MEDICARE ADVANTAGE AND ACO-REACH

When you truly want to learn how well a program is working, you do not go to politicians, investors, or administrators. You go to the workers on the front lines who provide the services of the program. For healthcare it means going to the medical professionals.

Physicians for a National Healthcare Program (PNHP) has been around since the 1980s and has over 25,000 members. You are urged to go to their websites, www.pnhp.org and www.protectmedicare.net to get the real story.

Admittedly it can be tedious to read about the unnecessary complexities that have been embedded in our healthcare systems to enable corporate welfare. Instead, browse PNHP's selection of free recorded webinars. Three webinars that deal with the threat to end traditional Medicare are:

* protectmedicare.net: Dr. Susan Rogers: “Wall St. is REACHing for Medicare” (5 min)

* pnhp.org | Member Resources | Webinars: Dr. Ed Weisbart: “Medicare Advantage: What single payer advocates need to know” (30 min)

*pnhp.org | Member Resources | Webinars: “Dr. Ed Weisbart on Direct Contracting Entities (15 min)

You can also sign up for email alerts from PNHP which will let you know about future webinars and political developments.

Most of the information in the following few paragraphs is summarized from PNHP sources.

THE PROBLEM

Two things are clear when comparing healthcare in the US with healthcare in similar countries. The US spends much more per capita, and the results, whether measured in life expectancy, infant mortality, or medical-related bankruptcies are worse.

Developing a system to meet health needs is nontrivial. New diagnostic tools and treatments are constantly being developed. Fraudulent billing must be detected and prevented. Facilities and medical personnel should be accessible without excessive waiting and should be based on a trusting doctor-patient relationship, but those resources should not be left idle. Administrative expenses should be minimized. There needs to be a fair plan to avoid overly burdensome costs to patients. As with every complex system, regular review and modification is needed to make sure parties do not game the processes. All countries must deal with these issues.

EARLY DAYS OF INSURANCE

During a post WWII wage freeze in the US, employers began offering health insurance as a job benefit. It was the old-fashioned nonprofit Blue Cross model, where rates and coverage were controlled by state insurance commissioners.

There were two problems with this model which got worse over time. More older people were now surviving into retirement, which meant they were no longer covered by an employer's group policy. Also, older people have many more medical expenses, and hence, to continue to be insured, had to pay much higher premiums. By the mid-1960s, popular pressure had built to point that Medicare (starting at age 65) was introduced.

INTRODUCTION OF MEDICARE

Medicare is one of the most effective Federal programs of all time. Even though it only covered 80% of one's medical bills and it excluded drugs, dental, vision, and hearing, studies have shown that the 65-70 age group has better health outcomes than the 60-65 age group.

The program was nonprofit and had administrative costs of around 2%. The gaps in Medicare coverage could be handled by purchasing supplemental private insurance. Although it makes sense to have 100% coverage, there were a number of well-funded financial interests that generated fear of the socialist boogeyman.

In the mid-1970s a new type of insurance emerged in the non-Medicare space, the Health Maintenance Organization (HMO). These were owned and run by clinics themselves, and touted improvements in efficiency and outcomes. This was initially the case. Annual checkups were included to catch problems early. In the days before electronic records, centralized paper files could eliminate redundant lab work, and the primary care physician could manage referrals to specialists appropriately.

Over time the HMO concept was corrupted. Many clinics could combine into a single organization. Co-pays and deductibles were introduced. There could be confusion over which providers were in-network and out of network. Unspent premiums could be redirected into administrative overhead, and, with corporate redefinition, into profit for shareholders.

MEDICARE ADVANTAGE ARRIVES

In the 1980s and 1990s, pilot Medicare Advantage plans (under various names) were authorized. They were private “capitated” plans, meaning that they promised equivalent coverage to Medicare in exchange for what was spent on the average Medicare participant. Any money that was not spent on care would be profit for the company. Perhaps these companies thought they could use advertising to attract mainly healthier seniors, but, in the end, they were unable to generate significant profits.

Over the next twenty years, Congress gradually decided that cost containment should not be the goal of Medicare Advantage, but rather the “accommodation of private interests” (i.e. corporate welfare) in the pursuit of privatization of government services. The capitation for Medicare Advantage plans would now be greater than the cost of the average Medicare participant. In addition, the capitation would be increased based on the past two years of a participant's diagnostic and treatment history. This enables Medicare Advantage to include low cost add-ons like dental cleanings and gym memberships that Medicare is prohibited from offering.

Medicare Advantage plans now have three ways to improve their profits: increasing market share, gaming the capitation formula, and delaying and denying payment for procedures. As opposed to Medicare's 2% overhead, Medicare Advantage allows 15% overhead.

THE PLAN TO END TRADITIONAL MEDICARE

But wait, there's more.... Donald Trump put financial bro (and former roommate of Jared Kushner) Adam Boehler in charge of the Center for Medicare and Medicaid Innovation (CMMI). CMMI is empowered to create pilot programs for Medicare and roll those pilots out to all Medicare participants without congressional approval and without statistical demonstration of their effectiveness.

Boehler's plan was to allow corporations called Direct Contracting Entities (DCEs) to provide incentives to primary care providers to get those providers to sign up with the DCE. Then every patient that saw that provider in the past two years would be automatically enrolled in the Medicare Advantage

plan owned by that DCE. This creates incentives for the physician to overstate symptoms (“upcoding”) to generate a higher capitation and to steer patients away from more expensive treatment options, even against better medical judgement. The state goal of CMMI is to have all Medicare participants in a DCE by 2030.

The Biden administration said it would terminate DCEs. But instead it made a few cosmetic changes and rebranded the project as ACO-REACH. These plans allow up to 40% overhead.