

From the Privatization of Health Care to The New York Health Act and Medicare for All

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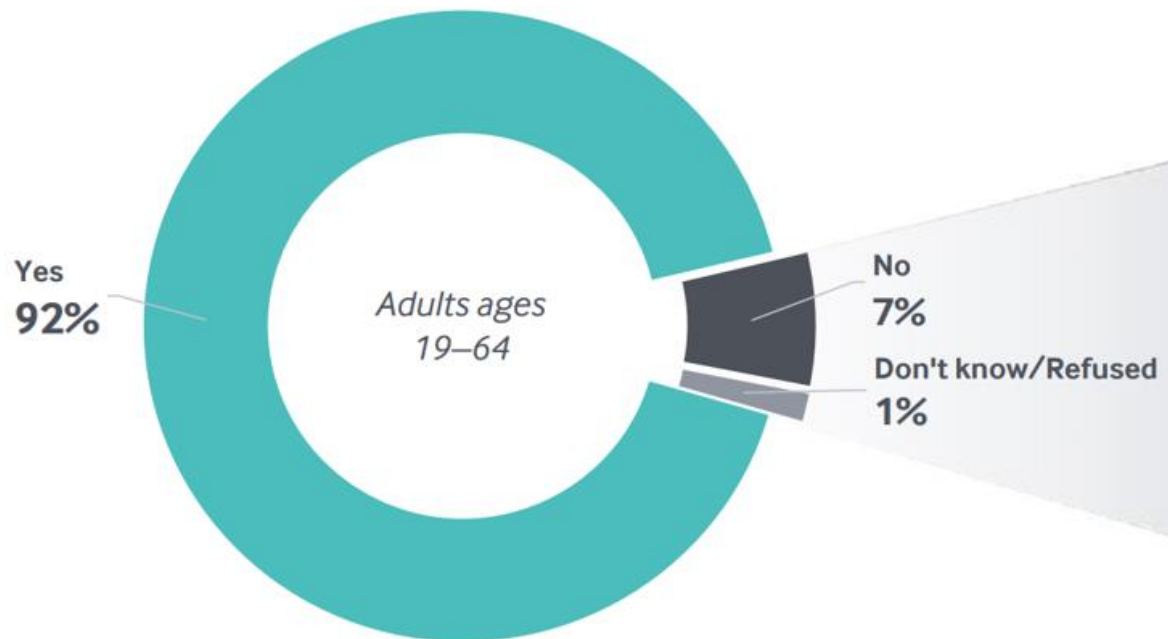
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January 2024

Evolution of US Health Insurance

- **1930s-1940s — Employer-based hospital and medical insurance from Blue Cross, a private non-profit company**
- **1950s — Commercial for-profit health insurance**
- **1965 — Medicare and Medicaid = public insurance**
- **1985 — Private Medicare plans (“Medicare Choice+”)**
- **2003 — Private “Medicare Advantage” plans**
- **2010 — Affordable Care Act (=Obamacare – more pvt insurance)**
- **2019 — “Direct Contracting Entities” (DCE/ACO-REACH)**
- **20??+ — NY Health Act → Medicare for All**

92% of Americans agree that we ALL have a right to affordable health care...



And support is independent of political affiliation

	Yes	No
Democrat	99	1
Republican	82	17
Independent	92	6

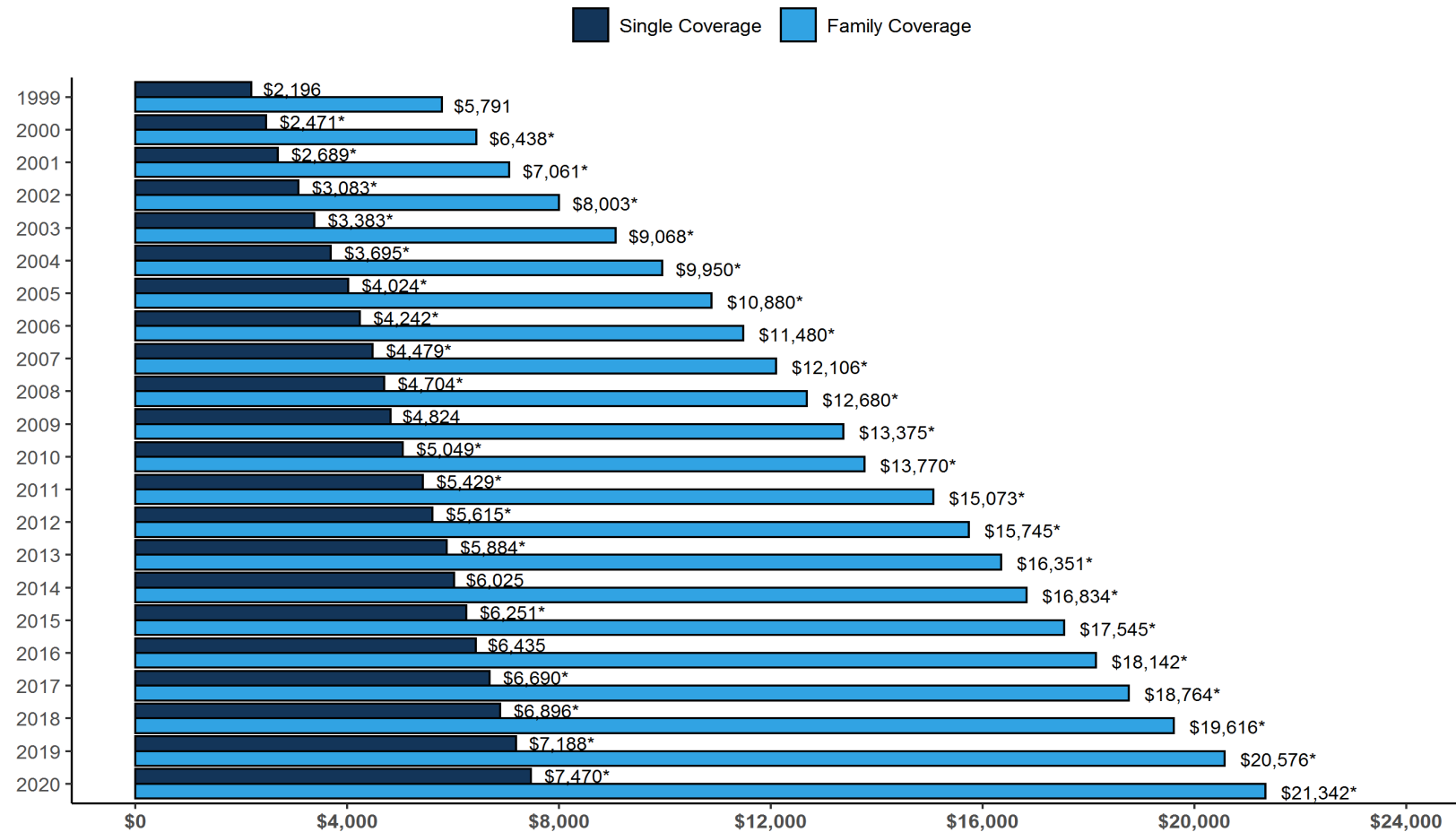
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Nov.–Dec. 2017.

...but we are far from that goal:

- 30 million Americans, including 1 million New Yorkers, are uninsured
- Millions more are underinsured due to rising deductibles and copays
- Costs continue to rise

Insurance premiums continue to rise, limiting possible wage increases

Average Annual Single and Family Employer Premiums, 1999-2020



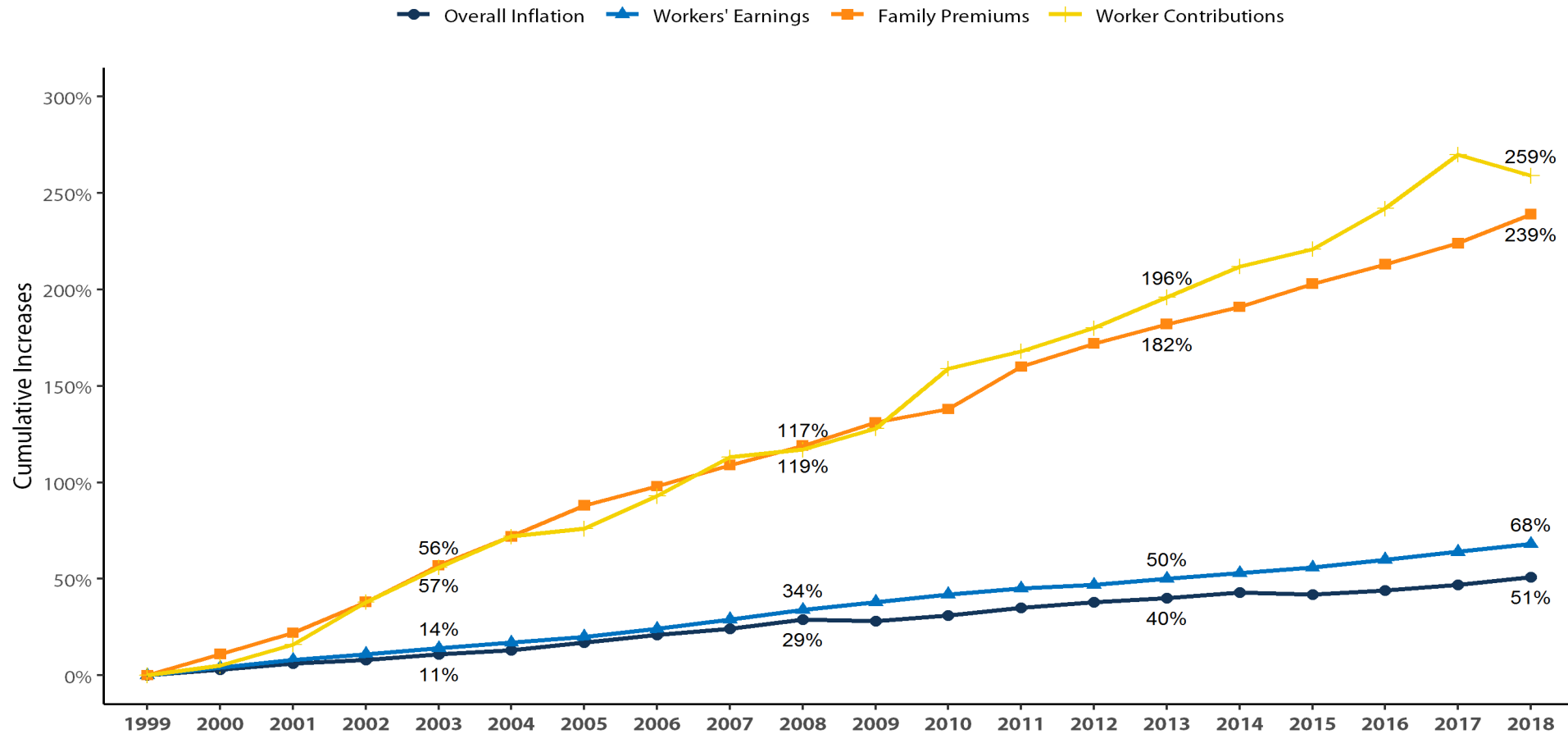
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017



Health care costs continue to outpace wages

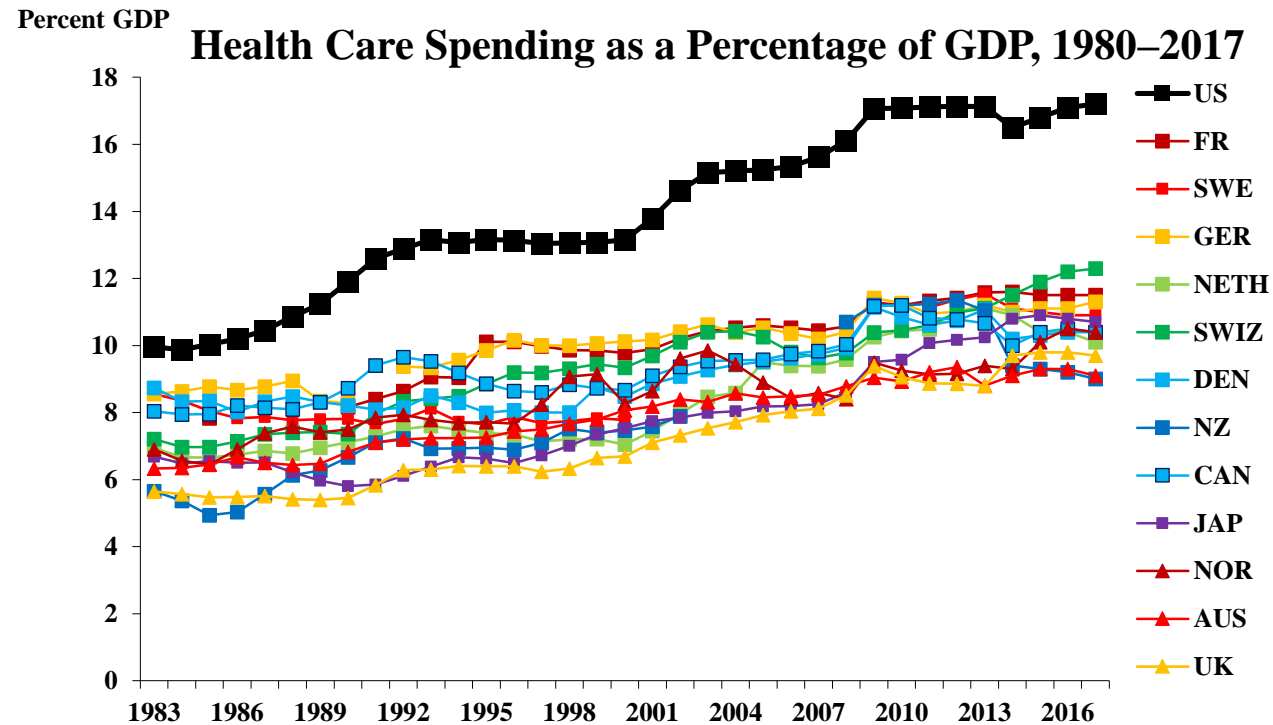
Cumulative Increases in family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2018



SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2018; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2018 (April to April).

