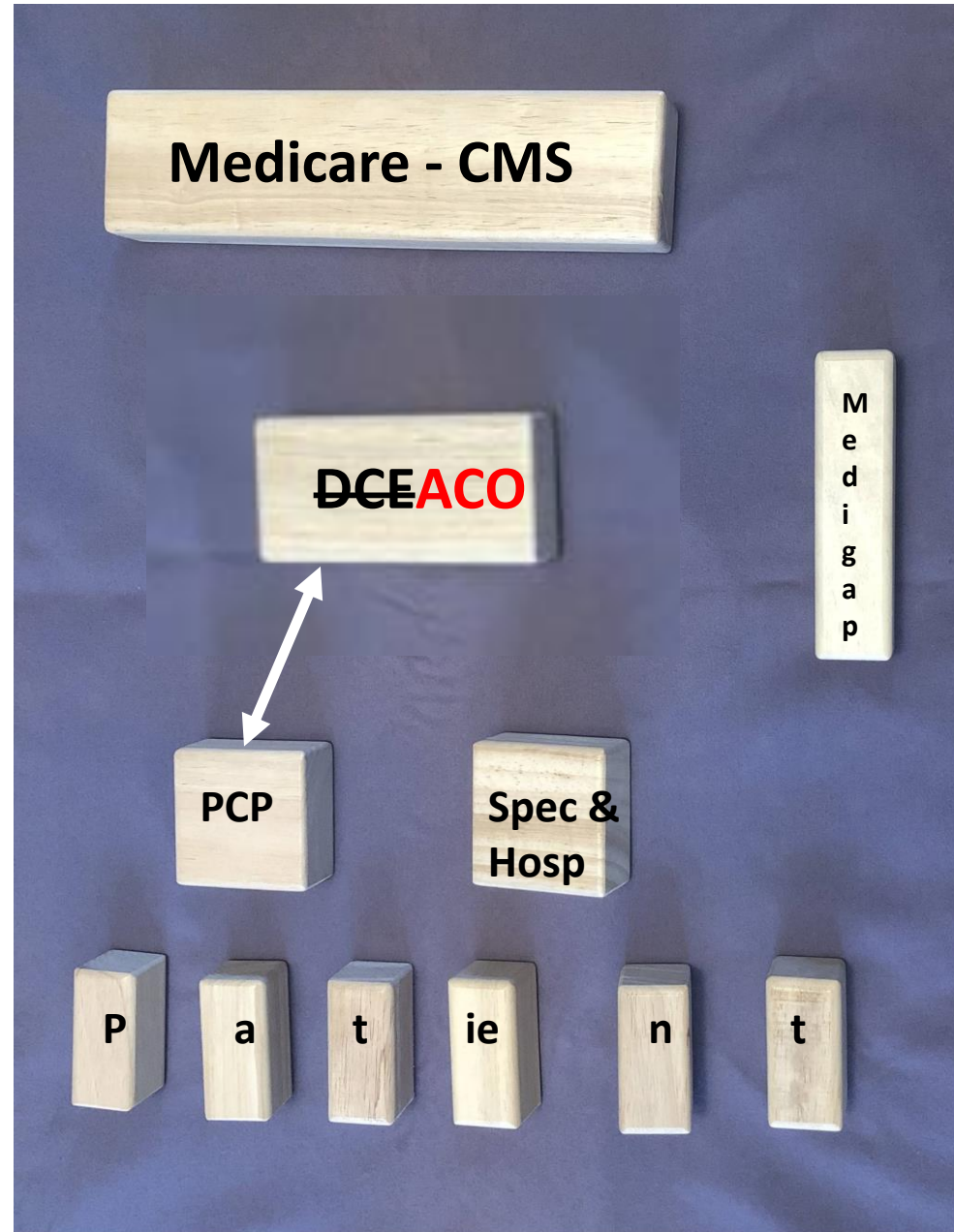
# So now comes: ~~Direct Contracting~~ **ACO REACH**

**Direct Contracting  
Entity:** →  
**Insurance company,  
venture capital firm,  
multispecialty  
practice**



# Direct Contracting

Primary care practices agree to have their Medicare financing come to them through a capitated payment from the **DCEACO**.



