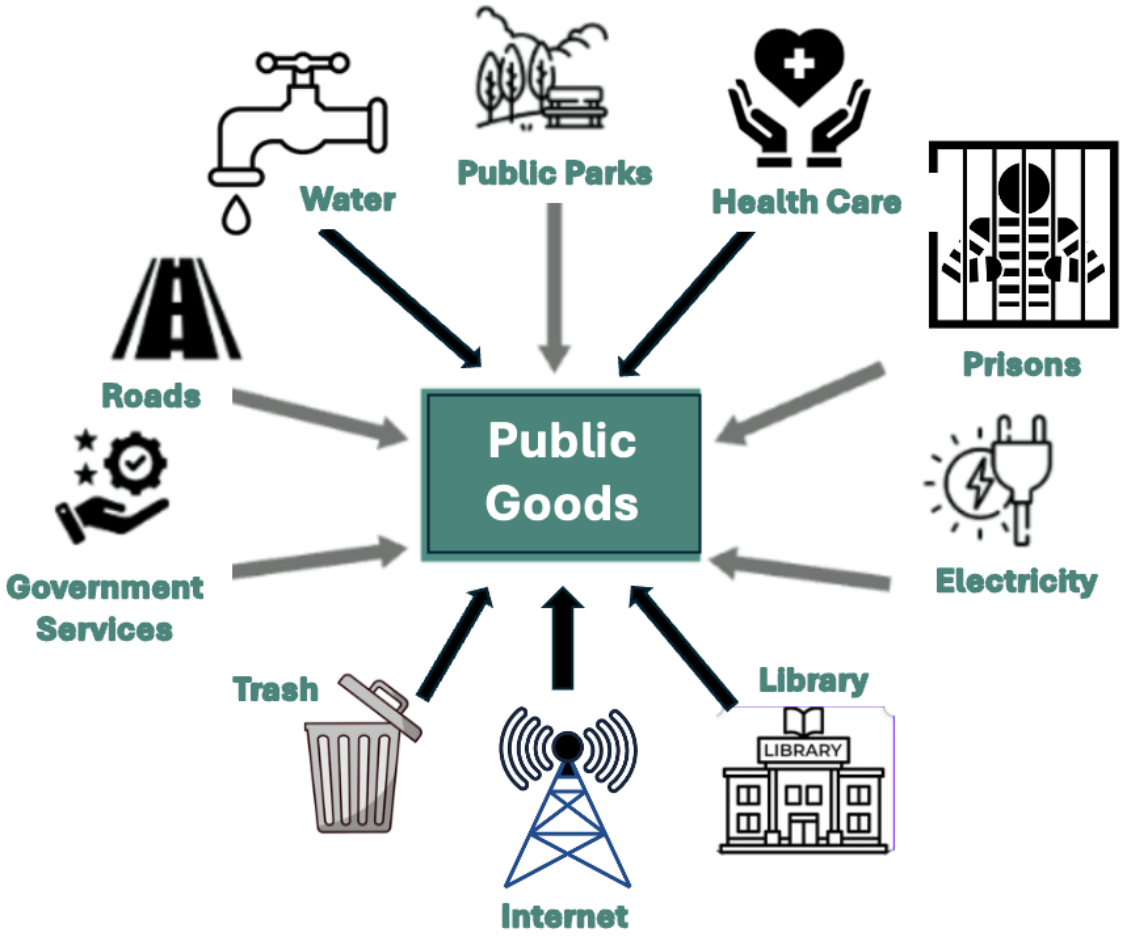
LEAGUE OF WOMEN VOTERS® OF VERMONT

VERMONT PRIVATIZATION STUDY REPORT



LWV Vermont Privatization Study Team

2023-24

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PRIVATIZATION STUDY (VT)

Charge by Convention

Study of Proposed Amendment to LWVUS Position on Privatization

Although the LWVUS Position specifies public health, public safety, and basic human needs on the list of public goods, it does not specify medical care; and it does not address League of Women Voters of Vermont (LWVVT) concerns about services that are currently provided by the private sector that would be better provided by the public sector.

At the 2023 State Convention of the League of Women Voters of Vermont, delegates voted on June 24 to conduct a study on privatization with the following scope:

> *To examine and evaluate the various ways that health care fits the criteria to be included as a public good as defined in our position; and whether the position should be expanded to include the other direction as well: movement of services that are public goods from the private sector to the public sector.*

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At a Special Convention on December 14, 2023, the League of Women Voters of Vermont (LWVVT) adopted a new position on privatization with the key statements: "*The League of Women Voters of Vermont believes that healthcare, like other programs that provide and protect basic human needs, should be considered a public good*," and "*where private entities fail to deliver, the League supports de-privatizing*." The full text of the new position, listed below, can be found at https://lwvofvt.org/positions/position-on-privatization.

Chapter 1
VERMONT POSITION ON PRIVATIZATION

The League of Women Voters of Vermont believes that health care, like other programs that provide and protect basic human needs, should be considered a public good. The LWVVT believes that public funding, oversight, and delivery of essential health care services (including tests, treatments, facilities, etc.) are necessary to optimize equity and access (including for racially, economically, geographically, and other underserved populations). Similarly, quality, transparency, accountability and affordability are critically necessary for effective administration. Further, the League supports public oversight of all aspects of health care from policy-making to administration to accountability, and public participation in policy-making and accountability, as essential.

LWVVT believes the current private-enterprise, for-profit business model for providing health care is inappropriate for the common good, or to meet the basic needs of the most vulnerable members of society. It is not working for most Americans, their providers, or their communities in the following ways:

- Private for-profit corporations have a fiduciary responsibility to their shareholders rather than to patients or public health. The LWVVT favors a system where fiduciary responsibility is to patients.
- Health care is not discretionary spending where consumers can choose what product or service, which brand, and how much to purchase. Patients do not have perfect information, and they are usually not able to make decisions and seek care based on comparison shopping. The LWVVT favors a system that ensures that patients needing health care have those needs assessed based on "standards of care," offered equitably and constrained by public policy rather than the patient's ability to pay.
- Lack of a profitable market for providers can create health-care deserts in poor or low-population areas. The LWVVT favors a system where all communities have access to quality basic health care because this will improve both individual and public health.

- Free market principles require that anyone who benefits from a service must pay for it, and anyone who does not pay for it should not benefit from it. The LWVVT favors a system where health care needs are met regardless of a patient's ability to pay because this will improve our longevity, and general welfare.
- People do not consume health care on a supply-demand curve. A person without a disease has no interest in purchasing treatment for that disease even if it is free. A person whose child's life depends upon a standard treatment should not have to forego their child's care because its purchase price is beyond their means. In addition, patients cannot legally vary the amount of a prescribed product they purchase based on price, nor would such variation typically serve their health.

In addition, the League supports health care as a public good for fiscal reasons. Our current multi-payer, multi-layered system contains significant financial waste, including excessive administrative costs and misdirected marketing costs that create additional barriers to care.

Therefore, where private entities fail to deliver, the League supports de-privatizing.

In sum, the League opposes further privatization of needed health care and favors de-privatization of services and facilities that are currently owned, managed or financed by for-profit corporations.

Adopted at Special Convention, December 14, 2023

Chapter 2

VERMONT HEALTH CARE STUDY TEAM HISTORY, PROCESS, & DELIVERABLES

History

The League of Women Voters of Vermont (LWVVT) has long supported a national single-payer insurance program and a state-based universal health care program as an interim alternative until the country achieves a national plan. In the meantime, the League is concerned about new trends that threaten the existing health care system. Medicare, the national insurance program for people over 65 years of age or with disabilities, is becoming increasingly privatized. This is causing harm to patients, exacerbating clinician burnout, and diverting funds from health care to wasteful administration costs and profit.

In response to increasing movement of Medicare money from traditional Medicare to private entities, LWVVT's Health Care Committee sought to advocate against ACO-REACH (Accountable Care Organization Realizing Equity, Access, and Community Health), a program under the auspices of Center for Medicare and Medicaid Innovation (CMMI) which is privatizing Medicare.

The Health Care Committee filed a Federal Action Request Form (FARF) in September 2022 seeking permission to advocate against the ACO-REACH program, based on the LWV Position on Health Care. LWVUS advised that instead LWVVT should refer to the Position on Privatization, citing two reasons for denying the advocacy request:

1. Health care is not in the list of public goods in the LWVUS Privatization Position (*Impact on Issues 2022-2024, p.67*)[1]
2. The LWVUS Privatization Position stipulates criteria and is silent on what should happen if those criteria are not met and what action Leagues could take about any good or service currently provided by the private sector that would be better provided by the public sector. Thus, deprivatization is not supported by the national League Privatization Position.

In addition, national staff explained that LWVUS strongly supports Medicare and is not sufficiently informed about the ACO-REACH program to approve advocacy opposing a Medicare-approved program.

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[1] *Impact on Issues 2022-2024 p.67. LWVUS Privatization Position.* https://lwvhealthcarereform.org/wp-content/uploads/2024/01/PrivatizePages_LWV_ImpactOnIssues2022-2024-pp67-68.pdf

Concerned that LWVUS was not considering health care as a public good, motivated by protecting Vermont and American health care infrastructure and workforce from accelerating privatization, and encouraged by equally concerned League health care reform advocates across the country, LWVVT decided to conduct a study to examine and evaluate whether Vermont might usefully update its own and the LWVUS Privatization Position with a Vermont position which addresses those "silent" issues, specifically:

- Does health care meet the criteria of a public good?
- Does accountability also include the possible movement of public goods and services from the private to the public sector (as well as from the public to the private, as described in the LWVUS position)

At its June 2023 Convention, LWVVT members voted to conduct a study on privatization. All members of the Health Care Committee served on the Privatization Study Team along with other League members with expertise in public policy. The Privatization Study Team worked between August and November 2023, keeping members apprised of the work and sharing resources through emails and the LWVVT Green Mountain Citizen newsletter.

Process

The team researched different definitions of key vocabulary, reviewing how words were used in the League *Impact on Issues 2022-2024*[2] and relevant literature. Per the LWVVT Convention charge, the Study Team initially focused on whether health care could be considered as a public good and what might warrant support to move health care services from private to public management (deprivatization). Soon team members expressed concerns about public goods listed in the national position for which privatization was not serving the public good. The team thus expanded the scope of their efforts to study more generally about public goods, common goods, privatization, corporatization, financialization, "the corporate practice of Medicine" (CPOM), and deprivatization.

The arguments around privatizing public goods typically include arguments about "efficiency" and the "free market." Public policy readings suggest health care is to be a particularly poor match for the "free market," so the team explored features needed for goods, products, or services to follow the classic "supply-demand curve" and what prevented health care services and supplies from responding to typical market forces.

As the team conducted its study of books, policy statements, and articles, privatization was repeatedly in the headlines. Members were constantly reminded of local and national urgency,

[2] *Impact on Issues 2022-2024*, https://www.lwv.org/sites/default/files/2023-02/LWV_ImpactOnIssues2022-2024.pdf

discussing the importance of acting to protect the common good in Vermont — but also around the country. Media reported increasing numbers of centi-millionaires and billionaires created by financialization and privatization, particularly of health care (20% of the US economy with half of spending coming from public funds). Wealth concentration suggested corporate capture of legislatures and public officials. Team members began seeing connections between wealth disparity and public policy failures.

The team provided regular updates to Vermont League members and the Vermont board, regularly soliciting feedback, ideas, introducing new members interested in the policy questions being studied.

In advance of the consensus meeting, the team developed and distributed consensus and discussion questions to members across the state.

CONSENSUS QUESTIONS

1. *Should healthcare be a private good or a public good?*
2. *If a good that is considered a "public good" is currently provided privately, under what circumstances should it stay privately delivered or be transferred to public delivery?*

At the consensus meeting on November 9, 2023, team member Eduardo Siqueira, retired professor of public policy at University of Massachusetts Boston, provided an overview of issues to align participants with a common framework and prepare participants to discuss what might be included in a new Vermont position. League participants discussed the meanings of "public goods," "privatized," "corporatized," "deprivatized," and so on. (*See Glossary*.) In particular, the Study Team clarified that "the privatization of health care" did not include clinicians delivering care in private practice but, rather, was about corporations with investors owning or managing health care goods or services, especially if those owning or managing the corporations were not serving as clinicians themselves.

This was followed by a robust discussion, and members came to consensus on the key issues:

1. Should healthcare be a private good or a public good?

Meeting Basic Human Needs[3]

[3] Meeting Basic Human Needs. http://meethumanneeds_lwv_impact2022-24_145-151-2.pdf

Through publicly-funded programs, the federal government provides varying levels of health insurance for people who are over 65 years of age; disabled; have served or currently serve in the military; work full-time for federal, state or local government; teach in public schools; or have low incomes insufficient to afford health care or health insurance. With the Affordable Care Act, the federal government provides subsidies for health insurance to assist people with low incomes, including those who do not meet the eligibility criteria for Medicaid in those states that have voted to expand Medicaid.

These programs are an indication that Americans believe health care is a common good. The team discussed the inefficiency in how the government currently finances and delivers health care, and how the U.S. could provide health care for everyone by eliminating administrative waste, which would be:

1. more fair; people paying taxes but not receiving health care would then obtain the public good they were providing for others
2. a fiscally more responsible way to manage taxpayer funds

2. Public vs. Private Delivery

If a good that is considered a "public good" is currently provided privately, under what circumstances should it stay privately delivered, or be transferred to public delivery?

The LWV national position clearly states that privatization should have accountability (*Impact on Issues 2022-2024, Position on Health Care pp.137-139*)[4]. Members could reasonably infer they should be able to advocate for deprivatization where private entities have failed to deliver on their promises.

...[T]he League believes the following considerations apply to most decisions to transfer public services, assets, and functions to the private sector. …

A provision and process to ensure services or assets will be returned to the government if a contractor fails to perform." (*Impact on Issues 2022-2024, p.68.*)[5]

LWVVT members felt it was important to positively affirm support for deprivatization with this new position that could be used at the local and state level, and potentially used to update the National position.

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[4] *Impact on Issues 2022-2024, Position on Health Care pp. 137-139.* https://lwvhealthcarereform.org/wp-content/uploads/2023/03/HealthCarePosition_LWV_ImpactOnIssues2022-2024pp.137-139.pdf

[5] *Impact on Issues 2022-2024, p.68.* https://lwvhealthcarereform.org/wp-content/uploads/2024/05/PublicPartic_LWV_ImpactOnIssues2022-2024VT.pdf

Members reviewed the considerations and requirements in the national position, and concluded that, as with privatization, criteria would vary depending on the good, service, or local conditions, but in general the same considerations and requirements would apply in decisions regarding deprivatization.

3. Transparency

Members expressed strong concern about the need for citizen participation in creating policy around public goods, as well as robust oversight. Language for this can be found in the position on Public Participation regarding Natural Resources (*Impact on Issues 2022-2024, pp.112-114*.)[6] LWVVT has focused on oversight and regulation of health care, and in ensuring Vermonters are given an opportunity to provide public input prior to decisions being made.

Among the bills that LWVVT advocated for in 2022, note Act No.167*, an act relating to health care reform initiatives, data collection, and access to home- and community-based services*.[7]

4. Consistent Accountability Standards

The Study Team had discussed the concern that nonprofits often act with the same financial motives as for-profit corporations. In discussion at the consensus meeting, LWVVT members decided that the criteria listed as considerations and requirements in the LWV national Health Care position were appropriate to apply to both for-profit and nonprofit entities.

LWVVT members did not see any reason to hold nonprofits to different standards than for-profits when it came to delivery of public goods. Mission-driven nonprofits would likely already be meeting those standards or be amenable to improving their services to meet standards.

5. Other Considerations

Members also discussed how health care does not follow "free market principles," and under what circumstances it makes sense for health care to be privatized. Might health care be a special case, given its supply, demand, and preponderance of third-party financing being so poorly aligned with free market principles? Does health care warrant special protections from

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[6] *Impact on Issues 2022-2024, pp.112-114. Public Participation Natural Resources* https://lwvhealthcarereform.org/wp-content/uploads/2024/05/PublicPartic_LWV_ImpactOnIssues2022-2024VT.pdf

[7] https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT167/ACT167%20As%20Enacted.pdf

profiteering? What if a service begins in the private sector? Should the League still use those criteria and consider deprivatizing, even if it was not previously public? Examples:

- What if a hospital has always been a private nonprofit hospital and a for-profit corporation wants to buy it? Does the public have a stake to prevent that?
- If a for-profit entity wished to build a health care facility to provide only the most lucrative services in an adequately served market, should the potential financial devastation to an existing entity be a reason to deny the new entity its Certificate of Need (CON)? This would not fit neatly into the mold of having previously been a public good that was now being privatized.

Local conditions in Vermont include private, nonprofit "designated agencies" on which the state relies for mental health services. The boards of trustees of these agencies are typically members of the community, often including clinicians, hospital administrators, and people with mental health conditions who receive services. Because of Vermont's rural nature and poor reimbursement, these agencies have not been targets of financialization. In addition, all of Vermont's hospitals are nonprofit, with community members serving on their boards. The largest hospital, the University of Vermont Health Network, (formerly University of Vermont Medical Center) has exhibited some monopolistic behaviors; Oversight is essential to protect access to care and affordable health care for all Vermonters.

6. Other Public Goods at Risk

Members expressed concern about other privatized public goods besides healthcare, including:

- Digital Equity (internet)
- Electricity Distribution
- Libraries
- Prisons
- Public Parks
- Roads
- Schools
- Trash
- United States Postal Service
- Water

Members felt the privatization position should include deprivatization as a means of accountability, regardless of which public good was under consideration, but they did not have enough information to come to consensus on what other public goods beyond health care are most at risk from privatization, to avoid disparate access, excessive charges, and/or worse quality.

DISCUSSION QUESTIONS

1. *How would disparities in healthcare be affected by making health care a public good rather than a private good?*
2. *Should healthcare be a public good for all ages?*
3. *What effect would equal access to healthcare for everyone have on the quality of life of Americans and the productivity of the United States?*

Discussion confirmed that considering health care a common good and supporting deprivatization where warranted by local conditions were consistent with League priorities in diversity, equity, and inclusion and regardless of age, ethnicity, health or disability, health care should be available to everyone. Discussion also included benefits to the country and its quality of life and economy of having healthier people able to access the right care at the right time in the right place.

Following direction of the consensus, the Privatization Study Team drafted a position that included health care as a basic human need that does not follow free market principles:

- health care is a common good
- deprivatization can be used as an accountability tool
- health care should not be for profit
- taxes funding private profits is inappropriate for public goods
- privatized public goods should maintain a fiduciary responsibility to residents
- public participation in policy making and oversight is essential.

The LWVVT Board of Directors approved the position on November 14 and announced a December 14 Special Convention to vote on the proposed position.

Deliverables

At this time, LWVVT can use its new privatization position for advocacy at the state and local level. In January 2024, Rep. Bobby Farlice-Rubio introduced bill numbers 24-0539 and 24-0540 to protect Vermont health care infrastructure and Electronic Health Records from privatization. LWVVT planned to use the new position to advocate for portions of this bill if it were taken up by the legislature.

By concurrence with this new LWVVT position, Leagues across the country could benefit from this privatization position for advocacy in their own locales and advocate against harmful privatization programs at local, state, and federal levels.

The intent of LWVVT and advocates in other states is to bring the new Vermont position to the LWVUS convention in June 2024 to update the LWVUS Position on Privatization by concurrence, adding health care as a public good and clarifying that Leagues may advocate that currently privatized public goods can be moved to the public sector if privatization is not meeting the fundamental goals of efficiently and equitably providing a public good.

Chapter 3
APPLYING THE VERMONT UPDATE

Before undertaking the privatization study, LWVVT had specifically identified privatization of health care as an increasing risk for Vermont residents. After adopting it, the Study Team, considered how to apply the position, including deprivatizing other common goods in Vermont, other states, and at the federal level.

Vermont, however, is unusual. The U.S. Census lists Vermont as the most rural state (64.9% of its population[8]) with just over 10% of its residents living below the poverty line. Its residents are also diligent about asserting their rights to transparency and frugality with high voter turnout even in off-year elections.[9] The 1777 Vermont Constitution asserts unusually strong citizen rights around community responsibilities, with private property being subservient to public needs and benefit.[10]

As elsewhere, however, health care in Vermont requires a very large share of the public purse, so it attracts profit-seeking. Third-party payments of public funds to private corporations allow revenues and costs to be opaque to public scrutiny and, for Vermonters, no public oversight of profits, administrative waste, and excessive costs can lead to the perception that deep federal pockets are waiting to be picked. In addition, moneyed interests have great capacity to spend on marketing, lobbying, and "framing the message." An example is the emphasis in the health care sector on "value-based care."

Studies of the health care system provide no evidence that "value-based care" saves money for taxpayers, employers, clinicians, or patients and often offers some evidence of harming quality of care and access to care.[11] Currently, "value-based care" requires "middle men" to administer the program, middle men who automatically build in expenses (and usually excess revenue or profit) not related to providing care.

For starters, those who study health care policy do not have meaningful measures of value, and even if defined, it would not be durable over time because of constantly evolving medical fields. Some policy experts argue that "value-based care" is inherently wasteful since

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[8] U.S. Census 2020, "Regional and State Patterns," press release Press Release Number CB22-CN.25 https://www.census.gov/newsroom/press-releases/2022/urban-rural populations.html#:~:text=Vermont%20was%20the%20most%20rural,Texas%20(4%2C744%2C808)

[9] Vermont Secretary of State Reports at https://sos.vermont.gov/elections/election-info-resources/elections-results-data

[10] Vermont Constitution 1777, particularly Articles II and IX, https://sos.vermont.gov/vsara/learn/constitution/1777-constitution/#:~:text=That%20every%20member%20of%20society,man's%20property%20can%20be%20justly

[11] STAT, "Value-based payment has produced little value. It needs a time-out," by Kip Sullivan, Ana Malinow, and Kay Tillow, July 26, 2022: https://www.statnews.com/2022/07/26/value-based-payment-produced-little-value

minimizing expenses often co-relates with reduced delivery and quality of care. To deliver cost-effective, high-quality care requires:

- making administration transparent and accountable
- eliminating excess profit
- requiring "excess revenues" by nonprofits be returned to the mission of health care or public health
- regulating salaries, benefits, bonuses, and other payments to executives and management not involved in the delivery of health care
- eliminating marketing and lobbying expenses

"Efficiencies" often harm quality of patient care and increasingly contribute to clinician moral injury and burnout.[12] Typically, the "value" in "value-based care" accrues to those able who carve out financial benefit for themselves.

Hospitals

The lead hospital for the University of Vermont Medical Health Network[13] is the tertiary care center and training site for medical students, residents, and fellows: University of Vermont Medical Center (UVMMC). Over the past decade, UVMMC has

- fought the state's efforts to develop a state-based universal health care system
- pushed for OneCare Vermont, a state-wide Accountable Care Organization (ACO), and then maneuvered to run the ACO, essentially deciding what they will pay themselves and other hospitals
- acquired four community hospitals, a psychiatric hospital, and a home health and hospice agency, deciding what services those five hospital offer, and where all six subsidiaries refer patients who require tertiary care.

These actions have led to reduced referrals to independent practices, longer wait times, and no evidence of "bending the curve" on the rising cost of health care.

LWVVT works with other health care advocates to assess what is happening and how Vermonters can make a difference to protect their health care infrastructure and make health care more affordable and accessible in Vermont.

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[12] See Chapter 6 on Fiduciary Duty in this report

[13] UVM Health Network claims to serve more than a million people in VT and NY https://www.uvmhealth.org/network-locations

Federally Qualified Health Centers (FQHC)

FQHCs provide comprehensive medical care for underserved areas and populations — both urban or rural.[14] Subject to regulations governed by Medicare and Medicaid and required to be non-profits, they employ physicians, nurses, and staff who manage billing, calculated on a sliding scale based on income. CMS and HHS require all visits to "be medically necessary."[15] LWVVT was surprised to learn that two Vermont clinics had contracted with private equity firms to manage their billing as a "direct contracting entity" (DCE), directly billing the federal government for all the clinic's Medicare patients.

This is an ACO-REACH program. Traditional Medicare reimburses health care providers on a fee-for-service (FFS) basis — that is, the billing department codes each service or lab test and CMS reimburses the provider. By contrast, ACO-REACH (also discussed elsewhere in this report), is reimbursed by value-based billing. CMS pays the ACO-REACH organization a capitated amount for each Medicare beneficiary they serve, and the ACO-REACH pays the providers. If the ACO-REACH has received more funding from CMS than they have paid out to providers, balance is shared by the ACO-REACH and providers. ACO-REACH organizations argue they provide higher quality outcomes at lower costs.[16]

A private corporation will likely seek to profit in a combination of ways: perhaps by optimizing billing codes (or exaggerating how ill patients are) to claim much higher federal reimbursements for each Medicare patient; perhaps by "up-charging" diagnoses and treatments (reporting the highest level of management or treatment, even if nothing above minimum is offered); perhaps by avoiding expensive care even for those patients where it might be "standard of care" for their conditions or even medically necessary; perhaps by avoiding ordinary preventive care and diagnostics, even if they are "standard of care." Why would physicians become complicit in these techniques? Each ACO-REACH keeps 100% of the first 25% it "saves" over an expected benchmark (a moving target that has its own corrupting effect[17]) so the ACO-REACH pays physicians a percentage of their salaries with the promise of a "bonus" if they meet certain savings metrics, for example, by having their patients use fewer Medicare services than expected — so physicians are motivated to reduce visits, diagnostic tests, treatments because it will raise their annual income.[18] Some physicians will be financially punished for doing right by their patients, others will suffer moral

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[14] FQHC Associates, "What Is an FQHA?" https://www.fqhc.org/what-is-an-fqhc

[15] Health & Human Services, "FQHC act Sheet": https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FQHC-Text-Only-Factsheet.pdf

[16] IluMed is an ACO-REACH: https://ilumed.com/resources/how-the-aco-reach-model-can-maximize-provider-profits/#:~:text=An%20ACO%20REACH%20organization%20manages,team%20then%20pays%20the%20providers.

[17] Health Justice Monitor, "REACH ACO Rules & Plunder of Public Funds," *April 2022* https://pnhp.org/news/reach-aco-rules-plunder-of-public-funds

[18] Health Justice Monitor, " Medicare REACH: Financial Incentives will Undermine Doctor-Patient Trust," 2022: https://pnhp.org/news/medicare-reach-financial-incentives-will-undermine-doctor-patient-trust

injury by facing daily conflicts of interest, and still others will do what the ACO-REACH wants and cut costs by delivering not only less care by lower quality care.

If there is fat to trim, the trimmings represent tax-payer funds and, any saved public funds should rightly pay for more health care or to reduce costs to patients. More concerning, private equity in health care has disastrous track record of pillaging facilities on which communities depend for their care; for example, firing physicians and registered nurses (in favor of lower-paid, less credential staff)[19] or selling the real estate out from under them.[20] LWVVT anticipates looking for model language for legislation to protect Vermont's health care infrastructure from what can appropriately be called "profiteering."

Long-Term Care Facilities

Vermont has 36 federally-regulated nursing homes and two additional homes that are regulated by the state. Pennsylvania-based Genesis HealthCare, a publicly-traded corporation that owns 425 long-term care facilities (LTCFs) in 29 states, owns nine nursing homes in Vermont, comprising one-third of the beds in the federally-regulated homes. In 2020, Genesis paid a settlement of $740,000 related to three serious falls and a death in three of its poorest-performing nursing homes in Vermont:

> The three facilities — St. Johnsbury Health & Rehabilitation Center, Berlin Health & Rehabilitation Center and Burlington Health & Rehabilitation Center — rank among the lowest rated in the state, according to the Centers for Medicare & Medicaid Services' Nursing Home Compare system. The St. Johnsbury and Berlin homes both have one out of five stars, based on metrics that include three years' worth of health inspections, staffing levels, and clinical outcomes for residents. The Burlington facility has two stars. The statewide average for nursing homes is 3.2 stars, while Genesis-owned homes average 2.6.[21]

These three nursing homes were among five that a private-equity backed firm applied to purchase during the financial struggles of the pandemic. Concerns were raised about quality of care in nursing homes in other states associated with these buyers, and ultimately they

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[19] NPR, "ERs staffed by private equity firms aim to cut costs by hiring fewer doctors," by Brett Kelman and Blake Farmer, February 11, 2023: https://www.npr.org/sections/health-shots/2023/02/11/1154962356/ers-hiring-fewer-doctors

[20] American Prospect, "Private Equity's Latest Scheme: Closing Urban Hospitals and Selling Off the Real Estate," by Mike Elk, July 11, 2019: https://prospect.org/health/private-equity-s-latest-scheme-closing-urban-hospitals-selling-real-estate

[21] https://www.sevendaysvt.com/OffMessage/archives/2020/02/20/nursing-home-conglomerate-settles-vermont-neglect-allegations-for-740000

withdrew their application.[22] As the Vermont population ages, the state will need to develop a plan for how to ensure humane care, especially for those who do not have loved ones to advocate for them. With this privatization position, the League could

- advocate for laws that prohibit private equity from purchasing LTCFs
- mobilize support for laws and policies that encourage community-owned care facilities
- provide public comment to regulatory bodies opposing purchases that appear to be contrary to the public interest
- lobby the Governor to develop a multi-year plan for long-term care and assisted living

Electronic Medical Records (also known as Electronic Health Records)

Electronic Medical Records (EMR or EHR) currently create conflicting concerns[23] as tools to

- expedite patient billing and reimbursement from public funds
- capture essential medical information to assist in providing acute or ongoing care
- protect people's privacy
- provide access to health records by specialists and others providers to assist in providing care, when patients give permission
- not overburden health-care providers.

Software companies have been trying to develop EMRs for 50-years, but in 2009 federal mandates accelerated adoption. Unfortunately, without a mandate for clear "inter-operability" standards, they still do not interface well.[24] Profit-seeking creates incentives to reduce sharing, as maintaining control of records increases switching costs for patients and creates barriers to access by auditors. Further, because learning to use software takes a great deal of

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[22] https://www.sevendaysvt.com/OffMessage/archives/2021/12/28/private-equity-group-drops-bid-to-purchase-five-vermont-nursing-homes

[23] Indian J Ophthalmol. "Electronic medical records – The good, the bad and the ugly," by Santosh G Honavar, 2020 Mar; 68(3): 417–418., doi: 10.4103/ijo.IJO_278_20, PMCID: PMC7043175, PMID: 32056991

[24] AMA, "7 EHR usability, safety challenges—and how to overcome them," by Tanya Albert Henry, Dec 11, 2023: https://www.ama-assn.org/practice-management/digital/7-ehr-usability-safety-challenges-and-how-overcome-them#:~:text=Interoperability.,different%20part%20of%20the%20hospital.

time for staff, there is motivation to not switch even if the product isn't working well for providers or patients; changing systems is extremely costly.

Private corporations also profit from software that benefits billing departments more than providers, particularly software that can intentionally or unintentionally lead to overbilling rather than improved patient care. Indeed, since the mandates to use EMR, a new third-party sector has emerged that scans EMRs for opportunities to "optimize their revenue cycle"[25] (that, is, upcode).[26]

Finally, private corporations lobby hard to protect their market, while states that might want to develop EMRs with public funds face daunting political and fiscal challenges.