It doesn't have to be this way!

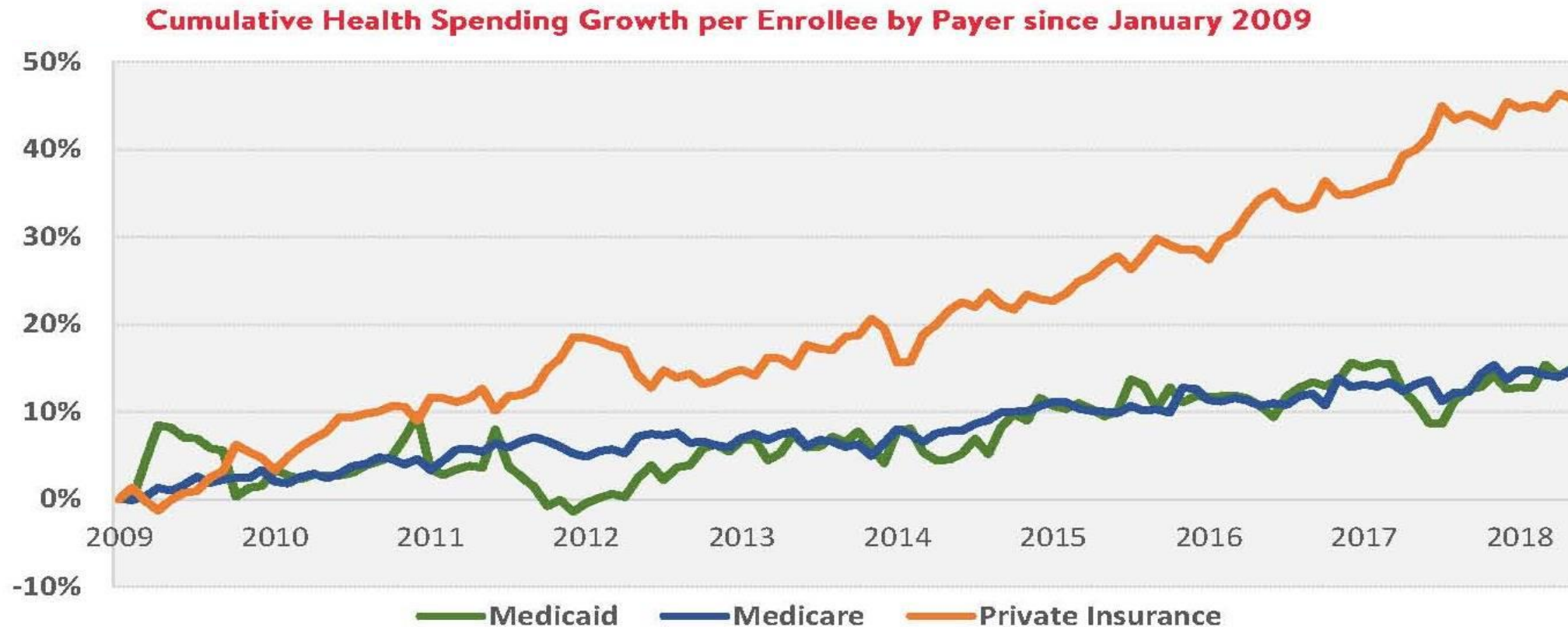
Every other country covers all their residents and spends half what we do — and many have no cost-sharing!



Source: OECD Health Data 2018.

What they know that we don't: Government has to oversee, regulate, and sometimes fund, health care.

Public Medicare and Medicaid control costs. Private insurance does not!

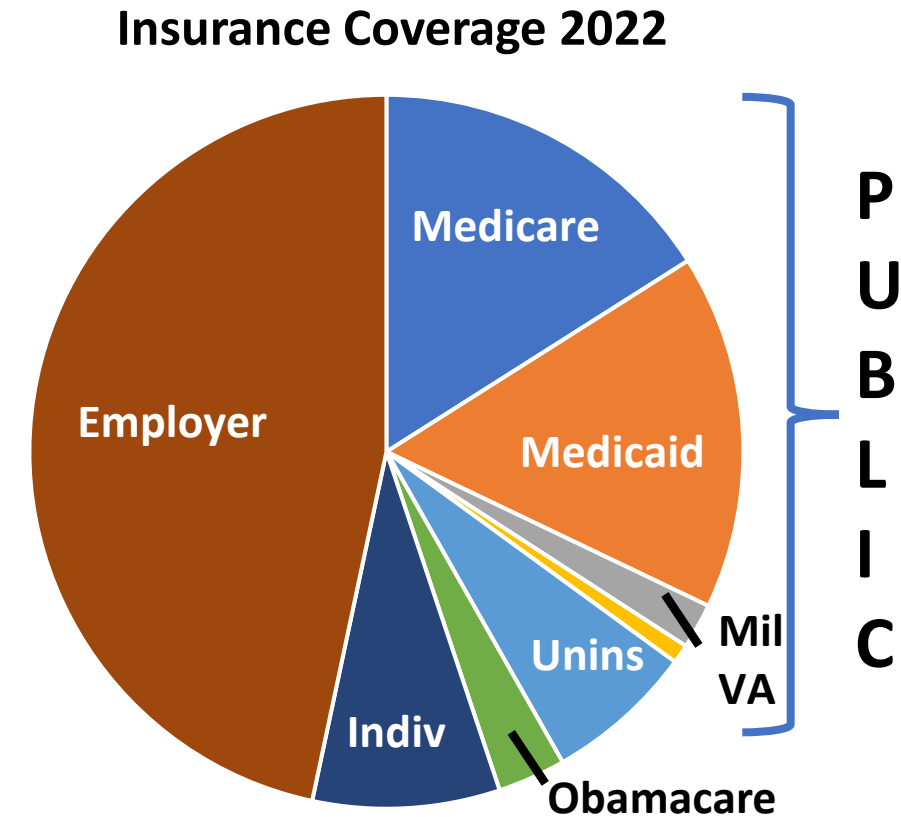


Source: "Growth in Spending on Privately Insurance Drives Much of US Health Spending Growth in 2017 and Early 2018", Altarum Institute, [https://altarum.org/sites/default/files/uploaded-related-files/Public Private Brief final.pdf](https://altarum.org/sites/default/files/uploaded-related-files/Public%20Private%20Brief%20final.pdf)

Medicare & Medicaid set reimbursement rates. Private insurance cannot.

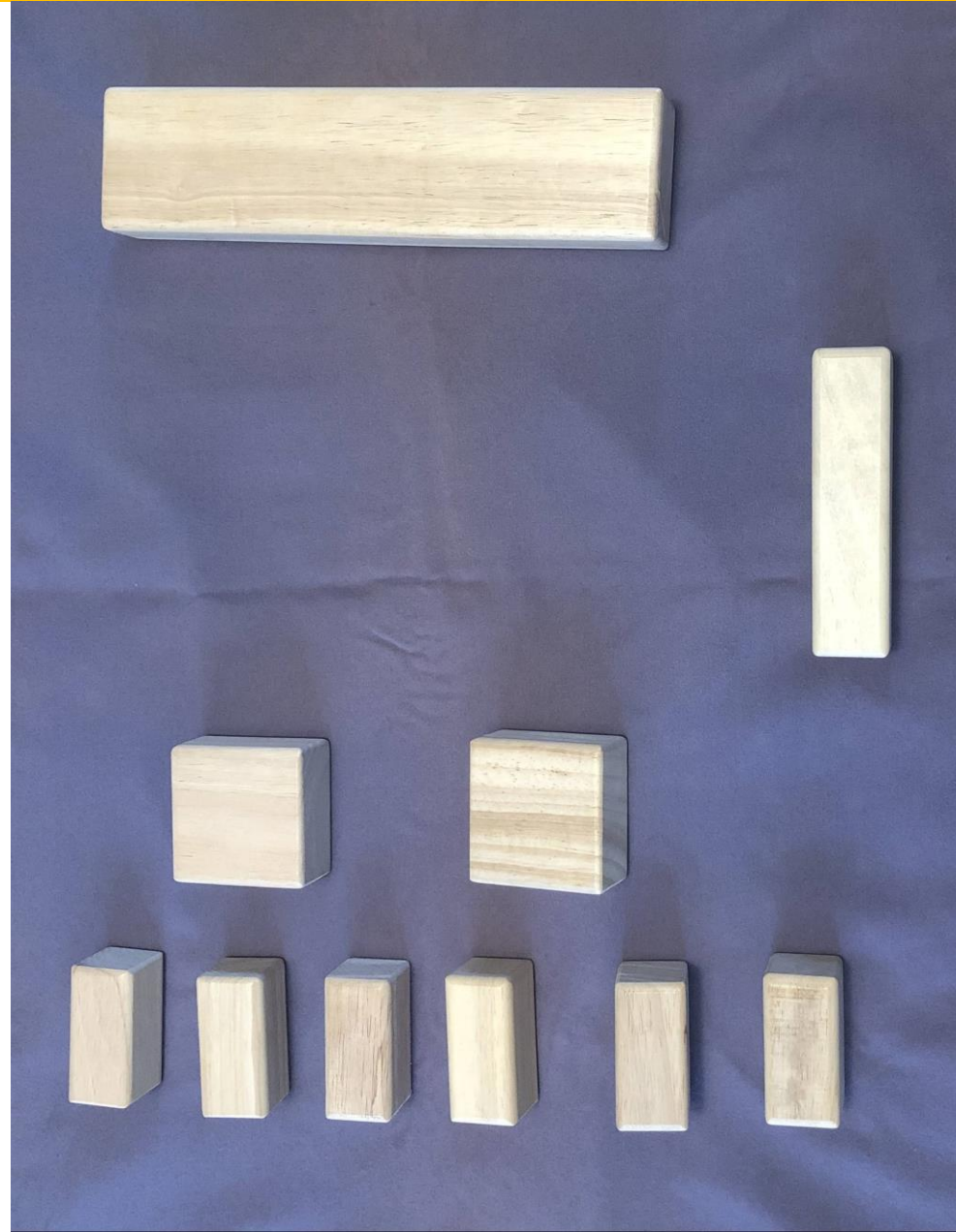
Private coverage dominates

- 1. Employer-based insurance**
- 2. Medicaid Managed Care**
- 3. Increasingly, Medicare is being privatized.**