# Why the focus on primary care?

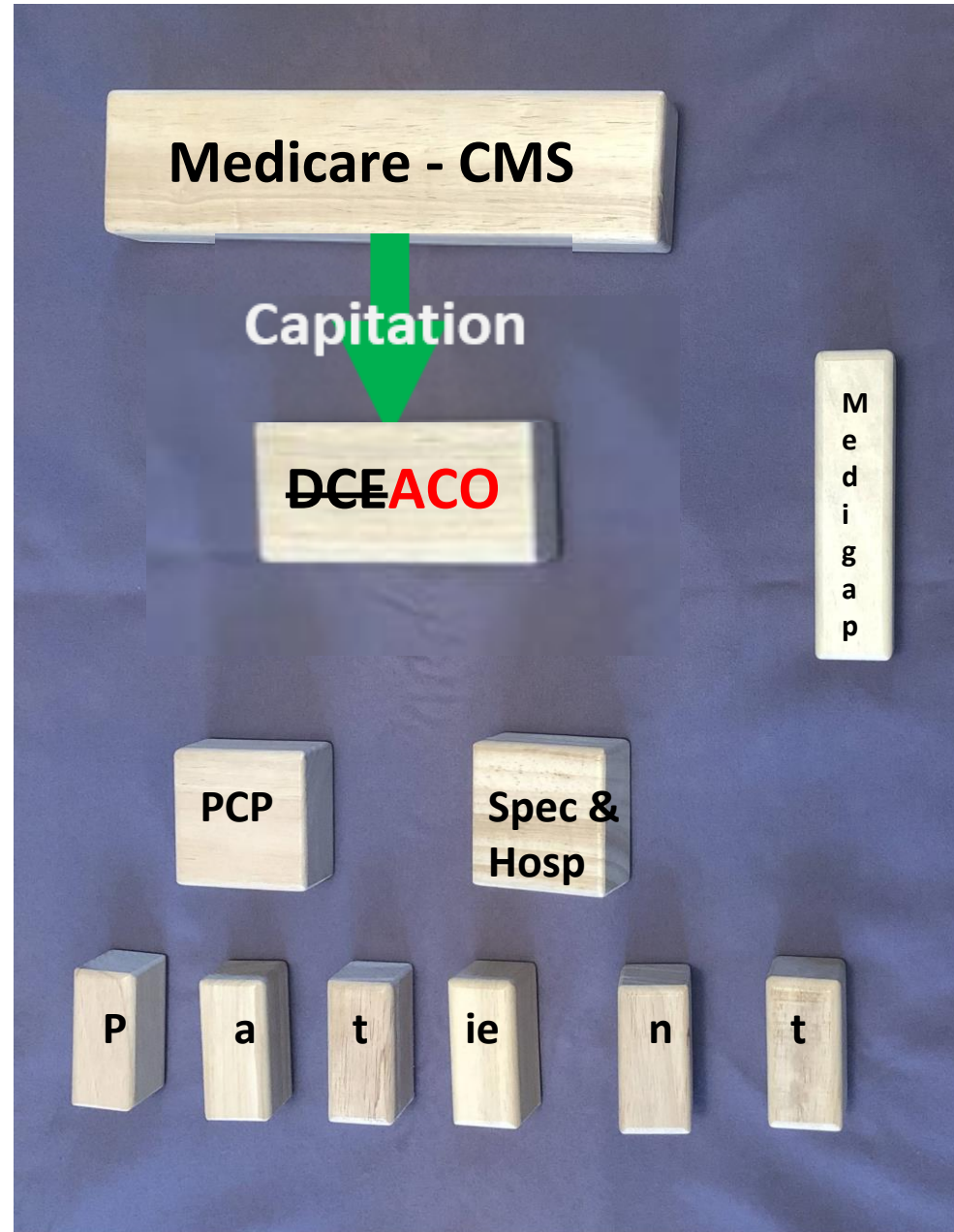
- **CMS sees “advancing primary care as a means to better managing health care overall.”**
- **Even though primary care accounts for only 3-5% of total health care spending<sup>1</sup>**
- **It is the linchpin of health care, where all the rest of medical and hospital spending can be controlled.**

<sup>1</sup>“Primary Care Spending in the Fee-for-Service Medicare Population,” R Reid, C Damberg, M Friedberg, RAND Corp., *Jama Internal Medicine*, July 2019 <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2730351>

# Direct Contracting

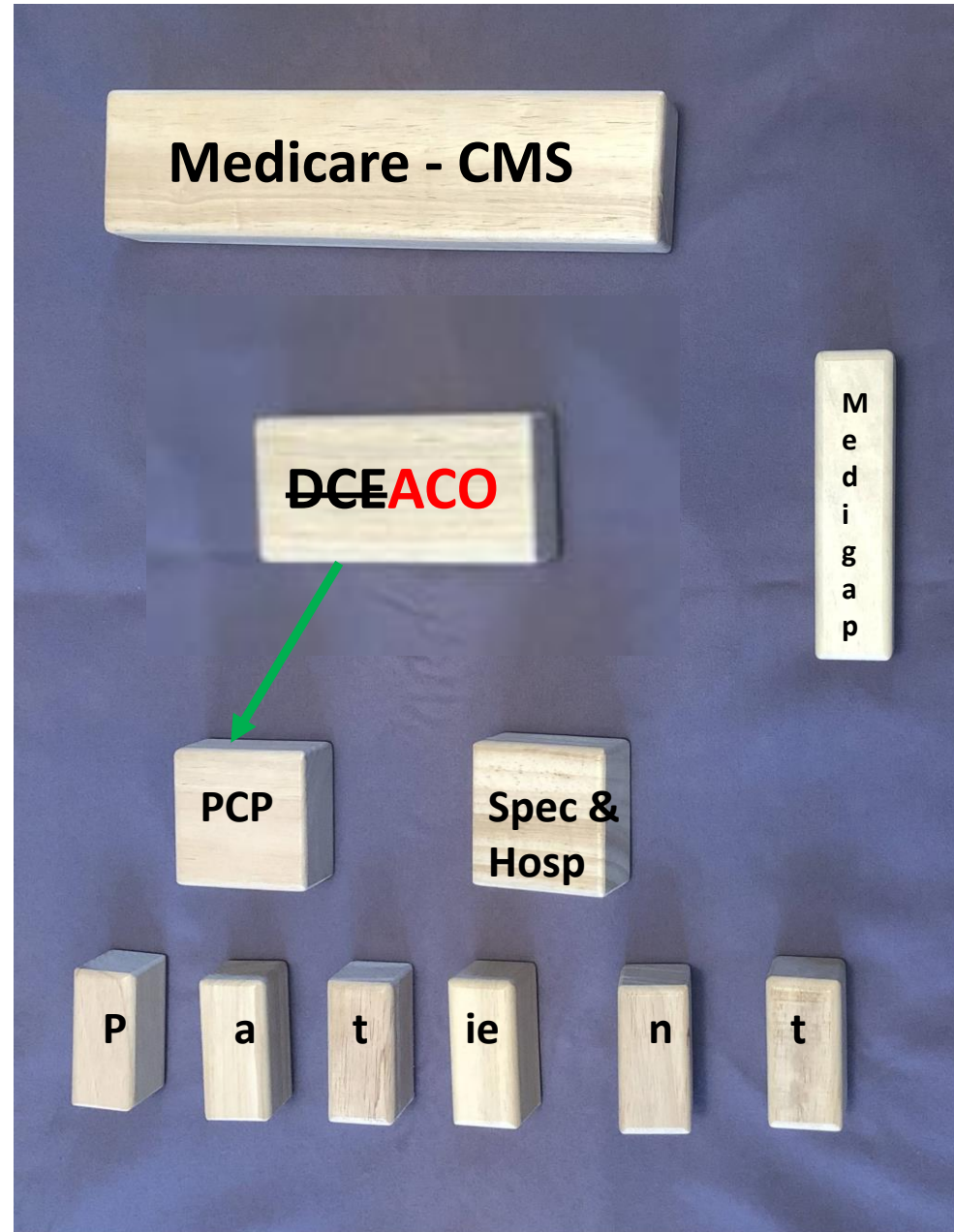
Medicare/CMS sends the DCE a monthly payment to cover the average “aligned”\* patient’s costs\*\*.