The Veterans Administration (VA) had a product that worked well and was in the public domain.[27] Germany used it as a basis for their national EMR. LWVVT found a sponsor for a bill proposing to study the feasibility and cost of using that software for all medical facilities in the state but, because the Veterans Administration is currently embarking on an electronic health record modernization program, the League will pause this initiative to evaluate how well the new system works at the VA.[28]

AHEAD (All-Payer Health Equity Approaches and Development)

The All-Payer Health Equity Approaches and Development (AHEAD) model is a new federal program[29] with a stated goal of "collaborat[ing] with states to curb health care cost growth; improve population health; and advance health equity by reducing disparities in health outcomes." LWVVT has not seen evidence that this is likely to be any more useful than the "OneCare" program that wasted $25.6 million without any improvement in health outcomes.[30]

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[25] https://www.aapc.com/about-us

[26] STAT "Upcoding: one reason Medicare Advantage companies pay clinicians to make home health checkups," by Robert M. Kaplan and Paul Tang, Jan. 19, 2023: https://www.statnews.com/2023/01/19/rein-in-upcoding-medicare-advantage-companies

[27] "The Veterans Health Administration: A Domestic Model for a National Health Care System?" by Said A. Ibrahim, Am J Public Health. 2007 December; 97(12): 2124–2126. doi: 10.2105/AJPH.2007.125575: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2089116

[28] VA Transition; https://digital.va.gov/ehr-modernization
Military.com, "Electronic Health Record System Unveiled at VA and Pentagon's Largest Shared Health Care Facility," by Patricia Kime, March 11, 2024: https://www.military.com/daily-news/2024/03/11/va-and-pentagon-roll-out-shared-electronic-health-record-system-chicago-bug-fixes-continue.html#:~:text=The%20VA%20signed%20a%20%2410,their%20initial%20accession%20until%20death

[29] CMS.gov, States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model https://www.cms.gov/priorities/innovation/innovation-models/ahead#:~:text=CMS%E2%80%99s%20goal%20in%20the%20AHEAD%20Model%20is%20to,health%20equity%20by%20reducing%20disparities%20in%20health%20outcomes

[30] https://auditor.vermont.gov/sites/auditor/files/documents/ACO%20Implementation%20Costs%20with%20letter.pdf

LWVVT will be "following the money" and looking at the data to see whether there is any improvement in population health and reduction in disparities in health outcomes, and advocating to legislators and the Green Mountain Care Board to stop looking to for-profit organizations (and nonprofits acting like for-profits) for solutions, and instead look to public health experts, health care providers, and patients.

Corporate Practice of Medicine

Many states have Corporate Practice of Medicine (CPOM) laws.[31] They have a mixed history, but today these laws seek to support fiduciary responsibility to the patient rather than to an employer (who might wish to have you keep working despite the risk to your health) or to corporate shareholders (who seek to maximize return on investment).

These CPOM laws require that physician practices be owned and managed by the physician, or by groups of physicians, or by the public (such as Federally Qualified Health Centers, or county hospitals). Some states have exceptions for non-profits and some have exceptions that hospitals can employ clinicians or can own or manage clinical practices.[32] Corporations have found loopholes in some states, but since Vermont does not have a CPOM law, LWVVT is looking at other states for model legislation to adapt for Vermont.

Pharmaceuticals

The cost of medications is literally killing Vermonters. Despite tax dollars funding basic science research for drug development, pharmaceutical companies use patent monopolies to maximize drug prices in the U.S. They sell exactly the same products, sometimes produced in the same factory with the same packaging, to other countries at far lower prices ("U.S. drug prices are nearly four times higher" and "Americans pay as much as 67 times more than consumers in other nations").[33]

Exacerbating excessive American drug costs, "pharmacy benefit managers" (PBMs) hike prices further with even less transparency. PBMs provide no benefit to patients, but their added cost to insurance companies' increases premiums.[34]

Insurance companies' choices to change their formularies frequently and without warning has made it even harder on patients and providers: a patient who has been stable for a long time

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[31] https://prospect.org/health/2023-11-13-ama-debates-federal-ban-corporate-medicine

[32] https://www.ama-assn.org/media/7661/download

[33] U.S. Ways And Means Committee, "Findings Confirm that Americans Pay Significantly More than Patients in Other Nations for the Same Prescription Drugs," Press Release, September 23, 2019 https://democrats-waysandmeans.house.gov/media-center/press-releases/ways-and-means-committee-releases-report-international-drug-pricing

[34] American Progress, "5 Things To Know About Pharmacy Benefit Managers," Mar 13, 2024, https://www.americanprogress.org/article/5-things-to-know-about-pharmacy-benefit-managers

on a medication may be forced to prove they are not stable on a cheaper drug (or a series of cheaper drugs) in what's known as "step therapy," before they are allowed to go back on the drug time-tested for them. This process has nothing to do with improving patient care and is entirely about saving money for the insurer. Based on the LWVUS Health Care Position, LWVVT wrote Governor Scott asking him to sign H. 766, *an act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts*,[35] which he has done.

A bigger step would be to propose legislation to eliminate PBMs and create a statewide drug formulary, purchasing pharmaceuticals in bulk for use by pharmacies throughout the state, with transparent and regulated prices. Policies for exceptions to the formulary would be developed by an advisory committee that included clinicians and patients. Supported by the Vermont Update and guided by the criteria in the national position, the League could advocate for a publicly managed statewide drug formulary.

Health Care Concerns Other Leagues Might Consider

With an update to the national position, local and state Leagues could take action at their respective levels immediately. Adopting the Vermont Update (either as a national or state position) would, to give some examples, allow Leagues to advocate for legislation to:

- Oppose for-profit hospices and nursing homes, defined by the ultimate owner even if the entity is part of an umbrella organization. (These typically cost more and deliver worse outcomes than non-profit entities.)[36]
- Support state take-back of managed care from for-profit Medicaid Managed Long-Term Care entities to reduce taxpayer expenditures without reducing quality of care for patients [37]
- Oppose private equity purchase of management of health care services or facilities, including any control by for-profit umbrella organization[38]

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[35] H. 766, *an act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts*. https://legislature.vermont.gov/bill/status/2024/H.766

[36] White House, " FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes," Feb 28, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes

RAND Corporation, "Care Experiences Are Worse in For-Profit Hospices Than in Not-for-Profit Hospices," February 27, 2023: https://www.rand.org/news/press/2023/02/27.html#:~:text=Those%20who%20received%20care%20from,better%20than%20the%20national%20average.

[37] PNHP, " Connecticut Medicaid Prospers Post Capitated Managed Care," Feb 2019, https://pnhp.org/news/connecticut-medicaid-prospers-post-capitated-managed-care

[38] Stateline, "'Shell game': When private equity comes to town, hospitals can see cutbacks, closures, but state laws can change the trajectory of the story," by Anna Claire Vollers - January 18, 2024:

- Support de-privatization of provider networks, facilities, or services, where private equity or other for-profit corporations have degraded quality of care, increased costs, or put the interests of shareholders above those of patients and public policy.

Other Common Goods

Leagues in other states may wish to use this position as a basis for advocacy for other common goods in addition to health care.

Use of Position for other Common Goods and Services

Although LWVVT has focused on health care in its own advocacy, Leagues in other states may also wish to use this position as a basis for advocacy for other common goods. The LWVUS Privatization position provides a basis to evaluate the transfer of public goods to the private sector. The proposed Vermont Update to the position could provide a basis to advocate for holding private entities accountable by deprivatizing a common good where privatization has failed criteria in the LWVUS Position. Examples might include deprivatizing:

- Rural and municipal broadband
- Municipal water
- Trash pickup/disposal
- Energy grid and/or distribution
- Parking and road repair
- For-profit prisons/jails or their management
- For-profit probation (with fees as onerous as payday lenders)

Leagues might also want to advocate for legislation or regulation so ensure that

- "Excess revenues" collected by non-profit providers of common goods or services are returned to tax payers or are reinvested in the mission for which the funds were collected
- First-right-of-refusal for communities to buy facilities or assets that have been serving the public when corporate entities seek to sell, close, merge, divest or consolidate.

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https://stateline.org/2024/01/18/shell-game-when-private-equity-comes-to-town-hospitals-can-see-cutbacks-closures. And federal regulations: https://www.reuters.com/legal/legalindustry/portfolio-company-reporting-under-corporate-transparency-act-2023-09-27

Chapter 4
PUBLIC GOODS & "FREE" MARKETS

The concept of a "free" market is more an idea (sometimes treated as an ideology) than a reality. In today's economies no markets are actually free in the sense Adam Smith might have envisioned: corporations, spanning the globe, operating in multiple currencies, across scores of regulatory environments derive power from their scale and from unimaginable access to resources. Similarly, customers exert more modern negotiating methods than simply the power to walk away: they mobilize boycotts, exercise undue influence on shareholder meetings, and can even manipulate stock markets (e.g., GameStop short selling). Even small, niche businesses on Etsy are too regulated to be considered "free."

All of these examples, however, are about commodities, not public goods. The challenge with discussing public goods as operating in "free markets" is that not only are the markets not free but the customers for those goods are not free to walk away. Further, public goods, by their nature — unlike Rolls-Royces ($30M) or diamond-studded Rolex watches ($127K) or private islands ($200M) — should be accessible to all rather than rationed, based on wealth. In this section we refer, therefore, to "free" markets, not "free markets."

"Free" markets are characterized by specific principles:

1. **Private Property Rights:** Individuals and businesses have the right to own and control private property, including resources, land, and goods. This principle ensures that individuals have the incentive to use resources efficiently.[39]

2. **Voluntary Exchange:** Transactions in a free market are based on voluntary agreements between buyers and sellers. Both parties engage in an exchange because they believe it will benefit each of them.[40]

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[39] While this is ideal, there are counter-arguments: an individual or business might not use private property efficiently if they don't see efficient use as beneficial to them — for example, owning multiple residences, particularly those never used even for vacations or pied-à-terres: it's estimated that almost half of London housing owned by foreign investors is kept empty (as, perhaps, a safe haven in a stable country). Similarly some pharmaceutical companies pay others not to produce generic versions so they can maintain their monopoly pricing. Only an economist would call these "efficient" uses.

[40] A "voluntary exchange" for a commodity often feels quite different from an exchange for a public good; for example, getting emergency treatment for a heart attack or broken leg is not really voluntary nor is gaining residential access to clean water.

3. **Perfect information**: Consumers must have all the information necessary about utility, quality, price, alternatives, etc., for them to make informed, voluntary choices.[41]

4. **Competition:** Free markets thrive on competition, where multiple sellers and buyers operate in the marketplace. Competition encourages efficiency, innovation, and delivery of better goods and services at lower prices. Consumers must have multiple choices and the capacity to weigh options and make a selection for a "free" market to function.[42]

5. **Price Mechanism:** Prices are determined by the interaction of supply and demand. Prices convey information about scarcity, preferences, and resource allocation, guiding individuals and businesses in their economic decisions. Prices must be transparent so that consumers can make informed decisions. Prices must be elastic (when prices go up, consumers buy less and when prices go down, consumers buy more) for suppliers to respond appropriately to adjust supply.[43]

6. **Profit Motive:** The pursuit of profit is a key incentive for individuals and businesses in a free market. In a truly free market, profits should signal that resources are being used efficiently, and they should encourage innovation and risk-taking.

7. **Consumer Sovereignty:** Consumers have the power to make choices in the market. Their preferences and demand shape production and influence the types of goods and services that are produced.[44]

8. **Limited Government Intervention:** In a "free" market, government intervention is generally limited to enforcing property rights, ensuring contracts are honored, and preventing fraud. Excessive government intervention is seen as potentially distorting market outcomes. If in reality, the market is not a "free"

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[41] Similarly, buying a car is usually associated with significant information on reliability, cost to own, included features, as well as state "lemon" laws — while no hospital or physician can guarantee the prognosis, duration, or cost of a cancer treatment; patients agree to cancer treatment based on trust, not perfect information.

[42] See Chapter 5 to note the long history of private actors repeatedly capturing local markets to optimize profits — a patient will pay, regardless of cost, when health care is life-saving.

[43] Consider drug prices for rare diseases: something with such limited demand should cost very little, but when it's a matter of "your money or your life," some very limited treatments can cost millions of dollars per year. Similarly, traditional pricing for water or electricity offers consumers bulk pricing: the more you use, the lower the rate — even in areas where potable water is exhaustible. The corporation extracting the water rarely pays any externality around depleting the source, so the actual cost to the public for excessive use is not captured.

[44] Should patients determine medical "standard of care" for themselves, perhaps in response to advertising of drugs or procedures? Should those who use public roads be able to use snow-chains and studded tires when roads pose no ice hazards? Is there a public interest that over-rules private interest for goods and services paid by public funds or affecting national or local security (e.g., public health)?

market and, if the services or goods are basic human needs or public goods, government intervention may be needed to ensure the common welfare.[45]

9. **Freedom of Entry and Exit:** Businesses can enter or exit the market freely. This principle promotes competition and allows for allocation of resources to the most efficient and competitive producers.[46]

10. **Rule of Law:** A system of laws that are transparent, predictable, and applied consistently is essential for the functioning of a free market. The rule of law provides a stable environment for economic activities.

11. **Profit and Loss Signals:** Profits and losses are signals that guide entrepreneurs and businesses in making decisions. Profits encourage activities that are valued by consumers, while losses signal the need for adjustments.[47]

Key characteristics of a "free" market include competition, supply and demand determining prices, and consumer choice. In the health care industry, there are elements of competition among private providers, and consumers often have choices in selecting services.

These principles collectively contribute to the efficiency, innovation, and adaptability of "free" markets. It's important to note that while these principles form the foundation of "free" market economics, real-world economies often involve a mix of "free" market elements and government interventions. The balance between these elements can vary across different economic systems.

The health care system in the United States is not aligned with the principles of a "free" market for several reasons:

1. **Limited Consumer Choice:** In many regions of the country, consumers may have limited options for health care providers due to factors like geography or insurance network restrictions. When consumers have fewer choices, they pay more. They end up paying higher prices for lack of choice — the opposite of a free market.

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[45] Note the Vermont Constitution, Art II: "That private property ought to be subservient to public uses when necessity requires it…."

[46] No private business should be compelled to operate in any particular geography, but are there limits to this freedom when businesses accept public funding? How should governments ensure rural residents have access to needed emergency care, ob-gyn care, behavioral care, when the free-market encourages providers (facilities and people) to move to the wealthiest ZIP codes? Is there a public interest in providing access to public goods in under-served areas?

[47] In a free market this would be true, but in a captured market, the controlling entity may not be the most valued and the entity providing the greatest value to the public good may suffer from adverse selection, as the provider of last resort, or have its funding siphoned off by inadequate auditing or corporate capture.

2. **Lack of Price Transparency:** Health care pricing is often opaque, making it challenging for consumers to make informed choices based on price and quality. This is a departure from the transparency required for "free" markets.[48] In addition, health care prices in the U.S. tend to be the highest among developed countries.

3. **Third-Party Payers:** Many health care transactions involve third-party payers, such as insurance companies or government programs such as Medicare and Medicaid. This creates a situation where neither the consumer (patient) nor the provider (physician, nurse) directly negotiates or pays for (or receives payment for) services, reducing the usual supply and demand interaction in other market transactions. Price negotiations are among insurance companies, employers, and government agencies — none of these entities receive health care or deliver it.

4. **Government Programs:** The U.S. has significant government involvement in health care through programs like Medicare and Medicaid. These programs provide health care coverage to specific populations and involve substantial government spending. The presence of government programs can distort competitive market dynamics and influence pricing.[49]

5. **Emergency Care Mandates:** Emergency care is required to be provided regardless of a patient's ability to pay. This obligation on health-care providers can be seen as a departure from market practice where services are exchanged for payment.

6. **High Degree of Regulation:** The health care industry is subject to extensive regulations at the federal, state, and local levels, covering licensure, safety standards, insurance requirements, and more. This level of regulation limits the ability of health-care providers and insurers to operate based on market forces.

In summary, the U.S. health care system incorporates elements of a "free" market, but government programs, third-party payment systems, local monopolies, anti-competitive market forces, and other factors contribute to a system that cannot be characterized as a

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[48] It should be noted that patients (who receive services) rarely negotiate with doctors (who deliver health-care service); nor is it typical that patients negotiate with third-party payers; the whole notion of price transparency is problematic when those "buying" and those "selling" the services are insulated from the actual price negotiation. This "price transparency" conundrum in health care is easily illustrated by showing that prices are not dependent on the service provided but on who is purchasing it: the Cleveland Clinic estimated that its 70,000 line items had 210 million different prices, depending on the plan and the degree of coverage and the negotiated price within that plan: JAMA 2018: 319; 691

[49] It should be noted that the rate of price increase for publicly-managed programs using public funds lags the rate increases of privately-managed programs using public funds.

"free" market.[50] Health care is also heavily regulated, and government intervention is common to ensure access, quality, and affordability.[51] For example, government programs such as Medicare and Medicaid play significant roles in serving otherwise underserved populations, and regulations are in place to ensure safety, ethical standards, and fair practices within the industry.

The health-care industry is often considered a complex mix of both market elements and government intervention. In many countries, including the United States, health care involves a combination of private and public entities. The balance between "free" market principles and the need for regulation and accessibility continues to be a subject of debate in health policy discussions. However, among developed countries that are members of the Organization for Economic Cooperation and Development (OECD), the U.S. has the most privatized and least regulated health-care system. Further, the per capita cost of health care in the U.S. is almost double the average of other OECD countries, with the U.S. spending more tax dollars per capita on health than any other country spends in total public and private funding.

Finally, economic analyses — health insurance companies, health care facilities, pharmacies, and manufacturers — suggest that the health care industry is composed of oligopolies which have control of prices and supply of goods in the industry. Therefore, it is not scientific to consider the U.S. health care sector a "free" market.

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[50] As discussed elsewhere in this report, private equity consolidations of emergency room physicians or dermatologists or anesthesiologists have created local monopolies; similarly, when local hospitals consolidate or are acquired by larger chains, local communities may lose services, such as reproductive health care or end-of-life care; and with an estimated 70% of all physicians now working for salaries for corporations, their free agency as physicians in providing care to patients can be severely impaired. A summary of recent developments of health care consolidation,:www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation

[51] Interestingly, many other developed countries focus regulatory efforts on third-party payers (insurers) to limit their profits and to encourage administrative efficiency. Regulation of providers focuses on safety and consistent medical standards. Perhaps when health care services are recognized as a public good, like public health and public safety, taxpayer funds are safer from treasure hunters and supply/demand around provider quality works better.

Michael F. Furukawa, Laura Kimmey, David J. Jones, Rachel M. Machta, Jing Guo, and Eugene C. Rich. Consolidation of Providers into Health Systems Increased Substantially, 2016–18. Health Affairs 2020 39:8, 1321-1325.

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Chapter 5

HOW FOR-PROFIT ENTITIES CAME TO DOMINATE AMERICAN HEALTH CARE

The current for-profit business model is not meeting basic needs of the most vulnerable among us, nor for most Americans, nor their providers nor their communities

Following World War II, most American hospitals were owned and managed by their communities or by religious organizations. Blue Cross (hospitalization insurance, initially offered in TX in 1929[52]) and Blue Shield (insurance for physician services, initially offered in California in 1933[53]) began as social welfare plans,[54] tax exempt with 501(c)(4) status. Premiums were priced through "community rating," meaning underwriters calculated the cost of health insurance based on the pool of enrollees in the local community (geography), who all paid the same rate.

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[52] "The enabling statute in Texas distinguished a health service corporation from traditional insurance," based on their mission, supported by local (charitable) funds: *Consumer Reports Advocacy* "Blue Cross History Compilation," 12/30/2007, p.7 https://advocacy.consumerreports.org/wp-content/uploads/2013/03/yourhealthdollar.org_blue-cross-history-compilation.pdf

[53] "Permanente medicine, developed by industrialist Henry J. Kaiser and enterprising physician Sidney Garfield, was launched to take care of workers in Kaiser's West Coast shipyards. The two had done this before: Garfield had set up a prepaid plan for workers on the Los Angeles Aqueduct project in 1933, and he and Kaiser had teamed up to care for workers at the Grand Coulee Dam in Washington state in the late 1930s," from Kaiser Permanente, " Health care coverage for workers' families didn't come easy," 1/15/2011 at https://about.kaiserpermanente.org/who-we-are/our-history/health-care-coverage-for-workerse28099-families-didne28099t-come

[54] Only in the 20th century did the concept of health insurance as a "product" emerge. Michael A. Morrisey, a professor in the Department of Policy and Organization in the School of Public Health at the University of Alabama Birmingham, notes: "health was regarded as uninsurable because hazards had to be both definite and measurable. Health was neither. The problem with offering a policy that paid when one was sick was that everyone had an incentive to declare herself sick once she had coverage. When the hospital service plans became popular, the commercial insurers found a way to resolve the problem. They didn't offer health insurance; they offered hospitalization coverage. An admission to a hospital was a definite event, determined by a physician. In 1934 commercial carriers began offering hospital coverage. Initially, they did not provide physician coverage, but they did offer surgical coverage, beginning in 1938, because surgeries were definite events." Michael A. Morrisey, Health Insurance, 2nd ed, Health Insurance Press, 2013, pp.6-7, accessed Dec23: *https://account.ache.org/iweb/upload/Morrisey2253_Chapter_1-3b5f4e08.pdf.* Note, however, that a 1947 US Public Health Service report concluded, "to be successful, plans must be true to their promotion of themselves as "civic organizations," and thus "must give the general public the feeling that the plan belongs to the public, that it is in truth a civic organization, of, by and for the public," *Op.Cit.,* Consumer Reports Advocacy, p.9.

The Emergence of Health Insurance of a Business & Adverse Selection

In 1940, only about 9% of Americans had health insurance. WWII wage controls prompted employers to offer job-based insurance to recruit workers. (Health insurance was not considered a "wage" and the IRS determined that employer-sponsored plans were tax exempt.) By 1950, half of Americans were covered. By 1960, it was 68%, a dramatically larger "market," with far greater profit potential for insurance companies.[55]

In the 1960s and 1970s, commercial insurers began to offer rates based on "experience rating," what we now often call "pre-existing" or "prior conditions,"[56] which allowed them to offer lower rates to relatively healthy enrollees (who, taken as their own pool, could be served at lower cost).[57] As less-costly enrollees exited community-rated pools, those pools had to raise rates because their average cost increased. Entities using experience rating thus "out-competed" those using community rating, leaving the sickest and poorest behind. No BCBS was using community rating by 1970.[58]

Medicare & Medicaid: Federal Initiatives Include Support for Private Insurance

In parallel, there was growing concern about the number of elderly Americans living on meager incomes and having no health insurance.

Passage of the landmark *Social Security Amendments of 1965* that created Medicare (health insurance for the elderly) and Medicaid (health insurance for those with low incomes) meant that many of the most expensive to insure were now covered by "social insurance,"[59] paid by income and payroll taxes levied on workers and their households.

Medicare, which also forced the nation's hospitals to racially desegregate care by tying federal

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[55] *Ibid.*, p.10

[56] Segmenting customers by relative profitability is a free-market best practice, resulting in "risk pools" based on expected cost (young males pay higher car insurance, houses in flood plains pay more to insure real estate, urban areas pay more for personal property). Similarly, young, healthy adults paid lower premiums than older, less-healthy adults; those with "prior conditions" often became uninsurable.

[57] *Ibid.*, Morrisey, p.11

[58] *Ibid.*, Morrisey, p.12

[59] "Social Insurance," according to the Social Security Administration (ssa.gov), "is based on the recognition that economic insecurity in a money economy arises in considerable part from interruptions to income from work caused by unemployment, retirement in old age, death of the family breadwinner, or disability, either short-term or long-term,"
https://www.ssa.gov/history/churches.html#:~:text=Social%20insurance%20is%20based%20on,%2Dterm%20or%20long%2Dterm.

(public) dollars to integrating patients, staff, and operations (food, laundry, housekeeping, etc.),[60] by legislative design provided a market space for for-profit entities: e.g., federal dollars only pay 80% of Part B (out-patient) expenses and put a ceiling on Part A (in-patient) expenses paid by federal dollars. Those "gaps" in coverage were and continue to be filled by private insurance, as Congress intended.[61] Similarly, Medicaid, designed to serve the indigent, with costs shared between federal and state tax dollars, by design allowed private administration, which has grown over time.

Today, so-called Medicaid "Managed Care," which accounts for about half of all Medicaid spending, when managed by for-profit companies has about 14% in overhead versus 10% for non-profits.[62] There is no requirement that private companies manage Medicaid, of course, except that they want to manage it because it is profitable.

(Later in this report, we'll explain how Connecticut decided to de-privatize Medicaid Managed Care, seeing both savings and improved outcomes within the first year.)

HMO's Introduced to Restrain Costs — Profit-Seeking Triggers Consolidation

The cost of health care continued to rise, however, and in 1973 Congress passed the *Health Maintenance Act* (HMO) to encourage HMOs (another free-market initiative) seeking improved patient care, decreased health care costs, and a greater emphasis on preventive health care.

HMOs achieved initial savings by creating "networks" of providers and negotiating reimbursement rates more favorable to insurers. When many providers had to compete for a limited number of HMO contracts, however, the larger and more powerful insurers dominated negotiations, cutting their cost-to-serve (their price to employers) by offering narrower networks and letting their networks "churn" (constantly shift doctors in and out), shifting coverage terms, and increasing cost-sharing to be paid by employees.
Although commercial/for-profit insurers began with significant market share (71% in 1988), by 2012 their enrollments were down to 1% of insured workers as more for-profit players entered with new products.[63]

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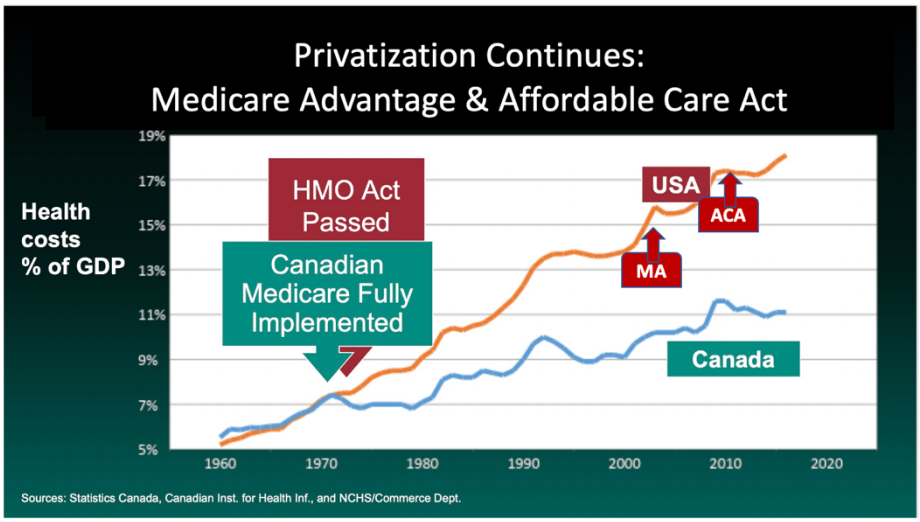
[60] For a robust documentary history of the 11 months it took to complete de-segregation, see *The Power to Heal*, https://www.blbfilmproductions.com

[61] For a detailed history of how these evolved, see Edward Berkowitz, "Medicare and Medicaid: The Past as Prologue," Health Care Finance Rev. 2005 Winter; 27(2): 11–23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194925

[62] Note also that on quality measures, publicly traded plans "scored 13 percentage points lower when it came to managing chronic illness, and 11 percentage points lower on a composite score measuring preventive care" Commonwealth Fund, "For-Profit Medicaid Managed Care Plans Spend More on Administrative Costs," June 15, 2011, available at: https://www.commonwealthfund.org/press-release/2011/new-report-medicaid-managed-care-plans-owned-publicly-traded-companies-have.

[63] Ibid., Morrisey.

The chart "**Privatization Continues**"[64] shows American health costs as a percentage of GDP. U.S. costs tracked with those of Canada until the 1960s when the two countries chose different policy reforms.



Despite threats of doctors' strikes (fed by scary ads paid by the AMA that blanketed Canadian broadcasting), the Canadian province of Saskatchewan adopted a publicly-financed universal-health program in 1962. Within months, the plan proved so popular that opposition dissolved and, year by year, over a decade, similar programs were adopted by every province, territory, and the federal government. The U.S., also concerned that health care costs had reached 8% of GDP but awash in another frenzied AMA campaign, led by Ronald Reagan against "socialized medicine," [65] doubled-down on free-market solutions. Although LBJ managed to pass Medicare for seniors, health costs for younger Americans kept rising. After Nixon got the HMO Act passed, Canadian and American health costs began to diverge. The gap has grown in the half century since — despite the U.S. increasingly privatizing health care (and privatizing publicly-funded health care), as market forces continually promise lower cost-to-serve for equal care because the free market is "efficient."

The U.S. market response to HMOs: providers recognized the need to gain competitive clout in negotiations and began their own consolidations. Some hospitals closed, and others merged.[66] Physician practices grew. Morrisey describes a consumer backlash against “pre-admission certification" (requiring HMO approval for hospital admissions), admission “reviews" (to deny coverage for unapproved hospital admissions), gatekeeping (using primary-care physicians to limit access to specialists), preventing physicians from discussing costly treatment options, and hospital discharges based on time not patient condition.[67]

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[64] Adapted from PNHP chart for PNHP-Metro Forum, "How Private Equity Makes US Sicker," PNHP-Metro Forum Oct 18, 2022, https://www.pnhpnymetro.org/past_forums

[65] In 1962, Kennedy introduced Medicare on national television, with 42 subsequent rallies. "Physicians' groups in numerous locations threatened boycotts. The AMA bombarded the airwaves with anti-Medicare advertisements, it enlisted Reagan's covert assistance to encourage anti-Medicare mail to Congress--the AMA's so-called "Operation Coffeecup" featuring a recording, "Ronald Reagan Speaks Out Against Socialized Medicine"; it placed an anti-Medicare article in the then very popular *Reader's Digest*; and it urged physicians who had members of Congress as patients to lobby them to oppose Medicare. Both sides blanketed the country with advertisements in every conceivable medium. It was one of the most intensive public-relations campaigns in history, and Medicare failed." MJ Skidmore, "Ronald Reagan and "Operation Coffeecup": a hidden episode in American political history," *J Am Cult*, 1989;12(3):89-96. https://pubmed.ncbi.nlm.nih.gov/11620198

[66] Ibid., Morrisey, "between 1990 and 2000, 100 or more hospital mergers occurred in eight of those 11 years."

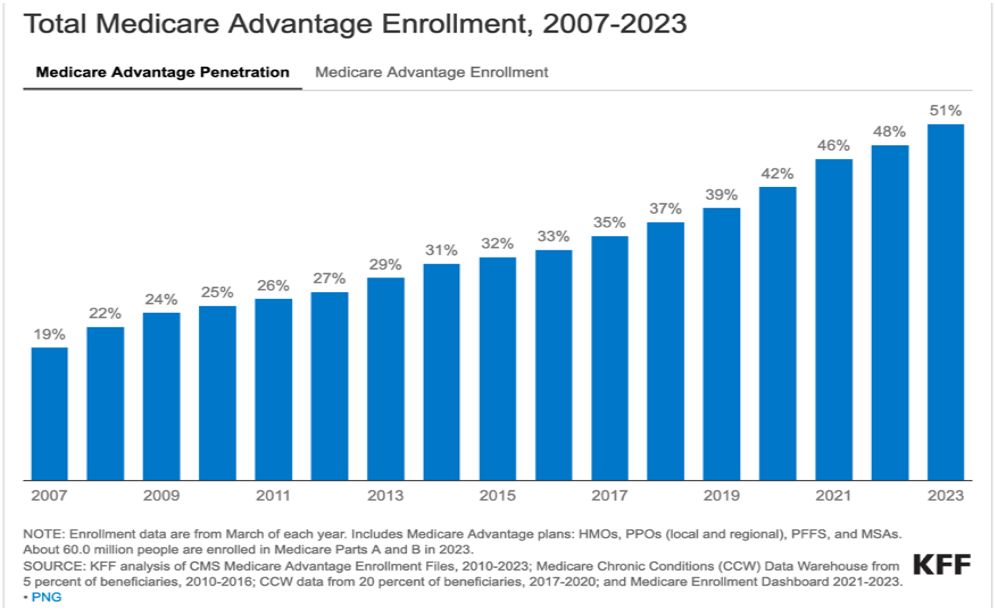
[67] Ibid., Morrisey, p 19.