Let's See How Health Care Finance Works

**Blocking out
how insurance
works
*(children's
blocks on an
infant blanket)***



Health Care Finance

The payer →

Source of funds

Primary care practice →

PCP

Spec & Hosp

Patients →

P a t i e n t

S
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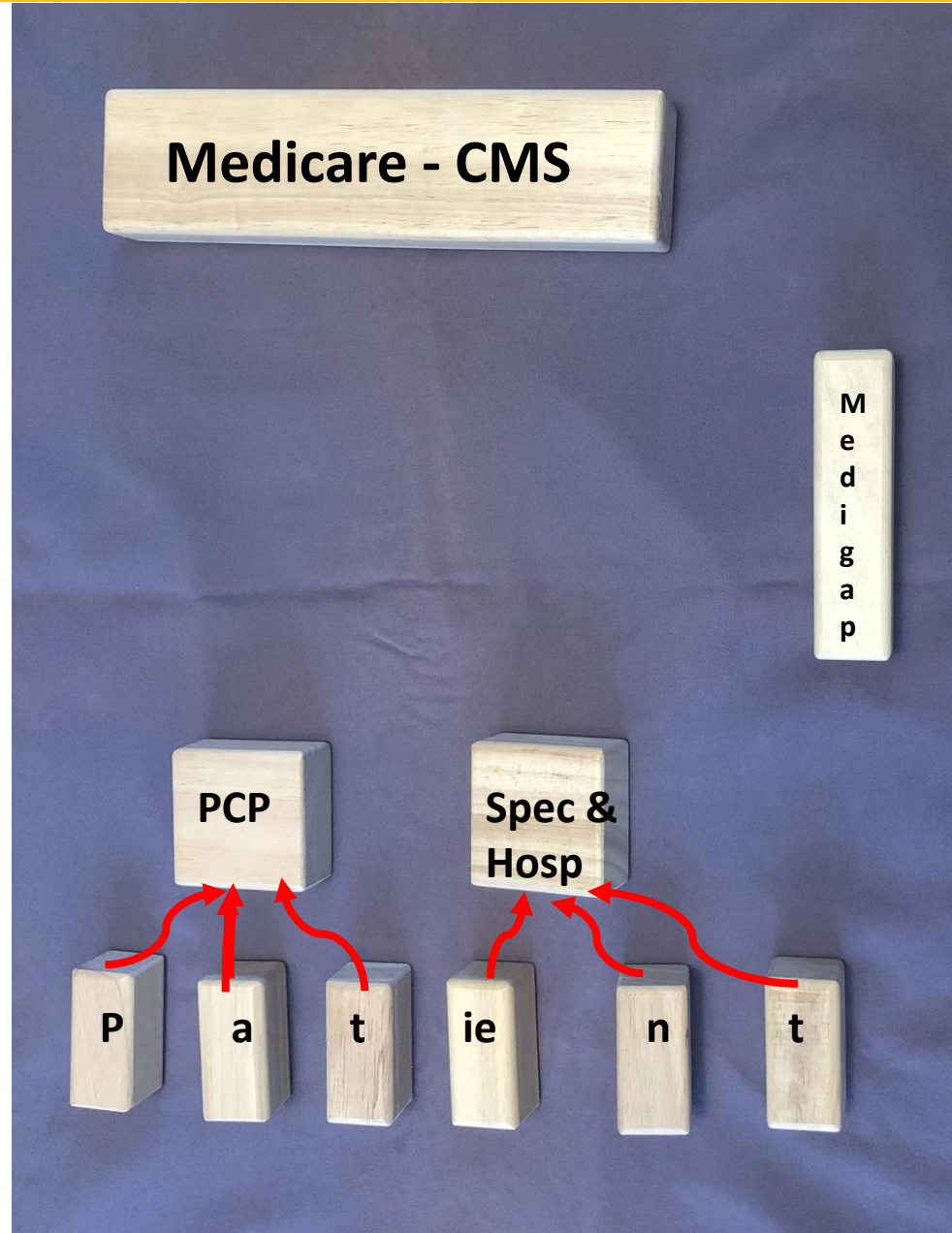
← The supplemental insurer

← Specialists and Hospitals

Traditional Medicare

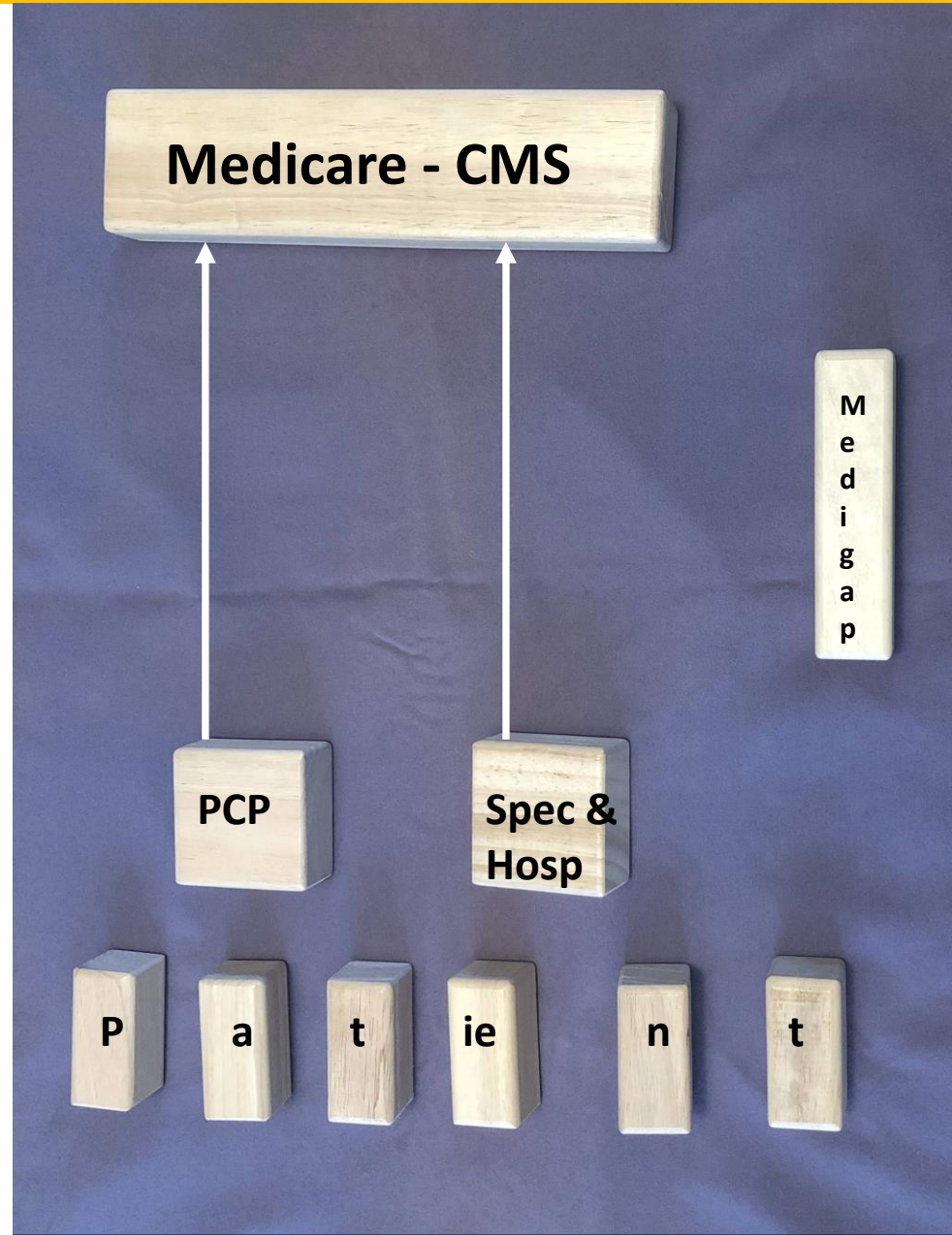
Medicare
uses a fee-for-
service system.

Patients with
illnesses see
their doctors.



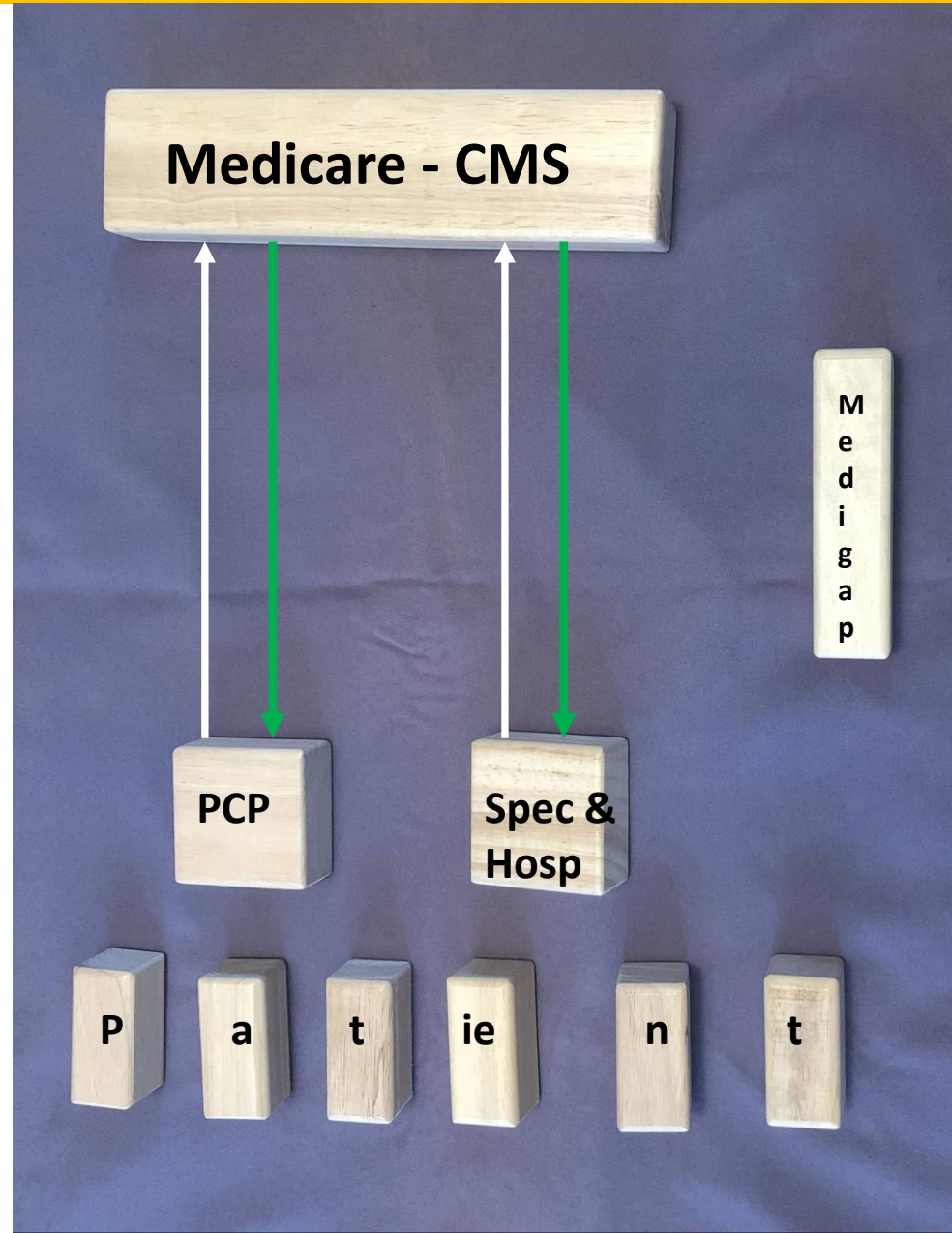
Traditional Medicare

Doctors (and hospitals) file a claim with Medicare.



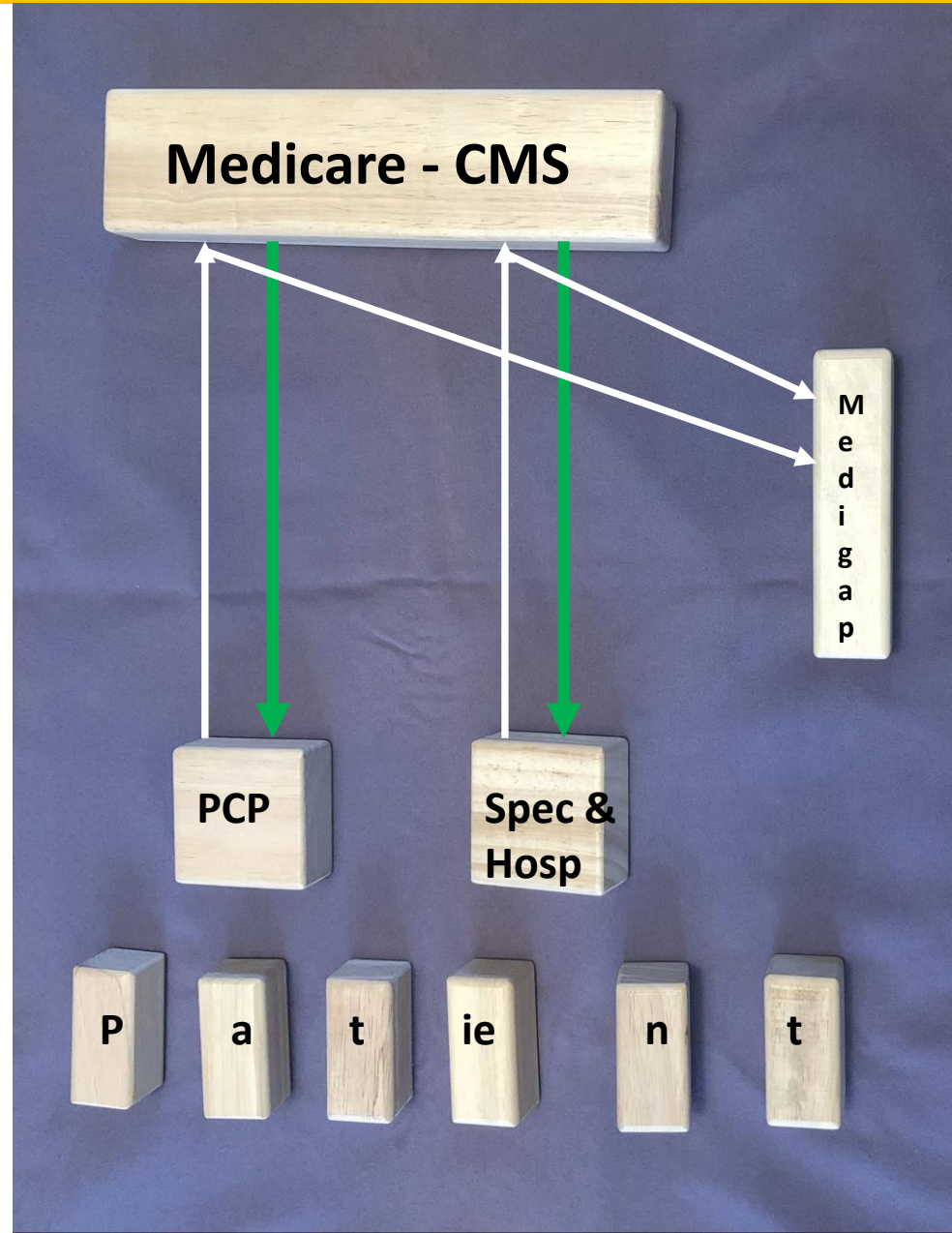
Traditional Medicare

Fee-for-service
Medicare pays 80%
of their bill
according to its fee
schedule.