- “Alignment” is based on past claims or patient choice.
- \*\* The DCE can choose to cover all Medicare-related costs, or just primary care costs.



# Direct Contracting

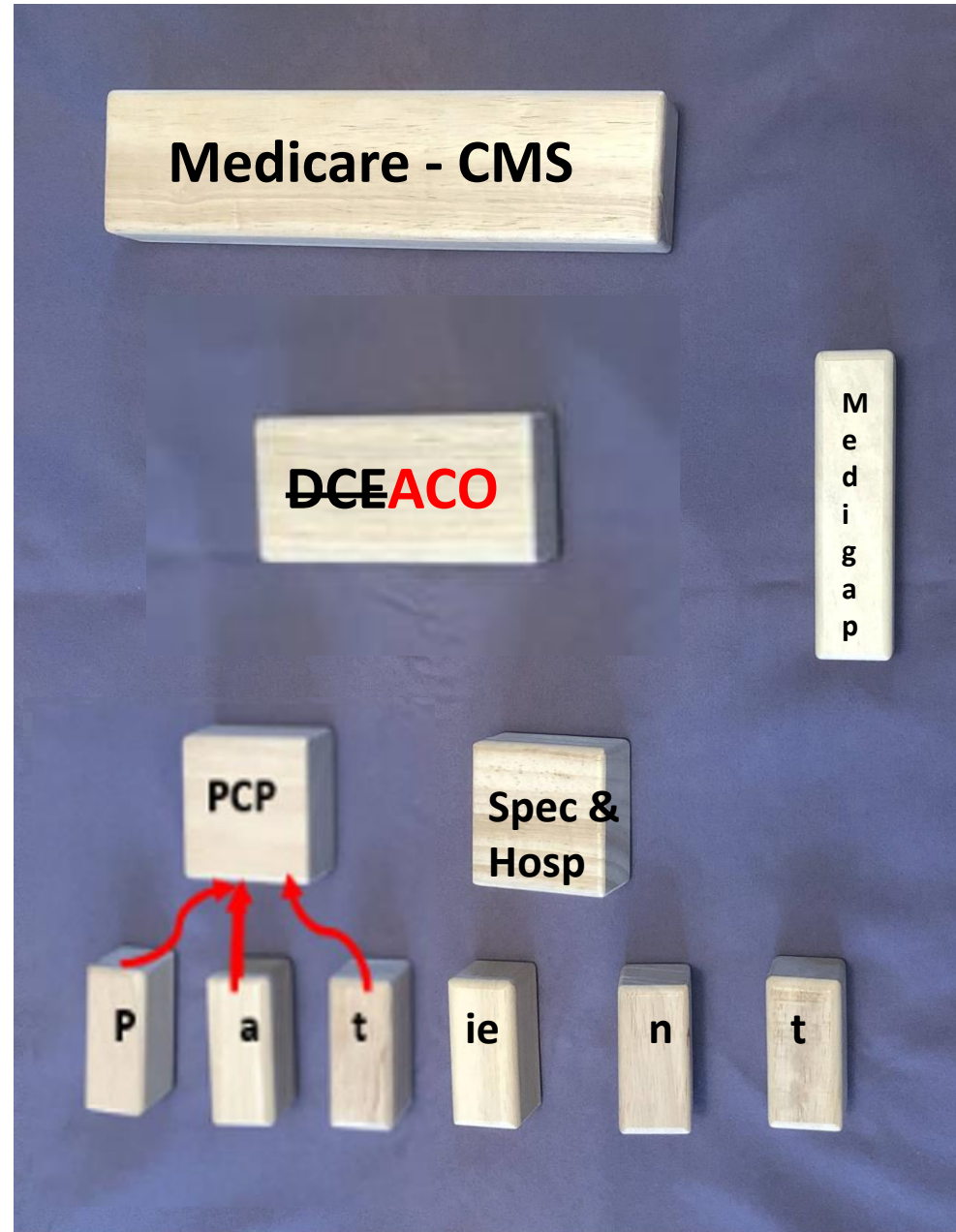
The DCE pays the PCPs a monthly negotiated capitated payment.



