California Says "No" to Privatization of Traditional Medicare

The California Legislature this month put the Golden State firmly on the side of protecting traditional Medicare.

Assembly Joint Resolution 4 (AJR 4), approved this month by both the Assembly and Senate, requests President Biden end a new Medicare program that promotes "corporate profiteering". The program, ACO REACH (Accountable Care Organization Realizing Equity and Community Health), was approved this year by the *Center for Medicare and Medicaid Innovation* (CMMI) without any Congressional approval or oversight.

Ending this program would not only be a boon to California with its 6.6 million seniors and people with disabilities, but to the entire nation which has enjoyed 58 years of traditional Medicare—the public program we all pay into with our taxes.

The acronym, ACO REACH, sounds pleasant but is wholly misleading. Instead, it has opened the floodgates to Wall Street plundering—by private equity firms, investment bankers, and venture capitalists.

Fifty-eight years ago, the idea of Medicare was to remove all cost sharing and provide unencumbered access to health care for seniors and disabled persons. From the 1970s forward, a healthcare revisionist history unrolled in pushback against President Lyndon Johnson's successful implementation of the Medicare program.

In 1972, the Nixon Administration allowed the insertion of certain middlemen, Health Maintenance Organizations (HMOs), into the Medicare payment process. These middlemen, mostly insurance companies, have demanded profits based on promises to deliver lower cost and improved care. The data indicate these promises have not been met. In fact, the data indicates just the opposite.

Medicare Advantage (MA), a privatized version of real Medicare, began in 2003 under the Bush Administration and furthers investors' goals. It allows non-medical middlemen to restrict provider networks, deny medically prescribed care, cherry pick the healthiest enrollees, lemon drop the sickest, and up-code health scores to make patients appear sicker as a way to game the Medicare Trust Fund. Medicare Advantage plans overcharge Medicare by more than $75 billion per year, and private equity companies reap many billions more.

It comes down to a payment model called capitation. While Medicare pays providers for services actually performed, Medicare Advantage collects a per-person monthly stipend from the Medicare Trust Fund in *anticipation* of expected, not actual, need. It's easy to see how making patients appear sicker will jack up that anticipated need

and thus the capitated payment—without oversight to record whether or not the anticipated need is addressed.

The ACO REACH payment model creates similar, dangerous incentives to restrict care. Already 2.1 million Americans have been enrolled in ACO REACH without their express knowledge or consent. Here's how it works: An investor buys into control over hospital and physician groups and all seniors therein are automatically "aligned" into the program. The only way to opt out is to find a new doctor who is not party to the scheme–not an easy proposition, especially in rural areas where physician populations are shrinking.

An important difference between Medicare Advantage and ACO REACH, however, has to do with that powerful profit incentive. Under this model, physicians become financial risk bearers, meaning they could be incentivized to restrict care in order to gain financially—a proposition that undermines doctor-patient trust. More troubling, while Medicare Advantage programs are required to spend 85 percent of monies received from Medicare on patient health, leaving them 15 percent for overhead and profit, ACO REACH programs may keep up to 40 percent while spending only 60 percent on patient care. Compare that to the 2 percent overhead spent by traditional, not-for-profit Medicare.

No wonder people are saying Medicare is going broke! As observed in a recent Health Justice Monitor post, "*the system has become maddeningly complex, with armies of functionaries working every angle, straddling every ethical line, to unlock a big safe full of money.*"

This ongoing privatization has created a $350-billion market that Wall Street and private equity firms are rushing to exploit, undermining Medicare's solvency and putting crucial decisions about patient care in the hands of private entities rather than doctors. Further, the Centers for Medicare and Medicaid Services' (CMS) declared goal is to have all Medicare recipients in privately managed programs by the year 2030. If this is allowed to happen, Medicare as we have known it will cease to exist as premiums rise and healthcare access is further restricted, delayed and denied.

California's passage of AJR-4 is an important step to put the entire nation on alert to this eventuality. The next step will be improving and expanding Medicare into a universal, single-payer, publicly financed healthcare system similar to those in so many other developed nations that value health as a human right available to all.

Please contact your California state senator today to say thank you for the final vote. This site lists the bill's sponsors. Humboldt's own SD 2 Sen. Mike McGuire is a co-author of the resolution. His office can be reached at (916) 651-4002.

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