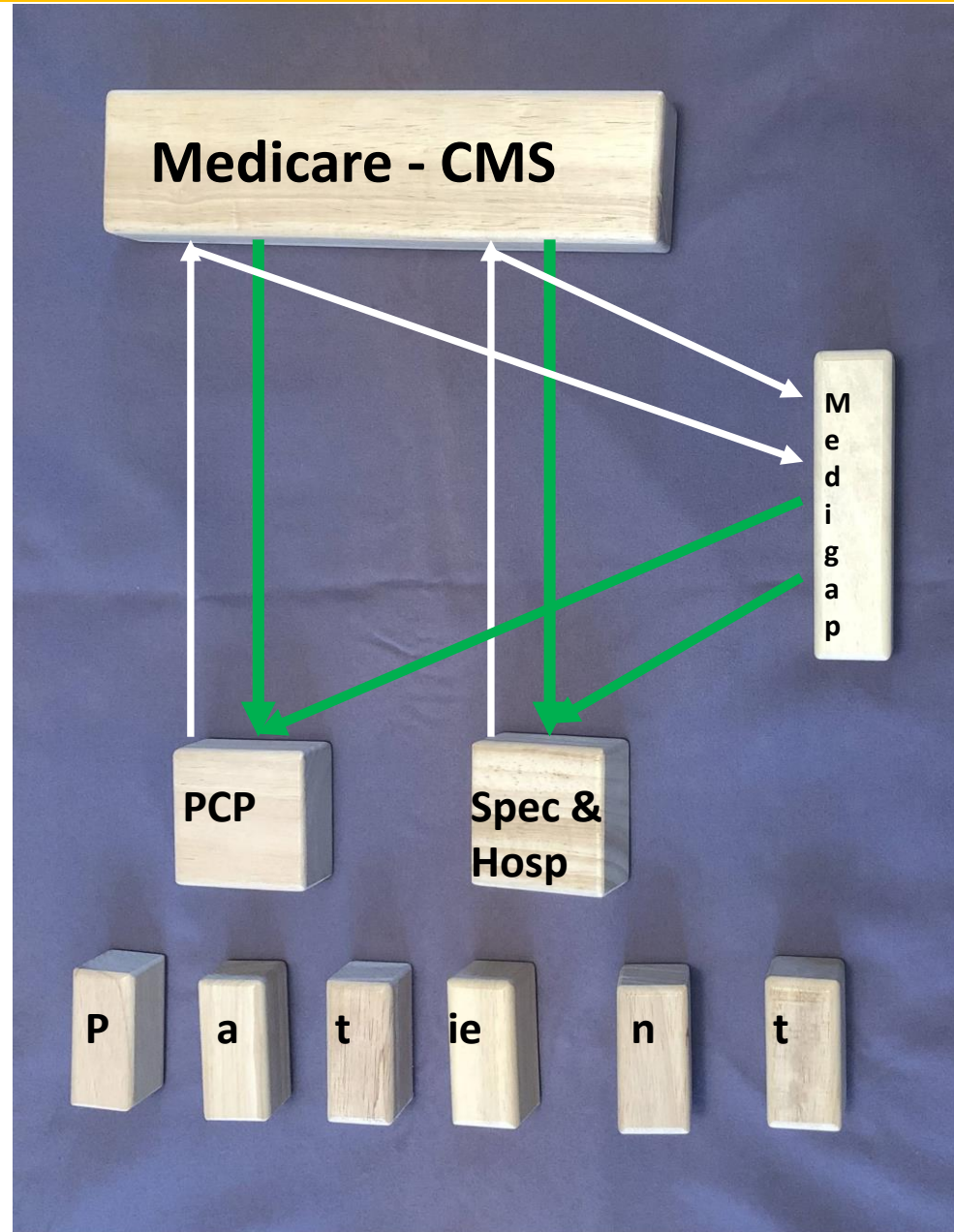
Traditional Medicare

Medicare forwards the claim to the supplemental (secondary or Medigap) carrier.



Traditional Medicare

The secondary carrier pays the rest of the bill.



That's our current form of public health coverage.

There are a number of things wrong with it:

- It doesn't cover dental, hearing, or vision.**
- It has costly deductibles and copays.**
- It has no limit on out-of-pocket expenses.**
- The average Medicare recipient spends more than \$6,000 per year on health care.**

This leads to claims the private sector can do better.

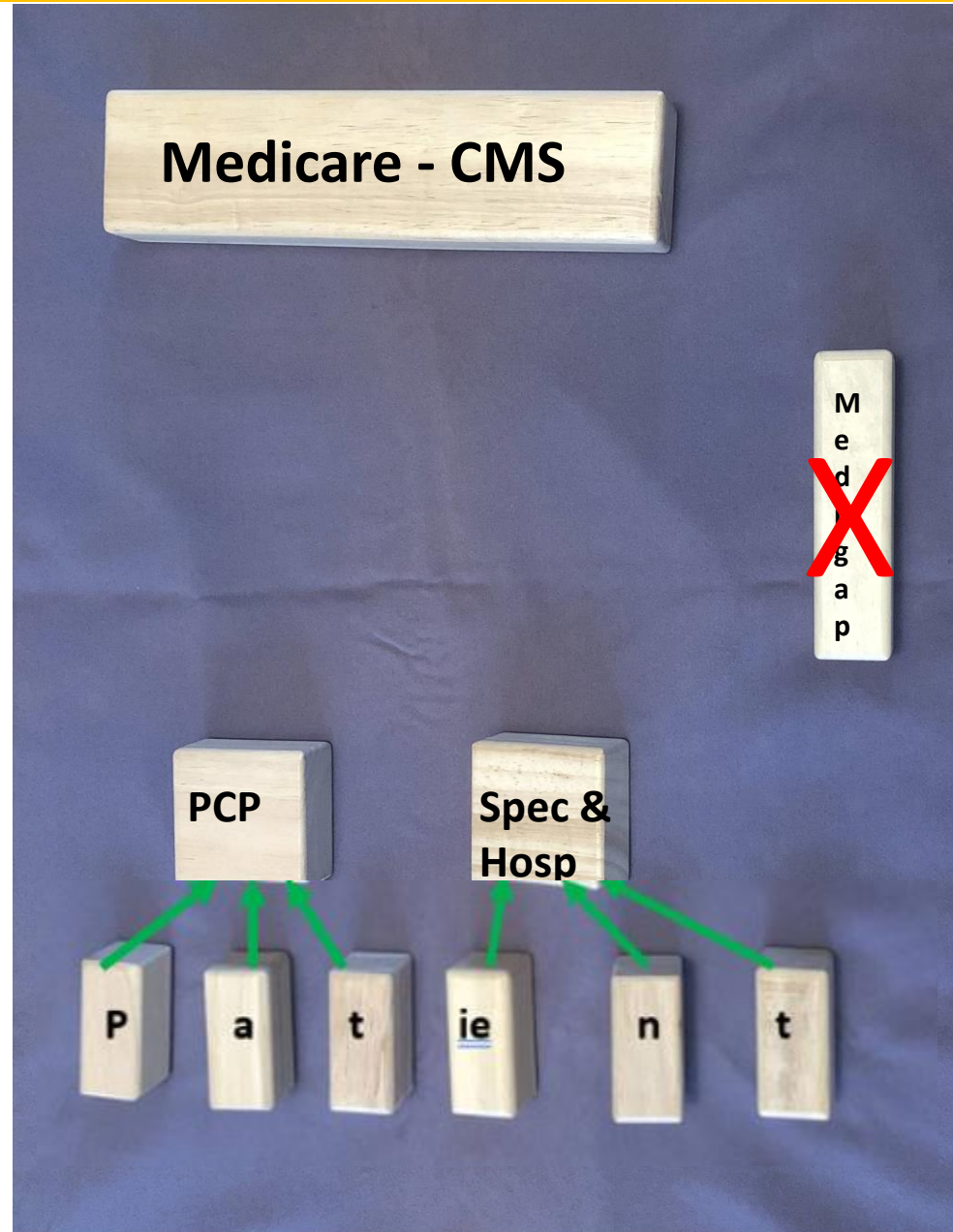
Enter privatization...

Medicare Privatization: Step 1

In 2003, Congress created a private insurance option which it called *Medicare Advantage*.

Medicare Advantage

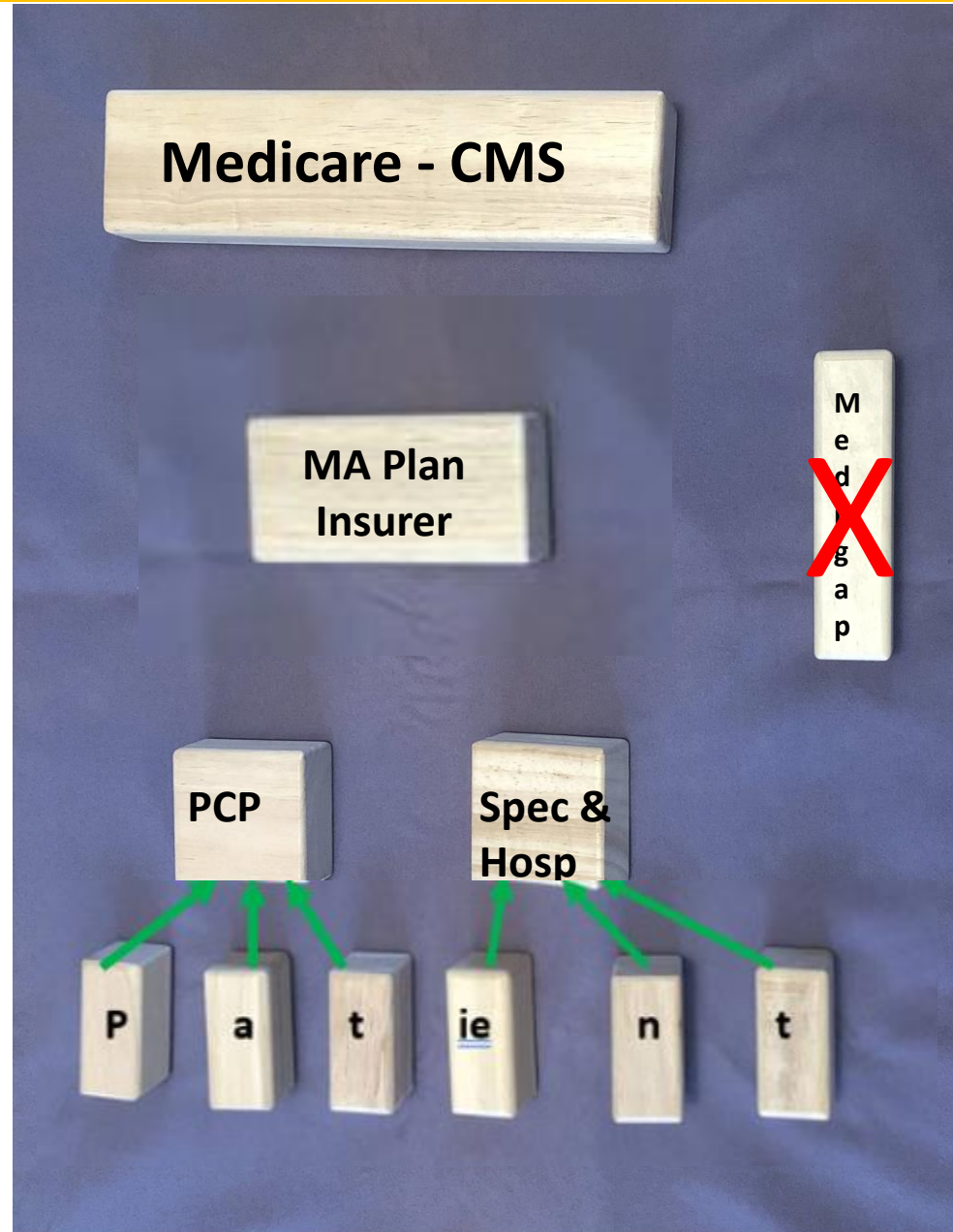
How it works:



Medicare Advantage

How it works:

Insert a middleman
between Medicare →
and your doctors.