The DCE keeps the difference between what CMS pays it and what it pays out to the PCPs, specialists, and hospitals.

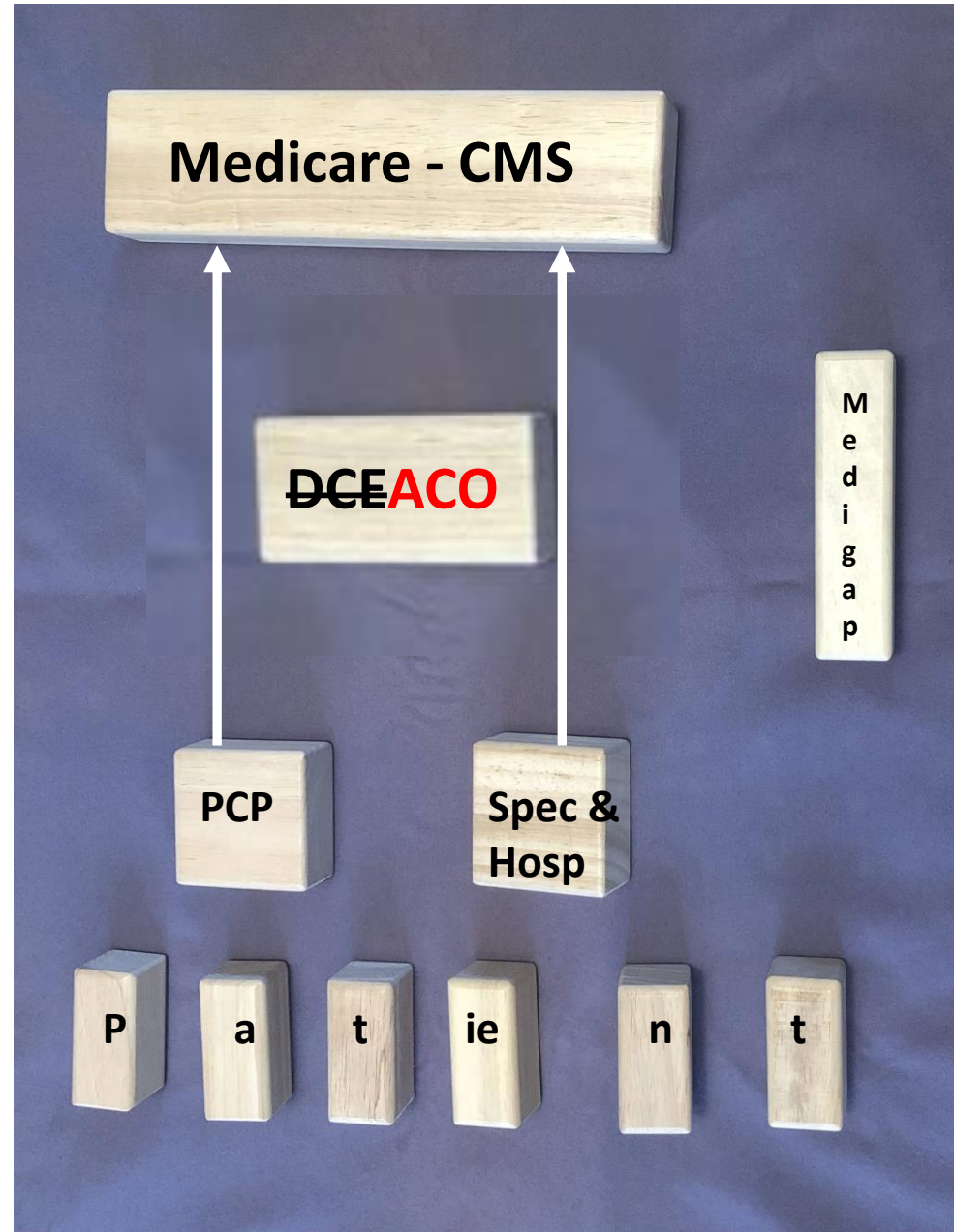
# Direct Contracting

What happens  
when patients see  
their PCPs?