PPOs (Preferred Provider Plans), frequently offering the “benefit" of a wider range of providers in exchange for higher premiums, also grew rapidly as large employers shifted to self-insured plans where they needed contracts coordinated (many PPOs didn't underwrite risks and therefore didn't act as insurers). After 2000, PPOs and HMO enrollments rapidly diminished as the increasing cost of health care triggered the emergence of high-deductible plans (HDHP) and reduced job-based health benefits — further shifting costs from insurers to the insured.

1997-2023: Free-Market Attempts to Rein in Costs — Public Funds Fuel Corporate Profits

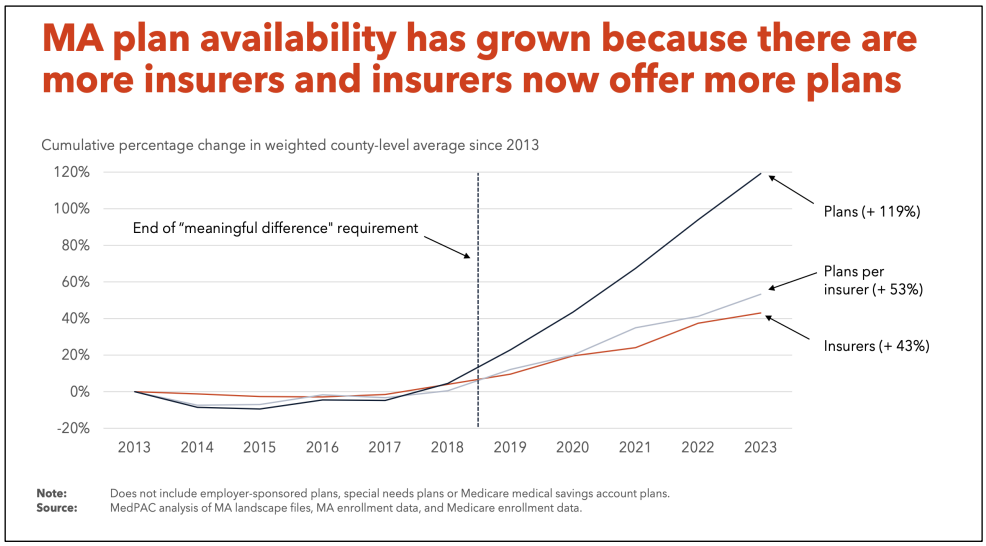
Privatizing Medicare

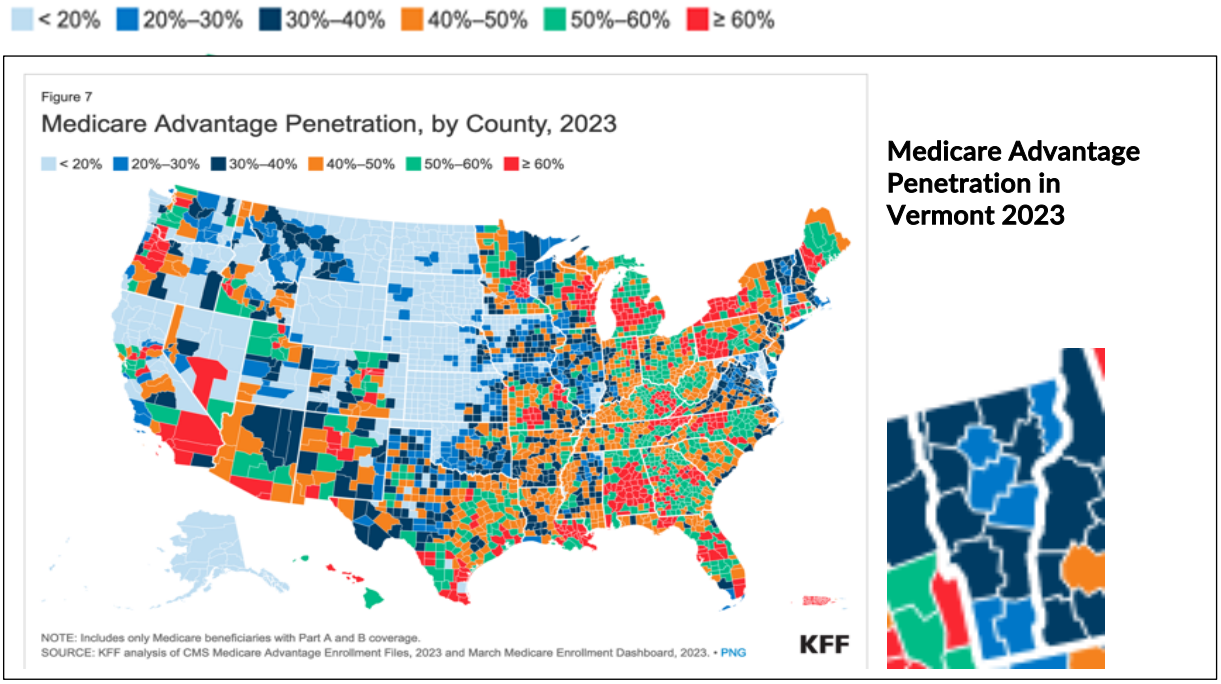
In repeated, albeit unsuccessful, attempts to use free-market principles to rein in health costs, the federal government has increasingly privatized Medicare. What do we mean by "privatizing" Medicare? It’s introducing "market-based reforms" by allowing for-profit entities to operate as middlemen between Medicare beneficiaries and the federal purse – managing these healthcare services on their promise of reducing costs – which reforms have not achieved,[68] although they have made public scrutiny too opaque to audit easily.



[68] "In the last decade, reams of evidence uncovered in lawsuits and audits revealed systematic overbilling of the government," "Without reforms, taxpayers will spend about $25 billion next year in “excess” payments to the private plans," "Profits on Medicare Advantage plans are at least double what insurers earn from other kinds of policies," "Fraud lawsuits brought against the companies also suggest that the plans were deliberately inflating the codes under review by Medicare officials," there is increasing public and Congressional "awareness of overbilling, but also ... concerns about deceptive marketing and denials of care," all from Reed Abelson and Margot Sanger-Katz, "Biden Plan to Cut Billions in Medicare Fraud Ignites Lobbying Frenzy," *New York Times*, March 22, 2023, https://www.nytimes.com/2023/03/22/health/medicare-insurance-fraud.html. "Medicare Advantage plans covering the same care as traditional Medicare cost 12 percent more," "private insurance is increasingly less efficient than Medicare," Archer, *Health Affairs*, 9/20/11, www.healthaffairs.org/do/10.1377/forefront.20110920.013390

Growth of Medicare Advantage Plan Availability





Medicare Part C programs were created in *the Medicare+Choice program of 1997* as part of a balanced budget compromise. In 2003 it was rebranded **Medicare Advantage** when drug plans were introduced in the *Medicare Prescription Drug, Improvement, and Modernization Act (MMA)*. Part D prohibited Medicare from negotiating volume discounts on prescriptions, making MA plans even more attractive to seniors and corporations.[69]

[69] KFF *Issue Brief*, 8/9/23, Ochieng, et al., www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends

Over the past 25 years, private insurers have increasingly entered the Medicare Advantage market (*see chart "MA Plan Availability*[70] showing increases since 2018 of 119% more plans, 43% more insurers).They have also increased ways to profit (*see KFF chart "One-third of Medicare..."*[71]).

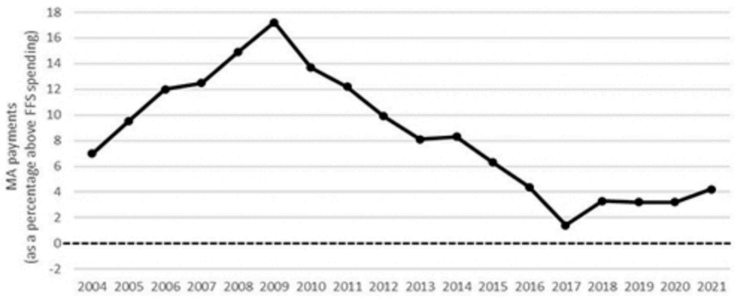
Today, the market is highly concentrated among a handful of dominant firms, both nationally and in local markets, with United Healthcare and Humana together accounting for 47 percent of enrollment in 2023 nationwide,"[72] leading to monopolistic behaviors. For-profit middlemen have increased, not reduced, how much taxpayers pay while offering care substandard to the care offered by Medicare.

Medicare Advantage programs cost the Medicare Trust Fund, on average, more per enrollee than Medicare does despite Medicare covering beneficiaries that are, on average, much sicker.

The amount above Medicare varied between 2004 and 2021, but according to MedPac,[73] from 2% more (in 2017) to 17% more in 2009, averaging about 6-7% more per year. (*See chart.*[74])

The increased costs have multiple causes.[75] Audits suggest, among other causes, significant fraud (e.g., charging for services not performed), over-billing (e.g., "up-coding" or using the highest billing codes available to increase reimbursement by painting patients as having more complex and worse health), as well as effectively violating Medicare

Figure 1. Medicare has paid more to MA plans than FFS Medicare spending would have been for the same enrollees, 2004–2021



March 3, 2021 / MedPAC Staff —https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/

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[70] MedPac.gov, Sept23, p.5, https://medpac.gov/wp-content/uploads/2023/03/Tab-D-Standardized-MA-Sept-2023.pdf

[71] KFF 2024 Spotlight: https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look

[72] KFF, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[73] "The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program." https://www.medpac.gov/what-we-do/

[74] MedPac Staff, 3/3/21, https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/

[75] That Medicare Advantage plans cost taxpayers more than traditional Medicare **has been known for 30 years:** "In **1995**, the U.S. General Accounting Office (GAO) warned Congress that Medicare was overpaying Health Maintenance Organizations (HMOs), the precursors to Medicare Advantage plans, by 6 to 28 percent compared to what it would have paid had all those HMO enrollees remained in traditional Medicare because most HMOs benefited from "favorable selection," meaning, healthier patients enrolled in HMOs. **In 1999**, the GAO again warned Congress that Medicare spent more on beneficiaries enrolled in HMOs than it would have had those beneficiaries been enrolled in traditional Medicare. The **following year**, the GAO told Congress that it was largely excess Medicare payments to HMOs, not their efficiencies, that allowed plans to attract large numbers of beneficiaries,

coverage guidelines by routinely denying and delaying covered care.[76] Some analysts estimate taxpayers have been over-charged as much as $88 billion.[77]

DCEs (Direct Contracting Entities)

As part of the ACA, CMS created the CMMI (Centers for Medicare & Medicaid Innovation) to improve quality and control costs within Medicare by testing new payment models. Few of the models tested have passed muster. One recent model, created during the Trump Administration and continued under the Biden Administration: DCEs (Direct Contracting Entities) that insert for-profit middlemen between provider groups and Medicare — unlike Medicare Advantage Plans, where patients who pay attention should know that in choosing an MA plan over Traditional Medicare, they are putting middlemen between themselves and their providers.

DCEs are more stealth. They move seniors who selected Traditional Medicare into for-profit programs, without the patients' knowledge or consent. DCE entities negotiate with physician practices, promising higher reimbursements and (because of fewer administrative tasks) more time with patients; once the physician is enrolled, the senior is automatically enrolled by being on the physician's roster. Like MA plans, DCEs "cherry pick and lemon drop,"[78] deny care, upcode, spend as little as 60 percent[79] on health care for beneficiaries (compared to Medicare Advantage's 85 percent and traditional Medicare's 97 percent), and keep the rest as profit."[80]

This privatizing of Medicare is termed "de-risking,"[81] meaning that the private insurers bear the risk of providing health insurance to seniors rather than taxpayers. But, in fact, the private insurers are taking the upside risk (profit) of covering healthy seniors and leaving all the downside risk (the unhealthiest and most expensive to serve) to taxpayers — it is exactly what

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again exceeding costs expected under the traditional program, adding billions to Medicare spending," Ana Malinow, "An Obscure Agency Is Threatening to Hand Medicare Over to Wall Street, *Truthout*, Dec 3, 2021, stress added, https://truthout.org/articles/an-obscure-agency-is-threatening-to-hand-medicare-over-to-wall-street

[76] CMS conducted 90 audits between 2011 and 2013, for example, discovering $650M in over-payments to Medicare Advantage companies, with some analysts calculating the over-payments as twice that high ($1.3B); the over-payments were calculated by sampling individual patient records to determine if patients had the diseases reimbursements had been targeted to treat, but health plans could not document that extra payments were due. A different 2015 audit of Humana Medicare Advantage alleged over $200M in over-billing for one year for that one insurer. Some audits have found payment errors on an average of 69% for some diagnosis codes. KFF, Fred Schulte, "Government lets health plans that ripped off Medicare keep the money," January 2023.

[77] To read about how and why these plans have cost taxpayers more money than Traditional Medicare, provided lower

[78] GAO.gov Government Accountability Office, Released: May 30, 2017, https://www.gao.gov/products/gao-17-393

[79] Richard Gilfillan and Donald M Berwick, "Medicare Advantage, Direct Contracting, and The Medicare Money Machine, Part II," Sept 30, 2021, Health Affairs, https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-2-building-aco

[80] Ibid., Malinow.

[81] Ibid., Malinow.

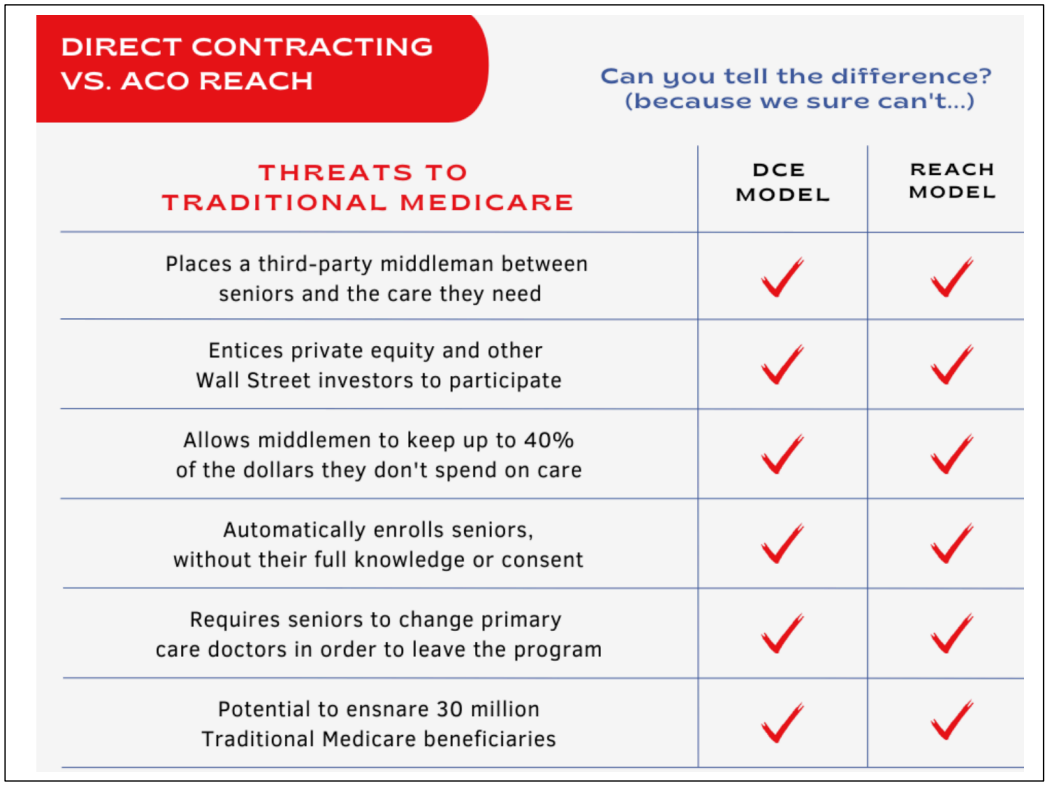
happened in the 1950s when commercial insurers attracted healthy adults into their "experience-rated" pools, leaving costly adults in the "community-rated" pools.

Insurance works best when risk is spread over large-population pools so that costly and catastrophic events are shared across the greatest number of beneficiaries. Profit works better when the healthiest populations can be creamed off (while claiming lower costs come from efficiency).

ACO/REACH (Accountable Care Organization/Realizing Equity, Access, and Community Health)

When the CMMI announced plans to move all Medicare beneficiaries into these new programs by 2030, Americans began writing Congress, the President, the head of CMS, and Dr. Liz Fowler, the plan's author and director of the CMS Innovation Center. The outcry was sufficiently loud that CMMI announced the launch of a new and improved plan for January 2023, the ACO/REACH (Accountable Care Organization/ Realizing Equity, Access, and Community Health). PNHP analysis concluded that ACO/REACH was a rebranding of DCEs and "retains the worst elements of the original program:

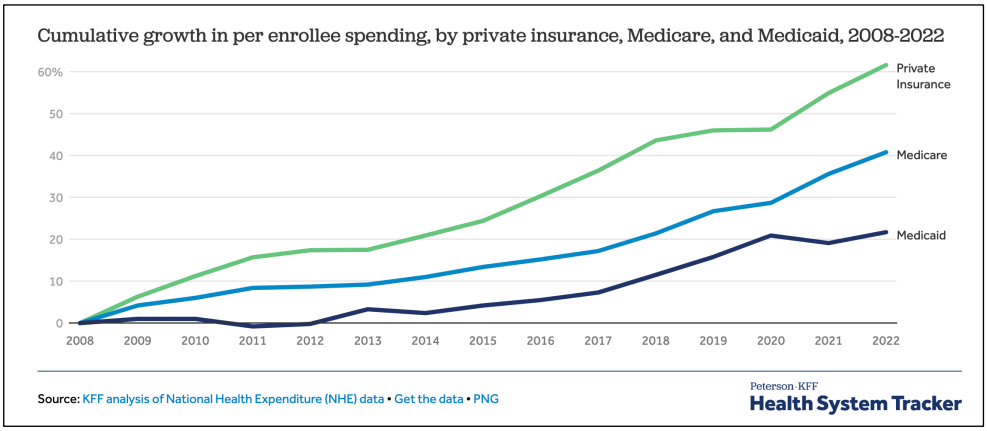
1. Inserting third-party middlemen between seniors and needed care;
2. Auto-enrolling seniors who *chose Traditional Medicare* into REACH, without their full understanding or consent; and
3. Paving the way for the complete privatization of Medicare by 2030."[82]



[82] PNHP, "Corporations Are REACHing for Traditional Medicare," https://pnhp.org/corporations-are-reaching-for-traditional-medicare

PNHP created a checklist to indicate the similarities (*see chart "Direct Contracting" vs ACO/ REACH.")*[83] Despite significant on-going protest, CMS has not yet withdrawn the program which pervades the entire U.S., 40% penetration in some Vermont counties, 60% penetration in some counties across the U.S. (*See maps "MA Penetration."*[84])

Adults Younger Than 65: Private Insurers Increase Their Markets & Their Profits



As has been discussed above, commercial health insurers, including employment-based health insurers, grew their market share within the U.S. population from about 9% in 1940 to 71% of those ineligible for Medicare or Medicaid in 1988.

The cost of health care continued to climb, however (*see chart "Cumulative growth in per enrollee spending..."*[85]); between 2008 and 2022, the per person cost of Medicaid grew 22%, Medicare grew 41%, while for-profit insurance cost grew by 62%, markedly faster. Does privatizing speed cost increases?

Looking at decades of data, KFF concluded in 2015 that publicly-funded programs tend to control per capita spending better than private insurance, writing,

> While Medicare and Medicaid are far from perfect, the purchasing power and policy levers available to large public programs appear to give them an edge over our fragmented private insurance system when it comes to controlling spending.[86]

From the American worker's perspective, however, for those not eligible for Medicaid or Medicare, there is only private insurance — whether through an employer-sponsored plan or

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[83] Ibid., PNHP

[84] KFF, NancyOchieng, et al, "Medicare Advantage in 2023: Enrollment Update and Key Trends" Aug 9, 2023, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends

[85] Peterson KFF, Health System Tracker, 12/15/23, www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changedtime/#Cumulative%20growth%20in%20per%20enrollee%20spending,%20by%20private%20insurance,%20Medicare,%20and%20Medicaid,%202008-2022

[86] KFF, Drew Altman, 4/18/15, https://www.kff.org/health-costs/perspective/public-vs-private-health-insurance-on-controlling-spending

an individual plan. Individual plans effectively priced many out of the market, causing some to choose high-deductible plans that left them under-insured and unable to afford routine preventive care, much less catastrophic events, or to choose to buy nothing, leaving them uninsured against any health emergency, much less routine preventive care.

According to the CDC, in 2008, almost 56M Americans (19%) were either uninsured or had been uninsured in the prior 12 months, and half of those had been without health insurance for more than a year. Another 20%, enrolled in high deductible plans, were effectively uninsured because they could not afford the cost-sharing required for care.[87] Only a few states had laws regulating insurance rate increases, and those that didn't saw frequent double-digit premium rate hikes, with some critics claiming the insurers managed their risk pools to maximize profits, not value, as noted throughout this period, and even in 2013, before the ACA took effect.[88]

In fact, all health-care costs had been rising at multiples of the rate of inflation over the prior decades and much faster than wages; for employer-based insurance, the cost of health insurance slowed wage increases (unions traded wage growth for health benefits and cost-sharing cut real growth). Analysis by the Economic Policy Institute concluded that between 1979 and 2013,

> The wages of middle-wage workers were totally flat or in decline over the 1980s, 1990s, and 2000s [... and] The wages of low-wage workers fared even worse, falling 5 percent from 1979 to 2013. In contrast, the hourly wages of high-wage workers rose 41 percent[89]

Worse, job-based health insurance fell precipitously: "The share of young college graduates who have employer-sponsored health insurance coverage fell from 61 percent in 1989 to 31 percent by 2012. Most of this health-benefit erosion occurred since 2000, when just over half (53 percent) of recent college graduates had employer-provided health insurance."[90] Job-based health insurance for those with high school degrees fell to 7%.[91]

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[87] CDC.gov Cohen RA, Health insurance coverage: Early release of estimates National Center for Health Statistics. June 2009,www.cdc.gov/nchs/data/nhis/earlyrelease/insur200906.htm#:~:text=In%202008%2C%2043.8%20million%20persons,the%20time%20of%20the%20interview.

[88] *NY Times*, "Health Insurers Raise Some Rates by Double Digits," Reed Abelson, 1/5/2013, https://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html

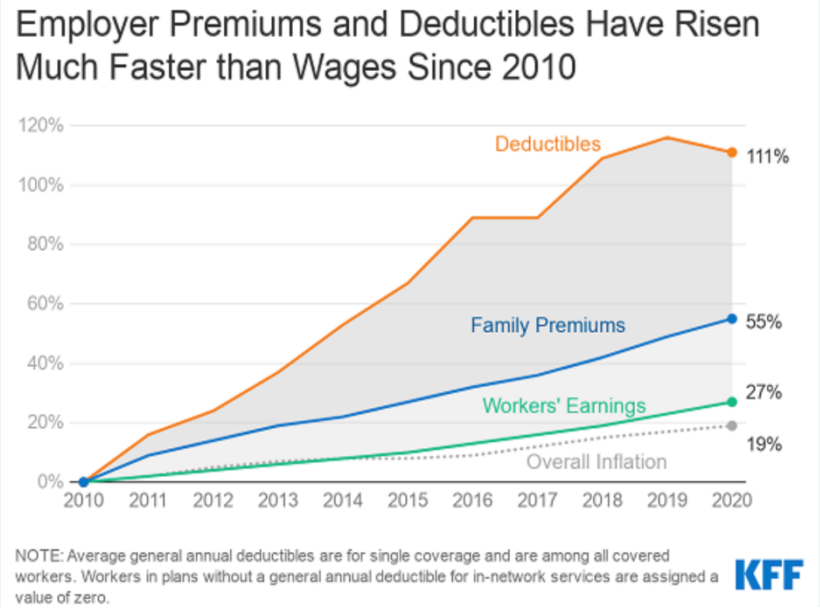
[89] Economic Policy Institute, Lawrence Mishel et al., "Wage Stagnation in Nine Charts," Jan 6, 2015, https://www.epi.org/publication/charting-wage-stagnation

[90] Ibid, EPI.

[91] Ibid. EPI.

Between 2010 and 2020, with wages growing about 8 points above inflation (27% to 19%), family premiums grew at double the rate of wages, and deductibles grew 4 times faster than wages. Employers, stressed by rising costs, increasingly shifted health costs to employees, as well as negotiating wage increases against decreased benefits. (*See chart, "Employer Premiums and Deductibles..."*[92])

When the Great Recession hit in 2008, millions of workers lost their jobs— and their health insurance. It took four years and the ACA for Americans to return to 2008 coverage levels.



Affordable Care Act of 2010

In March 2010, the *Affordable Care Act* (ACA) was enacted to provide a "marketplace" for those without insurance. It mandated that uninsured individuals purchase health insurance through a semi-regulated market of private insurers (the "exchanges"), and it offered "expanded Medicaid" to states, with most of the cost paid by federal taxes. By providing premium subsidies based on income to Americans not eligible for Medicaid, while mandating the purchase of private insurance on the exchanges, the ACA created a bonanza for privatization.

The premise of creating "exchanges" was to encourage competition and to lower the cost of premiums, but since insurers often defined insurance pools at the county level, there was only limited oversight across the highly fragmented landscape of 3,143 (county) markets within state-based insurance regulation. Insurance rates varied from plan to plan, county to county, and year to year. Although sometimes a catastrophic event for a single individual could spike premiums for every ACA beneficiary in that resident's plan, more often there was no explanation for rate increases other than a single insurer and/or a single hospital, unilaterally increasing revenue, knowing that their geographic monopoly would not lose customers.[93] By November of 2016, disconnects between premium increases and cost of care in the individual exchanges were grabbing headlines, e.g., "The Upshot," a *New York Times* column

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[92] KFF, News Release, Oct 8, 2020, https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-to-21342-in-2020-benchmark-kff-employer-health-benefit-survey-finds

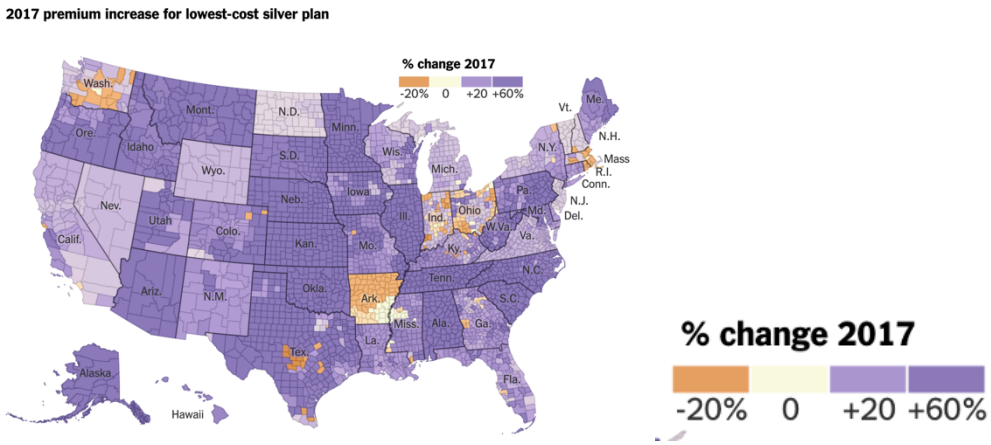
[93] *NY Times*, "Upshot: *One Reason Health Insurance Premiums Vary So Much,*" Eduardo Porter, 5/14/14, https://www.nytimes.com/2014/05/16/upshot/why-health-insurance-premiums-vary-so-much.html?searchResultPosition=2

offering analysis and visualization of news, offered maps, showing data by county to explain the 22% average increase in premium rates for 2017:[94]

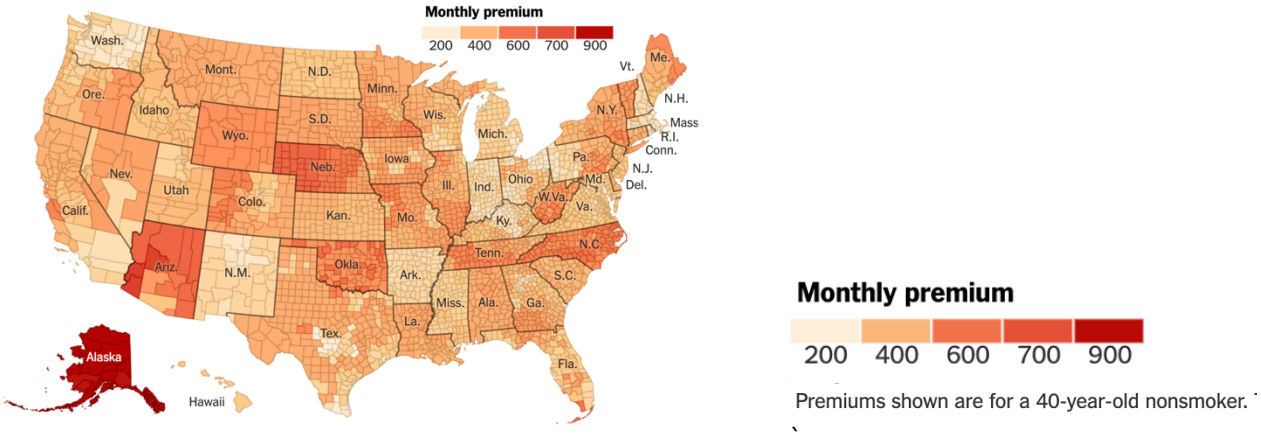
Obamacare Rates Are Rising

But there's a lot of variation. In some Arizona counties, prices for the most affordable midlevel plan are going up by 191 percent. In parts of Texas, premiums are going down by 30 percent.

