



The Privatization of Medicare:

The Frog in the Boiling Water

The privatization of Medicare is happening, gradually and largely behind the scenes, without any weigh-in of the public, much less legislators. Several ventures of the Centers for Medicare and Medicaid Services are moving the system in this direction, principal among them Medicare Advantage plans and ACO REACH pilot programs. The justification, of course, is cost containment.

Why is PsiAN taking a stand about a system-wide problem that affects only some of us and our patients? Mental health care providers have long experienced how private insurers have impeded the delivery of quality services while driving huge cost increases for patients. Changes in the Medicare system are leading to the quiet disappearance of adequate healthcare as an entitlement, without accomplishing cost containment. There are immediate as well as longer term consequences that alarm us and may create even more vulnerable, hard-to-reach groups.

The proverbial frog of Medicare was in the water as soon as it was created. Side by side with the passage of Medicare and Medicaid in 1968 as entitlement programs – rights for all Americans – has been a push to privatize them, the flame under the pot. The public has never voted on whether they want Medicare and Medicaid privatized. In fact, the public may not fully realize what privatization means, either in terms of how the system works or

the implications of these changes for our own healthcare and health. It's happening, nonetheless.

Medicare Advantage (MA) plans, which came into being in 1997, are an increasingly dominant part of the Medicare system; they have doubled over the last decade and are likely to pass 50% of Medicare enrollment for 2023. MA plans are essentially HMOs run by health insurance companies. While they seem to offer more services for beneficiaries, they are for-profit entities that limit services and access to providers in the pursuit of profit.

Along with Medicare Advantage plans, the Affordable Care Act (ACA) of 2010 is actually an example of privatization. The ACA is a market-based solution to the problem of universal coverage, quality healthcare and cost containment. As a senior Bush administration official responsible for driving the Medicare Drug bill through Congress in 2003 assured a group of investment managers, "(Obamacare) is not a government takeover of medicine. It is the privatization of health care," (Davidson, 2013).

Medicare Part D, the Drug plan, is also completely private: plans are owned and run by insurance and drug companies. Part D explicitly prevents the government from negotiating prices with drug companies as is done in countries with universal health programs. This is why the US spends about twice as much for drugs as these peer countries, and why restraints on some prices were finally legislated just this year as part of the Inflation Reduction Act of 2022.

The newest and most radical iteration of privatization of the healthcare system is what is called the ACO REACH program. This program is currently underway as a pilot within Traditional Medicare. Along with Medicare Advantage, it uses a capitation payment model: Medicare pays private entities a set amount per enrolled patient per year, in advance, and then those private entities are responsible for covering the patients' health care costs. According to the terms of the program, the government pays insurance companies more for sicker patients than it does for healthier ones.

That has enabled insurance companies to describe their patients as being as sick as possible (known as “upcoding”), resulting in [significantly overcharging the government](#). Needed services are also not being provided to these patients, because in a capitation model, providers keep more of the money paid to them when fewer services are utilized. In REACH plans, providers are allowed to make up to 40% profit. Compare that to Traditional Medicare, which spends less than 5% for overhead and, of course, has zero profit.

Despite two decades of research into various models of value-based care grounded in capitation models, [outcome studies indicate](#) “they have done little to improve Americans’ health or lower health costs.” An estimated 1.8 million Traditional Medicare plan holders have been moved into these programs in 2022—without their knowledge or permission--and there is a push from the CMS Innovation Center to convert all Traditional Medicare plans to ACO REACH-type programs within 8 years.

Proponents of the capitation system often describe it as “value over volume,” but it’s not clear who decides the value or volume. Their argument rests on an implicit logic that less “volume” means more “value,” and proposes that this can be achieved through proper management. There is very little evidence to support the idea that private sector providers like insurance companies, seeking profits, have provided superior clinical value (or, some would argue, equal clinical value) or contained costs.

Why is eliminating fee-for-service (FFS) so important to those pushing for capitation models? FFS was/is blamed for high healthcare costs, asserting that greedy clinicians over-billed for unnecessary services. In fact, Americans actually get LESS HEALTHCARE SERVICE per capita (outpatient visits, hospital days, surgeries, tests) than individuals in countries with universal systems (like Traditional Medicare) for TWICE the cost (Woolf & Aron, 2013). Thus, the problem isn’t FFS, it’s privatization – the market has too many expensive middlemen taking too much money out of the system for their profit.

The Inspector General's office In the Health and Human Services department has found that 13% more people in Medicare Advantage plans are denied necessary care than in Traditional Medicare and 18% were improperly denied (Medicare Payment Advisory Commission, 2022). Concrete evidence of poorer care can be seen in how patients in the last years of life on Medicare Advantage plans disenrolled at more than twice the rate (5% vs. 2%) of all other Medicare beneficiaries (US Government Accountability Office, 2021). And, returning to traditional Medicare after being on a Medicare Advantage plan is becoming much more difficult as patients have been identified as "sicker," and therefore less desirable to the supplemental plans, Medigap, that cover traditional Medicare deductibles and copays.