# Direct Contracting

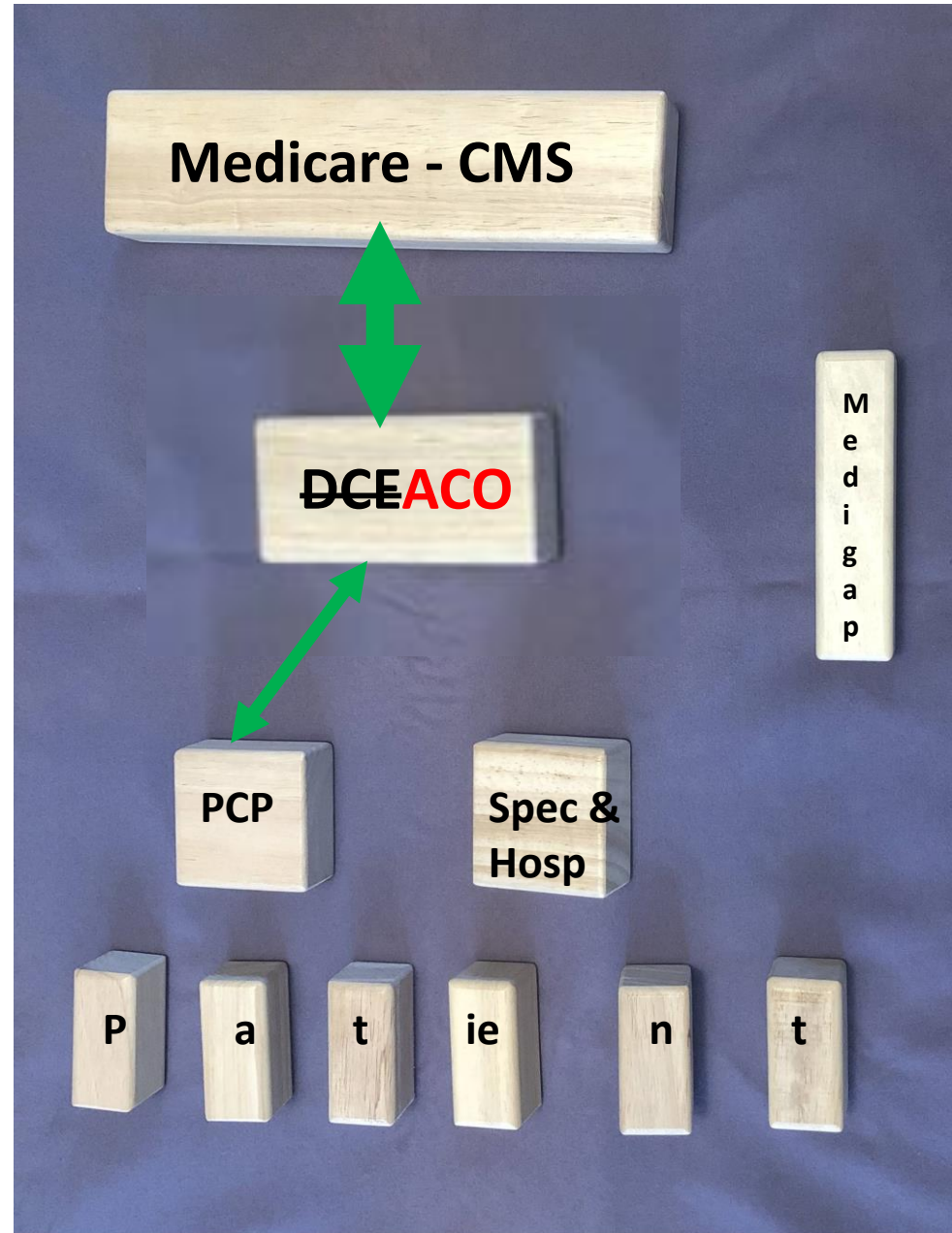
The PCPs submit claims to CMS, just as they would if CMS were going to reimburse them – but it does not!



Specialists & hospitals also submit their claims to CMS. They are paid either paid by CMS or directly by the DCE if it has accepted total capitation.

# Direct Contracting

Once a year, CMS compares Medicare spending for all services (“total cost of care”) delivered to aligned patients against the DCE’s benchmark to determine savings or losses. These are split between CMS and the DCE and its PCPs. They make money by limiting care.



This is identical with the Medicare Shared Savings Program (MSSP), also known as the Accountable Care Organization (ACO) Model.

# **The bottom line: Financial incentives will be used to limit spending on the delivery of health care.**

- PCPs will be encouraged to act as shadow gatekeepers, holding down referrals to specialists or inpatient care (or to refer to low-cost specialists or hospitals) by the expectation of receiving shared savings.**
- The DCEs will seek to minimize spending on care across the board, though this will not be clear to patients.**
- It will be nearly impossible for CMS to monitor the limitations on care that will take place.**

# Cochrane Review:

**“We found no evidence that financial incentives can improve patient outcomes.”**

-- Flodgren et al. “An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviors and patient outcomes,”  
Cochrane Collaboration, July 6, 2011. <https://pubmed.ncbi.nlm.nih.gov/21735443/>

# Why ACOs? ACOs actually save little money

## Promise vs. Practice: the Actual Financial Performance of Accountable Care Organizations



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James G. Kahn, MD, MPH<sup>1</sup>  
Kip R. Sullivan, JD<sup>2</sup>