2017 Premium Increase For Lowest Cost Silver Plan



Highest Increases Do Not Always Mean Highest Rates

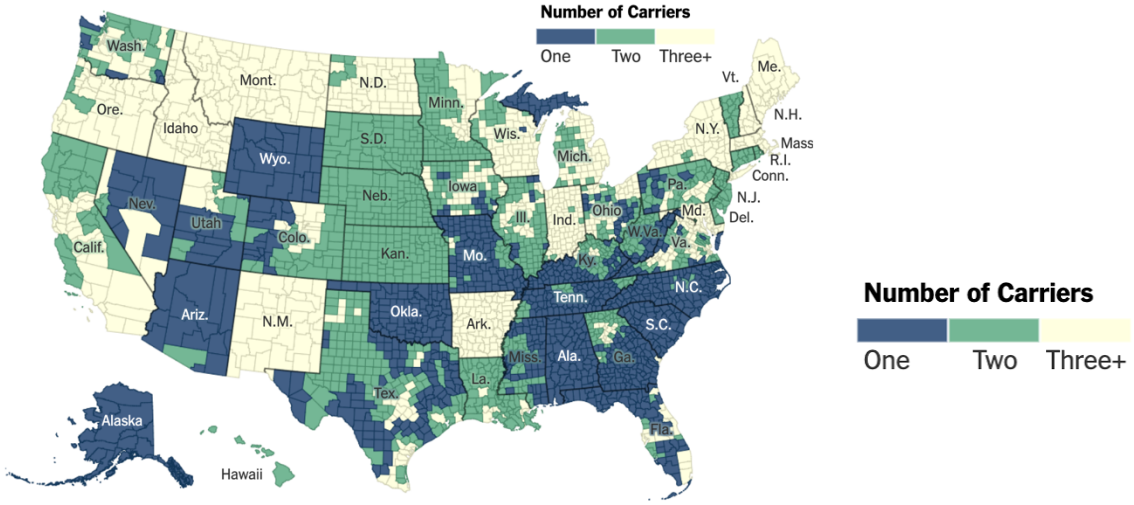


[94] Maps all from *NY Times*, Sources all McKinsey Center for U.S. Health System Reform, "Upshot: See Obamacare rates for every county in the country," by Margot Sanger-Katz, 11/4/2016, https://www.nytimes.com/2016/11/05/upshot/see-obamacare-rates-for-every-county-in-the-country.html

Competition Has Fallen

About 18 percent of people eligible for the Obamacare markets will live in counties with only one insurance carrier offering health plans next year.

Number of insurance carriers in the Obamacare markets



On the books, the ACA required insurers to provide at least some transparency on rate increases,[95] but transparency was often opaque. In 2011, CMS reported that insurers reported some of their highest profits in years, their stock was booming, and their financial reserves were at all-time highs.[96] When think tanks, reporters, and health advocates urged investigation of these unexplained profits, it became clear that insurance company projections of future medical costs were overblown: actual costs were far less than those used to set rates. The insurers pocketed the difference between revenue collected in premiums and costs paid out for care. Barclays Capital Equity Research concluded in a 2011 study, "for the top 14 health insurers and managed care companies: ... [13 of 14 had] average earnings over-estimates [of] 45.7 percent."[97]

Some state began rate reviews and then began trying to "claw" back excess revenue:

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[95] "The nation's major health insurers are barreling into a third year of record profits… Yet the companies continue to press for higher premiums, even though their reserve coffers are flush with profits and shareholders have been rewarded with new dividends." *New York Times*, "Health Insurers Making Record Profits as Many Postpone Care." May 13, 2011. https://www.nytimes.com/2011/05/14/business/14health.html

[96] CMS.gov, "Fighting Unreasonable Health Insurance Premium Increases," May 19, 2011, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/ratereview05192011a

[97] Barclays Capital Equity Research. *U.S. Health Care-Managed Care,* Joshua R. Raskin, et al. 9 May 2011, available from CMS.gov site: https://www.cms.gov/cciio/resources/files/downloads/rate_review_report_092011.pdf

- Rhode Island's Insurance Commissioner was able to use its rate review authority to reduce a proposed increase by a major insurer in that State by 6 percent – lowering a proposed increase of 7.9 percent to 1.9 percent.[98] .
- Californians were saved from rate increases totaling as much as 87 percent when a California carrier withdrew its proposed increase after it drew scrutiny from the State Insurance Commissioner.[99]
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent after public outcry drew attention to it.[100]
- In Connecticut, one insurer requested an increase of 20 percent. The Insurance Department rejected this increase as excessive, and because of the law in Connecticut, it cannot go into effect.[101]

Since 2010, the ACA has become increasingly popular, with Americans citing the value of not having "pre-existing conditions"[102] affect their access to (and cost of) insurance, with over half the population saying someone in their household benefits from this protection — although national polls continue to show a partisan divide.[103] Nonetheless, it is still perceived as too expensive for full access to routine care, with almost half the population avoiding scheduling routine care, skipping follow-up care, and not filling all prescriptions due to cost.

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[98] These three bullets were taken from CMS.gov site: "Fighting Unreasonable Health Insurance Premium Increases," https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/ratereview05192011a, with the first citing http://wrnihealthcareblog.wordpress.com/2011/03/09/koller-slashes-bcbs-proposed-rate-increase

[99] Ibid., CMS.gov, citing http://www.insurance.ca.gov/0400-news/0100-press-releases/2011/release040-11.cfm

[100] Ibid., CDC.gov, citing http://www.inforum.com/event/article/id/314397

[101] Ibid., CDC.gov

[102] "...protections for people with pre-existing medical conditions... prohibit insurance companies from denying coverage based on a person's medical history (known as guaranteed issue) and prohibit insurance companies from charging those with pre-existing conditions more for coverage (known as community rating). The July 2019 KFF Health Tracking Poll found that a majority of the public says it is very important for many of the ACA provisions to be kept in place, including the guaranteed issue provision (72%) and community rating (64%)." & "A KFF analysis estimates that 27% of adults ages 18-64 have a pre-existing condition that would have led to a denial of insurance in the individual market prior to the implementation of the ACA. An even larger share of the public believes they or someone in their family may belong in this category. According to the KFF polling data from 2020, about half of the public say they or someone in their household suffers from a pre-existing medical condition, such as asthma, diabetes, or high blood pressure." KFF, Polling, Apr 14, 2022, https://www.kff.org/affordable-care-act/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court

[103] "The most recent KFF Tracking Poll conducted in May 2023 found slightly more than half of the public (59%) hold a favorable opinion of the ACA while about four in ten (41%) hold a negative opinion of the law. Views of the ACA are still largely driven by partisanship: nearly nine in ten Democrats (89%) along with six in ten independents (62%) view the law favorably, while nearly three quarters of Republicans (73%) hold unfavorable views." Ibid, KFF Polling, Apr 14, 2022.

Current Status Quo — Profitability in the Health Care Sector Attracts Significant Investment by the Largest Companies Publicly Traded on U.S. Exchanges

With for-profit organizations seeking to profit from the trillions of dollars spent on healthcare each year, more than half of it from public funds, the Healthcare Sector has been a darling of Wall Street for two decades, with 8 healthcare stocks counted in the largest 25 U.S. companies in the Fortune 500,[104] and *Becker's Hospital Review*[105] listing the largest 25 health care companies in the top 250 of the Fortune 500 for 2022; further two behemoths are heavily investing in healthcare to increase profits:

- **9 HEALTH INSURANCE, MANAGED CARE COMPANIES, AND FACILITIES**
  - #5: **UnitedHealth Group**, with $324.16B in revenue, up 12.7% year over year
  - #14: **Cardinal Health** with $181.36B and up 11.6%
  - #15: **Cigna** with $180B up 3.7%%
  - #22: **Elevance** (formerly **Anthem**), with $157B up 13%
  - #25: **Centene**, $145B up 14.7%
  - #42: **Humana**, $93B up 11.8%
  - #66: **HCA Healthcare** $60B up 2.5%
  - #126: **Molina Healthcare**, $32B, up 15.1%
  - #215: **Tenet Healthcare**, $19. B, down (1.6%)

- **14 PHARMACEUTICAL AND HEALTH SERVICE SUPPLIERS**
  - #6: **CVS Health**, with $322.46B in revenue, up 10.4% year over year;
  - #9: **McKesson**, with $264B, up 11.6%
  - #11: **AmerisourceBergen** at $239B and up 11.5
  - #38: **Pfizer**, $100B up 23.4%
  - #40: **Johnson & Johnson,** $95B up 1.2%
  - #69: **Merck,** $59B up 15.8%
  - #73: **AbbVie**, $58B up 3.3%
  - #95: **Bristol-Myers Squibb**, $46B up (0.5%)
  - #99: **Abbott Laboratories**, $44B up 1.3%
  - #132: **Danaher,** $31B up 6.9%
  - #142: **Eli Lilly**, $29B up 0.8%
  - #150: **Gilead Sciences**, $27B down (0.1%)
  - #154: **Amgen**, $26B up 1.3%
  - #209: **Becton Dickinson**, $19B down (4.1%)

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[104] Fortune magazine's annual listing of the largest US corporations by revenue, of which the top 10 posted $3.7T in 2022, https://fortune.com/ranking/fortune500

[105] Bullets summarized from *Becker's Hospital Review*, "Fortune 500's top 25 healthcare companies," June 7, 2023, https://www.beckershospitalreview.com/rankings-and-ratings/fortune-500s-top-25-healthcare-companies-2023.html, with additional info noted as footnoted separately within the bullets.

#211: **Moderna**, $19B, up 4.3%
#244: **Stryker**, $18B up 7.8%

- #1: Walmart holds the top spot in the Fortune 500 rankings, with revenue of $611B — note 10% of its revenues currently come from health products **($61B** puts it at about **#65** with HCA Healthcare) with ambitious growth plans for this sector: it started a healthcare services business in 2018, reaching 75 locations by 2022, plans to double that footprint in 2024, noting that "90% of the U.S. population is located within 10 miles of a Walmart," so plans are for all supercenters to offer "primary care, dental care, behavioral health, labs and X-ray, audiology and Walmart Health Virtual Care telehealth services."[106]

- #2: Amazon is the 2nd largest U.S. company, with $514B in revenue, up 9.4%; Amazon is heavily investing in healthcare,[107] having purchased One Medical in 2023 and now offering it to Prime Members,[108] creating partnership with "some of the largest health systems in the country," and integrating One Medical with Amazon Pharmacy.[109]

Enter Private Equity — "Capitalism on Steroids"

Companies once termed "leveraged buy-out" firms (LBOs) because they were known for buying other companies by using debt (i.e., "leverage") are now called "private equity" (PE). They were also called "corporate raiders," as made famous in the movie "Pretty Woman," where the Richard Gere character (the raider) sought to win over the Ralph Bellamy character (the target owner of a ship-building company) by bringing the Julia Roberts character (the raider's humanizing escort) to dinner as his plus-one. Eventually, seeing his business through new eyes ("Julia's") the raider has a change of heart and decides to help the target save his company, the jobs of its employees and suppliers, and the economy of the factory's local community. A sub-plot involves the raider's second-in-command, portrayed as an incarnation of amoral ruthlessness, who seeks criminal revenge at the prospect of losing his share of the "billion-dollar" deal.

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[106] Walmart corporate news 3/22023: https://corporate.walmart.com/news/2023/03/02/walmart-health-nearly-doubles-in-size-with-launch-into-two-new-states-in-2024

[107] "When Amazon looks at health care, ... see two opportunities ... First, the supply chain in health care is a mess ... so many intermediaries ...[Second] price transparency.... Nobody really knows the price of anything. But it's a leap to think that by making the prices more transparent, we can save money in health care... Shopping for health care is nothing like shopping for the other items that Amazon might be selling and these kinds of ideas involving more consumerism in health care have not worked — and it's not like other companies have not tried," quoting Amitabh Chandra, Harvard Gazette, "Can Amazon Remake Health Care?" Aug 10, 2022, https://news.harvard.edu/gazette/story2022/08/can-amazon-remake-health-care

[108] https://health.amazon.com/prime

[109] https://www.beckershospitalreview.com/disruptors/amazons-one-medical-deal-1-year-later.html

Question: What exactly is Private Equity (PE)?

Answer: The equity, meaning shares in the company, is owned privately, that is, not traded on a public stock exchange. When a company's shares are traded publicly, the company is regulated by the SEC (the U.S. Securities and Exchange Commission) an independent agency, created after the 1929 crash to protect against market manipulation. The SEC requires transparency in financial operations, for example, through regular filings of financial statements. When private shares are traded, there are few regulations and even less transparency.

Promotion image for PNHP-NY Metro forum on private equity, Oct 2022

Despite the difficulty in acquiring fragmented data and transactions, often buried in disparate and unpublicized filings, there has been growing interest in the dramatic growth of PE firms within the health-care sector. A few academics have spent the better part of their careers shining light into this opaque corner of the economy that controls an ever-growing share of the American capital available for investment. Among these are Rosemary Batt and Eileen Appelbaum of the Cornell School of Industrial and Labor Relations (ILR) and the Center for Economic Policy Research (CEPR) who have written extensively about the increasingly dominate role of private equity in American health care and are widely recognized for their seminal research.

In 2000, PE invested $4.8B in buying health care entities; in 2020, PE purchased $105B. In 2021, PE spent $206B on health care entities. What have they purchased?

- 1990s and 2000s: they bought provider organizations, e.g., nursing homes and hospitals, "rolling them up into large for-profit chains
- 2010-2020: physician staffing firms for emergency medicine, radiology, anesthesiology; urgent care, ambulatory surgery, revenue cycle (billing), specialty practices in dermatology, dentistry, ophthalmology, gastroenterology, orthopedics, home healthcare agencies,[110] fertility clinics, neonatal care, primary care, cardiology, hospices, nursing homes[111]

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110 "Private Equity Buyouts in Healthcare: Who Wins, Who Loses? Eileen Appelbaum, Rosemary Batt." Working Paper No. 118" 3/15/20, doi.org/10.36687/inetwp118, www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf.

111 *The Hill*, Opinion, "Private equity is buying up health care, but the real problem is why doctors are selling," by Yashaswini Singh, Christopher Whaley12/21/23 https://thehill.com/opinion/healthcare/4365741-private-equity-is-buying-up-health-care-but-the-real-problem-is-why-doctors-are-selling/

- An educational forum on PE sponsored by the New York-Metro Chapter of Physicians for a National Health Program created a graphic with just a few of the many areas.[112]

Spotlight on Private Equity in Health Care Raises Public and Governmental Concerns

Applebaum and Batt explain the sudden recent media interest in PE and health care as dating from 2019 when

> two large private equity firms, with a 30 percent share of the market for outsourced emergency room doctors, were at the heart of the surprise medical-billing crisis. Patients who thought their insurance would cover their ER visit found instead that, in outsourced ER rooms, doctors could charge out-of-network rates, leaving patients with huge medical bills.[113]

Their research shows that PE controls over $4.5T in funding globally … and that 80% of the largest PE firms and transactions are American. They have targeted health care for two decades. In 2021, Eileen Applebaum testified at a hearing on Senator Warren's *Stop Wall Street Act*, saying

> The rising tide of capital flowing into PE funds has left them sitting on piles of dry powder. They are now in a better position than ever to buy up and hollow out large parts of the U.S. and global economies.[114]

In 2022, Professors Batt and Applebaum estimated that the "dry powder" available to PE firms to aim at U.S. businesses was between $1.5 and $2T, about 10% of the U.S. economy.

Question: What does Private Equity do with these investments?

Answer: They strip assets and financially restructure — namely mergers, spin-offs, acquisitions, and consolidation to gain market power in local, regional, and national markets.

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[112] Video of event here: https://www.youtube.com/watch?v=jW933Eu7wKg and presentation here: https://docs.google.com/presentation/d/1K_Tu1-OcbRj-Htt94iiJvSiHwujurDEYBjujm5FKdBY/edit?pli=1#slide=id.g9aa624ee39_5_42 transcript here: https://docs.google.com/document/d/15W1wIbx_C-xPw7XhsUgX1Uypj_P6HTOzELYH_oEIujU/edit

[113] *Ibid.*, Appelbaum and Batt. See also, *NYTimes*, "Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing,'" Sanger-Katz, et al., 9/13/19 www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html

[114] "Private Equity Buyouts in Healthcare: Who Wins, Who Loses? Eileen Appelbaum∗ and Rosemary Batt." Working Paper No. 118 March 15, 2020, https://doi.org/10.36687/inetwp118 www.ineteconomics.org/uploads/papers/WP at 118-Appelbaum-and-Batt-2-rb-Clean.pdf. See also, *NYTimes*, "Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing,'" Sanger-Katz, et al., 9/13/19 www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html

Market power allows monopolistic pricing, monopolistic control of employees, and/or monopoly over health access. As one 2023 study concluded:[115]

- in 28% of metropolitan statistical areas (MSAs), a single PE firm has more than 30% market share by full-time-equivalent physicians, and in 13% of MSAs, the single PE firm market share exceeds 50%.
- in 8 of the 10 physician practice specialties we study, we find ... price increases associated with PE's acquisition of a practice...[ranging] from 16% in oncology to 4% in primary care and dermatology....[and] per-patient expenditure increases for 6 of 10 specialties, ranging from 4% to 16% depending on the specialty.
- price increases ... are exceptionally high where a PE firm controls a competitively significant share of the local market ... where a single PE firm controls more than 30% of the market, ... for gastroenterology (18%), obstetrics and gynecology (16%), and dermatology (13%).

A year earlier, when the authors of this 2023 study were asked why they were focusing their research on private equity investments in the health sector, they replied:

> The short answer is that when the fundamental characteristics of the private equity business model are combined with the unique structure of the United States healthcare market, the results are potentially catastrophic for patients, payers, and the long-term stability of the healthcare supply chain. And, because the consequences in healthcare involve not just dollars but lives, these potential harms must not be ignored.[116]

Applebaum and Batt's research shows that in 2018, U.S. healthcare spending was $3.65 trillion, 4.6% higher than in 2017 "due to higher prices, not more visits to doctors or hospitals," and could largely be attributed to "higher prices paid by private insurers." They compare the 6.7% increase in 2018 for private insurers with 3.7% for Medicare and 2% for Medicaid. PE, having accelerated its investments across the entire health sector since 2010, and amped their investments after 2017, has played a significant role in reduced access to care, reduced quality of care, and increased cost.

What does PE say? They claim their value proposition as "turnaround agents," using financial skills to reduce costs by creating greater efficiency and to provide capital both to improve technology and also to consolidate fragmented markets. They promote the message that

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[115] "Monetizing medicine: private equity and competition in physician practice markets," Richard M. Scheffler et al., American Antitrust Institute, July 10, 2023, www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf

[116] Scheffler, et al., "Soaring Private Equity Investment In The Healthcare Sector: Consolidation Accelerated, Competition Undermined, And Patients At Risk" (American Antitrust Institute & UC-Berkeley Petris Center, 2021) petris.org/soaring-private-equity-investment-in-the-healthcare-sector-consolidation-accelerated-competition-undermined-and-patients-at-risk

private enterprise operating in the free market is always more efficient than public ownership and management, as well as more efficient than businesses that are too small to compete — not to mention providing investment returns far in excess of what the market provides.

During Senator Warren's 2021 *Stop the Steal* hearing, the Senator noted:

> We hear the standard talking points that private equity firms employ millions of people and create big returns for pension funds for teachers and firefighters. But when you fact-check those claims, it just turns out they're not true. In fact, private equity investments often result in fewer jobs and lower wages. And despite how hard they squeeze the businesses they acquire, private equity doesn't offer an above-market return to investors.[117]

How, specifically, does this happen? Professor Appelbaum explained in a letter supporting Warren's bill:

> Over the last decade, an increasing number of private equity and other private funds have taken controlling interests in hundreds of viable companies, using their assets to secure unsustainable loads of debt, and then stripping them of their wealth, preventing them from investing in the products and people that will allow the companies to thrive in the future. The funds charge investors high fees without providing them visibility or control into their activities and feed a growing market for risky corporate debt that is reaching dangerous levels.[118]

As explained in the 2020 research published with Rosemary Batts, which focused on PE in hospitals, outpatient care, physician staffing & emergency room services, and medical debt collection:

> In each of these segments, private equity has taken the lead in consolidating small providers, loading them with debt, and rolling them up into large powerhouses with substantial market power before exiting with handsome returns. [119]

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[117] Elizabeth Warren, 10/20/21, Press Release: https://www.warren.senate.gov/newsroom/press-releases/at-hearing-warren-pushes-for-reforming-the-broken-private-equity-industry-and-putting-an-end-to-their-destructive-practices

[118] Eileen Appelbaum, 7/17/19, Letter, https://cepr.net/letter-from-eileen-appelbaum-to-sen-elizabeth-warren-on-stop-wall-street-looting-act

[119] "Private Equity Buyouts in Healthcare: Who Wins, Who Loses? Eileen Appelbaum and Rosemary Batt. Working Paper No. 118 March 15, 2020, https://doi.org/10.36687/inetwp118 at www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf

Academics and academic centers have published significant research over the past decade, particularly in the most recent five years.[120] Many of these papers conclude with something like the following:

> Private equity is a decidedly corrupting influence in health care ... When treating the sick, healing the injured, and caring for those who cannot care for themselves become a means to an end, and that end is profit, the system has gone seriously awry.[121]

These reports have been the subject of numerous news articles and have triggered investigations led by national media; a sampling of the past five years follows this section. In an action that captured media attention, in September 2023, the Health Care Division of the FTC's Bureau of Competition issued an antitrust complaint against U.S. Anesthesia Partners (USAP) and "private equity firm Welsh, Carson, Anderson & Stowe, alleging the two executed a multi-year anticompetitive scheme to consolidate anesthesiology practices in Texas, drive up the price of anesthesia services provided to Texas patients, and boost their own profits," specifically

> USAP and Welsh Carson, which created USAP, engaged in a three-part strategy to consolidate and monopolize the anesthesiology market in Texas.
>
> - First, they executed a roll-up scheme, systematically buying up nearly every large anesthesia practice in Texas to create a single dominant provider with the power to demand higher prices.
> - Second, USAP and Welsh Carson further drove up anesthesia prices through price-setting agreements with remaining independent practices.
> - Third, USAP sidelined a significant competitor by striking a deal to keep it out of USAP's territory.[122]

More recently, in March 2024, Lina Khan, FTC Chair, held a hearing on private equity in health care, with riveting testimony from a wide range of speakers, many deeply critical.[123] In the FTC press release, Khan was quoted:

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[120] Appelbaum and Batt, with the CEPR, Institute for New Economic Thinking; Richard Scheffler and colleagues at UC Berkeley Petris Center Health Care Markets and Consumer Welfare and American Antitrust Institute ("The private equity business model is fundamentally incompatible with sound health care that serves patients,"); Corporate Governance Forum (Private Equity) and Systemic Justice at Harvard Law School; and many others.

[121] Harvard Law School *Systemic Justice Journal*, "The Private Equity Takeover of Medicine" Vol 1, 2021, https://systemicjustice.org/article/the-private-equity-takeover-of-medicine

[122] FTC Press Release 9/23/23, "FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas," at https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across

[123] Federal Trade Commission: "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care" - March 5, 2024 - Video at www.ftc.gov/media/private-capital-public-impact-ftc-workshop-private-equity-health-care-march-5-2024-video

> When private equity firms buy out healthcare facilities only to slash staffing and cut quality, patients lose out ...Through this inquiry, the FTC will continue scrutinizing private equity roll-ups, strip-and-flip tactics and other financial plays that can enrich executives but leave the American public worse off.[124]

It is possible that this attention will lead to regulatory and legislative change.

Private Equity in Headlines — A Sampling

- **Anesthesia Costs FTC 9/21/23** —"F.T.C. Sues Anesthesia Group Backed by Private-Equity Firm"

  > The federal agency claims the company's practices amount to antitrust activity, a new salvo in the government's scrutiny of health care consolidation that has led to higher prices[125]

- **Antitrust Probe 3/6/24** — "Federal agencies probe private equity's grip on health care"

  > Three federal agencies are teaming up to investigate[126] the growing influence of private equity firms and other corporations on the health-care industry.
  > The **Federal Trade Commission**, **Justice Department** and the **Department of Health and Human Services** jointly issued a request for information[127] yesterday seeking public feedback on health-care transactions, including smaller deals that might have slipped under the radar of antitrust authorities. Comments will be accepted until May 6[128]

- **Autism Services 7/26/23** — "New research shows private equity profiting off autism services"

  > Before 2001, neither commercial health insurance companies nor Medicaid covered services for people with autism. By 2015, thanks in large part to the advocacy of thousands of parents, all but seven states had mandates requiring commercial health plans to provide coverage for autism, with the remainder covered by 2019. According to research by Professor Rosemary Batt at Cornell University, the flood of insurance and taxpayer money[129] that followed quickly

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[124] Dept of Justice Press Release, "Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care: Agencies Seek Info on Transactions, Including Non-Reportable Deals, That May Harm Patients' Health, Workers' Safety, Quality of Care and Affordability," March 5, 2024 at www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue

[125] https://www.nytimes.com/2023/09/21/health/ftc-antitrust-healthcare.html

[126] https://www.hhs.gov/about/news/2024/03/05/issue-request-for-public-input-as-part-of-inquiry-into-impacts-of-corporate-ownership-trend-in-health-care.html

[127] https://content.govdelivery.com/attachments/USDOJOPA/2024/03/05/file_attachments/2803589/DOJ-FTC-HHS%20HCC%20RFI%20-%2003.04.24%20-%20FINAL.pdf

[128] https://www.washingtonpost.com/politics/2024/03/06/physicians-beg-relief-amid-change-healthcare-payment-crisis

[129] https://medicalxpress.com/tags/taxpayer+money

flowed into the pockets of private equity firms. Between 2017 and 2022, private equity firms completed 85% of all mergers and acquisitions in autism services. It is the highest rate[130] among health care segments.[131]

- **Billing 4/7/24** — "In Battle Over Health Care Costs, Private Equity Plays Both Sides"

  As medical practices owned by private equity firms fuel overbilling, a payment tool also backed by such investors helps insurers boost their profits[132]

- **Billing 4/7/24** — "Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill"

  A little-known data firm helps health insurers make more when less of an out-of-network claim gets paid. Patients can be on the hook for the difference. The formula for MultiPlan and the insurance companies is simple: The smaller the reimbursement, the larger their fee[133]

- **Billing 9/13/19** —"Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing'"

  Two doctor-staffing companies are pushing back against legislation that could hit their bottom lines.[134]

- **Billing Fraud 3/1/21** —"How private equity extracted hundreds of millions of dollars from a firm accused of Medicare fraud"

  Apria, which rents out ventilators and other equipment, settled with federal prosecutors over accusations of submitting thousands of false claims the same month it delivered a debt-funded dividend to investors[135]

- **Concierge Care 3/20/24** —"Hospitals cash in on a private equity-backed trend: Concierge physician care"

  Nonprofit hospitals created largely to serve the poor are adding concierge physician practices, charging patients annual membership fees of $2,000 or more for easier access to their doctors.[136]

- **Concierge Care 4/4/24** —"Hospitals cash in on a private equity-backed trend: Concierge physician care"

  Some concierge physicians say their more attentive care means healthier patients. A study published last year by researchers at the University of

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[130] https://medicalxpress.com/tags/highest+rate

[131] https://medicalxpress.com/news/2023-07-private-equity-profiting-autism.html

[132] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-private-equity.html

[133] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html

[134] https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html

[135] https://www.washingtonpost.com/business/2021/03/01/blackstone-healthcare-private-equity-dividend-apria

[136] https://medicalxpress.com/news/2024-04-hospitals-cash-private-equity-trend.html

California-Berkeley and University of Pennsylvania found no impact on mortality rates. What the study did find: higher costs.[137]

- **Dermatology 10/26/18** — "Why Private Equity Is Furious Over a Paper in a Dermatology Journal"

  Dermatologists account for one percent of physicians in the United States, but 15 percent of recent private equity acquisitions of medical practices have involved dermatology practices.[138] Other specialties that have attracted private equity investment include orthopedics, radiology, cardiology, urgent care, anesthesiology and ophthalmology... This week a lawyer for Advanced Dermatology and Cosmetic Surgery, which is backed by private equity and is the largest dermatology practice in the United States, called the general counsel at the University of Florida, where two of the authors are employed, demanding specific changes to the paper.[139]

- **Dermatology 12/20/21** — "'Get that money!' Dermatologist says patient care suffered after private equity-backed firm bought her practice"

  A former doctor at a private-equity-owned dermatology chain alleges lost biopsies, overbooking and questionable quality control in the company-owned lab.

  Physicians have a duty to put their patients' interests first. But when aggressive financiers take over medical operations[140], the push for profits can take precedence, doctors in an array of specialties have told NBC News. Paying bonuses for increased patient visits may result in unnecessary appointments and costs, for example.[141]

- **Dermatology 3/9/22** — "Debt valuation of private equity-backed dermatology groups down"

  Debt valuation of dermatology private equity-backed groups (DPEGs) decreased prior to the COVID-19 pandemic and then decreased further during the pandemic, according to a study published online March 9 in JAMA Dermatology[142]

- **Hospital Efficiency: 1/19/24** — "Who is most efficient in health care? Study finds, surprisingly, it's the VA"

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[137] https://www.fiercehealthcare.com/providers/hospitals-cash-private-equity-backed-trend-concierge-physician-care

[138] https://jamanetwork.com/journals/jamadermatology/article-abstract/2664345

[139] https://www.nytimes.com/2018/10/26/health/private-equity-dermatology.html

[140] https://www.nbcnews.com/health/health-care/private-equity-firms-now-control-many-hospitals-ers-nursing-homes-n1203161

[141] https://www.nbcnews.com/health/health-care/get-money-dermatologist-says-patient-care-suffered-private-equity-back-rcna9152

[142] https://medicalxpress.com/news/2022-03-debt-valuation-private-equity-backed-dermatology.html

> Private-sector hospitals, clinics, and insurers are bloated, bureaucratic nightmares compared to efficiently run Veterans Administration facilities that put care over profits, a new study reveals[143]

- **Hospital Errors 12/26/23** —"Serious Medical Errors Rose After Private Equity Firms Bought Hospitals"

> A new study shows an increase in the rate of inpatient complications, including infections and falls, though patients were no more likely to die[144]

- **Hospital Service Cuts 11/16/21** —"Private equity-acquired hospitals focus on increasing provision of technology-intensive, profitable services"

> Privately-acquired hospitals are significantly more likely to offer services that maximize profit and cut those that don't... New research from Duke University[145]

- **Hospital Takeovers: 1/22/24** —"When private equity comes to town, hospitals can see cutbacks, closures"

> Peggy Malone walks the quiet halls of Crozer-Chester Medical Center, the Pennsylvania hospital where she's worked as a registered nurse for the past 35 years, with the feeling she's drifting through a ghost town.[146]

- **Hospital Takeovers: 12/26/23** — "Quality of care declines after private equity takes over hospitals, finds nationwide analysis"

> Patients are more likely to fall, get new infections, or experience other forms of harm during their stay in a hospital after it is acquired by a private equity firm, according to a new study led by researchers at Harvard Medical School and published in 12/26/23 issue of JAMA [147]

- **Nursing Long-Term Care Harm 12/16/21** — "Private equity long-term care homes have the highest mortality rate during COVID-19"

> The COVID-19 pandemic revealed that for-profit long-term care homes had worse patient outcomes than not-for-profit homes.[148]

- **Nursing Home Harm: 3/20/24** — "Concerns grow over quality of care as investor groups buy not-for-profit nursing homes"

> Shelly Olson's mother, who has dementia, has lived at the Scandia Village nursing home in rural Sister Bay, Wisconsin, for almost five years. At first, Olson said, her mother received great care at the facility, then owned by a

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[143] https://medicalxpress.com/news/2024-01-efficient-health-va.html

[144] https://www.nytimes.com/2023/12/26/upshot/hospitals-medical-errors.htm

[145] https://medicalxpress.com/news/2021-11-private-equity-acquired-hospitals-focus-provision.html

[146] https://medicalxpress.com/news/2024-01-private-equity-town-hospitals-cutbacks.html

[147] https://medicalxpress.com/news/2023-12-quality-declines-private-equity-hospitals.html#google_vignette

[148] https://medicalxpress.com/news/2021-12-private-equity-long-term-homes-highest.html

not-for-profit organization... [then it was sold to a for-profit] ... For-profit groups own about 72% of the roughly 15,000 nursing homes in the United States, which serve more than 1.3 million residents.... the type of for-profit companies that own these facilities has shifted toward private equity, real estate investment trusts, and complicated ownership structures ... studies [show]... that nursing homes owned by for-profit companies—particularly investors in private equity[149] and real estate—tend to have skimpier staffing, lower quality ratings, and more regulatory violations ... [150]

- **Nursing Home Lower Harm/Costs 11/20/21** —"Private equity ownership of nursing homes linked to lower quality of care, higher Medicare costs"

  Nursing homes acquired by private equity companies saw an increase in emergency room visits and hospitalizations among long-stay residents and an uptick in Medicare costs, according to a new study from Weill Cornell Medicine[151]

- **Nursing Homes Harm 11/25/18** — "Overdoses, bedsores, broken bones: What happened when a private-equity firm sought to care for society's most vulnerable"

  Under the ownership of the Carlyle Group, one of the richest private-equity firms in the world, the ManorCare nursing-home chain struggled financially until it filed for bankruptcy in March. During the five years preceding the bankruptcy, the second-largest nursing-home chain in the United States exposed its roughly 25,000 patients to increasing health risks, according to inspection records analyzed by *The Washington Post*.