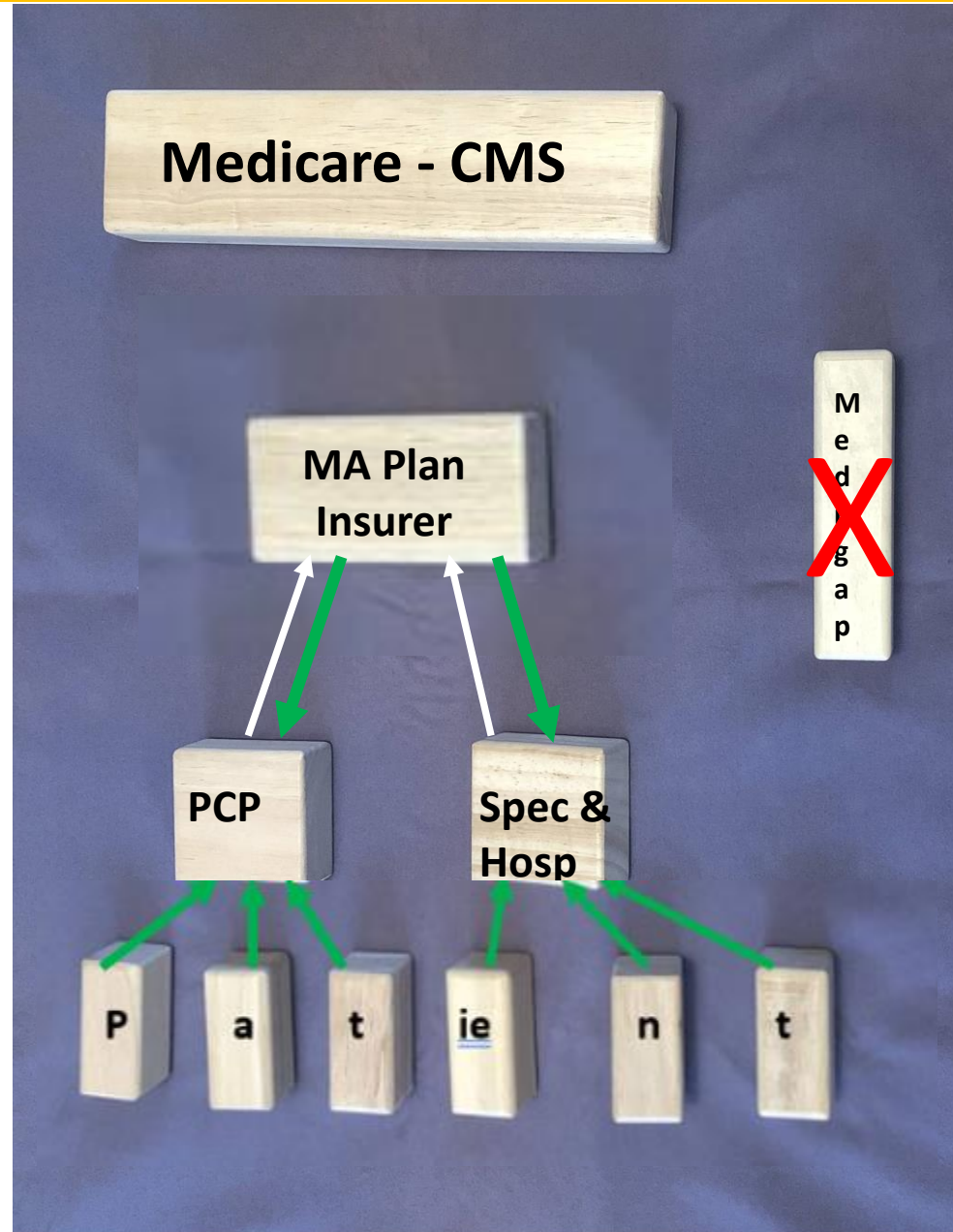


Medicare Advantage

How it works:

Insert a middleman
between Medicare →
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1. Medicare recipients
choose an MA plan. →

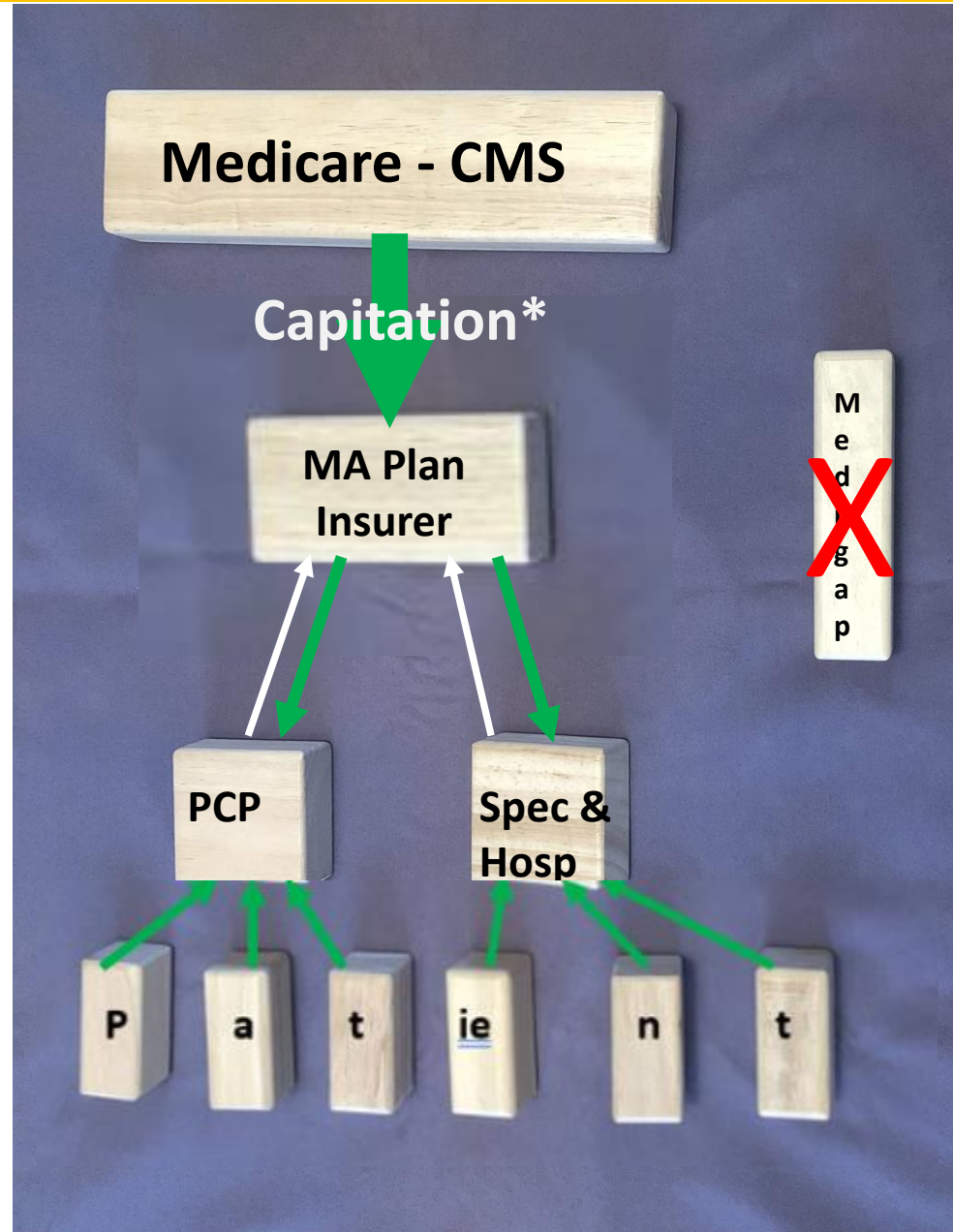


Medicare Advantage

How it works:

2. Medicare sends the insurer a fixed monthly payment to cover each member's costs. →

1. Medicare recipients choose an MA plan. →



*Capitation = Fixed payment per member regardless of spending on care

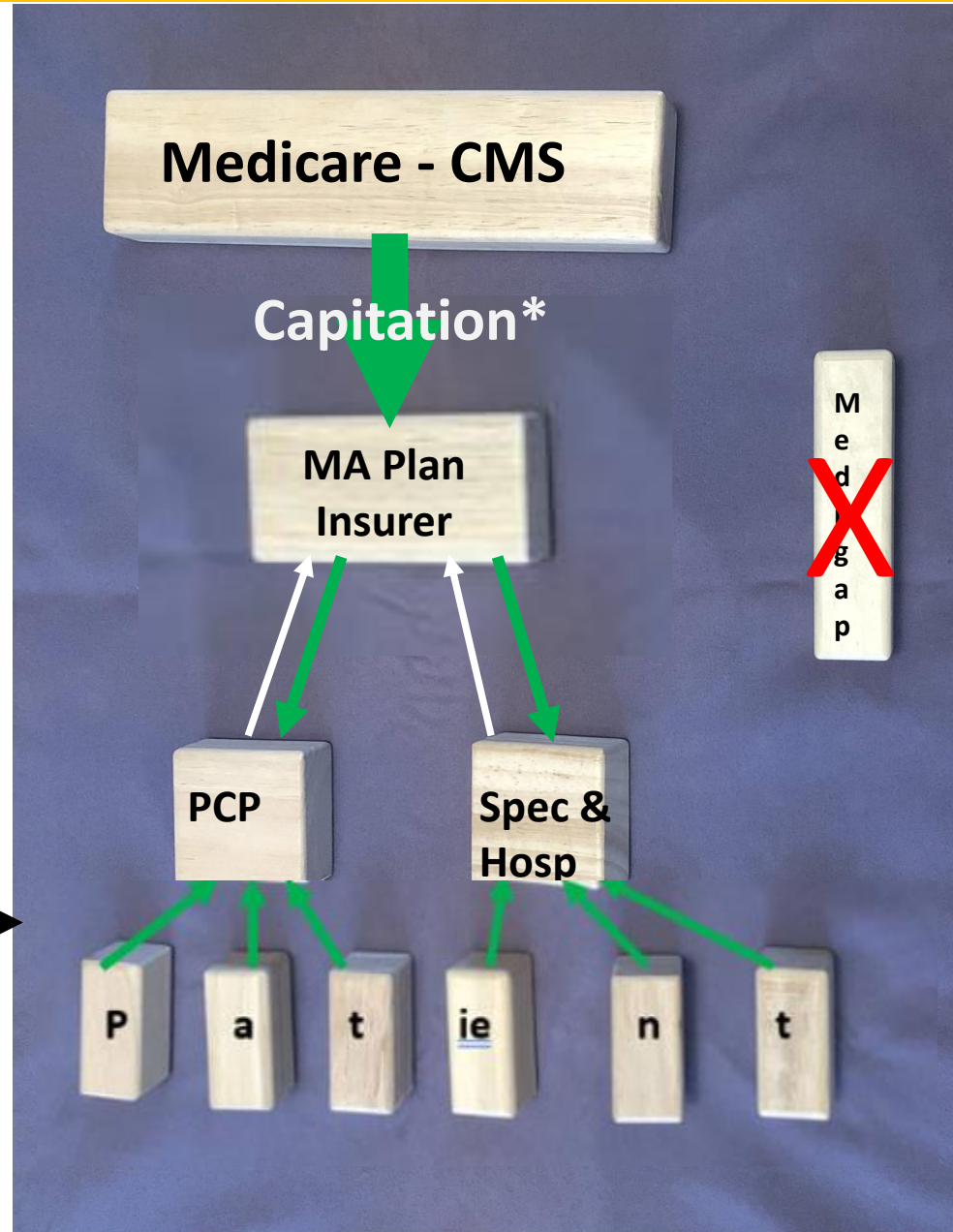
Medicare Advantage

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3. Patients pay copays (saves the insurer money & discourages seeking care). →