J Gen Intern Med

DOI: 10.1007/s11606-021-07089-6

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### INTRODUCTION

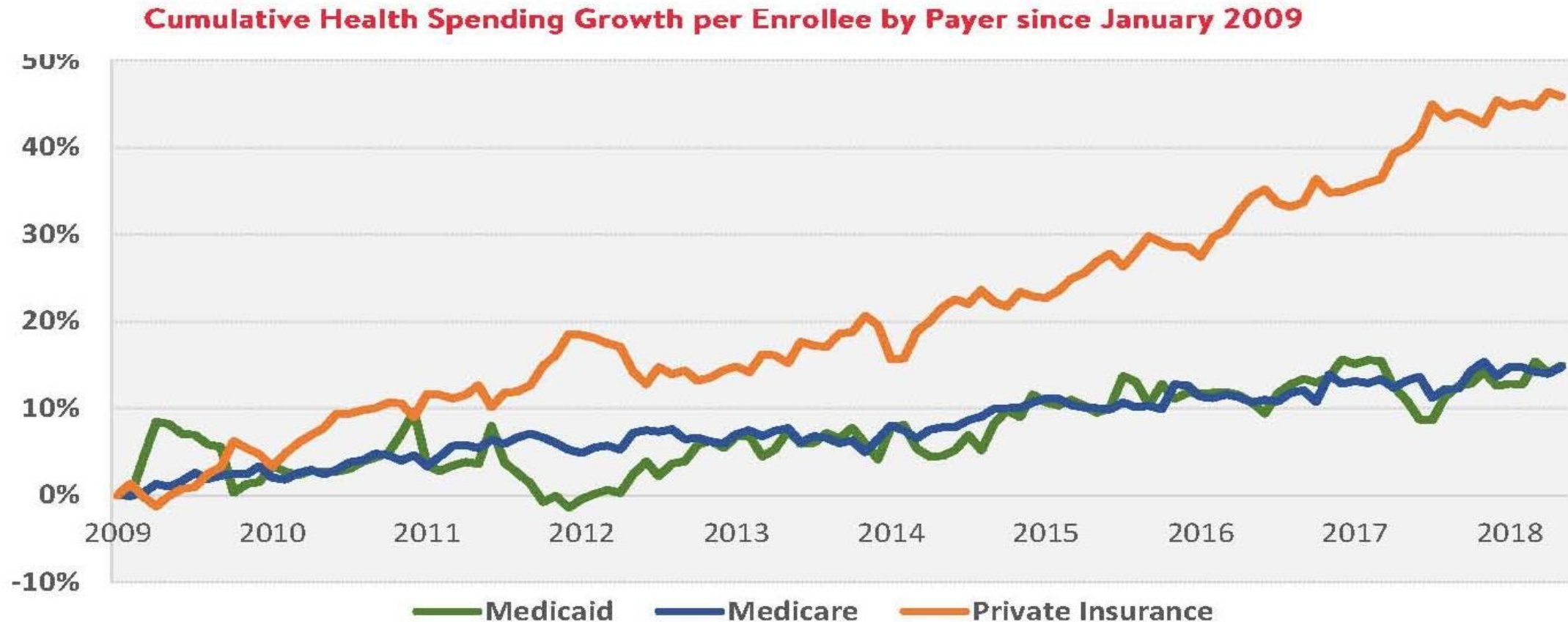
In 2005, the Centers for Medicare and Medicaid Services (CMS) launched “accountable care organizations” (ACOs). The intent for this voluntary program was to financially incentivize provider groups to reduce fee-for-service billings while maintaining care quality. Some analysts believed ACOs to be a pivotal mechanism to control Medicare spending.<sup>1</sup> Others questioned the theoretical basis.<sup>2</sup> Recent ACO assessments conclude that 2019 net savings are minimal despite

### RESULTS

Findings are in Table 1. The Physician Group Practice (PGP) demonstration saved CMS 0.3% net over 5 years (2005–2010). Pioneer saved CMS several tenths of a percent net from 2012 to 2016, without the ACOs that dropped out, most of which were losing money. The Medicare Shared Savings Program (MSSP) lost CMS money for 4 years, and in year 5 (2017) yielded CMS net savings of 0.3%. Next Generation saved CMS 0.2% net in its first year and lost 0.3% over the full program.

There was little difference between the two analytic methods. The range for both benchmark and counterfactual approaches was CMS 0.7% savings to 0.3% added costs. For program years with both methods, results differed by 0.1%.

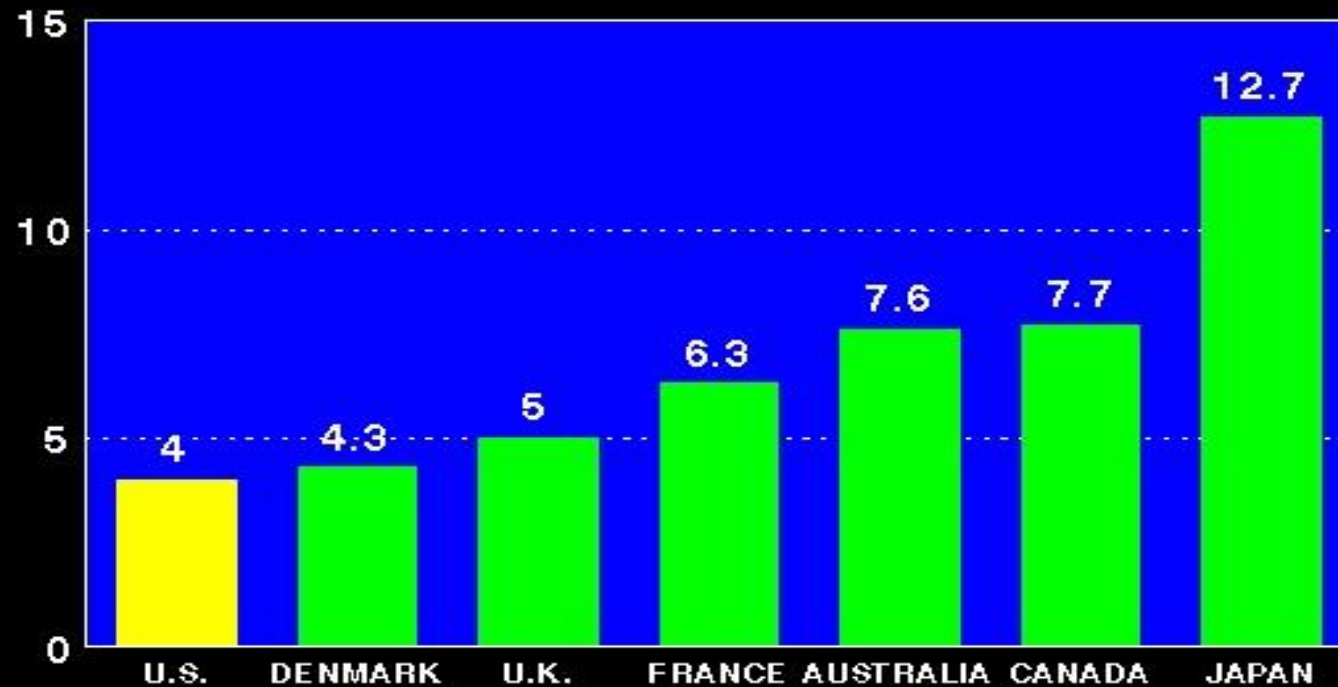
# Reason for small savings: Medicare is already very efficient.