  "Carlyle was a very interesting group to deal with," said Andrew Porch, a consultant on quality statistics to whom HCR ManorCare referred questions about health-code violations. "They're all bankers and investment people. We had some very tough conversations where they did not know a thing about this business at all." [152]

- **Nursing Homes and Hospitals Harm 7/19/23** —"Private equity takeovers of health care services linked to patient harm"

  Private equity ownership of health care services such as nursing homes and hospitals is associated with harmful impacts on costs and quality of care,

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[149] https://medicalxpress.com/tags/private+equity

[150] https://medicalxpress.com/news/2024-03-quality-investor-groups-buy-profit.html

[151] https://medicalxpress.com/news/2021-11-private-equity-ownership-nursing-homes.html

[152] https://www.washingtonpost.com/business/economy/opioid-overdoses-bedsores-and-broken-bones-what-happened-when-a-private-equity-firm-sought-profits-in-caring-for-societys-most-vulnerable/2018/11/25/09089a4a-ed14-11e8-baac-2a674e91502b_story.html

suggests a review of the latest evidence published by The *British Medical Journal* today[153]

- **Outsourced Services 8/23/21** —"Hospitals often outsource important services to companies that prioritize profit over patients"

  Hospitals have long embraced the practice of outsourcing some services to specialized companies. Much of this outsourcing is for nonclinical tasks such as laundry, information technology and cybersecurity, and outsourcing[154]

- **PE Returns Over-rated 12/4/21** —"Is Private Equity Overrated?"

  The strategy's returns increasingly may not provide the stellar performance that investors have been sold...Since 2017, investors have poured more than $1 trillion into global private equity buyout funds. That amount dwarfs the cash directed to venture capital, real estate funds, private debt, hedge funds and just about any other form of alternative investment, according to McKinsey. Public pension funds invested in private equity actually had worse returns than from the S&P 500 — 12.8 percent, net of fees (13.7 percent for the S&P 500) if today's returns were high enough "given the illiquidity of private equity."[155]

- **Physician Practices 9/2/22** —"Study raises red flags about corporatization of health care, investigator says"

  New research reveals private equity firms that acquire physician-owned medical practices appear to be imposing measures to squeeze out more profits[156]

- **Physician Staffing 7/10/23** —"Who Employs Your Doctor? Increasingly, a Private Equity Firm"

  A new study finds that private equity firms own more than half of all specialists in certain U.S. markets[157]

- **Preventive Care Cost 1/24/24** — "Opinion: Ouch. That 'free' annual checkup might cost you. Here's why"

  The mammogram itself was covered, per the ACA's rules, but the fee for the equipment and the facility was not.

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[153] https://medicalxpress.com/news/2023-07-private-equity-takeovers-health-linked.html

[154] https://medicalxpress.com/news/2021-08-hospitals-outsource-important-companies-prioritize.html

[155] https://www.nytimes.com/2021/12/04/business/is-private-equity-overrated.html

[156] https://medicalxpress.com/news/2022-09-red-flags-corporatization-health.html

[157] https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html

> The ACA's designers might have assumed that they had spelled out with sufficient clarity that millions of Americans would no longer have to pay for certain types of preventive care, including mammograms, colonoscopies and recommended vaccines, in addition to doctor visits to screen for disease. But the law's authors didn't reckon with America's ever-creative medical billing juggernaut.[158]

- **Preventive Care Costs 1/24/24** — "The colonoscopies were free but the 'surgical trays' came with $600 price tags"

  > Chantal Panozzo and her husband followed their primary care doctors' orders last year after they both turned 45, now the recommended age to start screening for colorectal cancer. They scheduled their first routine colonoscopies ... By law, preventive services—including routine colonoscopies—are available at zero cost to patients.
  >
  > The practice is part of the private-equity-backed GI Alliance, which has more than 800 gastroenterologists working in 15 states, including Florida, Missouri, and Texas.
  >
  > "The insurance company is supposed to pay the full claim, but there is no requirement on the provider to code the claim correctly"[159]

- **Preventive Care Costs 5/31/22** — "Betting on 'golden age' of colonoscopies, private equity invests in gastro docs"

  > Mariel booked an appointment and learned she would be on the hook for a $1,100 colonoscopy—about three times what she had paid for the same test in a different state. Preventive colonoscopies are covered without patient cost sharing under the Affordable Care Act, but colonoscopies for patients with existing conditions, like Mariel, are not. A 2019 study found patients with inflammatory bowel diseases, including Crohn's disease, incur about $23,000 in health care[160] costs a year.... its management group, the GI Alliance, operates in a dozen states with more than 400 locations—and is growing fast....With market dominance comes the business opportunity to set and maintain high prices. "It's pretty much the only game in town," Mariel said.[161]

- **Psychiatric Care 4/13/22** —"Profit strategy: Psychiatric facilities prioritize out-of-state kids"

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[158] https://www.washingtonpost.com/opinions/2024/01/24/affordable-care-act-free-preventative-care

[159] https://medicalxpress.com/news/2024-01-colonoscopies-free-surgical-trays-price.html

[160] https://medicalxpress.com/tags/health+care

[161] https://medicalxpress.com/news/2022-05-golden-age-colonoscopies-private-equity.html

South Carolina children who need immediate, around-the-clock psychiatric care risk being stranded for days—even weeks—waiting for help, only to be sent hundreds of miles away from home for treatment[162]

- **Workforce Stability Harmed 1/9/23** —"Private equity changes workforce stability in physician-owned medical practices"

  New research reveals private equity firms that acquire physician-owned medical practices experience greater replacement of the workforce and rely more heavily on advanced practice providers—such as physician assistants[163]

[162] https://medicalxpress.com/news/2022-04-profit-strategy-psychiatric-facilities-prioritize.html

[163] https://medicalxpress.com/news/2023-01-private-equity-workforce-stability-physician-owned.html

Chapter 6

FIDUCIARY DUTY IN PROFIT & NONPROFIT MODELS

Often associated with financial care, "fiduciary" is not limited to financial areas. Tellingly, even Investopedia.com notes the expansive range of relationships where the term "fiduciary" can apply:

> A fiduciary, in any context, is a person who is ethically or legally obliged to act in the best interests of another party. A doctor or an accountant takes on a fiduciary role.[164]

This section addresses fiduciary duties of the following:

- Physicians
- Financial Advisors & Guardians
- Twentieth-Century Corporations
- Modern Corporations
- DCEs & ACO/REACH
- Case Study of Private Equity (PE) Control of ERs

Fiduciary Duties of Physicians

When most people think of the duty of physicians to their patients, they think of the Hippocratic Oath, an oath that may not have originated with Hippocrates, often called "The Father of Medicine," a Greek who lived 2500 years ago when the Parthenon was being designed and constructed. Today, most physicians still swear an Oath, almost all of which declare a first duty to the health and well-being of the patient above all other considerations.[165]

Changes in medical practice and approach have triggered variations in the oath, now sometimes called a pledge. Most particularly the promise to never introduce a deadly drug to take a life has been adapted to allow abortion and euthanasia, just as the stricture against ever taking a knife to a patient has given way to surgery as a respected field, just as the paternalistic approach of physicians making all decisions for patients has evolved into discussions of patient's rights, informed consent, and culturally competent care. As medicine has evolved, the complexity of moral and ethical decisions has also evolved, but there is widespread agreement — among physicians and patients — that the oath ought to require

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[164] Investopedia.com: https://www.investopedia.com/financial-edge/0912/5-misconceptions-about-a-fiduciary.aspx

[165] Rachel Hajar, "The Physician's Oath: An Historical Perspective," Heart Views 2017 Oct-Dec; 18(4): 154–159. doi: 10.4103/Heartviews.Heartviews_131_17

physicians to focus their efforts on the well-being of the patient, that is, the well-being of an informed patient (or their conscientious and informed health proxy) and their agreement.

What Is "Moral Injury"?

"Moral injury," as a concept, has been recognized for millennia, according to Elizabeth Svoboda, in an article for *Scientific American* in 2022, although the term was coined, she wrote, in the 1990s by Veterans Administration psychiatrist Jonathan Shay.[166] Shay said that moral injury

> arises when a service member does something in war that violates their own ideals, ethics, or attachments. The diagnosis PTSD does not capture this. PTSD does a pretty good job of describing a kind of fear syndrome.... PTSD, as officially defined, is rarely what wrecks veterans' lives or crushes them to suicide. Moral injury ... does both.[167]

Svoboda wrote about the pandemic creating moral injury among health professionals, as:

> a specific trauma that arises when people face situations that deeply violate their conscience or threaten their core values. Those who grapple with it... can struggle with guilt, anger and a consuming sense that they can't forgive themselves or others.[168]

Worse, the moral injury caused by the pandemic, Svoboda wrote, had broad repercussions for our greater sense of community, as well as for individual doctors:

> The need to abandon her own standards and watch people suffer and die was hard enough for McGowan. Just as disorienting, though, was the sense that more and more patients no longer cared what happened to her or anyone else. She had assumed she and her patients played by the same basic rules—that she would try her utmost to help them get better and that they would support her or at least treat her humanely.[169]

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[166] *Scientific American*, "Moral Injury Is an Invisible Epidemic That Affects Millions," 9/19/2022, Elizabeth Svoboda, https://www.scientificamerican.com/article/moral-injury-is-an-invisible-epidemic-that-affects-millions/#:~:text=Ancient%20Origins,predates%20its%20naming%20by%20millennia.

[167] Jonathan Shay, "Moral Injury," *Intertexts*, Spring 2012, https://muse.jhu.edu/article/492650/pdf 10.1353/itx.2012.0000

[168] Ibid, Svoboda

[169] Ibid, Svoboda

Does today's privatized health system exacerbate moral injury among MDs?

Sharon Clark argues that physicians in Ancient Greece were regarded as **tradesmen**, for having the goals of "treating the rich and looking out for themselves." The oath transformed public perception of those who took it; no longer tradesmen but professionals, using their knowledge to "serve the best interests of the patients." Today, she sees most physicians as continuing to believe in the professional creed, but frustrated by the business of medicine:

> Modern challenges demand that physicians deal more and more with insurance companies and corporate medicine. As financial entities increasingly try to control physicians, the practice of medicine may become less and less of a profession able to achieve ideal goals for the individual patients. Medicine, as a noble profession, faces the conflicting forces of health economics on a daily basis and even with varying forms of “economic credentialing.” At the same time as health care becomes more controlled and more infiltrated by businesses, the physician has been demoted to a "provider." [170]

Clark, posits that when doctors must work in an increasingly corporate environment, the idealism expressed in the Oath may contribute to their feeling morally compromised:

> This difference of the physicians’ ethical perspectives from the business leaders regarding the philosophy of the value of the individual’s health and life may be related to some aspect of physician burnout.[171]

Clark might usefully have commented on how these changes have also affected patients, specifically their trust in physicians:

> More and more people talk of health care less as a noble profession and more as a business.[172]
>
> With fewer and fewer Americans having a "family doctor," almost half avoiding even routine care because they can't afford cost-sharing, and even affluent Americans sometimes struggling to pay for care,[173] it is no wonder

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[170] Sharon A Clark, "The Impact of the Hippocratic Oath in 2018: The Conflict of the Ideal of the Physician, the Knowledgeable Humanitarian, Versus the Corporate Medical Allegiance to Financial Models Contributes to Burnout," Cureus. 2018 Jul; 10(7): e3076, Published online 2018 Jul 30. doi: 10.7759/cureus.3076. See also: “Feeling like the enemy: the emotion management and alienation of hospital doctors," John-Paul Byrne , et al., Front Sociology, 2023 Aug 24:8:1232555. doi: 10.3389/fsoc.2023.1232555. eCollection 2023.

[171] *Ibid.*, Clark.

[172] *Ibid.*, Clark.

[173] "Remarkably, [even] a high-income person in the U.S. was more likely to report financial barriers than a [non- U.S.] low-income person relative to nearly all the other countries surveyed: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the U.K," Commonwealth Fund, "Press Release: New International Study: U.S. Health System Ranks Last Among 11 Countries; Many Americans Struggle to Afford Care as

> that a two-millennium tradition of professionalism risks devolving into something more transactional, more like the ancient Greek medical "tradesmen" who served themselves by treating only the rich. This "deterioration of hospital doctors' relationship with work," writes John-Paul Byrne , "is a threat to health systems and organizations."[174]

Despite the challenges and threats to trust in the today's physician-patient relationship, Gallop polling on honesty and ethics suggests the relationship, while frayed, exceeds all other professions —except for nurses, who have ranked #1 for trust by double digits for 33 of the past 34 years. Doctors' trail nurses by 14 to 22 points, but Gallop typically finds that nurses, doctors, pharmacists and vets, are all in the top five.[175]

Despite the harm suggested by all the above — to doctors and nurses and other providers, patient trust, our sense of community, and our health systems and organizations — there may be some hope that so many health care workers are suffering moral injury: namely, their ideals remain focused on putting the well-being of patients first.

Fiduciary Duties of Financial Advisors & Guardians

When people hear the phrase "fiduciary duty," they often think of **financial advisors** who pledge to put the financial interests of the investors they advise above their own financial interests. Companies that offer investment services meeting "fiduciary standards" often mention that their advisors are legally required to avoid all conflicts of interests, meaning avoiding situations where the advisor's (personal or corporate) financial interest might be in conflict with their client's. They promise to avoid investments that other advisors might recommend, such as investments in annuities or managed funds that deliver hidden commissions— or other "back-door" financial incentives — that benefit the advisor to the detriment of the investor. That said, the onus is on investors to recognize whether their advisor is, indeed, legally required to be a fiduciary. If an investor is harmed by trusting someone who isn't legally a "fiduciary," there is often limited legal recourse, or none.[176]

Income Inequality Widens," Aug 04, 2021, https://www.commonwealthfund.org/press-release/2021/new-international-study-us-health-system-ranks-last-among-11-countries-many

[174] "Feeling like the enemy: the emotion management and alienation of hospital doctors," John-Paul Byrne , et al., Front Sociology, 2023 Aug 24:8:1232555. doi: 10.3389/fsoc.2023.1232555. eCollection 2023.

[175] "Charted: The most trusted professions in America, according to Gallup" *Advisory Board*, March 2023, https://www.advisory.com/daily-briefing/2023/01/18/trusted-professionals#:~:text=2%2C%202022.,for%20over%2020%20years%20now, and Gallop, https://news.gallup.com/poll/467804/nurses-retain-top-ethics-rating-below-2020-high.aspx

[176] *WaPo*, Michelle Singletary, "Should your financial adviser act in your best interest? You decide," 2/9/2017, https://www.washingtonpost.com/business/get-there/should-your-financial-adviser-act-in-your-best-interest-you-decide/2017/02/09/3c207270-ed6d-11e6-b4ff-ac2cf509efe5_story.html

We may also think of those who act in a legal capacity as having fiduciary duties. People appointed by a Court to be "**legal guardians,**" for example, are expected to protect and serve "wards" who are not considered capable of advocating for themselves, e.g., minors, adults with diminished cognition or neurological incapacity, and, too often, nursing home patients, regardless of capacity. Conflicting financial incentives can corrupt this trust, for example, by nursing homes and hospitals who sue for guardianship (sometimes without notifying the next of kin), not to protect the patient, but purely to collect on debt. One study by the *Syracuse Law Review* provided multiple case studies, noting that 29% of the hundreds it investigated were filed by hospitals and nursing homes — one such case study involved a Virginia hospital abusing guardianship for hundreds of nursing home patients by creating highly conflicted relationships that enriched lawyers beholden to the hospital.[177]

Similarly, a study by Hunter College reported in the *New York Times* details a case study where an elderly husband, protesting a sudden doubling of co-pays in bills presented by his 90-year-old wife's nursing home, could not prevent the nursing home from gaining guardianship over all her finances (and therefore his). The study found that of 700 guardianship cases brought in Manhattan over a decade, 28% were brought by nursing homes and hospitals, noting that

> ... lawyers and others versed in the guardianship process agree that nursing homes primarily use such petitions as a means of bill collection — a purpose never intended by the Legislature when it enacted the guardianship statute in 1993.[178]

Fiduciary Duties of 20th-Century Corporations — How Car Manufacturers Evolved

Both Private Equity (PE) and ACO/REACH investments in health care, sometimes described as capitalism on steroids, have sometimes put physicians on their boards or listed them as owners. It is reasonable to ask, "Does having a physician, whose first duty is to patients, on a corporate board cause that corporation to reduce its emphasis on investor/shareholder value?" The short answer is "No."

Seventy or eighty years ago, the answer might have been, "Yes."

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[177] *Syracuse Law Review*, Alison Hirschel & Lori Smetanka, "The use and misuse of guardianship by Hospitals and nursing homes," vol 72:255, Sept 2022, pp. 263-266, https://lawreview.syr.edu/wp-content/uploads/2022/09/255-289-Hirschel-2.pdf

[178] *NYTimes*, by Nin Bwenarwin, To Collect Debts, Nursing Homes Are Seizing Control Over Patients," 1/25/2015, https://www.nytimes.com/2015/01/26/nyregion/to-collect-debts-nursing-home-seizing-control-over-patients.html

Corporate "Duty" Privileges Engineering

Henry Ford has been credited by Berkeley labor economist Harley Shaiken with creating the American "industrial middle class, and an economy ... driven by consumer demand."[179] In 1914, Ford wanted to expand the number of assembly lines in his Dearborn, IL, factory, but had to first stabilize a workforce so dissatisfied with working conditions that he had had to hire 40,000 workers to fill 14,000 jobs in 1914,[180] a retention problem twice as bad as Amazon's today.[181]

Famously, Ford doubled the average factory-worker wage to $5 per day, stabilizing his workforce, allowing dramatically increased automation across his assembly lines (assembly time per car dropped from 13 man-hours in 1909 to 93 minutes in 1916), triggering dramatic increases in production (from 18,664 cars in 1909 to 785,432 in 1916), allowing equally dramatic price reductions (from $950 in 1909 to $360 in 1916[182] to $260 in 1925).[183]

Although Ford's effect on workers and their communities constitutes historical fact, his intent, as he put it later, was to "build a motor car for the great multitude ... so low in price that no man making a good salary will be unable to own one."[184] Doing that also caused him to create the "weekend" — **not** to help workers but to serve the bottom line: A 6-day week of 9-hour days only allowed 54 hours of productivity per week for one shift (or 108 hours across two shifts). By contrast, an 8-hour standard workday allowed 3 shifts per day — 120 hours for a standard five-day week — which could eventually become 168 hours for a 24/7 week.
Ford kept company ownership privately held to keep control. He famously commented that customers could have any color they wanted so long as it was black — because black was the fastest drying color and that color contributed to the fastest assembly per car. Customers would get the cars he chose for them when they paid cash.

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[179] Henry Shaiken, quoted in NPR's "The Middle Class Took Off 100 Years Ago ... Thanks To Henry Ford?" 1/27/14, https://www.npr.org/2014/01/27/267145552/the-middle-class-took-off-100-years-ago-thanks-to-henry-ford

[180] Ronnie Schreiber, "Henry Ford Paid His Workers $5 a Day So They Wouldn't Quit, Not So They Could Afford Model Ts" in The Truth About Cars, 10/13/2014, https://www.thetruthaboutcars.com/2014/10/henry-ford-paid-workers-5-day-wouldnt-quit-afford-model-ts

[181] "Data has shown that the company has had a turnover rate of about 150 percent a year." NPR "Amazon & the Labor Shortage" 12/1/2021, https://www.nytimes.com/2021/12/01/podcasts/the-daily/amazon-pandemic-labor-shortage.html#:~:text=Data%20has%20shown%20that%20the,people%20all%20of%20the%20time.

[182] https://billofrightsinstitute.org/essays/henry-ford-and-alfred-p-sloan-industrialization-and-competition

[183] Personal note: in 1925, my father, a high school junior, bought a Ford to manage his growing newspaper-delivery network of school-boys; he handed over cash, was led to the next car in the lot (they were all the same), was shown how to start the car, and he drove off. Ford.com, " The Moving Assembly Line And The Five-Dollar Workday," https://corporate.ford.com/articles/history/moving-assembly-line.html#:~:text=Henry%20Ford%20stated%3A%20%E2%80%9CWe%20believe,A%20assembly%20line%20circa%201931.

[184] https://billofrightsinstitute.org/essays/henry-ford-and-alfred-p-sloan-industrialization-and-competition

Customers Gain Influence

Alfred Sloan, who founded GM, had a somewhat different vision. He took GM public in 1916, selling shares on the New York Stock Exchange. Ford believed Sloan did this to avoid bankruptcy, dismissing GM's viability, but within ten years, GM was threatening Ford's market leadership.

Sloan let customers buy GM products on credit and initiated "planned obsolescence," creating multiple "brands" and new models annually, in multiple colors and priced to attract customers of different income levels. As Sloan put it, GM existed "not . . . to make motor cars" but "to make money."[185]

Competition with GM changed Ford. But Ford remained resolute against Ford going public, keeping ownership in private hands. It remained off the stock market until 1956, when it debuted at number 3 of the Fortune 500, behind General Motors.[186] After 1927, Ford's focus shifted from strictly production engineering to customers, offering credit, colors besides black, and new models. By 1941, during the Great Depression, Ford was saying, "From the start I had my own ideas about how the business should run. I wanted it to benefit everybody who contributed to its success-stockholders, labor and the American public."[187]

Corporations Add Consideration of Communities

By the 1950s, American business philosophy was described by *Time* magazine as focused not only on "profit and loss" in the balance sheet but on "profit and loss to the community." *Time* called this "capitalism with a conscience," "enlightened conservatism," "people's capitalism," and, most popularly, "The New Conservatism."[188]

Rick Wartzman, executive director of the Drucker Institute at Claremont Graduate University in 2014, wrote that in 1956,

> big companies prided themselves on taking care of a full range of constituents: their shareholders, yes, but also their customers, their suppliers and their workers.[189]

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[185] https://billofrightsinstitute.org/essays/henry-ford-and-alfred-p-sloan-industrialization-and-competition

[186] https://www.fool.com/investing/2019/01/16/63-years-later-what-can-investors-learn-from-fords.aspx

[187] Henry Ford Talks About War, Defense, Stockholders by B.C Forbes, *Forbes* Magazine9/1/1941, quoted in https://www.thehenryford.org/collections-and-research/digital-resources/popular-topics/henry-ford-quotes

[188] November 1956 *Time* magazine quoted in *Harvard Business Review*, https://hbr.org/2014/08/whatever-happened-to-corporate-stewardship

[189] *Ibid*, Wartzman.

To make this shift in attitudes starker, Wartzman quotes 1950's business leader J. D. Zellerbach:

> The majority of Americans ... regard business management as a stewardship, and they expect it to operate the economy as a public trust for the benefit of all the people.[190]

Corporations Focus on Shareholders — and Short-Term Profits

That social contract of the 1950s and 1960s, according to Wartzman,

> began to fray in the 1970s, and it has since been totally ripped apart. Myriad culprits are to blame, including rapidly advancing technology, heightened global competition, the weakening of unions and, perhaps more than anything, **a horribly misplaced mindset that has elevated stockowners above all other groups**.[191]

Where did this "horribly misplaced mindset" come from? Milton Friedman, the University of Chicago free-market economist, who wrote in 1970:

> There is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits.[192]

It was slow to be accepted in the 1970s, but Friedman's approach gained ground in the 1980s. So-called "corporate raiders" launched hostile takeovers fueled by junk bonds. Business leaders began seeing stock price as either a vulnerability or a weapon. The social contract went from frayed to destroyed as corporate executives

> tossed aside their more complacent and paternalistic management style, and with it a host of inhibitions against laying off workers, cutting wages and benefits, closing plants, spinning off divisions, taking on debt, moving production overseas.[193]

Greed became "good," to quote Gordon Gekko in the 1987 Hollywood hit "Wall Street." Robert Reich, Former United States Secretary of Labor, described the period like this:

> During the whole of the 1970s, there were only 13 hostile takeovers of big companies valued at $1 billion or more. During the 1980s, there were 150. Between 1979 and 1989, financial entrepreneurs mounted more than 2,000

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[190] *Ibid*. Wartzman, emphasis added. Zellerbach was chairman of the board of the Crown Zellerbach Corporation, which produced the specially-coated paper that gave *Time* and *Life* magazine their glossy colored photographs

[191] *Ibid*. Wartzman, emphasis added

[192] https://www.mckinsey.com/featured-insights/corporate-purpose/from-there-to-here-50-years-of-thinking-on-the-social-responsibility-of-business

[193] *The American Prospect*, "When Shareholder Capitalism Came to Town" by Steven Pearlstein, 4/19/2014 https://prospect.org/economy/shareholder-capitalism-came-town

> leveraged buyouts, in which they bought out shareholders with borrowed money, each buyout exceeding $250 million.
>
> As a result, CEOs across America, facing the possibility of being replaced by a CEO who would maximize shareholder value, began to view their responsibilities differently. Few events change minds more profoundly than the imminent possibility of being sacked.[194]

According to Reich, this dramatic increase in hostile takeovers triggered a "decline of the common good over the last four or five decades," and

> Wall Street became the most powerful force in the economy, and CEOs began to devote themselves entirely and obsessively to maximizing the short-term value of shares of stock — whatever it took.
>
> **Before then, it was assumed that large corporations had responsibilities to all their "stakeholders"— not just their shareholders, but also their employees, the communities where their operations were located, their customers, and the public at large.**
>
> In the 1940s and 1950s, CEOs of major corporations like GE, General Motors, Coca-Cola, and Eastman Kodak ...[lobbied] for measures to expand jobs... argued that unions "serve the common good" ... [and even] lobbied for stronger environmental protections and for passage of the Environmental Protection Act.
>
> Starting in the 1980s ... a wholly different understanding of the corporation emerged.
>
> **The raiders targeted companies that could deliver higher returns to their shareholders if they abandoned their other stakeholders — by fighting unions, cutting workers' pay or firing them, automating as many jobs as possible, outsourcing other jobs, and abandoning their original communities by shuttering factories and moving jobs to states with lower labor costs or abroad.**[195]

Corporations Now Exist to Maximize Shareholder Value

Over the course of the period Reich describes, from the 1980s through the 2000s, corporate raiders made extraordinary profits by dismantling the companies they acquired. A niche business evolved, as some (usually privately held) companies began rebranding, rehabilitating their activities as dedicated to making under-performing corporations operate more "efficiently" — asserting they created (or salvaged) value, rather than destroying it:

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[194] Robert Reich, "The End of Stakeholder Capitalism," 9/1/23, https://robertreich.substack.com/p/jack-welch-and-the-end-of-stakeholder

[195] *Ibid.*, Reich, emphasis is in the original

As Reich puts it:

> SINCE THEN, corporate raiders have morphed into more respectable “private equity managers” and “activist investors.” Hostile takeovers have become rare because **corporate norms have changed: It’s now *assumed* that corporations exist only to maximize shareholder returns**.
>
> Corporations have used their profits to give shareholders dividends and to buy back their shares of stock — thereby reducing the number of shares outstanding and giving stock prices short-term boosts. All of this has meant more money for the top executives of big companies, whose pay started to be linked to share prices in the early 1990s. **CEO pay soared from an average of 20 times that of the typical worker in the 1960s to almost 380 times by 2023.** [196]

Although the protagonists of the 1987 movie "Wall Street" seem headed to prison at the end of the movie, they project glamor and glitz:

> In reviewing the film's sequel 23 years later, *Variety* noted that though the original film was "intended as a cautionary tale on the pitfalls of unchecked ambition and greed, Stone's 1987 original instead had the effect of turning Douglas' hugely charismatic (and Oscar-winning) villain into a household name and boardroom icon – an inspiration to the very power players and Wall Street wannabes for whom he set such a terrible example."[197]

The 1990 Hollywood hit "Pretty Woman" features a corporate raider seeking to dismantle a family-owned business, only to change his mind because he falls in love with a woman who offers him redemption when he chooses to confess, atone, and sin no more. In stark contrast, is the raider's corporate lawyer who is so enraged by his boss's scuttling the deal that he shows himself both immoral and criminal. The movie has it both ways: the Gear character is redeemed by a good woman, but his business practices, which have made him so wealthy, at the end taint only the lawyer.

Popular Backlash — Still Fringe

In the past decade, there has been periodic commentary on the dangers associated with Friedman's "horribly misplaced mindset." A recent McKinsey white paper — on the 50-year anniversary of Friedman's answer to "a fundamental question: what is the role of business in society?" noted

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[196] *Ibid*, Reich, emphasis added

[197] *Variety*, "Wall Street: Money Never Sleeps," Justin Chang, 5/14/2010, https://variety.com/2010/film/markets-festivals/wall-street-money-never-sleeps-1117942753/, quoted in https://en.wikipedia.org/wiki/Wall_Street_(1987_film)

> That view has long influenced management thinking, corporate governance, and strategic moves. But more recently, many leaders have sought to expand that definition to consider all the stakeholders who stand to gain—or lose—from organizations' decisions.[198]

In 2019, for example, a Harvard Law School Forum on Corporate Governance, entitled "*Towards Accountable Capitalism: Remaking Corporate Law Through Stakeholder Governance*" argues against "shareholder primacy," describing it as a "singular goal" for "maximizing shareholder value" which

> often comes at the expense of investments in workers, innovation, and long-term growth—has contributed to today's high-profit, low wage economy. [199]
>
> They describe it as a "flawed theory in corporate law and policy" that ignores "Increasing economic evidence ... that shareholder primacy is not benefiting other corporate stakeholders, including workers, suppliers, consumers, or communities," and has allowed corporations to organize trillions of dollars of capital and create wealth beyond what most countries possess, ultimately exacerbating economic inequality by building incredible **wealth for shareholders while contributing to decades of wage stagnation**.[200]

They recommend a number of public policy changes:[201]

- "Rewrite corporate purpose statements, so that corporations are committed by law to act in the public's best interests"
- Extend Board Fiduciary Duty to All Stakeholders (so that directors no longer "are only accountable to shareholders for their decisions") because it "would benefit corporate prosperity at large."
- Federalize Corporate Governance — to disable the "state-driven incorporation model, which exploits states' pursuit of incorporation revenue and has driven a "race to the bottom" for shareholder-friendly incorporation laws"— by establishing "federal chartering for our large corporations"[202]

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[198] https://www.mckinsey.com/featured-insights/corporate-purpose/from-there-to-here-50-years-of-thinking-on-the-social-responsibility-of-business

[199] Harvard Law School Forum on Corporate Governance, entitled "Towards Accountable Capitalism: Remaking Corporate Law Through Stakeholder Governance," posted by Lenore Palladino, Kristina Karlsson, 2/11/2019 https://corpgov.law.harvard.edu/2019/02/11/towards-accountable-capitalism-remaking-corporate-law-through-stakeholder-governance/#comments

[200] *Ibid*, HLS Forum

[201] All points from *Ibid*, HLS Forum

[202] *Ibid*, HLS Forum: "Today, 66 percent of Fortune 500 corporations are established in Delaware due to its lax corporate laws."