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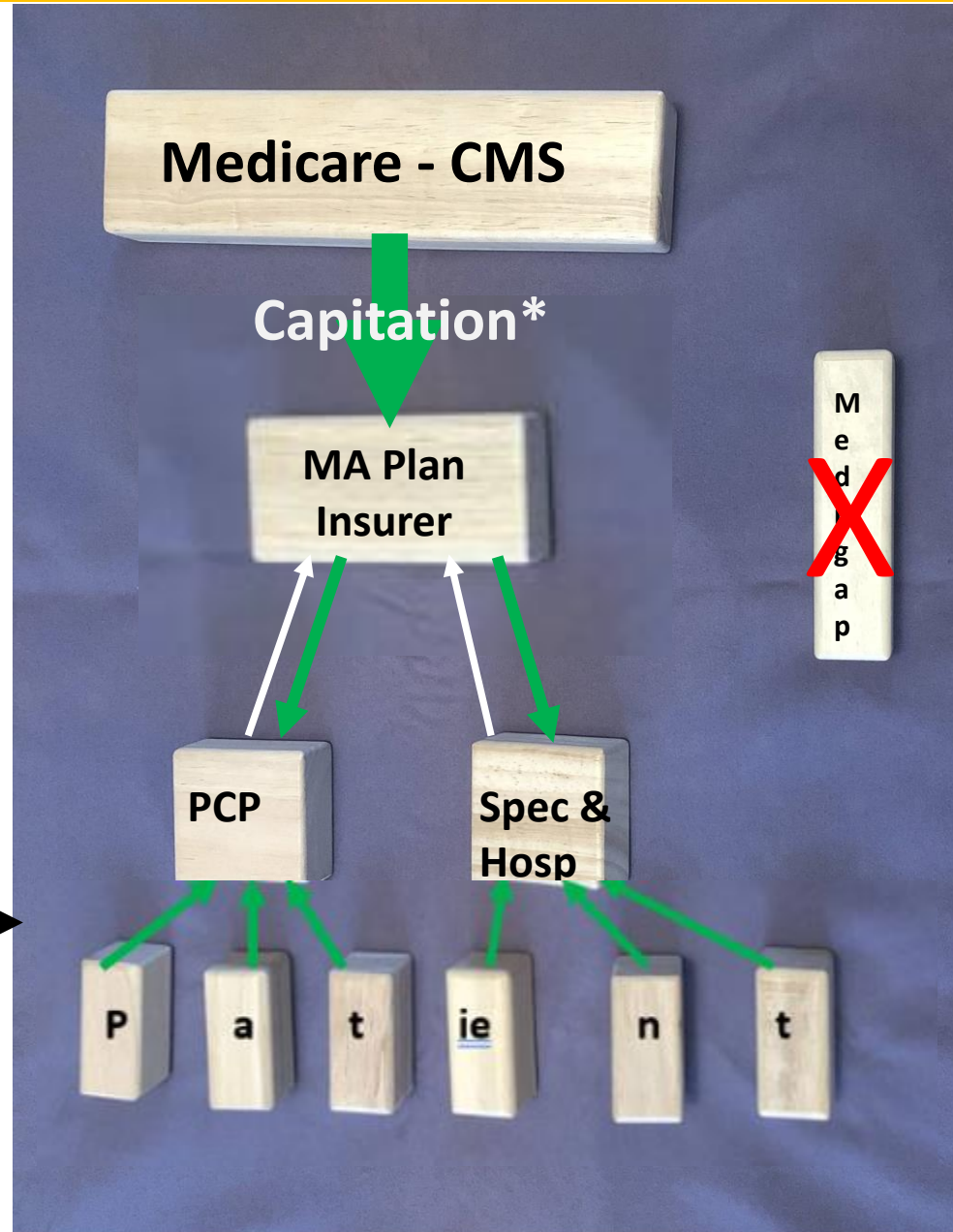
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No supplemental insurance is allowed.

As a result, MA plans have much less money to spend on health care than Traditional Medicare.

*Capitation = Fixed payment per member regardless of spending on care

How Do Private Medicare Advantage Plans Make Money?

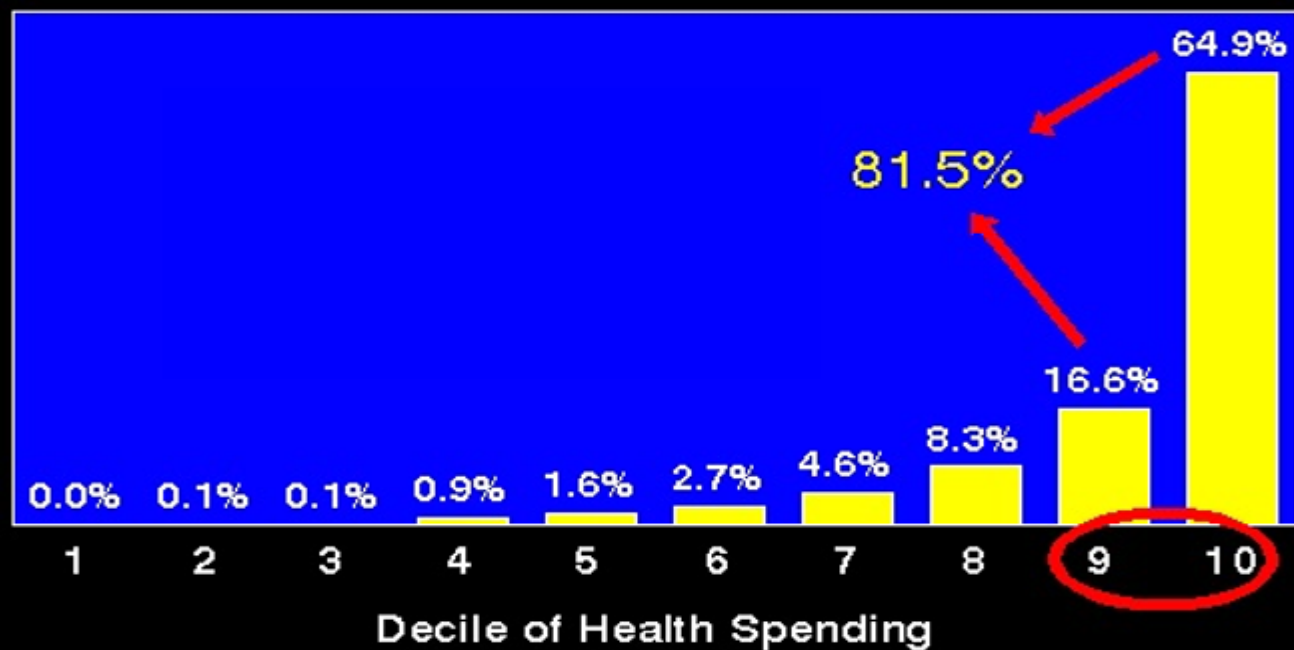
- 1. Federal subsidy (~4% above Traditional Medicare cost)**
- 2. Patients share the cost through copays → less use**
- 3. Attract healthy people, discourage sick ones.**
- 4. Lower payments to doctors and hospitals, leading to limited choice for patients (“narrow networks”)**
- 5. Require prior approval for costly care**
- 6. Just plain fraud (“upcoding” of illness seriousness)**

Why do so many people join Medicare Advantage? It costs less, and most people are healthy and 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

The Bottom Line:

Medicare Advantage...

- Costs the government more than public Medicare**
- Gives patients less care than public Medicare**
- Nevertheless, one-half of all Medicare recipients are now in Medicare Advantage because, as long as they're healthy, it costs them less.**

Medicare Privatization: Step 2

CMS has created a new “model” for the rest of us:

Direct Contracting, rebranded as ACO REACH.

Right now, it’s being tested. But they had 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 .”

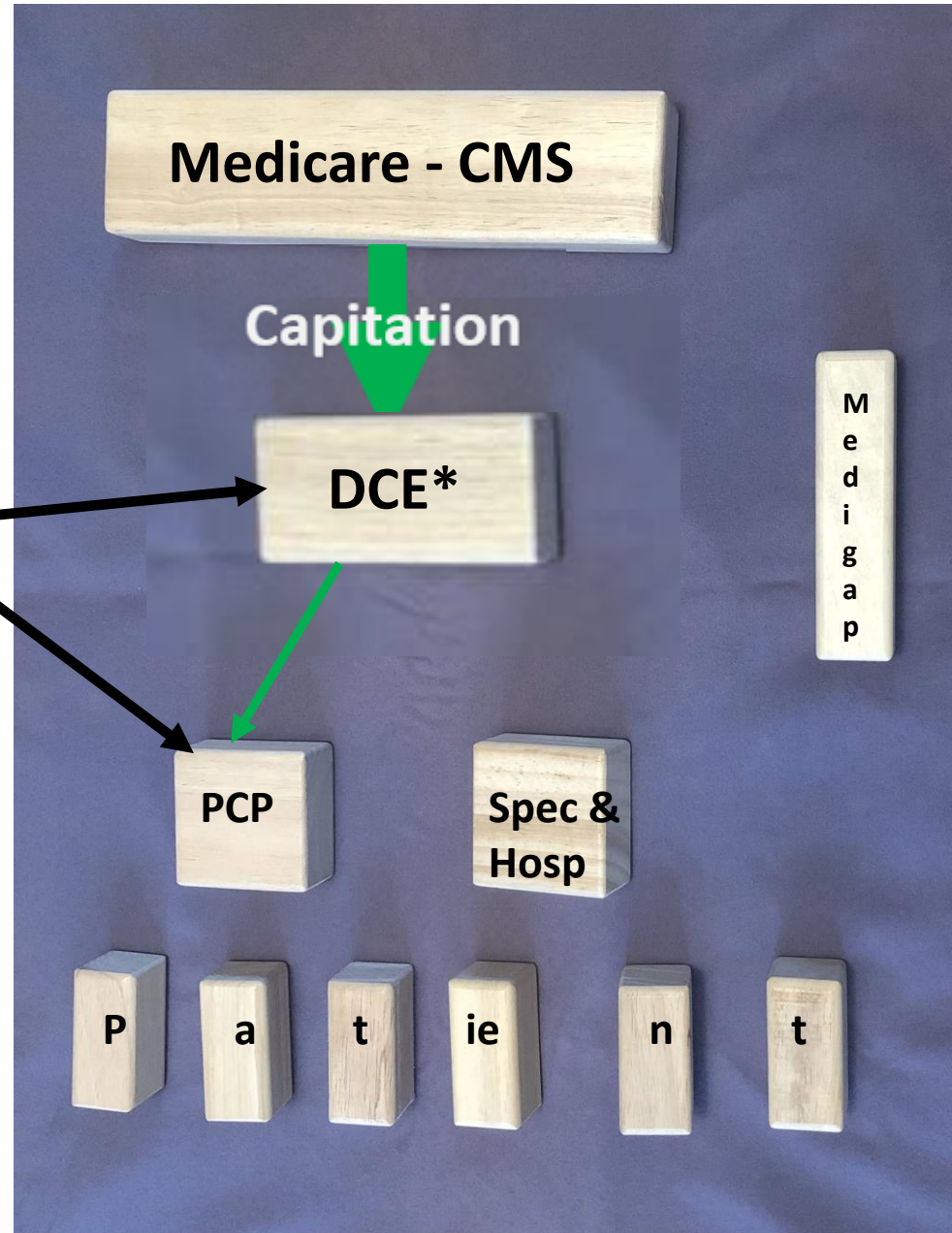
-- Liz Fowler, Director, Center for Medicare and Medicaid Innovation, CMS.

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

Direct Contracting/ACO REACH

How it works:

1. Doctors choose to be in Direct Contracting.



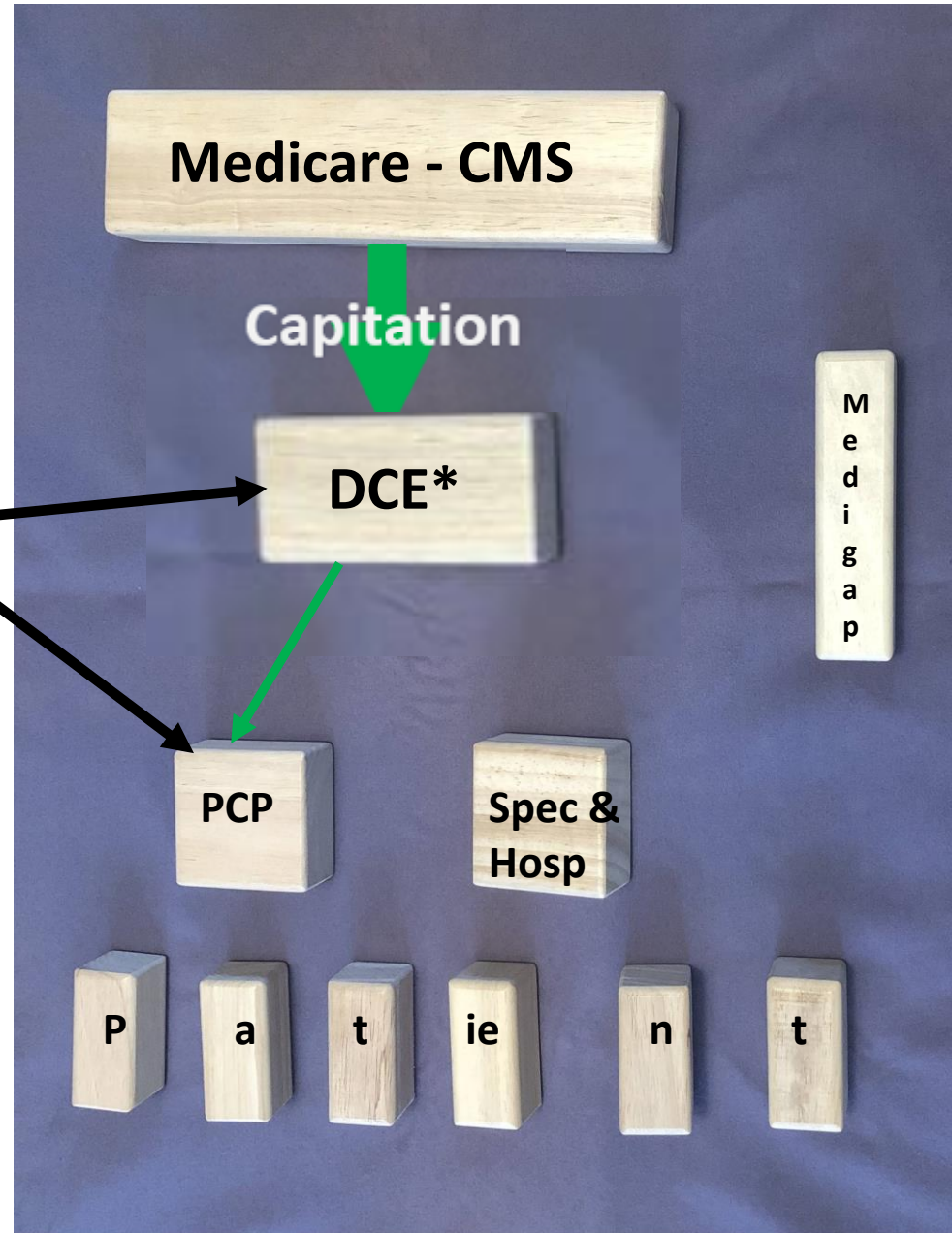
* DCE = Direct Contracting Entity = Insurance company, venture capital firm, etc.