Source: "Growth in Spending on Privately Insurance Drives Much of US Health Spending Growth in 2017 and Early 2018", Altarum Institute, [https://altarum.org/sites/default/files/uploaded-related-files/Public Private Brief final.pdf](https://altarum.org/sites/default/files/uploaded-related-files/Public%20Private%20Brief%20final.pdf)

# Is fee-for-service causing overuse of physician services and increasing costs?

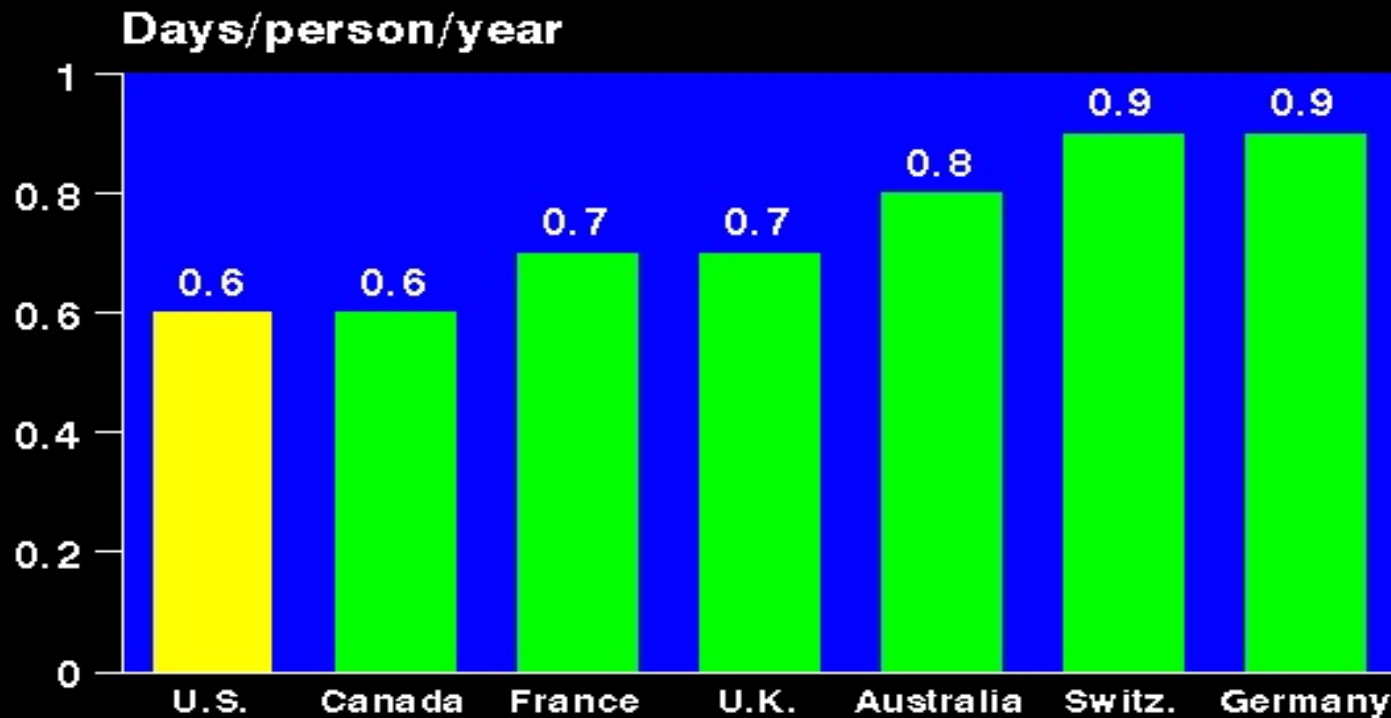
## Physician Visits Per Capita



Source: OECD, 2017 - Data are for 2016 or most recent available year

# Is fee-for-service causing overuse of hospital services?

## Hospital Inpatient Days Per Capita



Source: OECD, 2015 & AHRQ - Note: Figures are for 2014 or most recent available

# In fact, it has been known for a long time that the US does not overuse health services

HEALTH SPENDING

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## It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.


by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and  
Varduhi Petrosyan

# It's Still The Prices, Stupid: Why The US Spends So Much On Health Care

**“On key measures of health care resources per capita (hospital beds, physicians, and nurses), the US still provides significantly fewer resources compared to the OECD median country...US policy makers should focus on prices in the private sector.”**