A comment to the HLS posting noted that[203]

> small shareholders, especially buy-and-hold shareholders (e.g. 401k), are also disadvantaged today. The massive share buy-backs do a lot for management, which gets its numbers up for bonus season and may be able to cash in, but the market-goosing effects are ephemeral and often will in no way benefit non-trading shareholders. Dividends would put real money in their pockets for spending or reinvestment and would be much more beneficial to them, but seem to be disfavored.
>
> Dividends are the conceptually correct way to return resources to shareholders and should be favored over buy-backs. Pro-dividend policies, in turn, would tend to counter management's [sic] tendency to short-termism, encourage longer investment perspectives, and mesh with the broader stakeholder perspective by focusing on generating returns from ongoing investments, rather than just cashing in when the opportunity arises.

Apparently aligned with this backlash against shareholder primacy, in 2019 the Business Roundtable announced a brand new "Statement on the purpose of a corporation," signed by 181 CEOs who committed to lead their companies for the benefit of all stakeholders—customers, employees, suppliers, communities, and shareholders," [204] while declaring the 1997 statement that "endorsed the principles of shareholder primacy" superseded. The new statement, according to the press release, asserted on behalf of the signees: that they

> share a fundamental commitment to all of our stakeholders. We commit to:
>
> - Delivering value to our customers.
> - Investing in our employees.
> - Dealing fairly and ethically with our suppliers.
> - Supporting the communities in which we work.
> - Protect the environment by embracing sustainable practices across our businesses.
> - Generating long-term value for shareholders
> - Transparency and effective engagement with shareholders.[205]

The new position received an enormous amount of ink in business and mainstream media. Two years later, *Fortune* Magazine featured a report by researchers at Harvard Law

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[203] *Ibid*, HLS Forum, comment posted 2/11/2019 by Newcavendish

[204] "Business Roundtable Redefines the Purpose of a Corporation to Promote An Economy That Serves All Americans," *Business Roundtable* 8/19/2019 https://opportunity.businessroundtable.org/ourcommitment

[205] BRT press release: https://s3.amazonaws.com/brt.org/BRT-StatementonthePurposeofaCorporationJuly2021.pdf

School's Program on Corporate Governance,[206] who found no corporate governance documents amended to remove the primacy of shareholder value, nor any amendments to bylaws directing company leaders to consider additional interests, nor any changes to compensation incentives, nor more responsiveness to shareholder proposals on these:

> At 27 of the signatory companies, shareholders requested votes on proposals to implement the principles in the statement. In about half the cases, the companies sought permission from the Security and Exchange Commission to deny the vote. For all the proposals that went to a vote, the researchers find, "the company invariably recommended that shareholders vote against them."
>
> Most striking is how the companies argued their cases ... most of the companies made the same argument: We already serve stakeholders and have done so for years.
>
> Citigroup ... argued that the BRT statement simply "memorializes the Company's current practices and policies." BlackRock said "the Company's actions and disclosures already embody the commitments included in the BRT Statement" and therefore "no changes to the Company's existing governance and management systems are required."

One might ask what was the point of announcing the new commitment? The authors of the report hypothesize:

> Rather than produce material benefits to stakeholders, the main impact of such pledges might be to insulate corporate leaders from shareholders and to deflect outside pressures to adopt governmental measures that would truly serve stakeholders.[207]

A similar hypothesis about the Business Roundtable motivation suggests the need to ameliorate another driver of government regulation or legislation:

The new focus on shareholders also hasn't been a big winner with the public. Gallup polls show that **people's trust in and respect for big corporations** has been on a long, slow decline in recent decades-at the moment, **only Congress and health-maintenance organizations rank lower**[208]

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[206] *Fortune*, "Two years after the Business Roundtable statement on shareholder capitalism, has anything changed?" 8/28/2021, Harvard Law School, Program on Corporate Governance, https://pcg.law.harvard.edu/; source document for *Fortune* quotes: "Will Corporations Deliver Value to All Stakeholders?" by Lucian A. Bebchuk, Roberto Tallarita, August 4, 2021 at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3899421

[207] https://fortune.com/2021/08/05/business-roundtable-letter-statement-on-the-purpose-of-a-corporation-stakeholder-capitalism-american-ceos

[208] *Ibid.*, Pearlstein, American Prospect (also see https://www.washingtonpost.com/news/wonk/wp/2013/09/09/how-the-cult-of-shareholder-value-wrecked-american-business), emphasis added.

Environmental, Social, and Governance (ESG) Efforts to Change U.S. Corporate Practices

For much of the second half of the twentieth century, activists periodically targeted corporations and their customers to change their business practices for political ends — to be fairer or more sustainable or to achieve more respect and diversity in workplaces. The first mainstream attention came in 2004 when the United Nations released *Who Cares Wins*,[209] a report that encouraged a pivot to ESG practices long-term for all corporate leaders, investors, analysts, consumers, everyone.[210]

Since then, there has been continued controversy. One measure of success is how much money is invested in so-called ESG funds. Between 2011 and 2021, the number of ESG funds grew from about 80 to over 400. Between 2004 and 2019, investments grew from about $3 trillion to $30 trillion,[211] and investment dollars doubled between 2019 and 2020.[212] The scale of these investments shows its power. Further, McKinsey reported in 2019 that companies that pay attention to ESG "do not experience a drag on value creation" because ESG often "correlates with higher equity returns," "a reduction in downside risk," "lower loan and credit default swap spreads and higher credit ratings."[213]

With so much positive news about the benefits of ESG practices and investing, one might not expect backlash; however, backlash is growing at both state and federal levels:

> In 2023, at least 165 anti-ESG bills have been introduced across 37 U.S. states, many seeking to prohibit state agencies from doing business with firms that screen out industries they seek to protect—such as fossil fuels in Texas—or mandating that asset managers for state funds de-prioritize ESG criteria in making investment decisions. At the federal level, legislators are focused on the mechanics of how ESG-related decisions are made, including the role of proxy advisors, shareholder resolutions, and asset management firms.[214] In the House, more than half a dozen anti-ESG hearings have been

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[209] U.N. Global Compact, 2004: https://www.unepfi.org/fileadmin/events/2004/stocks/who_cares_wins_global_compact_2004.pdf

[210] https://www.thecorporategovernanceinstitute.com/insights/lexicon/what-is-the-history-of-esg

[211] *McKinsey Quarterly*, "Five ways that ESG creates value" by Witold Henisz, Tim Koller, and Robin Nuttall, Nov 2019, https://www.mckinsey.com/capabilities/strategy-and-corporate-finance/our-insights/five-ways-that-esg-creates-value.

[212] CSIS, " What Does the ESG Backlash Mean for Human Rights?," 8/16/2023, https://www.csis.org/analysis/what-does-esg-backlash-mean-human-rights

[213] *Ibid*, McKinsey

[214] *Pensions & Investments,* "Anti ESG Bills Advance" 7/28/2023: https://www.pionline.com/esg/anti-esg-bills-advanced-house-financial-services-committee

> held since May, concluding with party-line votes[215] on four related pieces of legislation.
>
> Much of the backlash has been focused on the "E" in ESG, and in particular the incorporation of climate change considerations into investment decisions—though some social issues, especially company efforts to address anti-LGBTQ+ and specifically anti-transgender bias, have come under attack. The term "ESG" has also been increasingly applied to company initiatives that have nothing to do with investors (such as Bud Light's partnership with social media influencer Dylan Mulvaney)—so much so that Blackrock CEO Larry Fink has declared the term to be too politicized[216] to continue to use.[217]

Just as shareholder primacy remains in force for U.S. corporations, while it is questioned and amended in Europe, ESG practices, though attacked in the U.S., are increasingly accepted and codified globally:[218]

> UN Principles for Responsible Investment (PRI) ...has grown from 63 signatories when it launched in 2006 to more than 5,300 [in 2003, with] ... more than $120 trillion in assets. ... more than 3,000 U.S. companies operating in Europe are now subject to the European Union's Corporate Sustainability Reporting Directive[219], [as of January 2023]
>
> European Union is expected to adopt a Human Rights and Environmental Due Diligence Directive, [requiring all] companies doing business in Europe to assess human rights and environmental risks in their supply chains, and will similarly apply to large U.S. companies doing business in Europe.

Nevertheless, the Conference Board in September 2023 expected increased backlash in the U.S. against ESG, reporting that a survey

> of more than 100 large U.S. companies, [where} nearly half said they have already experienced ESG backlash, and 61 percent expect it to persist or intensify in the next two years. ... a majority of companies we surveyed are concerned they will face opposition from federal and state officials and candidates. Moreover, a growing number of firms also expect pushback from employees, consumers, business partners, the media, and investors.[220]

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[215] Ibid., Pensions & Investments.https://www.pionline.com/esg/anti-esg-bills-advanced-house-financial-services-committee

[216] https://www.pionline.com/esg/anti-esg-bills-advanced-house-financial-services-committee

[217] *Ibid*, CSIS

[218] *Ibid*, CSIS — source of next three points

[219] https://www.unpri.org/signatories/signatory-resources/signatory-directory

[220] Conference Board, Sept 2023, https://www.conference-board.org/publications/barrons-ESG-backlash-is-real-and-growing

DCEs & ACO/REACH — Do MDs on Boards Ensure Fiduciary Care to Patients?

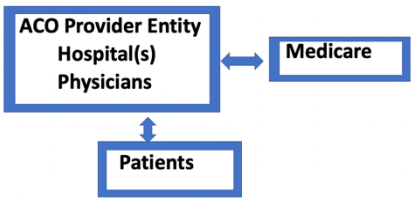
As part of the ACA (Affordable Care Act, AKA Obamacare), CMS created the CMMI (Centers for Medicare & Medicaid Innovation). Its purpose: to improve quality and control costs within Medicare by testing new payment models. CMMI introduced DCEs (Direct Contracting Entities) during the Trump Administration and they were (briefly) continued under the Biden Administration until public outcry caused a CMMI to replace them with ACO/REACH programs (also discussed elsewhere in this study report.)

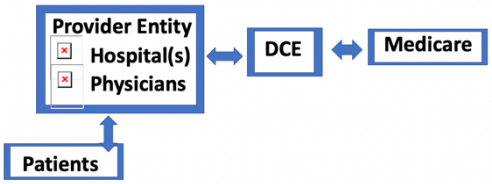
Both DCEs and ACO/REACH programs put physicians on their boards — promoting them as different from other investor-owned middlemen that siphon off taxpayer dollars for private profit. Their premise: board members who are physicians will ensure that patient needs are protected, just as ACOs (Affordable Care Organizations) protect patients.

Neither history nor common sense supports the premise that putting physicians on the boards of investor-owned corporations changes the business models of those corporations.

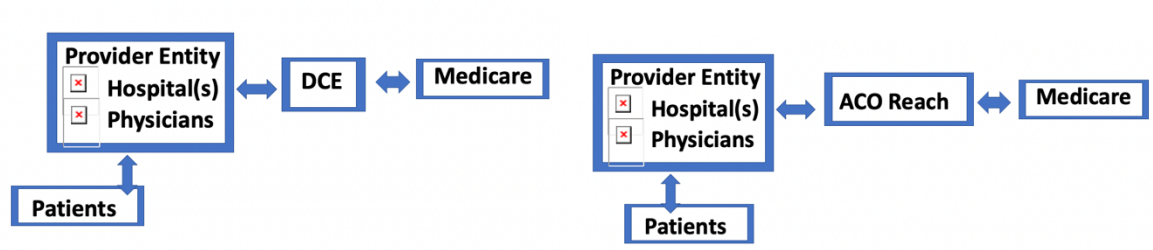
ACOs are providers. The boards of ACO's are established boards of existing hospitals (or already existing medical groups), rather than new entities. They are ACOs by virtue of having shared savings contracts with Medicare where, at the end of the year, per patient costs are compared to their benchmark, e.g., per patient costs of prior years.

By contrast, DCE entities are third-party corporations that sit between providers and Medicare — and patients may not learn they are in a DCE despite having constrained care or being guided away from physicians they have seen before.





ACOs provide healthcare. DCEs and ACO/REACH entities are investor-owned corporations and don't themselves provide healthcare services. ACO-REACH entities are DCEs that have been rebranded with a new name. Both capture unknowing patients who had chosen Traditional Medicare. They stand between providers and Medicare, operating with their own business models, typically as for-profit corporations regulated by the SEC (or as private equity, not really regulated by the SEC). Like other private corporations, their investors are motivated by profit, not social or environmental benefit. In 2021 over half of GLO PRO DCE's had Private Entity or Venture Capital investors, signaling how highly profitable they can be.



ACO-REACH entities claim to be like ACOs because they require having providers and at least one patient on their boards, but the presence of diverse stakeholders on corporate boards does not change the fiduciary responsibility of boards. Any assumed "social impact" influence by such board representation will be legally constrained. ACO-REACH board decisions will be required to maximize investor value, not focus on those served by any provider network with which they have a contract. Besides the legal constraints on board members, financial incentives offered to investors/members will conflict with (and thus discourage) any other considerations.

Bluntly, physicians and patients who serve on a corporate (for-profit) board must make decisions to maximize shareholder/investor value or put themselves at risk of legal challenges. As one poster to a recent Harvard Law School Forum on Corporate Governance wrote:

> The dominant framework of corporate governance is "shareholder primacy," or "shareholder value maximization." ...A corporation's board owes its "fiduciary duties" exclusively to shareholders ...Crucially, if corporate leaders' decisions are driven by other priorities, they can be challenged either by "activist" investors threatening to take over boards, or by legal action ...What's more, corporate insiders have been further incentivized to run companies with share price maximization as their north star because company executives receive increasing amounts of their compensation in ways that tie it to rising share value, ultimately uniting their interests with shareholders.[221]

This theory of "shareholder primacy," as discussed above, is most compellingly associated with economist Milton Friedman who described the doctrine of corporate "social responsibility" as:

> a "fundamentally subversive doctrine" in a free society, ...[because] in such a society, "there is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits so long

221 "Towards Accountable Capitalism: Remaking Corporate Law Through Stakeholder Governance," by Lenore Palladino and Kristina Karlsson, Roosevelt Institute, Feb 11, 2019 https://corpgov.law.harvard.edu/2019/02/11/towards-accountable-capitalism-remaking-corporate-law-through-stakeholder-governance

> as it stays within the rules of the game, which is to say, engages in open and free competition without deception fraud."[222]

The Business Roundtable recently announced a new "standard" that would loosen shareholder primacy so that corporate boards could include in their decision making such concerns as climate change, wage issues, health and safety issues. That announcement, also discussed above, has been criticized as a public relations gambit designed to tamp down on regulation. Although others have offered substantive arguments for how shareholder primacy has harmed American workers, communities, corporations themselves, and even democracy, they have largely gone unheeded because, as *Fortune* notes,

> There is no requirement on corporations to look after their stakeholders and for the most part they do not, because if they did, they would incur the wrath of their shareholders. That was illustrated all too clearly by the immediate knee-jerk response of the Council of Institutional Investors to the Roundtable declaration last year, which expressed its disapproval by stating that the Roundtable had failed to recognize shareholders as owners as well as providers of capital, and that "accountability to everyone means accountability to no one."[223]

Case Study of Private Equity Control of Emergency Rooms (ER)

Should anyone doubt the insignificant value of appointing doctors to boards of directors or their "supervising" business operations of investor-owned corporations, we can look to some of the examples detailed in Gretchen Morgenson and Joshua Rosner's *These Are the Plunderers: How Private Equity Runs — and Wrecks America.*[224]

They describe the role of private equity's takeover of Emergency Medicine; by 2020, Blackstone Inc. and Kohlberg Kravis Roberts & Co (also known as KKR & Co. Inc. or KKR,) owned contracts on more than a third of all emergency rooms (ER) and other PE firms brought the total to 40%. Envision HealthCare (owned by KKR) provided physicians and other healthcare staff to 540 facilities in 45 states.[225]

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[222] "A Friedman doctrine —The Social Responsibility Of Business Is to Increase Its Profits," Milton Friedman, *NY Times*, 9/13/1970. https://www.nytimes.com/1970/09/13/archives/a-friedman-doctrine-the-social-responsibility-of-business-is-to.html

[223] https://fortune.com/2020/09/13/milton-friedman-anniversary-business-purpose/ quoting Council of Institutional Investors here: https://www.cii.org/aug19_brt_response

[224] Gretchen Morgenson and Joshua Rosner, *These Are the Plunderers: How Private Equity Runs — and Wrecks America,* Simon & Schuster, 2023

[225] *Ibid*, p.196.

The authors note many state laws that prohibit corporations from practicing medicine and doctor fee-splitting with non-doctors, that require providers to put patient needs first, and that only licensed providers may own/operate healthcare facilities, etc. They then describe organizational structures that appear to be run by physicians (which therefore appear legal), but actually have corporate control (violating the spirit of the law, if not its letter).

The doctors receive a title and a salary "for the use of their licenses," but have "no oversight of the operation and can be terminated by the corporation states.[226] One such doctor (who we will return to in a few paragraphs), **Gregory Byrne**, "owned" 300 practices in California, Florida, Massachusetts, New York and elsewhere; the address of all those practices was the Envision headquarters in Tennessee, and the profits flowed to Envision.[227] When Envision was sued by "activist investors" (who happened to be emergency room physicians angry about what they saw as a corporation practicing medicine), Envision stonewalled.

Morgenson describes one "most disturbing example" from 2017. An ER doctor name Ray Brovont sued for wrongful dismissal from Overland, a Kansas City ER owned by HCA, "which often contracts with Envision and TeamHealth to run its emergency departments."[228] When Brovont began working at Overland, which required having an MD available 24/7, he was told that ER physicians were required to leave the ER whenever a "code blue" occurred.

> elsewhere in the hospital, even if it meant leaving the emergency department without a physician to handle code blues there. For many hours each day, the emergency department was staffed with only one MD.[229]

Then the hospital added a "new and separate pediatric emergency room" which doubled its size. This staffing violated guidelines of the American College of Surgeons and it violated federal law, the Emergency Medical Treatment and Labor Act."

Brovent began advocating up the corporate chain to solve this problem by hiring another MD. He received an email response saying,

> HCA is a for-profit company traded on the New York Stock Exchange... Many of their staffing decisions are financially motivated. EmCare is no different. Profits are in everyone's best interest.

After continued advocacy because the staffing dangers were not being resolved, Brovont was told that he was "unfit" to remain as Medical Director, with the comment:

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[226] *Ibid,* p.196.

[227] *Ibid.,*p.198.

[228] *Ibid.,* p.199.

[229] *Ibid.,* p.201. Also source for the next three quotes.

> You know you cash the check every month to be a corporate representative, and there is a responsibility as the corporate representative to support the corporation's objectives.[230]

Worse than just being fired, he was also blackballed from all nearby facilities, and his colleagues who had signed letters and petitions suddenly found themselves in a

> “weird cult of coercion" where you'd be fired if you didn't do what you were told. Younger doctors, shouldering significant amounts of student loan debt, reported being especially fearful of losing their positions if they complained. So they went quiet.

After finally finding a job, Bovine sued Envision for wrongful termination, and discovery brought forth more distressing details. The titulary owner of the Overland ER practice was **Gregory Byrne**, who had had no role in the Overland's ER operations or in the termination of Brovont. Indeed, Brovont had "never met or heard" of him.[231]

This is what the corporate practice of medicine looks like. Fiduciary care goes to shareholders, not to patients, nor to the community.

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[230] *Ibid.*, p.202. Also source for next quote

[231] *Ibid.*, p.203.

Chapter 7

PRIVATIZATION OF MEDICARE CMMI & MEDICARE ADVANTAGE

This section focuses on the federal health insurance program: Medicare. Over the past decade or so, privatization initiatives have made accelerated claims on the Medicare trust fund. Medicare Advantage is run by for-profit insurers; and now Medicare pilot programs are allowing for-profit corporations to manage the care of people who chose traditional Medicare (and have not agreed to be part of privatized plans). This privatization has continued on both fronts despite its failing to deliver promised benefits and engaging in a variety of fraudulent activities.

In the summer of 2021, the Healthcare Committee of the League of Women Voters of Vermont learned that for-profit corporations were inserting themselves into traditional Medicare, the much beloved publicly-funded health insurance program that, since 1965, has covered people over age 65 and people with disabilities.

CMMI, Center for Medicaid and Medicare Innovation

As part of the Affordable Care Act (ACA) legislation in 2010, Congress created a new division within the Centers for Medicare and Medicaid Services (CMS). This was the Center for Medicaid and Medicare Innovation (CMMI), charged with "developing and testing new payment and service delivery models to improve patient care, lower costs, and align patient systems to promote patient-centered practices."[232]

CMMI was given the authority to create programs hidden from public oversight and without transparent accountability: there appears to be no Congressional authority around challenging "pilot programs" CMMI initiates that fail to achieve goals, much less for ending pilots that undermine the mission, goals, or fiscal health of Medicare.

In 2017-2018 CMMI initiated a program under the then-Republican administration in which private, for-profit corporations, including private-equity-funded corporations, could manage billing and policy for provider groups without having to seek agreement from patients — patients who had specifically chosen traditional Medicare. (*See Chapter 5.)* Operating between provider groups and CMS, such profit-seeking entities used coding software to maximize reimbursements from public funds, installed performance metrics on providers to maximize

[232] https://www.cms.gov/priorities/innovation/overview

patient visits per day (reducing time per visit), and required prior authorizations, reviewed by algorithms to approve/deny referrals, diagnostic tests and treatments, "rather than credentialed human experts."[233]

With these new CMMI "pilots," for-profit corporations could, for the first time, access Medicare funds (that is, taxpayer dollars) for patients who had specifically chosen traditional Medicare (most beneficiaries) — not just those selecting Medicare Advantage (MA).

Unlike selecting Medicare Advantage, choosing traditional Medicare had meant avoiding almost all "prior authorizations" (approvals for specialist visits, diagnostic tests, treatments, etc.) and few constraints on a patient's choices of primary care and specialist doctors (about 90% of non-pediatric physicians accept Medicare). Medicare Advantage patients are constrained by "networks" (in some counties, over 70% of physicians refuse Medicare Advantage plans as do many prestigious specialty cancer centers such as Sloan Kettering in NYC and Mayo Clinic in MN, FL, AZ, etc.). And there are other limitations associated with Medicare Advantage.

Medicare Advantage

Medicare Advantage plans were first authorized in the early 1980s by Congress in response to lobbyist pressure to provide opportunities for insurance companies to access funds set aside for Medicare recipients. (*See Chapter 5.*) Lawmakers, at the time, were persuaded that "value-based care" could reduce Medicare expenditures by motivating healthcare providers to help people stay healthy or get healthy faster. "Value-based care" meant insurers were paid a set amount for each patient ("capitated") rather than paid for each visit or service (fee-for-service or FFS). It was a relatively new concept without much supporting data, but it seemed rational within a free-market perspective. Subsequent research has concluded that the for-profit Medicare Advantage approach has significantly raised costs and harmed patients, physicians, and health infrastructure.[234]

Over the years, CMS rules have evolved in ways that allow corporations to increase their reimbursements from the Medicare trust fund, for example, by moving patients with more complex health needs into brackets with higher capitated payments because those patients require more care and more expensive treatments. Too many Medicare Advantage plans have systematically gamed such protocols, however, exaggerating patient health conditions to gain increased levels of reimbursement (as much as thousands of dollars more per year per

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[233] "Over a period of two months last year, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of 1.2 seconds on each case, the documents show. The company has reported it covers or administers health care plans for 18 million people." ProPublica, "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," by Rucker, et al., March 25, 2023: https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

[234] Physicians for a National Health Program, "Taking Advantage: How Corporate Health Insurers Harm America's Seniors," May 23, 2024, https://pnhp.org/harmsreport

patient). Recently publicized hidden government audits suggest that such overpayments were common and CMS knew about them even a decade ago and that CMS has yet to collect on those overpayments, nor has CMS punished the fraud (the federal False Claims Act allows fines up to $1000 per instance, exclusion from government insurance programs, and criminal penalties).[235] When CMS pursues such fraud, insurers such as United Health (#4 on the Fortune 500 list of largest American companies[236] and the most profitable of all companies in the health sector) sued to overturn Medicare's overpayment rules and initially won in court, causing prosecutors to drop ongoing similar suits. Recently one such suit has been reversed.[237]

Medicare Advantage programs have also committed more garden-variety reimbursement fraud, seeking reimbursement for services that were not delivered or multiple reimbursements for the same service. A 2022 study estimated that the annual over-billing could easily be as high as $140 billion per year, not counting savings from delay and denial of care, from cherry-picking and lemon-dropping[238] or from additional cost to insurance customers of paying for executive bonuses predicated on fraudulently-achieved benchmarks and profits.

Medicare Advantage: Too Good To Be True?

Medicare Advantage programs (also called Medicare C) often offer in-patient and out-patient health care (Medicare A and Medicare B) and, often, prescription drugs (now called Medicare D), as a comprehensive single plan for one premium. This is unlike traditional Medicare where coverage of Medicare A (in-patient) has no charge if the beneficiary or their spouse paid into the system for (typically) ten years; Medicare B (which pays 80% of out-patient expenses) where premiums are deducted from Social Security (the amount set by the level of retirement income) and beneficiaries cover the 20% "gap" in coverage by self-insurance (paying out-of-pocket as needed) or by buying separate for-profit "supplemental insurance" (also called "gap insurance" and "Medigap insurance") which has varying levels of coverage and out-of-pocket fees; and Medicare D (for prescriptions) which is also purchased separately from for-profit insurers. Medicare Advantage makes buying health insurance less complicated, and many plans also appear to have less expensive premiums/overall costs.

Medicare Advantage plans also market heavily, with ads and practices that many find deceptive.[239] Academic health policy analysts estimate that such

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[235] NPR, "Hidden audits reveal millions in overcharges by Medicare Advantage plans," by Schulte and Hacker, Nov. 21, 2022: https://www.npr.org/sections/health-shots/2022/11/21/1137500875/audit-medicare-advantage-overcharged-medicare

[236] https://www.healthcaredive.com/news/unitedhealthcare-loses-medicare-advantage-overpayment-suit/605034

[237] Healthcare Dive, "UnitedHealthcare loses Medicare Advantage overpayment suit," by Rebecca Pifer, Aug.16, 2021: https://www.healthcaredive.com/news/unitedhealthcare-loses-medicare-advantage-overpayment-suit/605034

[238] PNHP, "Our Payments, Their Profits: Quantifying Overpayments in the Medicare Advantage Program," https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf

[239] KFF, "How Health Insurers and Brokers Are Marketing Medicare," by Jeannie Fuglestein Biniek, et al., Sept 20, 2023: https://www.kff.org/report-section/how-health-insurers-and-brokers-are-marketing-medicare-report

> Deceptive and fraudulent advertising for Medicare Advantage plans cost taxpayers $6 billion in 2022[240]

How are these marketing efforts "deceptive and fraudulent"? Most obviously, their branding, the toll-free numbers they tout, and their claims suggest that the advertisers represent Medicare, not for-profit insurers. Less obviously,

> While MA plans advertise comprehensive, inexpensive coverage, they fail to make clear the realities of poor coverage through restricted networks, prior authorizations and denials of care, and high costs for their supplemental benefits … Overall, MA costs taxpayers billions more than Traditional Medicare (TM), enriches large insurance companies, and provides less reliable coverage.[241]

If Medicare Advantage customers are deceived, so are providers. The Center for Economic and Policy Research (CEPR) notes:[242]

> According to a 2022 Government Accountability Office (GAO) report, MA plans improperly rejected 18% of payment denials to providers.[243] While a growing number of hospitals and health systems are ending their relationships with MA plans; in comparison, only 1.1% of non-pediatric physicians have opted out of the TM program.[244]
>
> Additionally, MA plans are more likely to direct patients to lower-quality providers. A 2018 study in PubMed Central (PMC) shows that MA enrollees were more likely to be enrolled in lower quality skilled nursing facilities compared to TM based on 32 unique quality measures gathered by the Centers for Medicare & Medicaid Services (CMS).[245] Similarly, a 2023 study

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[240] CEPR, "Medicare Advantage and Deceptive Advertising," by Brandon Novick, Nov 7, 2023: https://www.cepr.net/report/medicare-advantage-and-deceptive-marketing

[241] Ibid., cited as Cristi Grimm, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (U.S. Department of Health and Human Services Office of Inspector General, April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[242] Ibid., cited as Jakob Emerson, "Hospitals Are Dropping Medicare Advantage Left and Right," Becker's Hospital Review, October 9, 2023, https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html.

[243] Ibid., cited as Nancy Ochieng and Gabrielle Clerveau, "How Many Physicians Have Opted Out of the Medicare Program?," Kaiser Family Foundation, September 11, 2023, https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program

[244] David J. Meyers, Vincent Mor, and Momotazur Rahman, "Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees," Health Affairs 37, no. 1 (2018): 78–85, https://doi.org/10.1377/hlthaff.2017.0714.

[245] Ibid., cited as David J. Meyers, Vincent Mor, and Momotazur Rahman, "Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees," Health Affairs 37, no. 1 (2018): 78–85, https://doi.org/10.1377/hlthaff.2017.0714.

published in *JAMA* found that MA enrollees are significantly less likely to go to high quality home health agencies (HHAs) than TM beneficiaries.[246].

Increasing numbers of medical centers and providers refuse to take Medicare Advantage,[247] particularly those offering specialty care, for example, prestigious cancer centers Sloan Kettering in NYC and the Mayo Clinic in AZ, FL, and MN. Of course, seniors seeing thousands of Medicare Advantage ads and talking with brokers do not hear about already narrow networks narrowing.

Cherry Picking & Lemon Dropping

Medicare Advantage plans also use marketing to target the healthiest patients by including benefits like fitness centers, while not offering services that are attractive to people who are less healthy. This is called "cherry picking."

This is called "lemon dropping" and results in for-profit insurers shifting financial risk to the public purse. Lemon-dropping techniques include offering narrow networks of providers, for example, by not including specialists or hospitals who treat more costly illnesses and by not covering medications that are used by more expensive patients, even if the medication itself is not expensive. Narrow networks and formularies cause less healthy patients to choose traditional Medicare where no patient pays exorbitantly for using an "out-of-network" provider. Narrow networks and formularies also cause patients who get seriously ill and are faced with the exorbitant additional costs associated with out-of-network specialists or hospitals to transfer out of Medicare Advantage and into traditional Medicare.

In 46 states, Americans who spend two years in a Medicare Advantage plan and then wish to transfer to traditional Medicare face challenges purchasing Medigap insurance: for-profit insurers are permitted to refuse coverage outright or to charge higher rates based on "risk-adjustment" (how sick the patient is). Four states have "guaranteed issue" protection, that is requiring Medigap insurers to issue premiums and price them continuously at "community risk" rates, that is, at a standard rate for everyone in the general risk pool and whenever they may wish to purchase a Medigap plan (CT, MA, ME, NY).[248] Eight states require community ratings regardless of age of the Medicare beneficiary (AR, CT, MA, ME, MN, NY, VT, and WA); this means that Medigap rates cannot rise for a continuously covered 80 year old or 90 year

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[246] Ibid., cited as Margot L. Schwartz et al., "Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries," JAMA Network Open 2, no. 9 (September 4, 2019): e1910622, https://doi.org/10.1001/jamanetworkopen.2019.10622

[247] "Onerous authorization requirements and high denial rates have health systems considering whether to drop Medicare Advantage plans," according to Becker's Hospital Review, "Nearly half of health systems are considering dropping Medicare Advantage plans," Andrew Cass, March 22, 2024: https://www.beckershospitalreview.com/finance/nearly-half-of-health-systems-are-considering-dropping-ma-plans.html

[248] KFF, "Medigap Enrollment and Consumer Protections Vary Across States," 2018 https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states

old; the premium price must remain the same for all Medicare beneficiaries in that insurer's risk pool.