Moreover, Medicare Advantage (MA) cost taxpayers \$106 billion more from 2010-2019 due to overpayment, mainly from upcoding, nearly \$34 billion of this during 2018 and 2019. Spending on MA is expected to increase by \$600 billion from 2023 to 2031, with as much as two-thirds going to insurance company profits (Schulte, 2021). In 2020 Medicare paid 4% more for beneficiaries in MA than Traditional Medicare plans and \$12 billion alone from upcoding (Medicare Payment Advisory Commission, 2022). It is eminently clear from a range of metrics that MA is significantly more expensive than TM despite claims by the government and insurers that capitation is the better way to manage cost.

Finally, another reminder of the higher costs of MA plans: we see their [misleading advertisements](#) on TV especially these days during open enrollment. Costs for these ads are part of the costs of our healthcare system. In some good news, these glowing ads did get government attention. Starting next year, insurers will not be able to air any television ads for Medicare Advantage plans before getting approval from federal regulators (King, 2022). The new requirement is part of a larger effort by the CMS to address concerns in MA marketing practices. This initiative comes as a Senate panel is also investigating how MA plans reach customers. "It is unacceptable for this magnitude of fraudsters and scam artists to be running amok in Medicare," said Sen. Ron Wyden (US Senate Finance

Committee, (Wilkins, 2022). We also think it's unacceptable that part of our health care dollar is spent on misleading advertising, as well as on the regulatory action required to curb it.

From an historical overview of past efforts to privatize Medicare, Geyman (2004) reviewed the track record of private Medicare plans over the last 20 years with regard to choice, reliability, cost containment, benefits, quality of care, efficiency, public satisfaction, and fraud. In all these areas, privatized Medicare has performed less well than original Medicare. Moreover, privatization can be seen as a betrayal of the social contract between the government and the public. It is undoubtedly fair to say that many of us who enrolled in Traditional Medicare did so to preserve our right to choose our practitioners. This entitlement would seem to be targeted for extinction.

So how does it happen that Medicare Advantage, a more restrictive and more costly system, wins out over Traditional Medicare, a more humane, effective and less expensive system? Part of the answer involves money, both real and in our political ideologies. The reality and power of financial entities to buy influence on both sides of the political aisle is massive, of course. Private equity in health care increased 20-fold from \$5 billion in 2000 to \$100 billion in 2019 (Applebaum and Batt, 2020) But the power of cultural ideology, if not illusion, is also at issue here, as seen in the expectation that the market is better able to bring about a solution than government nonprofit systems.

That this expectation is illusory is borne out by the excess costs of the US market-based system, in contrast to all other universal systems which deliver far more at far lower cost. We might also see the US system as a hidden jobs program for all of the non-healthcare workers employed in the system that contribute little if anything to healthcare outcome but much to healthcare cost. "When a middleman makes profits from managing your healthcare they inevitably do so by limiting the care you get" (Schorr Saxe, in Wilkins, B., 2022).

To bring the issue home to the mental health world, we need only look back to the days in the 1990's and early 2000's where the worst abuses of managed care occurred in the forms of utilization review, preauthorization, session limits, and other tactics under the rubric of "medical necessity." Insurance companies positioned these policies as necessary to maintain proper care and to guard against greedy providers, however they were actually to limit or eliminate services. Insurers have since found other ways to curtail care (low reimbursements and audits), and we can assume that these tactics and more will be employed when corporate entities take over traditional Medicare. Mental health has long been a vulnerable target for service cuts, and we've seen that over and over again. The passage of the Mental Health Parity and Addiction Act of 2007 was passed to protect the accessibility of mental health services, but enforcing fair and adequate coverage remains an uphill battle despite it. There's absolutely no indication that the privatization of Medicare will improve this situation.

What are we to do about this dismantling of Medicare as a public entitlement? As with our therapeutic work, a fundamental direction involves helping our patients develop a deeper understanding of themselves and the world around them. Given the stealthy nature of the implementation of privatization through ACO REACH, as well as the dangers of privatization and capitation, our initial efforts need to be in the realm of consciousness-raising. The public needs accurate information as well as insight into what is going on so that they can make better sense of what is happening around and to them. By expanding our understanding of the forces affecting all of us, we can better protect our work and educate the public regarding their options and the impact of their choices. Moreover, this understanding forms a crucial foundation for individual and collective action.

To help educate and protect our patients and fellow therapists, PsiAN has prepared a [guide](#) that defines Traditional Medicare and Medicare Advantage plans and clearly outlines their differences. Please feel free to share our guide widely. We hope our guide, this article, and other advocacy actions of PsiAN help to alert the public that the frog is in

the water and the water is getting hot. Many organizations, such as [Physicians for a National Health Plan](#), are working to get the frog out of the water altogether.

We hope that Medicare as a social entitlement can be rescued before it's too late. It is a crucial protection against market forces determining standards of health care. Private insurers, whose motives are entirely different than those of the government, need to be held accountable for providing health care services that respect the intention as well as the letter of the law and follow generally accepted standards of care. Our ongoing advocacy for public awareness and insurer accountability is the role we play in maintaining the social contract.

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