[Gerard F. Anderson](#), [Peter Hussey](#), and [Varduhi Petrosyan](#)

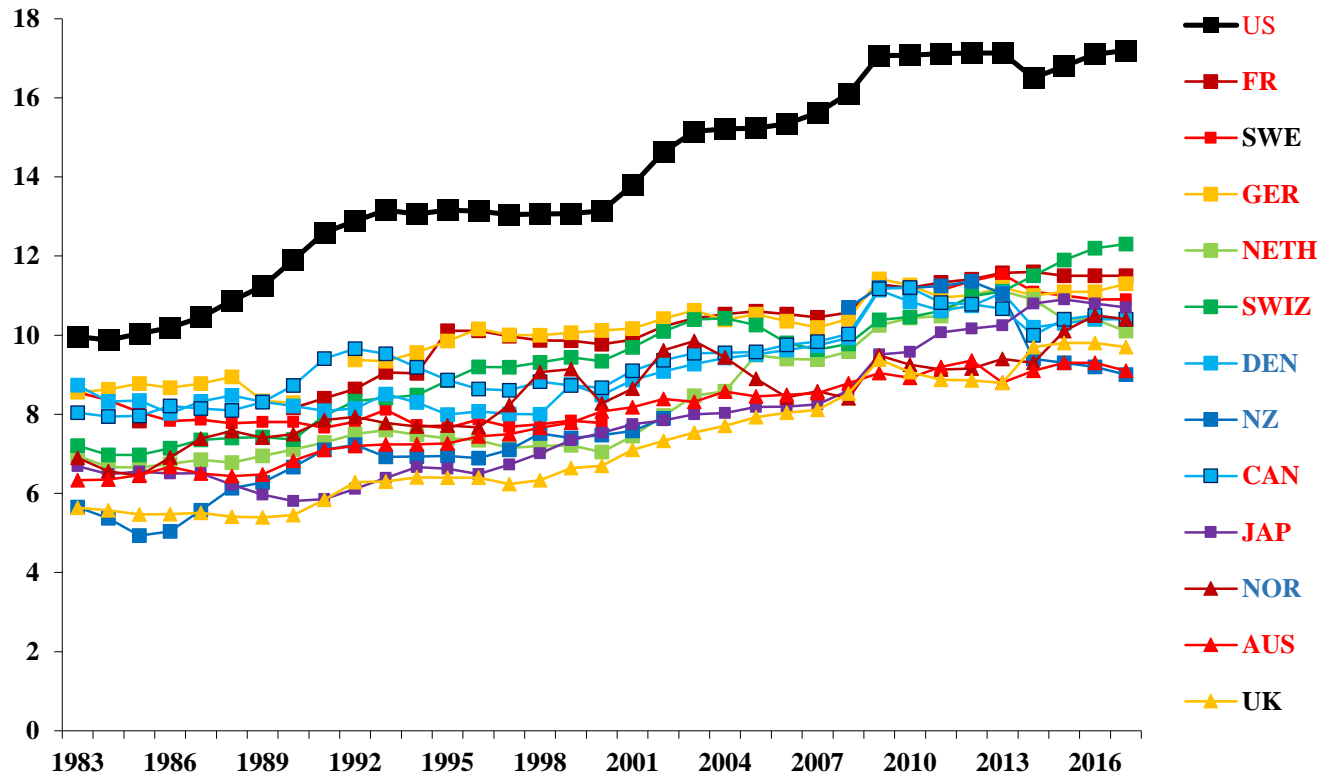
[AFFILIATIONS](#) 

PUBLISHED: JANUARY 2019  [Free Access](#)

<https://doi.org/10.1377/hlthaff.2018.05144>

# The rest of the world uses fee-for-service and spends far less than we do.

Percent GDP Health Care Spending as a Percentage of GDP, 1980–2017



**Payment for Primary Care**  
**Fee for service**  
**FFS + Capitation**  
**Capitation**

Source: OECD Health Data 2018.

**Fee-for-service works when government controls the rates – as with Medicare!**

**We treat health care as if it were a market.  
It's been known for a long time that it is not!  
Patients are not “consumers” who can shop for care.**

**THE AMERICAN  
ECONOMIC REVIEW**

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VOLUME LIII

DECEMBER 1963

NUMBER 5

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UNCERTAINTY AND THE WELFARE  
ECONOMICS OF MEDICAL CARE

*By* KENNETH J. ARROW\*

# **So Why are US costs So High?**

**It's Not Fee-for-Service.**

**It's the Free Market in Prices, Stupid!**

- **Our costs are high, and getting higher, because we allow prices to be set by the suppliers of health services, drug, and medical supplies, and to be paid by private insurers.**
- **No other country allows such free-wheeling price-setting in its health care system. All use administered prices controlled by government – and Medicare already uses them!**
- **A single payer program would use administered prices to control costs without the “alternate payment models” now being forced onto providers in our health care system.**

# **The Real Way to Control Costs!**

- **In tennis we say, “Don’t change a winning game.”**

*Keep fee-for-service.*

- **Adopt single payer Medicare for All**
- **Set physician and hospital prices through negotiation between government and representative organizations, as other countries do.**

*Publicly-funded single payer is the answer to both controlling costs and privatization.*

# For more information and action:

- [www.protectmedicare.net](http://www.protectmedicare.net)
- [www.pnhp.org](http://www.pnhp.org)
- [www.pnhpnymetro.org](http://www.pnhpnymetro.org)

Thank you

Questions?