Prior Authorizations, Delays, Denials of Care, and Look-Backs

Other strategies for Medicare Advantage programs to save money include excessive prior authorizations and denial of care. For some diagnostic imaging and procedures, it can make sense to require prior authorizations, but traditional Medicare has few requirements for prior authorizations. However, Medicare Advantage programs have expanded the use of prior authorizations to the extent they have become primarily a tool to deny needed care to patients. This burdens both patients and providers: patients who can suffer worse outcomes from delayed care and unnecessary worries during the appeals process; and providers who must spend significant amounts of uncompensated time appealing these decisions if, in fact, the denial is appealed, which few are.[249]

"Look-backs" occur after a provider — an individual, clinician, a diagnostic imaging service, a hospital, etc. — has already provided a service which was approved and reimbursed. Insurers "look back" and deny the claim, "clawing back" the payment.[250] These look-back denials may be triggered by non-clinicians with no medical expertise or, increasingly, by algorithms overriding payments in batches of hundreds or thousands.[251] This is practicing medicine without a license, which states should be able to address through their medical licensing process but, because this is a federal program, states have little recourse.

Bottom Line

As the rest of this study report details, privatization is threatening the financial underpinnings of Medicare, increasing how much Americans spend on healthcare (almost 60% of which is paid by taxes), and harming individual patients, their families, and their providers. As detailed elsewhere, privatization is also threatening many other public goods, services, and assets. All of these, including health care, are urgent issues at the local, state, and federal levels.

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[249] "In 2021, MA plans denied approximately 6% of the 35 million prior authorization requests submitted. Although only 11% of these denials were appealed, the decisions were overturned in 82% of appealed cases," in "Coverage Denials in Medicare Advantage—Balancing Access and Efficiency," *JAMA Health Forum.* 2024;5(3):e240028. doi:10.1001/jamahealthforum.2024.0028

[250] Modern Healthcare, "Insurance companies ramp up efforts to claw back money from providers," by Carolyn Hudson, March 20, 2023: https://www.modernhealthcare.com/health-insurance-recoupment-clawback-providers-crowe

[251] Healthcare Dive, "Cigna Sued Over Algorithm Allegedly Used To Deny Claims," July 25, 2023, by Rebecca Pifer, https://www.healthcaredive.com/news/cigna-lawsuit-algorithm-claims-denials-california/688857

Chapter 8

PROs & CONS FOR VERMONT UPDATE

PROS: ADOPT THE POSITION	CONS: DON'T ADOPT THE POSITION
1. *Should everyone in the United States have access to affordable health care?*	
A country with our stature and resources should ensure that all its people have access to health care. It's the right thing to do. The United States spends more public dollars (raised through taxes) per capita on health care than any other country. We are already paying enough to provide health care for everyone, if all the funds actually went to health care instead of excessive administrative costs and profits. Fiscal responsibility would require us to use those funds to cover what taxpayers intended: health care, not administration and profit. People can go bankrupt from medical debt even when they have insurance, and even without catastrophic illness. Half of US bankruptcies involve medical debt, with most of these for people who had insurance.	Health care is not a human right. We cannot afford to make **unlimited** health care a public good for everyone living in the United States. People's access to health care should be influenced by their ability to pay. If we provide health care without asking anything in return, people will abuse the system. If they have insurance and cannot afford deductibles and copays, they should take advantage of less expensive plans. Before we make any changes, we should be sure it is not regulations that are causing the high cost of health care.
2. *If health care is a public good for people on Medicare (over 65 or disabled), should it be a public good for everyone?*	
Everyone should have access to health care without coverage gaps or limits due to age, loss of employment, catastrophic illness or accident, exceeding income or asset limits for public assistance, etc. Deductibles are so high that people are not accessing the care they need. Communities benefit from people who are pregnant or raising families getting the care they need. Economies benefit from adults being healthy enough to be fully productive. Lack of health care affects the whole community. Using the health care system to keep everyone well (and not contagious), and to be ready for public health emergencies, serves everyone.	There is nothing wrong with providing care relative to what people can pay. People who are young and healthy should not have to pay higher premiums to cover the medical costs of people who are old and ill. It is not fair to make society pay for people's poor lifestyle, diet, or insurance-purchase decisions. Providing health care as a public good to people with disabilities who are over 65 years means we have compassion for them, not that they have a right to it. Private corporations do not want to insure the elderly or disabled at a price they can afford, so we, as a society, decided to pool funds gathered over a lifetime of employment, to provide that insurance. We do not have an obligation to do this.

PROS: ADOPT THE POSITION	CONS: DON'T ADOPT THE POSITION
3. Should hospitals be distributed such that rural or inner-city residents can (geographically and culturally) access care?	
Everyone deserves to have a hospital within a distance that's safe for preserving health. We need farmers to grow our food, and we want hospitals to be distributed such that they are available when we travel for work or recreation. People with limited resources may have trouble getting to a hospital in a different part of town or distant town.	Constantly losing money is not a sustainable business model. If we want local access to health care for everyone, we need a model that does not constantly lose money. Telehealth and other remote-delivery options could be part of a less costly solution.
4. Should people be limited in their choice of doctor based on what they can afford for insurance and what contracts employers of doctors may choose to sign?	
People who are happy with their doctor should be able to keep their doctor. People should be able to choose their doctor based on recommendations, distance to get to them, and other factors that they value, and not be limited by corporations.	Corporations have data showing they manage care more efficiently & effectively, in part because of in-network models. If a patient's doctor is not in their insurance network, they can change doctors.
5. Private for-profit corporations have a fiduciary responsibility to their shareholders rather than to patients or public health. Should the allocation of health care resources be made on the basis of responsibility to patients and communities?	
Health-care resources for individuals should be allocated based on medical need, determined by clinical standards of care. Health-care resources for communities should be allocated based on public health assessment of community needs. Because health-care cannot follow free-market principles, allocation of resources should not be left to the "free market." Whereas equity is crucial in the distribution of basic human needs, the "free" market does not take equity into account in allocation of goods and services. Health-care is not a commodity and people who need health-care are not customers. Making the provision of health-care a financial transaction distorts the cooperative nature of the ideal provider-patient relationship.	The majority of hospitals in the U.S. are non-profit . Funds collected for the purpose of providing health care can also be used to pay for private profit, as we do with prisons and road construction. Duplicating health-care administration functions is the price we pay for the better service and customer-aligned care a competitive environment provides. Spending tax-payer dollars wisely means letting the free-market work for us.

PROS: ADOPT THE POSITION	CONS: DON'T ADOPT THE POSITION
6. Should there be public participation in decisions about health-care policy and its evaluation?	
Because the public must live with the medical, financial, and societal impacts of health-care policy, they must be engaged in making these decisions.	The general public does not know enough about health-care policy to contribute meaningfully, and they might cause misdirection of resources or other problems.
7. Should there be public participation in oversight of health-care policy?	
After policy is implemented, oversight and enforcement are crucial for meeting health care policy goals and public health goals. Because health-care involves a large chunk of our economy and entities seeking profit have resources to thwart actions intended for the public good, transparency is essential for access by journalists and the public to factual information; and the public must have a seat at the table for oversight. Elected representatives are subject to lobbying by special interests; true public oversight requires representatives from nonprofit stakeholders across a broad range of constituencies, including civic groups.	The general public does not know enough about health-care policy to contribute meaningfully to oversight. Public participation in oversight could waste time and funds in lengthy decision making and highly contentious stand-offs, or could cause derailment of appropriate health policy. Public policy should recognize that corporations have great experience in managing health-care costs while making a profit. The public already has oversight through their elected representatives.
8. Should health-care decisions be made by patients and the providers they choose?	
Health-care decisions should be made by patients, who have to live or die with the results; and their chosen health care providers who have the training and experience to guide them in their health-care decisions; with input from their trusted advisors and family. Physicians make their decisions based on medical standards of care and this should not vary based on income or insurance coverage of the patient. Research shows that, compared to people in countries with better outcomes and lower costs, U.S. residents under-utilize health services, seeing doctors less frequently and having shorter hospital stays. Unlike other developed countries, part of the decision to seek basic care is whether they can afford it, before they have a chance to get advice from their health-care providers.	Patients have a bias for wanting as much care as they can get, which is wasteful. Health-care providers have a vested interest in providing more care than is needed to increase their earnings and to protect them from malpractice lawsuits. A corporation can reduce overall costs by overriding provider decisions that cause over-utilization, by providing incentives to reduce the amount of care provided; and by ensuring only medically necessary care is provided. Without corporate restraints, U.S. residents would over-utilize health services even more than they do today, further accelerating health care costs.

Chapter 9

FREQUENTLY ASKED QUESTIONS

Below, you'll find answers to questions that have been asked about the LWVVT Privatization Position.

1. Why do we need a new position on privatization? Is the LWVUS position not adequate?
2. Why does Vermont consider the topic of Privatization in health care so important?
3. Do you propose the Vermont Update should replace the LWVUS position?
4. Is the proposed update intended to add to the LWVUS Health Care Position under "*Social Policy*" or the Privatization position under "*Representative Government*"?
5. Does the Vermont position oppose all private options?
6. Without definitions and descriptions of the process for taking control of currently and historically private health services, would we be inadvertently manipulated into supporting an unintended move?
7. What are the criteria for "*failing to deliver*"?

Q 1.

Why do we need a new position on Privatization? Is the LWVUS Position not adequate?

The LWVUS Position is open to interpretation in a way that has prevented members from advocacy.

a) Although health care is specified as a basic human need for which government should set standards and to which government should ensure access (*Impact on Issues 2022-2024 p.145, Meeting Basic Human Needs*),[252] and public health is specified in the privatization position, health care is not specified as a common good in the privatization position.

b) The LWVUS Privatization Position[253] stipulates criteria that should be met before a service or good is transferred from the public sector to the private sector, and lists the following among considerations when privatizing a public good:

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[252] *Impact on Issues 2022-2024 p.145, Meeting Basic Human Needs*. https://lwvhealthcarereform.org/wp-content/uploads/2024/04/MeetHumanNeeds_LWV_Impact2022-24_145-151-2.pdf

[253] https://lwvhealthcarereform.org/wp-content/uploads/2024/01/PrivatizePages_LWV_ImpactOnIssues2022-2024-pp67-68.pdf

- "A provision and process to ensure the services or assets will be returned to the government if a contractor fails to perform"
- "Adequate oversight and periodic performance monitoring of the privatized services by the government entity to ensure that the private entity is complying with all relevant laws and regulations, contract terms and conditions, and ethical standards, including public disclosure and comment."

  However, it is silent on what should happen if those criteria are not met. This has been interpreted as not allowing Leagues to advocate for deprivatization even when the criteria are not being met.

c) The position does not address services currently provided by the private sector that would be better for the common good if they were provided by the public sector.

Therefore, the new position articulates the basis for

- considering health care (as distinct from public health) a common good
- providing a process for returning privatized common goods and services that are not serving the common good back to being publicly managed services
- converting private health care that is not serving the public good to publicly managed, even if it was historically always private.

Q 2.

Why does Vermont consider the topic of Privatization in Health Care so important?

In 2022, 17.3% of the U.S. GDP was spent on health care. This is a huge portion of our economy, pulling up resources that could go to housing, education, etc.[254]
Over half of health-care expenditures in the U.S. are funded by taxpayers (Medicare, Medicaid, VA, military; property taxes for local municipal and school employees; federal and state taxes for federal and state employees and for subsidies to assist people with low incomes to afford insurance). Because lobbyists have successfully created opportunities to overcharge the government while skimping on services, profit-seeking entities are attracted to these programs and have huge incentives to target the system. Even fraud is lucrative, since infrequent audits exact few penalties, which are trivial relative to the financial gains.[255]

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[254] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=The%20data%20 are%20 presented%20by,For%20additional%20information%2C%20see%20below.

[255] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4880216

Despite paying for so many other people's insurance, many working-age adults are at risk for bankruptcy if they actually get sick, even if they have health insurance:

> In 2022, 43% of working-age adults were inadequately insured[256]. These are individuals who were uninsured (9%), had a gap in coverage (11%) or were insured all year but had coverage that didn't provide them with affordable access to healthcare (23%).[257]

The "third party payor" placed between the provider organization and the government reduces accountability and increases opportunities to manipulate prices, among other problems.

Privatized health-care tends to cost more and yield worse results compared to public health-care. Incentives in privatized health-care are not set up to provide the better results we deserve.

Privatization is also destroying our health-care infrastructure.

a) A private hospital system that "acquires" a struggling hospital has incentives to refer care to another hospital and close less profitable hospitals, creating "health care deserts." This happens even where the "less profitable" hospital was financially stable.[258]

b) A hospital or clinic may also be purchased for its real-estate value, removing the resource from the health care infrastructure.[259]

c) A private entity that buys up multiple practices in the same specialty can achieve monopoly power to raise prices and cut corners to reduce costs, which can often reduce quality.[260]

d) A private entity has incentives to cut costs, which may include overworking employees, which reduces quality; underpaying employees, which can lead to worker shortages; and adding administrative burden to manipulate charges for services and/or delay — or deny — needed services, which contributes to moral injury. All of these actions can also contribute to provider burnout and impair provider recruitment and retention, exacerbating shortages.

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[256] https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey#:~:text=Forty%2Dthree%20percent%20of%20working,to%20health%20care%20(23%25)

[257] https://www.forbes.com/sites/joshuacohen/2024/01/01/us-healthcare-system-leaves-far-too-many-people-underinsured/?sh=174eb5b93366

[258] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050

[259] https://www.newyorker.com/magazine/2021/06/07/the-death-of-hahnemann-hospital

[260] https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across

e) A private entity that skims off the lucrative business in the area (orthopedic surgi-center, for example) can harm the viability of a non-profit entity (community hospital) trying to serve the public good.

Governments are incentivized to prioritize health and public welfare. For-profit organizations, both traditional corporations and private equity-backed firms, are incentivized to prioritize profit. An increasing share of the $4.5 trillion[261] the U.S. spends on health care profits corporate owners and investors. Researchers estimate private equity has invested nearly $1 trillion[262] in the U.S. health sector over the past decade, and $200B just in 2021. The LWV Vermont concurrence provides a basis for Leagues to put patient needs before profits when the public good demands. It also adds consequences for profit-seeking organizations that prioritize profits over health.

Q 3.

Do you propose the Vermont Update should replace the LWVUS position?

No, the LWVUS Position will remain in force. Think of the Vermont Update as a supplement to the current position. If delegates choose to concur, LWVUS will use exact language from the concurrence to update or clarify elements of their position.

Q 4.

Is the proposed update intended to add to the LWVUS Health Care Position under "*Social Policy*" or the Privatization position under "*Representative Government*"?

The intent is to update the LWVUS Position on Privatization, which is in the "Representative Government" section of "*Impact on Issues, 2022-24*."

The proposed update will not affect the LWVUS Health Care Position.

The proposed concurrence addresses what is public vs. private, which is an issue of representative government. It focuses on who owns, manages or administers goods or services that the public believes are "necessary to preserve the common good, to protect national or local security, or to meet the needs of the most vulnerable members of society."

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[261] Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data

[262] https://www.takemedicineback.org

The Vermont study was motivated by concerns relating to health care, but relies on the existing LWVUS Position to allow advocacy for all the public goods already covered by it, and to guide the considerations for deprivatizing.

Q 5.

Does the Vermont position oppose all private options?

Not at all! Like the LWVUS Privatization Position, the Vermont Update would allow Leagues to use the position to support or oppose legislation and regulation they prioritize. It does not require Leagues to oppose private options. We would note that the LWVUS Health Care position supports all essential health care services be funded by the public.

Even were all of health care publicly funded, delivery could still be private. We would expect private clinicians (doctors, nurse practitioners, physical therapists, nutritionists, etc.) to be in clinician-owned private practices, either soloists or group practices but owned by the clinicians, not by for-profit corporations. Alternatively, if state law allows, clinicians might be employed by a non-profit, such as a hospital, acting as a mission-driven non-profit that returns "excess revenues" to working on their mission.

Some states have "corporate practice of medicine" (CPOM) laws that, for reasons of conflict of interest, do not allow employment of physicians by any corporations, including hospitals, but some CPOM laws allow them to be employed by some non-profit corporations. Among the private non-profit corporations that provide health care-related goods and services, some serve the public good but others act like for-profit corporations: upcoding their billing; limiting how much charity care they provide; suing patients who may be eligible for financial aid (even putting liens on residences and garnishing wages); and putting "excess revenues" in high-yield investments or even setting up venture-capital divisions.

Our position focuses on providing a basis to advocate against for-profit ownership or administration of health care goods and services, and against organizations that do not serve the common good while controlling a good or service essential to the common good. For example, a League could choose to advocate for legislation prohibiting new for-profit hospices or nursing homes or to allow new facilities only if they met certain cost, quality, and transparency metrics. Another example: a League could choose to support de-privatization of an entity (category of entity) that was not serving good public policy through its control of a good or service essential to the common good.

Any time you invoke the name of the League in advocacy, you must be sure your action does not conflict with any League position or League values. Should your League learn of legislation that would de-privatize a health care service that is currently privately delivered, the board or advocacy committee would likely want to assess whether that service is accessible to those who need it, affordable for individuals, meets quality standards, and (if public funding

is involved) cost efficient for the public purse. If it is, there may be no reason to support the legislation. If there are problems around accessibility, affordability, quality, fiscal responsibility or transparency, then your board or advocacy committee would need to consider the bill's purpose, its public policy implications, and its likely consequence before deciding to oppose, support, or seek to amend the legislation.

Without a position, a League cannot advocate for a bill; with a position, a League is not required to act. Having a position allows a League to choose to advocate or not.

In the Vermont study, we determined that health care does not follow free market principles and because profit-seeking too often reduces access to health care or quality of care, Leagues should be empowered to advocate against policies that allow profit from health care. We did not study whether other public goods and services should only be non-profit.

Our study did cause us to conclude that Leagues should be able to advocate for accountability around privatized public goods (as defined in the LWVUS Position on Privatization) when they are not meeting the criteria in the position.[263] This could include deprivatizing.

Q 6.

Without definitions and descriptions of the process for taking control of currently and historically private health services, would we be inadvertently manipulated into supporting an unintended move?

For example, couldn't state or federal government unfriendly to women's reproductive health services — which are currently delivered through the private sector — introduce legislation or regulation seeking to reform such services, accusing such services of "failing to deliver" using bogus criteria:

- ***the waiting times for appointments are too long***
- ***the prices are not transparent, etc.***

They could argue that the LWV agrees (!) due to the new deprivatization clause.

I will separate this question into two:

a) **Can Leagues be manipulated into supporting something that is contrary to the public interest?**

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[263] *Impact on Issues p.67-68*. https://lwvhealthcarereform.org/wp-content/uploads/2024/01/PrivatizePages_LWV_ImpactOnIssues2022-2024-pp67-68.pdf

Leagues do NOT advocate for issues that our positions oppose and they do NOT oppose issues our positions support. Actions must be consistent with ALL our positions.

Because someone might try to manipulate a League into thinking it was for the public interest, Leagues must themselves study the issues, review relevant positions, and look for potential unintended consequences of actions before making a decision to support or oppose a policy or bill.

Please note the Meeting Basic Human Needs position says:

> **Access to Health Care**
>
> LWVUS believes that access to health care includes the following: preventive care, primary care, maternal and child health care, emergency care, catastrophic care, nursing home care, and mental health care, as well as access to substance abuse programs, health and sex education programs, and nutrition programs.[264]

According to the American College of Obstetricians and Gynecologists:

> "Maternal care refers to all aspects of antepartum, intrapartum, and postpartum care."[265]

For this question, reproductive services include, but are not limited to, sex education; contraception as a part of primary care; all antepartum and intrapartum care, including abortion when the patient and her provider agree that terminating a pregnancy is the best course; emergency care, which may include terminating a pregnancy, and postpartum care, which includes care after terminating a pregnancy or after a miscarriage.

b) Could adding deprivatization to the Privatization Position force Leagues into supporting closing clinics like Planned Parenthood, which have historically provided health care privately, saying the wait times were too long or other reasons they were "failing to deliver"?

When the League has a position on some issue, it does not require any League to advocate for legislation that the position appears to support. Leagues should always consider their own priorities and whether their advocacy is appropriate for or against any specific piece of legislation or regulation.

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[264] *Impact on Issues 2022-2024 p.146,* Meeting Basic Human Needs. http://meethumanneeds_lwv_impact2022-24_145-151-2.pdf

[265] American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care#:~:text=Maternal%20care%20refers%20to%20all,%2C%20intrapartum%2C%20and%20postpartum%20care.

However, the Vermont study also considered whether the same criteria in the Update–for turning something public over to private hands — also apply for a service being provided privately (without a specific contract).That is, if the goods or service provider doesn't meet the criteria in the Update of transparency, accountability, ensuring the public good etc., this position Update would allow Leagues to support laws or regulations to put those goods or services under public control.

If a for-profit long-term nursing facility (LTNF) had high staff turnover with worse patient outcomes than the national average, a League could consider all factors and decide whether to support a bill that would eliminate some or all for-profit LTCFs. If they studied the bill and wanted to advocate for it, the Vermont Update would allow, not require, them to do so.

Q 7.

What are the criteria for "*failing to deliver*"?

Criteria that speak to this are found in the LWVUS position: The Vermont position operationalizes what had only been envisioned; the LWVUS Position clearly provides consequences for failing to live up to the considerations–namely that "the services or assets will be returned to the government."

There are three areas listing criteria in the LWVUS Position:

a) The first paragraph says in order to privatize a service, one must confirm that "transparency, accountability, and preservation of the common good are ensured

b) The second is a bulleted list of "considerations [that] apply to most decisions to transfer public services, assets, and functions to the private sector. It very specifically mentions "a provision and a process" [to ensure their return to the government if the contractor fails to perform][266]

c) Third, there follows discussion of state laws and regulations, with a list of "best practices" and the explicit expectation that states "control the process and delivery ... within a state's jurisdiction" over the kinds of goods and services defined by the position.

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[266] *Impact on Issues 2022-2024, p.68.*https://lwvhealthcarereform.org/wp-content/uploads/2024/01/PrivatizePages_LWV_ImpactOnIssues2022-2024-pp67-68.pdf

https://www.lwv.org/impact-issues

APPENDICES

APPENDIX A

OTHER LWVUS POSITIONS RELEVANT TO THE VERMONT UPDATE

A consideration in creating a position, or in choosing a path of advocacy, is to consider all relevant League positions — what exactly does the League support, what does it oppose, and where is it silent. Further, any new position may have nothing in it that conflicts with established positions.

In addition to ensuring that a new position is consistent with all League positions, *Impact on Issues 2022-2024* recommends that Leagues "apply a DEI lens" to any position they are utilizing.

In reviewing the LWVUS *Impact on Issues 2022-24*, LWVVT Study Team found four areas relevant to the Vermont Privatization issues they were studying:

- Meeting Basic Human Needs
- Fiscal Policy
- Public Participation
- Health Care

Meeting Basic Human Needs (

> "Persons who are unable to work, whose earnings are inadequate, or for whom jobs are not available have the right to an income and/or services sufficient to meet their basic needs for food, shelter, and access to health care.
>
> The federal government should set minimum, uniform standards and guidelines for social welfare programs and should bear primary responsibility for financing programs designed to help meet the basic needs of individuals and families. State and local governments, as well as the private sector, should have a secondary role in financing food, housing, and health care programs…[267]

[267] *Impact on Issues, 2022-2024 page 146,* Meeting Basic Human Needs. https://lwvhealthcarereform.org/wp-content/uploads/2024/04/MeetHumanNeeds_LWV_Impact2022-24_145-151-2.pdf

Access to Health Care

> LWVUS believes that access to health care includes the following: preventive care, primary care, maternal and child health care, emergency care, catastrophic care, nursing home care, and mental health care, as well as access to substance abuse programs, health and sex education programs, and nutrition programs.[268]

Because the "Meeting Basic Human Needs" position (*Impact on Issues 2022-2024, p. 146*) states that government should bear responsibility for ensuring access to minimum standards of health care, Leagues could interpret that to mean that LWVUS already considers health care a public good and could act at the local and state level already. However, to reduce inconsistent interpretation, members felt it was important to update the national privatization position by explicitly aligning the two LWVUS positions to both define health care as a public good and a basic need.

Health Care

The proposed update to the position on privatization complements the health care position. The goals of the health care position are usually summarized and supporting universal, affordable and equitable health care. The opening paragraph lays this out in more detail:

> ... that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.[269]

Because the intrusion of the profit motive in the health care sector reduces affordability, efficiency and economical delivery of care, it has contributed to the fact that health care continues to become an increasingly greater proportion of our gross domestic product (GDP). It has also led to less equitable distribution of health care.

Providing health care as a public good is inherent in the health care position, as the League favors progressive general taxes to pay for a national health program, instead of the regressive method of financing health care through individual insurance premiums.

The private sector could have a role in health care administration. For instance, a private contractor could provide the services for determining eligibility and for paying claims:

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[268] *Ibid*., "Meeting Basic Needs," p. 145
[269] *Impact on Issues 2022-24*, Health Care, pp 137-139: https://www.lwv.org/impact-issues

> The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state, and/or regional government agencies.[270]

However:

> The League supports the single-payer concept as a viable and desirable approach to implementing League positions on equitable access, affordability, and financial feasibility.[271]

This clear statement that the League supports health care fully funded by the public sector should be sufficient for League members to support deprivatization of health care, including advocacy for deprivatizing Medicare (to support reining in Medicare Advantage failures), and opposing efforts to further privatize Medicare (to oppose programs such as the former Direct Contracting Entities program and current ACO/REACH and future privatization schemes as they are proposed).

Public Participation

Members expressed strong concern about the need for citizen participation in creating policy around public goods, as well as robust oversight. Language for this can be found in the position on Public Participation regarding natural resources. LWV Vermont has been focused on oversight and regulation of health care and, in particular, ensuring Vermonters are given an opportunity to provide public input before and during decision-making.

Although the League's position on Public Participation was developed initially to support protecting the environment and managing our natural resources,[272] the principles are broadly applicable.

> The public has a right to know about pollution levels, dangers to health and the environment, and proposed resource management policies and options.[273]

Additional hazards to health and management of the work force also warrant public understanding for voting purposes, and public input and oversight for a democratic process.

The position lays out general principles that could apply to any public good with the League asserting it supports:

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[270] Ibid., *Impact on Issues 2022-24*, Health Care

[271] Ibid., *Impact on Issues 2022-24*, Health Care

[272] Note that the Public Participation position is in the Natural Resources section of *Impact on Issues*, rather than in Representative Government.

[273] *Impact on Issues, 2022-2024 pp112-114, Public Participation*. https://lwvhealthcarereform.org/wp-content/uploads/2024/05/PublicPartic_LWV_ImpactOnIssues2022-2024VT.pdf

> The public has a right to participate in decision-making at each phase in the process and at each level of government involvement.
>
> Officials should make a special effort to develop readily understandable procedures for public involvement and to ensure that the public has adequate information to participate effectively. Public records should be readily accessible at all governmental levels. Adequate funding is needed to ensure opportunities for public education and effective public participation in all aspects of the decision-making process.
>
> ...Hearings should be held in easily accessible locations, at convenient times and, when possible, in the area concerned. The hearing procedures and other opportunities for public comment should actively encourage citizen participation in decision-making.
>
> ...Mechanisms for citizen appeal must be guaranteed, including access to the courts. Due process rights for the affected public and private parties must be assured. [274]

Fiscal Policy

The League's position on policy states

> The League of Women Voters of the United States believes that federal fiscal policy should provide for adequate and flexible funding of federal government programs through an equitable tax system that is progressive overall and that relies primarily on a broad-based income tax; responsible deficit policies; and a federal role in providing mandatory, universal, old-age, survivors, disability, and health insurance…
>
> The League of Women Voters of the United States believes that the federal government has a role in funding and providing for old-age, survivors, disability, and health insurance. For such insurance programs, participation should be mandatory, and coverage should be universal.[275]

In addition, it states

> The government also should achieve whatever savings possible through improved efficiency and management. [276]

The proposed update to the privatization position would allow Leagues to advocate for deprivatization where savings could be achieved through improved efficiency and

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[274] *Impact on Issues, 2022-2024 pp112-114, Public Participation.* https://lwvhealthcarereform.org/wp-content/uploads/2024/05/PublicPartic_LWV_ImpactOnIssues2022-2024VT.pdf

[275] *Ibid., Impact on Issues 2022-24*, Fiscal Policy

[276] *Impact on Issues 2022-24*, Fiscal Policy, pp 134-135: https://www.lwv.org/impact-issues

management, especially where privatization has led to reduced efficiency, including the diversion of public funds from taxes to profit and administrative waste whether in health care or any other privatized management of a public good.

Diversity, Equity, and Inclusion (DEI)

Privatization is a DEI issue where it reduces access, affordability, or transparency or increases disparities of equity or outcome in any public good. Similarly, where de-privatization would improve public benefit, the League viewing the issue through a DEI lens is likely to add weight to any League decision on the importance of advocating on the issue.[277]

[277] "Applying Diversity, Equity, and Inclusion (DEI) Lens to Our Work," p. 3 of *Impact on Issues 2022-24*, https://www.lwv.org/impact-issues

APPENDIX B

CASE STUDY: CONNECTICUT DEPRIVATIZED MEDICAID MANAGED CARE

Two Parts:

1. **Comment by Jim Kahn,**[278] **writing in *Health Justice Monitor***[279]
2. **Transcript**[280] **of presentation by Sheldon Toubman**[281]

Comment by: Jim Kahn

The transformation of Connecticut Medicaid from the main implementation model (capitated for-profit managed care plans) to fee-for-service with enhanced support for care coordination is incredibly important. It demonstrates the greater efficiency (14% drop in per-person costs 2012-18 while **Medicaid as a whole rose 10%**[282]) and higher quality of care achieved with payment directly to providers. **Strong performance continued through the latest data (FY 2020**).[283]

This experience demolishes the myth that commercial insurers can magically reduce costs and raise quality while extracting huge profits. And it serves as an object lesson in how committed and resourceful advocates can overcome the influence of corporate money in order to advance the proper purposes of public funds for health care.

Two evaluations favorably review this experience – from **Harvard Law School**[284] and the **Connecticut Health Policy Project**.[285] For more information, contact Sheldon Toubman **sheldon.toubman@gmail.com**.

Recently I complained about "Medicaid News Noise." This isn't more noise – it's revelatory. The truly impressive Connecticut Medicaid story should inspire similar broad reforms in other states, and ultimately inform provider payment under single payer.