Direct Contracting/ACO REACH

How it works:

2. Medicare/CMS sends the DCE a monthly payment for each Medicare recipient in the doctor's practice.

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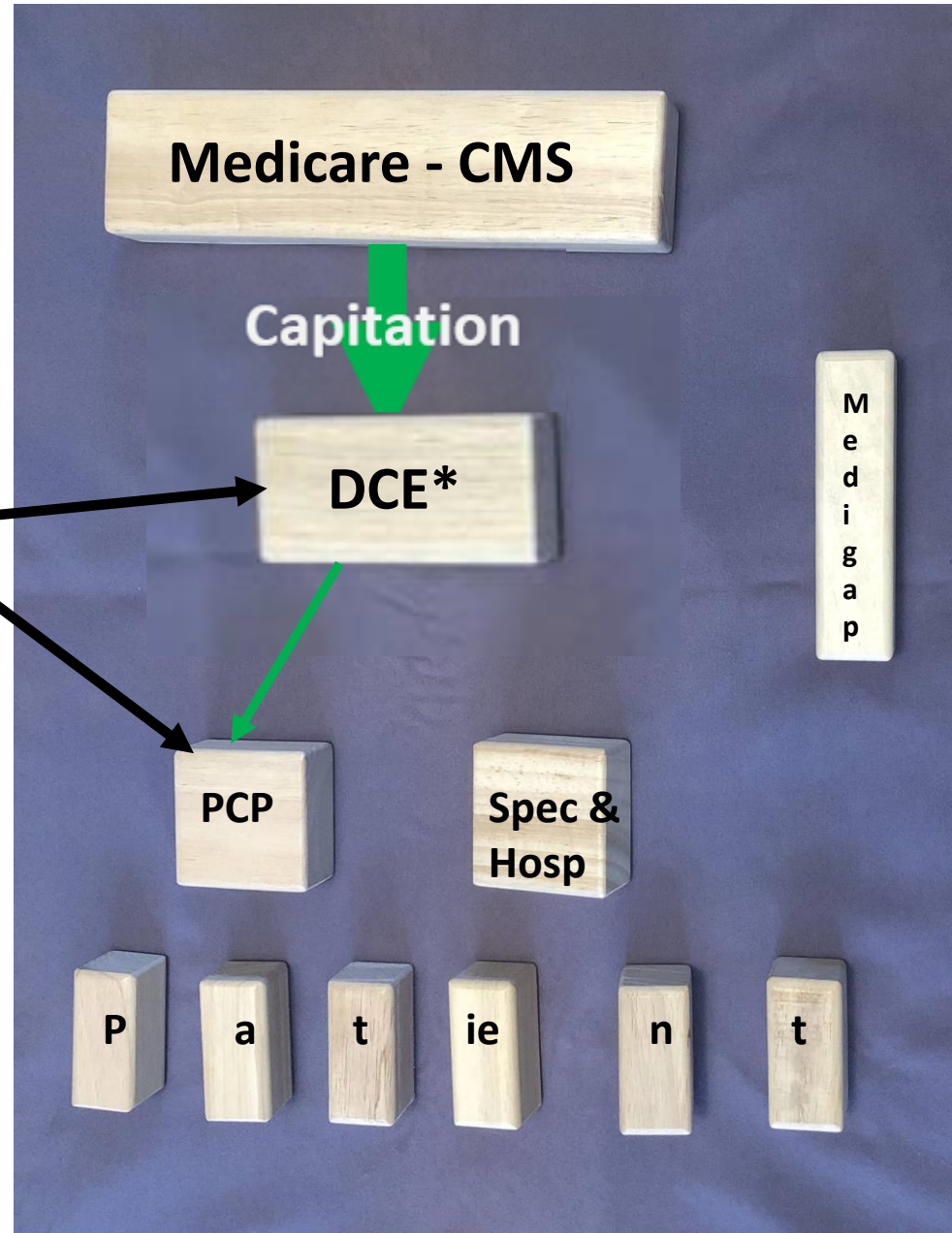
Direct Contracting/ACO REACH

How it works: 2.

Medicare/CMS sends the DCE a monthly payment for each Medicare recipient in the doctor's practice.

1. Doctors choose to be in Direct Contracting.

3. The DCE pays the PCPs a monthly negotiated per-person payment.



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Direct Contracting/ACO REACH

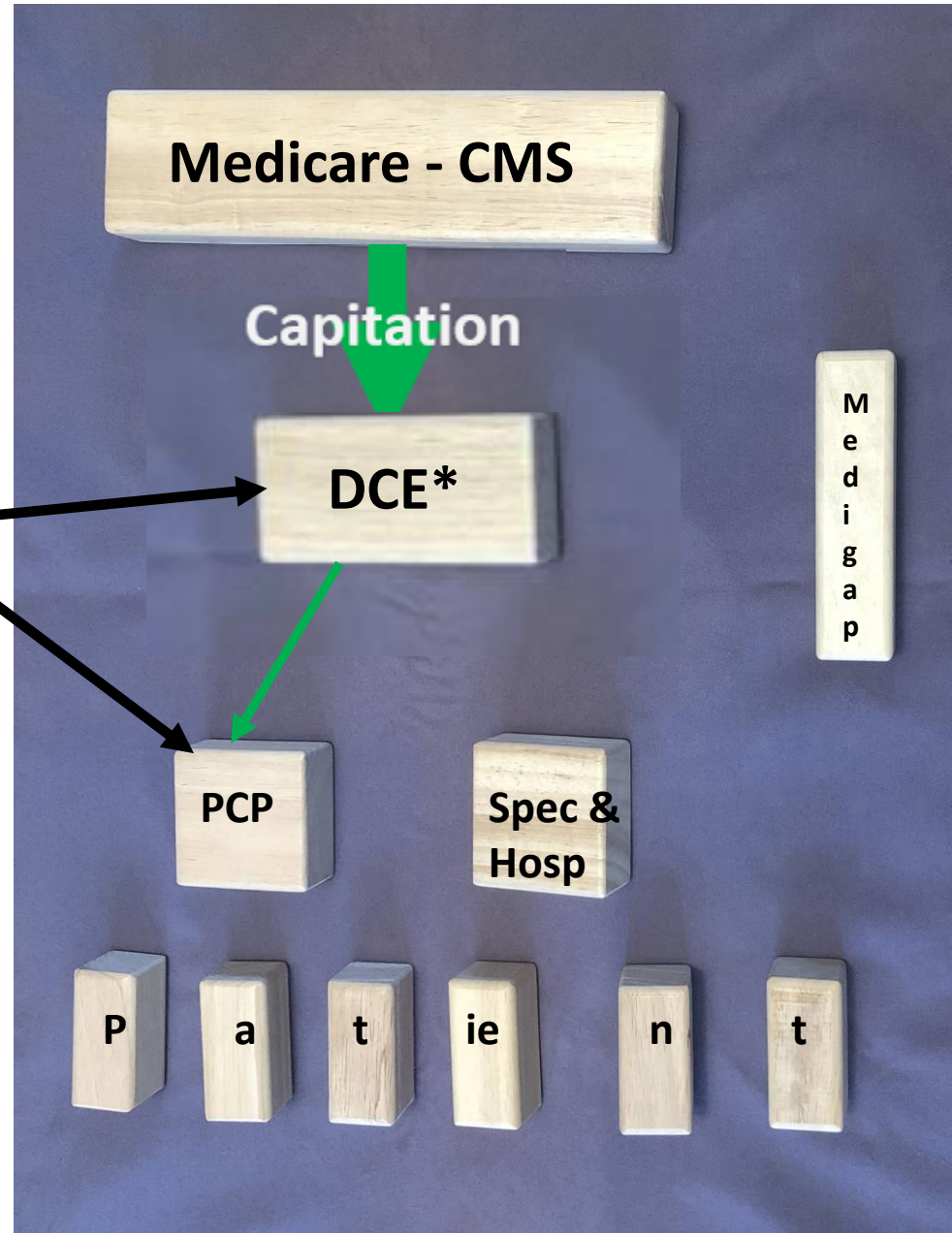
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Notice: The patient isn't involved in the decision to join.



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Direct Contracting/ACO REACH

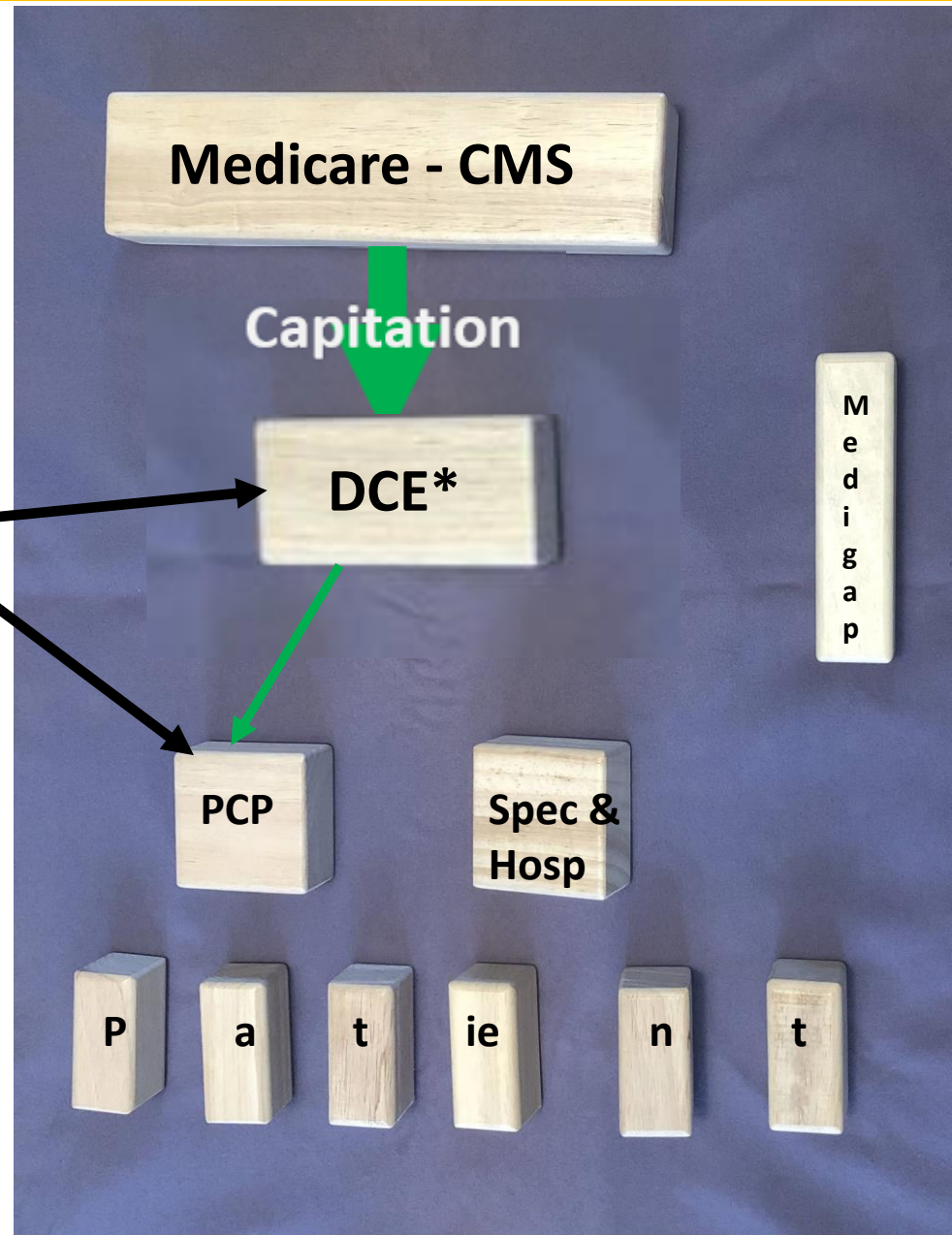
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1. Doctors choose to be in Direct Contracting.

3. The DCE pays the PCPs a monthly negotiated per-person payment.

Notice: The patient isn't involved in the decision to join and may not even know about it.



The DCE makes money by paying the PCPs, specialists, and hospitals less than it receives from CMS. Both get a bonus if they save CMS money. The less care they give, the more money they make!

* DCE = Direct Contracting Entity = Insurance company, venture capital firm, etc.

Q. Why is privatization occurring?

A#1: The belief that the private sector is more efficient than the public sector (Clearly false in health care!)

A#2: Political influence of profitmaking interests

The Real Way to Control Costs!

