**Threats to Original Medicare – Privatizing and Monetizing Medicare Apr 2022**

**Medicare** is the **federal health insurance program** created in 1965 for people 65 and older, regardless of income, medical history, or health status. The program was expanded in 1972 to cover some persons under 65 with long-term disabilities, including blindness, end-stage renal failure, and other. Medicare covers hospitalization, some outpatient costs, and, with the passage of Medicare Part D, prescription drugs. Medicare doesn’t cover everything, so, most people purchase a supplemental policy for outpatient services, commonly called **Medigap or Medicare Supplemental Insurance**. Medicare enrollees may purchase these policies without undergoing an underwriting process if purchased at age 65, and are guaranteed coverage.

**Traditional Medicare** reimburses providers – doctors, hospitals, other – directly, at a set rate. Seniors have free choice of providers. Traditional Medicare spends **98% of funds on patient care; 2% on administration**.

The 1972 Social Security Amendments allowed the introduction of Health Maintenance Organizations (HMO), run by private insurance companies, to enter the market with new payment models that included “risk-sharing agreements” which opened the door to privatizing Medicare.

**Medicare Advantage** is a version of Medicare run by commercial insurance companies. Beneficiaries sign over their Medicare to an insurance company. Medicare pays these insurers a set amount per enrollee per month (called capitation). The insurers pay providers for health care and are allowed to keep what they don’t spend on care as profit. In 2020, Medicare Advantage plans spent **82% of revenue on patient care** and kept **18% as overhead and profit.** Medicare Advantage plans drive up their profits by using “managed care” strategies including networks, pre-authorizations, denials, drug formularies, etc. In addition, they use a tactic called “upcoding” to add diagnoses or increase the severity of a diagnosis to raise “risk scores” and charge Medicare higher annual fees for enrollees. Advantage plans are overcharging by $billions per year. This is draining the Medicare Trust fund. Due to very aggressive marketing, the number of Medicare beneficiaries enrolled in Medicare Advantage is up to 42% of total Medicare beneficiaries. Insurance companies selling Medicare Advantage plans have an incentive to seek out healthier seniors and make it more difficult for higher need seniors to get services. Those who leave these plans may not be able to afford another supplemental plan if required to go through medical underwriting and qualify for coverage.

**Medicare Part D** – a prescription drug benefit for seniors, passed in 2003 and implemented in about 2006, did not include a funding mechanism, and is covered by general revenues, premiums, and state funds.

The newest and **most dangerous threat to Medicare** is a payment model called **Direct Contracting**, devised by the Center for Medicare and Medicaid Innovation (CMMI), an agency within Centers for Medicare and Medicaid Services (CMS), in which enrollees who have chosen traditional Medicare can be involuntarily assigned to any one of dozens of for-profit direct contracting “entities” (DCE) who have applied to participate in this program. These DCEs can be for profit/investor-owned insurance companies, physician groups, health systems, or other “entities”. Similar to Medicare Advantage, DCEs are paid an annual fee by Medicare in return for accepting the “risk” of paying for enrollees’ health care but these “entities” will be allowed to keep **as much as 40%** of those capitation fees **as overhead and profit**. Activists and advocates learned of this scheme in 2021 and raised objections. CMMI recently re-designed and rebranded DCEs to include some requirements for increased emphasis on “health equity” and promised to include providers and consumer advocates on boards of directors. This new program is called **ACO REACH** or Accountable Care Organization Reaching Equity, Access, and Community Health. All enrollees in traditional Medicare are to be involuntarily assigned to one of these entities which **will end Medicare as we know it by 2030**. <https://hca-mn.org>

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**The Minnesota Health Plan**

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**Physicians for a National Health Program – Minnesota**

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