- **Provide comprehensive benefits**
 - **Have a public agency pay for all health care –
a “single payer”**
 - **Set physician and hospital prices through
negotiation between government and
representative organizations, as other countries do.**
- Publicly-funded single payer is the answer to cost
control and privatization.*

The Public Route to Health Care Reform: Sanders & Jayapal Medicare for All Acts



- **Extend Medicare to everyone**
- **Comprehensive benefits including long-term care**
- **Free choice of provider**
- **No cost-sharing**
- **Public agency pays the bills**
- **Funded by progressive taxes**

Health Care Reform in New York State: *New York Health Act*

A6058/S5474

Passed in
2015, 2016,
2017 & 2018 w
2:1 majorities

33 co-sponsors & 9
recently-elected supporters



Amy Paulin



Gustavo Rivera

- A single State fund covers every resident and full-time worker
- Comprehensive benefits
- No deductibles, no co-pays
- No Medicare Part B & Part D premiums
- Funded by existing public funds & progressive tax on payroll and non-payroll (“investment”) income
- Costs less than we are now spending!

Comprehensive Benefits

Everything covered by:

- Childrens Health Insurance Program (CHIP)
- Medicaid
- Medicare
- Health Benefits for State and Retired State Employees

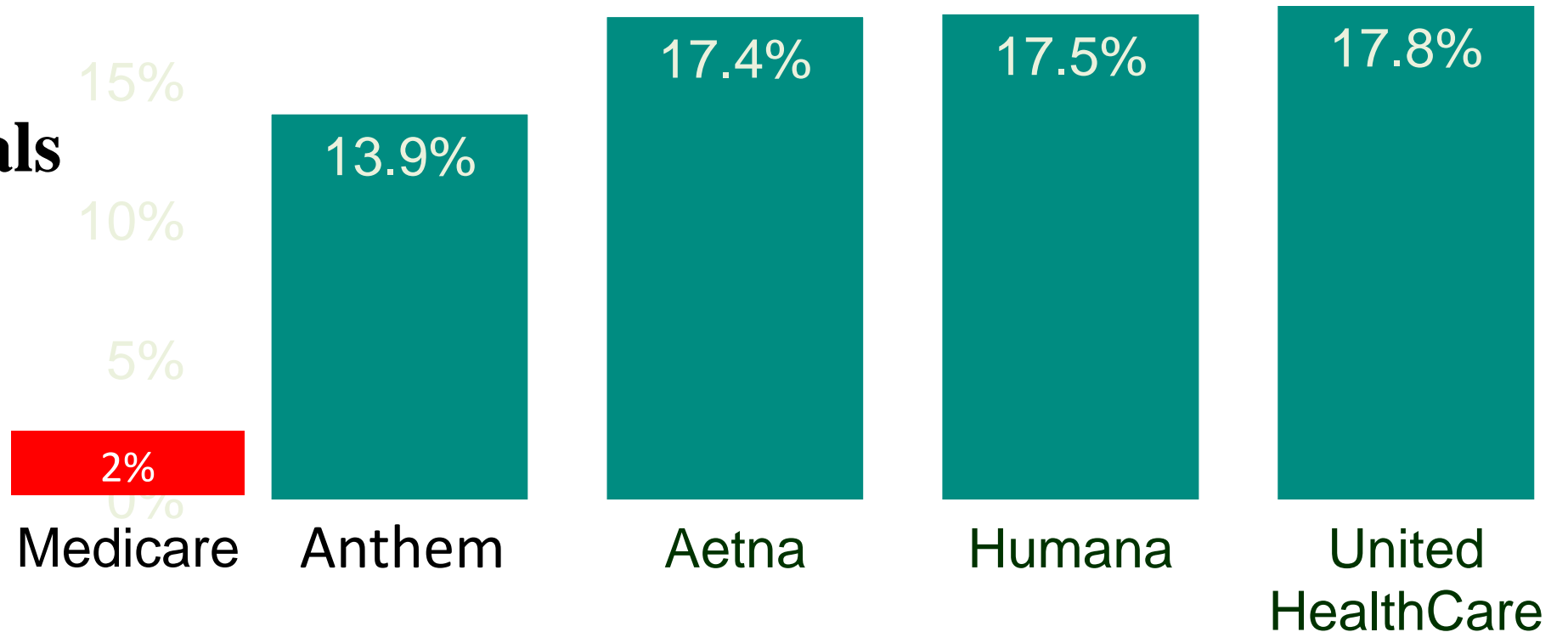
Includes:

Primary and preventive care
Inpatient & outpatient hospital care
Prescription drugs
Dental, vision, and hearing care
Long-term care

Big Savings from Single Payer: Private insurance overhead is far greater* than the cost of a public program

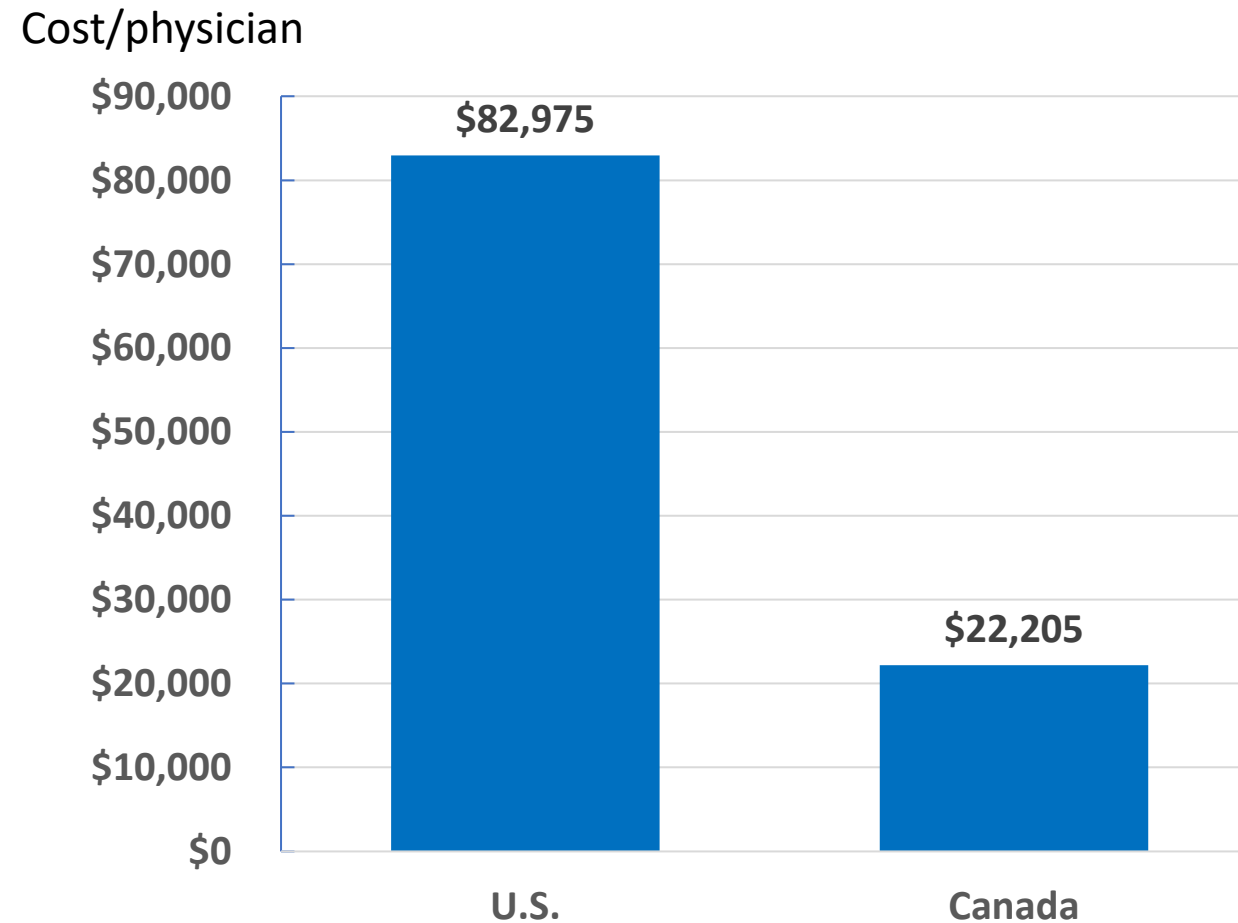
*

- ✓ Prior approvals
- ✓ Marketing
- ✓ CEO salaries
- ✓ Profits



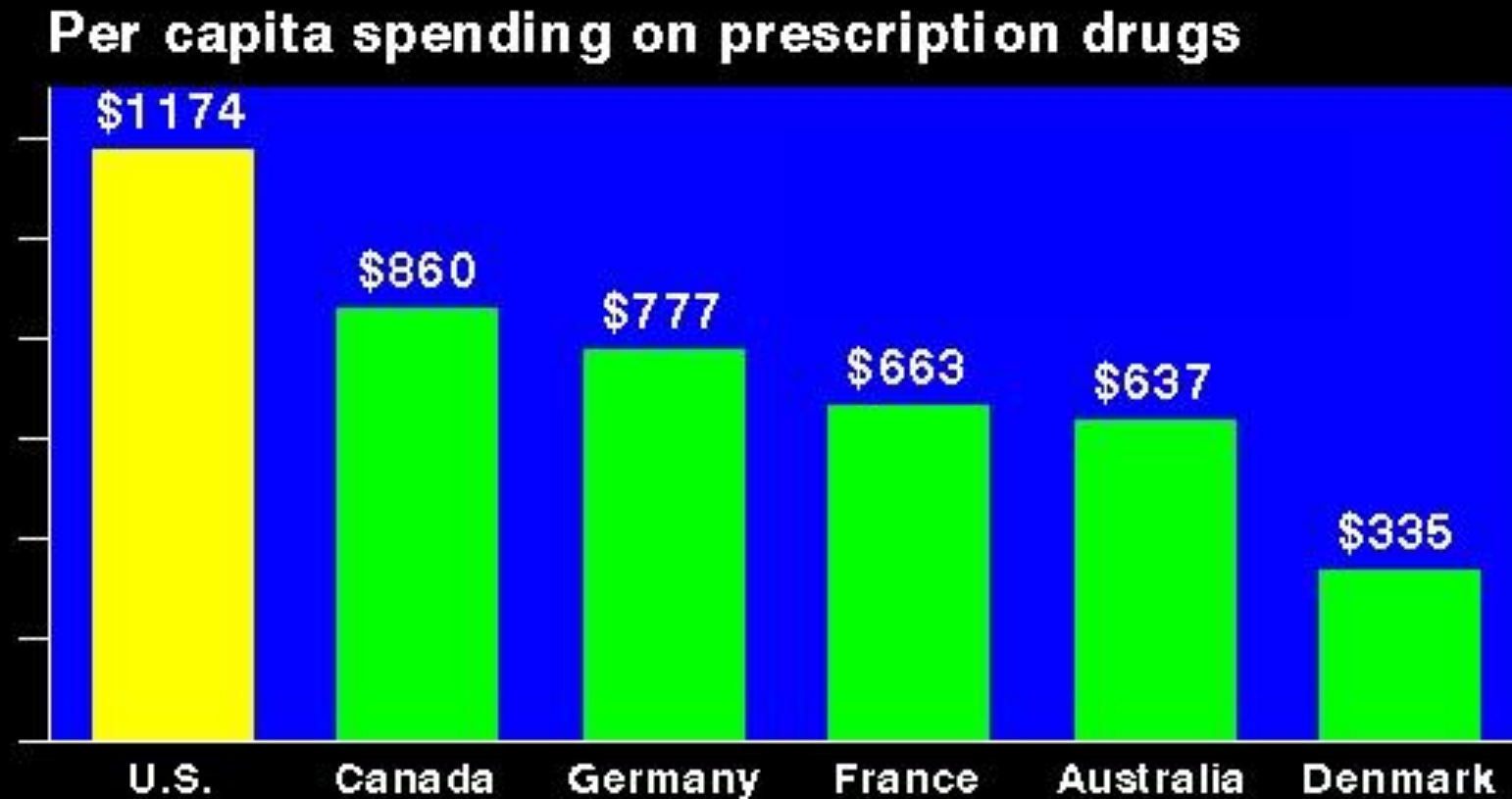
Source: SEC Filings/Reports to Shareholders. Data for Q1 or Q2 2017

Big Savings from Single Payer: Provider Administrative Expenses (US versus Canada)



Source: Morra, Dante, et al. "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers." *Health Affairs* 30, no. 8 (2011): 1443–1450.

Big Savings from Single Payer: Every other country controls drug prices and spends, on average, one-half what we do



Source: OECD, 2018;

Note: Data are for 2016 or most recent year available

Good for All New Yorkers

- **Guaranteed access to healthcare regardless of income, employment, or immigration status**
- **Leaving a job won't mean losing health care**
- **No financial barriers of any kind to receiving care**
- **No need to “spend down” to get long-term care**
- **Greater equality of access to health care**
- **Control of the society's spending on health care**

Physicians for a National Health Program

www.pnhpnymetro.org

Campaign for NY Health

www.Nyhcampaign.org

www.protectmedicare.net