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[278] Kahn, is an expert in policy modeling in health care, cost-effectiveness analysis, and evidence-based medicine, read his bio at https://pnhp.org/about/speakers-bureau/james-g-kahn

[279] from: Health Justice Monitor, https://healthjusticemonitor.org/2022/03/25/connecticut-medicaid-prospers-post-capitated-managed-care

[280] Transcript: https://pnhp.org/system/assets/uploads/2022/03/CTManagedCare_Toubman.pdf

[281] Toubman, has served Connecticut over 31 years in legal services programs and led the effort to de-privatize Connecticut Medicaid Managed Care in 2011-12: https://www.disrightsct.org/meet-our-staff

[282] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time

[283] https://www.cga.ct.gov/ph/med/related/20190106_Council Meetings & Presentations/20210108/HUSKY Financial Trends January 2021 .pdf

[284] https://chlpi.org/wp-content/uploads/2014/01/PATHS-Innovations-and-Insights-in-Medicaid-Managed-Care-3.21.16.pdf

[285] http://cthealthpolicy.org/wp-content/uploads/2019/02/Medicaid-2019-brief-formatted-copy.pdf

HOW CONNECTICUT ELIMINATED CAPITATED MANAGED CARE IN MEDICAID

A talk presented by Sheldon Toubman, then with New Haven Legal Assistance Association

edited Transcript – February 2019

In 2012, Connecticut replaced managed care organizations (MCOs) in its Medicaid program with a program of "managed fee for service". Enhanced care coordination for all Medicaid recipients became an important part of this program, which has reduced Medicaid spending and provided better service to patients. In this talk, presented to the PNHP-NYMetro Research/Study Group, Sheldon Toubman, then at New Haven Legal Assistance, describes the process by which it happened.

I have been a legal aid lawyer with New Haven Legal Assistance for almost 28 years and other programs for three years beyond that [since August 2021, Toubman moved to Disability Rights Connecticut]. For most of that time, I have been focusing on the Medicaid Program.

In that role, I came of age in Medicaid advocacy in Connecticut in 1995 as the state was moving from the traditional Medicaid fee for service program, where the provider provides the service and they then bill for the service, to what other states were increasingly doing at the time, a capitated managed care system in which the state pays a fixed amount of money per member per month for health care services.

I will give you the background of what we had in Connecticut, the strategy that advocates came up with, and then where we are today. It was seven years ago, January 2012, that Connecticut made the transition to what I call "managed fee for service", or single payer. We've now had seven years of experience and I can tell you exactly what we've gotten for our money. Recognize that Connecticut is rather unusual. There are only four states that don't have capitated managed care running their Medicaid program as you do in New York.

So, when the capitated managed care model rolled out, there were eleven MCOs, Managed Care Organizations. We were told that the state was going to save money by paying them 95% of what we would otherwise have paid for the same health services under Medicaid. You won't be surprised that the managed care industry managed to convince the state not to reduce its fees, but to pay it 100% of current spending. And you'll not be surprised to hear the industry said that actually it's not getting enough, so it needs more money, even though the whole premise was that it's going to save money. (I should say that this was for our family and children population, not the elderly and disabled population, which is a sicker population;

generally, family, kids and pregnant women are healthier populations. That is the group that was in the managed care system.)

This dynamic started right away -- they were always demanding more money, but the state had become dependent on them.

The MCOs also argued that they were going to improve care because they are uniquely in a position to coordinate care. This is especially noteworthy because there is always a complaint from Medicaid recipients that their care is uncoordinated, that they see a lot of different doctors and nobody is watching out for them. So MCOs would say they're going to coordinate care so that the state saves money, improves access to care, and thus improves the quality of care.

However, in practice, what we saw constantly was routine lack of access to services. It was horrendous in the case of behavioral health, where kids who had been abused would be told they get a limited number of sessions and, if their provider was willing, they could beg for more. These abusive practices were partly a function of the fact that the MCOs subcontracted with other capitated insurance companies, so if the MCO was getting, say, $200 a month for all health care, they could contract for $11 a head to a specialized for-profit company to provide behavioral health, and those companies were even worse in restricting access to care.

The basic problem with capitated MCOs is the same as with commercial insurance: every dollar of health care they provide comes out of their pocket. So the incentives were pretty obvious. Their messaging in response was always, along the lines of: "Don't worry about that. Yes, it seems that way, but if they get sick, it's on our dime. If somebody's not taken care of and they end up in the hospital, we have to pay for that. So we have a real incentive to coordinate care and make sure that bad things like that don't happen. We're going to keep people healthy."

The reason that was false is, first of all, these are mostly for-profit, publicly-traded companies. All they care about is how well they're doing this quarter. So if they can keep someone's diabetes under control and keep them out of the hospital next year or the year after, that's interesting but it's not relevant to what they're trying to do. They're trying to profit right now.

Second, people move from one plan to another, and so it may save money only for another plan, so they don't see the benefit. The consequence is that they never did the things they said they would do. They never coordinated care. They never did the kinds of things that were necessary to prevent complex conditions from developing. And even on basic measures, like the Early and Periodic Screening, Diagnostic and Treatment requirements of federal Medicaid law, they were doing abysmally.

And then there was dental access, which was terrible. There was pharmaceutical access, which was terrible. At some point, advocates decided that the basic financial model, where

they make money by denying care, was just not going to work. There was no way we were going to reform that basic economic model and make it work for our clients.

We started with a lawsuit. In 1999, we filed a class action suit against HealthNet and the state, which is ultimately responsible for all Medicaid services even if contracting with MCOs. Our specific allegation was that they were not compliant with due process. They were constantly denying services, but patients were not getting written notice of it. They learned about it because their doctor would say, "I tried to get approval, but they wouldn't grant it." There was no written notice to the patient of what the decision was, why it was decided and, more importantly, their right to appeal. These basic rights apply to all state and federal government benefit programs. So we brought a lawsuit saying they weren't providing written notices and in the few cases where they did, the notices were grossly defective. For example, in one case the reason given for being denied was you don't meet our company's criteria, unspecified.

One of the things we uncovered is that, routinely, people would be denied drugs which were covered under Medicaid and therefore covered under these contracts with MCOs. When they were denied, even when they were sent the written notice, it said the drug is not covered for you, which was not true. The drug was simply not on their formulary, which means the prescriber had to go through prior authorization, but it didn't say that. It was basically a substantive access issue created by misrepresentation of the rules. So our lawsuit included this issue.

One of the things we did with the lawsuit was to get a lot of media attention. This was the first class action suit ever brought in this country against a Medicaid-contracted insurance company. (Most of the time, people just sue the state; they don't sue the insurance companies.) Press was really important because insurers really care about bad publicity. They are in a competitive marketplace, especially if they're in the commercial sphere as well as the Medicaid world. They worry about their name, and their brand. They don't want to be associated with problems. So we did a lot of press focusing on one MCO, but we also talked about problems with other MCOs as well.

Advocates emphasized that this system is a black box. No one can tell what they are doing. We know people are routinely being denied service, because they come to our office and tell us that. Getting data on dollars and numbers of denials was really difficult, and the state couldn't even get the information. So, one of the things that happened that we were involved in was finding some other avenue.
We started focusing on recipients' lack of access to providers, meaning that they just couldn't find one. They couldn't find a cardiologist, a neurologist. Various specialties just didn't take Medicaid under any plan. This was a huge issue, related to low payment rates, i.e., specialists were being paid too little by the MCOs. So we wanted to get information about the rates paid. Someone filed a request under the state's Freedom of Information Act, the open records law, asking for the payment rates for each of certain kinds of specialists, for each of a set of codes, for each of the MCOs.

The state responded saying, essentially, "We don't have that data and the Freedom of Information Act applies only to what's in the possession of the state." The state correctly said, "We don't have the rates that the docs are being paid." But we have in our state law, special to Connecticut and maybe to Pennsylvania, that a large, privately-owned contractor which is providing at least $2.5 million a year in services and is essentially performing a “governmental function,” that is, it taking on a role of government, is subject to that law. And that was really easy to show because the elderly and disabled populations in Medicaid were not in managed care, so all the things that the insurance companies were doing for the family population, the state itself was doing for the elderly and disabled populations, i.e., MCOs were performing that same governmental role. So advocates crafted a second Freedom of Information Act asking for the provider rates directly from the MCOs.

In addition, parallel to the request for MCO provider rate information, advocates got involved in trying to get information about the numbers of pharmacy denials for lack of prior authorization. One of the ways insurances companies block access to drugs is they impose extra burdens and quantity limits for medication requests. We wanted to know how often that happens. So we made a FOIA request essentially saying to the state, "If you don't have the data, please get it from the MCOs. They have to provide it under the FOIA because they’re performing a governmental function in running a portion of the Medicaid program in general, and providing prescription drugs in particular.”

This caused a firestorm. Initially, the state denied that the MCOs were performing a governmental function. We appealed that denial to the Freedom of Information Commission which enforces our open records law. It was a standing room-only hearing because the entire industry was really worried that we were going to have a situation where private parties would be subject to the law, and a Freedom of Information Act request could be submitted by anyone. That's a scary thought if you're a corporate entity.

Advocates got great media coverage about this, because the messaging was that these entities didn't want to be accountable for how they spent the taxpayers’ money. They just want to take the money and not be accountable. And advocates said the state officials don't want to hold them accountable either.

We won before the Freedom of Information Commission, but it was appealed to the superior court by some of the MCOs. The state Attorney General then joined the side that was going after managed care organizations, which really annoyed the state agency. In any event, while this was pending, we put pressure on the governor, and there were op eds and editorials saying, "Yes, you should hold these state contractors accountable." It got to the point where the governor gave up and said to the MCOs, essentially, All right, you're going to be bound by this obligation, no matter what the courts say. You're taking hundreds of millions of dollars in taxpayer money, so you should be accountable and we're going to put it in the contract.

Several of the big MCOs balked, so the governor pulled the trigger and basically said, "Okay, fine, you're out of the program, but in the meantime, we're going to turn you into non-risk entities." That is, they would be administrative service organization contractors, not insurance companies taking financial risk. This was really important because this is what advocates wanted, and ultimately what they got, but not at this point. It was just temporary.

The governor also said she was going to find other insurers which would accept this FOIA requirement. At about the same time, she decided to create a new subsidized program for lower income but non-Medicaid recipients called Charter Oak Health Plan, and she needed insurance companies to run it despite the uncertain costs of this new population. She went to the insurance companies and said, basically: If you agree to run my Charter Oak plan and take the risk, we'll give you this very lucrative business of Medicaid clients. An RFP went out, and it did include that the insurers would be accountable under the Freedom of Information Act and they got three bidders. So, the three bidders agreed to contract on a risk basis, and advocates were back to square one, after they thought they had won.

Advocates then started exploring how much the new companies were being paid. Whatever capitated rate the state pays a Managed Care Organization has to be approved by the federal Medicaid agency, and so they have to be audited. (Half or more of the state money paid to MCOs is actually federal money.) Advocates felt that the rate that the auditors found was acceptable was actually excessive. The state Comptroller then contracted with an accounting firm to come in to audit the auditors. They found the payments to the MCOs were at least $50 million/year too high. Advocates concluded they were being paid excessively through what was essentially a legal bribe from the Governor, to get them to run the Charter Oak business, which was her priority.

Another thing that was happening under the earlier set of MCOs was that a group of pediatricians was focusing on the Medicaid provider network and the fact that it appeared to be bogus. That is, the list of doctors and other providers listed by the plans on their websites were not real, practicing providers or they were real people but were not really participating in the plans which listed them. So, these folks pushed to get a “secret shopper” survey done, where people got dummy Medicaid ID numbers and called up real providers and tried to set up real appointments for real medical problems. It was fictitious, but it sounded real to the office they were calling. The results were really disturbing and eye opening. For all of the MCOs, only about 25% of the time could people get an appointment, and the vast majority of times, the provider said, "I'm not participating in Medicaid" or "I'm not participating in Medicaid under your plan," or "I'm not participating for new patients." So, the vast majority of the time, the lists were bogus.

This was really important because, about the same time this study came out, we finally received through the FOIA effort the provider rates that the MCOs were paying. Though they always claimed that they paid generously, it turned out they were mostly just paying the same low Medicaid rates already paid by the state under the rest of the Medicaid program. So, the

suspicions appeared to be correct that the reason specialists wouldn't see these folks was because of the low rates.

In addition, under the last set of MCOs, we started uncovering more misrepresentation of drugs being not covered when, in fact they just required prior authorization. Two very different reasons. When electronically denying drugs, two of the MCOs chose not to use the code which states the drug required prior authorization, which was the case, and, instead, used a code which said the drug was not covered at all. We emphasized that the MCOs were committing a kind of fraud, misrepresenting what is covered under the plan. So even though they were now subject to the Freedom of Information Act as a matter of contract, they were still misrepresenting what their coverage was in order to cut corners.

At this point, advocates decided to offer an alternative, saying something like, "You know, this is not working. This capitated managed care for poor people is not working. Maybe we should do what some other states are doing." The federal Medicaid statute offers an alternative type of managed care that doesn't involve capitation at all. It's called Primary Care Case Management. What this means is the state pays primary care providers extra to manage care. The MCOs always claim to manage care, but we all know they only manage cost.

So, advocates suggested that Connecticut adopt, at least on a pilot basis, what other states like North Carolina and Oklahoma were doing, which is to pay primary care providers directly to coordinate care or manage care, paying them to actually coordinate care in a meaningful way. Advocates got a pilot plan through the legislature. It was very small, and the state Medicaid agency did not want to implement it, but advocates made a lot of noise about the fact they were not implementing it.

Then, in 2010, we had a governor's race. Advocates educated all of the candidates about the problems of managed care and we pointed out that this Primary Care Case Management (PCCM) model seemed to be working well in other states. We think that we should basically ditch this whole experiment with insurance companies. When Governor Malloy won in 2010, he set up various committees to develop issue briefs, and advocates lobbied those groups to lay out the PCCM option, emphasizing that capitated managed care wasn't working, and was quite expensive.

So, three weeks into his administration, in early 2011, Governor Malloy announced that he was going to show the door to the MCOs and adopt some form of Primary Case Care Management, using primary care providers to coordinate care, and also contract with an Administrative Service Organization (ASO), as the insurers had temporarily been turned into over the FOIA dispute. The ASO would take on some of the role that insurance companies play, but not on a risk basis, handling things like prior authorizations, recruiting providers, and so on. Behavioral health and dental services were contracted to different ASOs to manage those services, respectively, also on a non-risk basis.

That announcement was made in February 2011, and an RFP was issued not too long thereafter. Connecticut chose a non-profit entity, Community Health Network of Connecticut, to take on that role. It used to be a not-for-profit, capitated MCO, and it was now being turned into an ASO.

We then got involved in advocating for what the patient-centered medical home (PCMH) requirements were going to be for the PCCM-like program, because we were really going to use those to manage or coordinate care. We had to beef up the requirements on primary care providers and went with National Committee for Quality Assurance (NCQA) accreditation of PCMHs as the standard. They had to be accredited as a patient-centered medical home in order to participate and get paid extra for doing care coordination.

That's the basic history. Now, I want to fast forward to where we are today. It has not been absolutely perfect. There have been problems. But, overall, it has been a dramatic improvement, and the materials that have been distributed tell the story. Just in the hard dollars, in per member per month cost. (You don't look at total costs under the Medicaid program in part because our program, like that of all the blue states, did a Medicaid expansion and those total costs have gone up substantially because there are a lot more people covered. Connecticut Medicaid member per month costs are down 14% from $706 in the first quarter of 2012 to $610 in the first quarter of 2018. So, that's six years, and the costs went down. As a result, Connecticut, which is one of the highest health care cost states in the country -- our per-enrollment costs had been the 9th highest, now they're 22nd. So, we've actually done very well through this model in terms of total per member per month costs: To have costs go down when, in every state that has managed care, they always demand more money. To not have that hanging over you, if you're a state agency, it's pretty nice that you actually have control of the cost.

The other question is, how much of those total costs are actually going to health care? As we all know, there are huge administrative costs that go into the private risk-based insurance system. When we had managed care companies, it was hard to get the data, but we found routinely 20%, even 25% or higher administrative overhead. We actually saw about 40% at one point for administrative costs for one of the plans, under the CHIP program. Based upon the data that has been available now for a few years, we have done really well on both the total costs and the medical loss ratio, which is now about 96.5% [97% as of 2021]. Only 3.5 cents on the dollar goes to administrative costs, paying for the ASO and the state's own administrative costs. The rest is all going to health care. So it's a win-win in terms of the cost and where the money goes.

We really care about quality, about access to care. The data there is pretty good as well. Some really basic stuff like significant increases in preventive care, 16.3% from 2015 to 2017, hospital admissions per thousand down 6.29%, readmissions down 3.52%.

There are several reasons, but one of them is the use of patient-centered medical homes. Close to half of our Medicaid population is now attributed to accredited patient-centered medical homes. They have the infrastructure for adequately coordinating care so people don't end up in the hospital, and they provide routine care and the child visits and screenings and so on. Under the new system, the state has the data on what is being done and doesn't have to beg an insurance company to give them the data.

Though the primary responsibility for coordinating care lies with the primary care providers, the medical ASO (CHNCT) has done extra things to coordinate care. Their major program is called Intensive Care Management. This involves identifying people who are the frequent flyers, who go in and out of the ER frequently and need special attention, as well as individuals referred to the program. They have an aggressive outreach program where they literally go out to the people where they are in their community and try to get them in contact with their primary care provider. Ideally, it's a patient-centered medical home, to make sure that going forward, somebody is actually looking out for the various issues they have -- behavioral health issues, medication access issues, home care, whatever. The result is that, for their Intensive Care Management members, in 2017 the total cost of care dropped 12%.

So, ER usage has gone down 25% and hospitalization dropped significantly. They actually have developed good programs to do the very thing which the MCOs always claimed they did but never actually did to actually coordinate care. If you do this, you keep people out of the ER and avoid readmissions, you save money. Again, it's not perfect, and we've got issues, but we think the system has worked to save money the right way, not by denying services but by providing better service.

The last thing to point out is the handout "Medicaid's Care Management program is saving lives and money, but savings may be going to PCMH+ ACOs." ACOs, Accountable Care Organizations, are the latest thing that everybody who's anybody in health policy is supposed to believe in as the answer to our problems with health care cost. ACOs put financial risk onto (generally larger) provider groups instead of insurance companies.
The idea, mostly pushed in Medicare but now in Medicaid as well, is that you put provider groups at financial risk and they'll somehow do the right thing, keep costs down but not in a bad way, not by harming access, denying services, denying referrals. Somehow, they'll do it in the right way. To me, that's frankly religion. It's belief in a system that hasn't been proven, that you can't really prove and has been very controversial. Unfortunately, Connecticut has adopted a shared savings type of ACO program, called PCMH+, that is very different from patient-centered medical homes, PCMH without the "plus". And the primary difference is the use of a shared savings payment model in PCMH+.

If groups of providers respond positively to an RFP, they're in a system where any of the money they save on the total cost of care of their own patients, using actuarial data and some risk adjustment, they get to keep half of. Advocates are very concerned. We have one year of

data now, and it suggests that this is not saving money and may be harming access to care. We don't know where that's going at this point.

The basic point about our system: under managed fee-for-service, the state maintains the risk, and is using both insurance companies on a non-risk basis to do certain administrative actions in a good way to meet the goals of improving care while keeping costs down, and PCMHs to coordinate care on a regular basis. There's still an access problem with specialists because of low reimbursement rates.

About 45% of the Medicaid population is within an accredited PCMH. It's a little hard to know exactly what the PCMHs are doing in terms of care coordination, though we do have numbers that show they are doing better than non-PCMHs on most indicators.

Costs have been relatively flat since we made the transition, suggesting that we are getting some decent care coordination for the elderly/disabled population as well for families with kids which had been in the capitated MCO system.

At the time of the transition, there were three MCOs, Community Health Network of CT, Aetna, and UnitedHealth (CHNCT, the one non-profit, became the non-risk contracted ASO). For-profit entities have lobbied hard with successive governors to come back into the program on a risk basis, but we've managed to hold them off. It's saving money, so that's a strong argument for keeping what we have, and we're also pointing out access and quality gains, as well as the high medical loss ratios. And, over time, the State Medicaid agency became very invested in the new program, which was producing good results.

We tried to get consumers involved in designing and then advocating for the new program. However, it was very hard to get them engaged.

It was important overall that advocates had a period in which the managed care organizations were revealed to have been doing bad things, violating the idea of transparency, resisting the Freedom of Information requests, essentially committing a form of fraud in terms of misrepresenting pharmacy coverage, etc. These were important in discrediting them as part of the story. Advocates never would have gotten what they got from the governor if they hadn't done that. Although advocates could produce white papers saying to the candidates that they should do this or that, the reality is that the climate was what really mattered. They worked really hard at getting media to expose the shortcomings in the system, which changed that climate.

Advocates didn't have great data, because the MCOs kept their cards close to the vest. So it was really hard to produce actual numbers of denials or whatever. It was a challenge. Advocates basically said that state officials don't want to hold huge state contractors accountable with our taxpayer money, so that is why we don't have the necessary data, even as they had a lot of anecdotal stories of harm.

In the absence of data, what do you do? You paint a picture based upon what you do have of an industry that is not capable of being reformed. And so advocates made the case that we should do an alternative, the non-risk form of managed care known as PCCM, saying essentially "Here's another way to do it. It's not radical. Other states are doing it. And it's right in the federal Medicaid Act. It's not a big deal."

You can't win this battle on the basis of the money wasted on risk-based insurers alone. Advocates did a lot of outreach to providers, particularly in the behavioral health area, to develop individual stories of abuse. Advocates learned the techniques the MCOs were using to deny services, the games they played. So they produced a survey which said, "Have you seen this?" We had a one-page referral form and said, don't give us the name of the client, but do you have a client who has experienced this and if so, please tell us what's going on. The horror stories were just unbelievable. Advocates emphasized these kids' cases, and got media attention which was very sympathetic.

Having providers know we were looking was very important. When advocates met with some of them, they said, "We've been looking for a way out for years. We needed you," or words to that effect, so the advocates' names got around. And providers contacted them, and they worked together to tell their stories.

APPENDIX C

CASE STUDY: PRIVATE EQUITY STRIP-MINES HOSPITALS[286]

THE AMERICAN PROSPECT

IDEAS, POLITICS & POWER

Massachusetts Wakes Up to a Hospital Nightmare

Erstwhile Boston media darling Steward Health Care has been strip-mining hospitals for a decade now. The power elite may finally be paying attention.

BY MAUREEN TKACIK. JANUARY 26, 2024

Residents at Steward Health Care's Carney Hospital in Dorchester, Massachusetts, called the graduate medical education accreditation agency to have the failing program shut down.

The group of fresh medical school grads knew something wasn't right with Steward Health Care when they showed up in Dorchester, Massachusetts to start their residencies in Carney Hospital's inaugural family medicine residency class during the summer of 2014 and learned the president who had recruited them had already been fired.

Soon afterward, a Steward administrator admitted the new family medicine clinic and the pediatric ward they had toured on their recruitment visit were never actually opening, and that the nearby hospital at which residents were supposed to learn how to deliver babies was being shuttered entirely. Shortly after that, they showed up to work to learn their program director had been fired. Ultimately, the residents decided to call the graduate medical accreditation agency and get the program shut down.

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[286] The American Prospect, 2024.1.24 https://prospect.org/health/2024-01-26-massachusetts-hospital-nightmare-steward-health

“It was all smoke and mirrors...they had no intention of giving us any of the resources we needed to learn what we needed to learn or do a good job,” remembers a preventative medicine physician and former Carney medical resident, recalling an afternoon when a patient had a heart attack and she had to Google “how to operate an EKG machine” because she could not find a single nurse or technician in the building to help her. “It’s hard to convey how much of a crisis it felt like as a first-year resident,” another former Carney resident, family physician Stephanie Arnold, wrote in an essay for the *Prospect* last year about her experiences working for private equity owned health care providers.

It was not the first or last time Steward has been accused of making big, empty promises. In 2011, they promised the urologists of Brockton they were building a prostate cancer “center of excellence” at Good Samaritan Hospital: That never happened, though Steward apparently upgraded the ICU’s wiring, which we know because they allegedly skipped out on paying the contractor who did the job. In 2017, Steward told the government of Malta that it would turn the Mediterranean micro-state’s three aging hospitals into a hub for medical tourism, but instead they spent the 400 million euros they got for the job on … a lot of lawyers; an appeals court judge last fall called the contract a “simulation” designed “to draft contracts intended not to deliver quality medical service, but other things.” And in 2019, Steward promised the community of West Monroe, Louisiana, that Glenwood Regional Medical Center would become a leader in a “groundbreaking” new form of cardiac surgery; last fall, the state health department threatened to shut down the hospital after an inspection revealed it was so behind on its water, sewer, and utility bills its hot water had been cut off. State Rep. Mike Echols, who represents northern Louisiana and used to operate a large physician practice in the state, described Steward to the *Prospect* as “one of those corporate terrorists who come in and loot the ship and drain it dry.”

Indeed. Yesterday, Steward announced it would be closing a hospital it owns in Texas at 7 a.m. next Friday. Its New England Sinai Hospital is shutting soon after that. The company has hired the restructuring adviser AlixPartners, which is often a precursor to a Chapter 11 filing. Physicians say that few of its 30-some hospitals are in shape to survive. Carney Hospital has long been nicknamed “Carnage,” and a group of Steward hospitals formerly named Wuesthoff Health System are still widely known within their northeastern Florida community as “Worst Off.”

For years, officials in Steward’s home base of Massachusetts, where a media darling cardiac surgeon named Ralph de la Torre founded the hospital chain in 2010, had conspicuously little to say about the company that owns nine hospitals comprising more than 2,000 beds in the state. That changed this week, when the state’s 11-member congressional delegation, all Democrats, issued an unusual joint statement in response to a *Boston Globe* story about the company’s insolvency, demanding an explanation of its “financial position, the status of their Massachusetts facilities, and their plans to ensure the communities they serve are not abandoned.” Attorney General Andrea Campbell, who as a Boston City Council member had Steward’s neglected Carney Hospital in her district, offered an even more tepid comment on

the matter to the public radio station WBUR: "We're currently in problem-solving mode, willing to use every power available to us to protect these priorities, while *looking to a time in the near future to seriously address how Steward got in this situation*" (italics mine).

Uhh … call me maybe? (A message left with Campbell's office was not returned.)

I happen to be one of quite a few observers who can tell you *exactly* how Steward "got in this situation." For ten years, the hospital chain, which originated as an agglomeration of nun-operated Boston-area neighborhood hospitals known as Caritas Christi, was owned by the private equity firm Cerberus, which extracted more than $800 million in excess of its investment out of the hospitals, then left during the pandemic. Company founder de la Torre was left to "finish the job," which took more than three years because de la Torre, despite his penchant for mega-yachts and private jets, kept getting new bailouts from an Alabama real-estate investment trust called Medical Properties Trust. Last year, MPT finally started to run out of cash—in part because most of its other tenants were not a whole lot more solvent than Steward—and the Justice Department sued Steward for violating the Stark Law against physician kickbacks, the flouting of which appears in hindsight to have been the entire underlying premise of Steward's business model, back when he pretended to have one. As it stands, the company hasn't had so much as a chief financial officer in more than a year, though its president identified himself as the company's CFO in a court filing in October.

Indeed, the mystery here is not "how Steward got in this situation" but *what in God's name* took the state of Elizabeth Warren and Maura Healey so long to notice the brazenness at work in their proverbial backyard.

YOU CAN PROBABLY GUESS HOW THE "PRIVATE EQUITY" PHASE of this story went, especially given that Cerberus, named after the three-headed dog that guards the gates of Hell, has a reputation for sophisticated Mafia-style bust-outs. There's a whole book on its disembowelment of the Anchor Hocking Glass Company of Lancaster, Ohio, a *New York Times Magazine* story on the (not-so-mysterious) "financial engineering mystery" of how it made hundreds of millions of dollars buying up 18 gun manufacturers and bankrupting all of them; a chapter of private equity scholars Eileen Appelbaum and Rosemary Batt's *Private Equity at Work* chronicling its profitable liquidation of the department store chain Mervyn's, etc. In its time running Steward, Cerberus sold off most of its real estate and other monetizable assets for about $1.5 billion, pocketed the vast majority of the proceeds, sued the Massachusetts state agency that collects health care data in lieu of complying with laws requiring hospitals to disclose their financial obligations, and finally moved its headquarters to Texas in 2018 in what seems like a pretty shameless attempt to avoid all the people they'd promised to invest $400 million in "bringing health care back to the community." Finally in 2020, having quadrupled its money, Cerberus began to sell out.

Post-Cerberus, when Steward should have been in bankruptcy court, its story instead got much wilder. For some reason, de la Torre had so ingratiated himself to MPT founder/CEO Ed

Aldag, whose $1.25 billion purchase of Steward's real estate had enabled Cerberus to get its requisite windfall, that MPT kept plowing money into Steward for no apparent reason. MPT financed Steward's purchases of dozens of Sun Belt hospitals and random international forays like the Malta venture, while lending money to help it make the $400 million-plus annual rent payments it owed back to MPT. The investment trust even lent de la Torre the cash to buy out Cerberus in 2021, after which the former cardiac surgeon issued Steward's shareholders—who mostly consisted of de la Torre himself—a $110 million dividend. In all, MPT has shoveled at least $5.5 billion into Steward over the past eight years. MPT now claims it is owed $50 million in back rent by the health system, but a cash flow analysis by the REIT analyst Robert Simone, who has been covering MPT's demise for the research firm Hedgeye, suggests Steward's unpaid rent bill to MPT for the past two years alone totals at least $261 million.

What became of all this money? Well, we have a good idea what Steward *didn't* do with it, because dozens of companies have sued it for not paying its bills. The angry creditors include a supplier of cadavers and body bags in Texas, an exterminator it hired to conduct a "bat eviction" of the ceilings above an intensive care unit in Florida, a California medical device supplier, nurse staffing agencies, and electrical contractors. A pizza shop in Brockton, Massachusetts, cut Steward off long ago, and a physician in Florida told the *Prospect* Steward still owes his practice more than $400,000 for treating its patients in 2021 and 2022. These unpaid bills have jeopardized patient safety in countless ways; *The Boston Globe* recently reported that a recently repossessed medical device could have saved the life of a patient who died at St. Elizabeth's Hospital last fall.

It's unclear, in part because Steward has refused to release financial statements to anyone who demands them despite having been ordered by the SEC to disclose them to MPT shareholders last year, what Steward *has* done with the money. We do have evidence that Ralph de la Torre bought a $40 million mega-yacht a few months after he paid himself an apparent nine-figure dividend, and that at some point in 2022 a vehicle called Sagamore Capital Management that is controlled by de la Torre's close associate Robert Gendron acquired a Dassault corporate jet he supposedly uses for business purposes. We mostly know these things thanks to financial analyst Robert Simone, who writes about REITs for the trade publication Hedgeye and tracks the movements of de la Torre like more mainstream pundits track Taylor Swift and Elon Musk. A few weeks ago, on the day de la Torre sent an all-staff email blaming an influx of "undocumented immigrants" for Steward's "challenging" year, Simone posted on X that his yacht was at that very moment off the coast of Ecuador.

We also know, thanks to forensic investigations conducted by Maltese media outlets in conjunction with the investigative journalism nonprofit behind the Panama and Paradise Papers, that Steward wired at least 5.9 million euros between 2017 and 2020 to a Swiss entity called Accutor AG that in turn sent payments to the former Maltese prime minister who facilitated Steward's privatization of the nation's hospitals. Financial statements obtained by the hedge fund research outlet Viceroy Research show that 230,000 euros were wired directly

from an entity that shared an address with St. Elizabeth's Hospital during the spring of 2019, with one payment landing two weeks after that hospital's nurses held an informational picket to raise awareness of the 160 incident reports they had collected in the preceding months documenting specific cases in which Steward's short-staffing had threatened patient safety.

ONCE UPON A TIME, DE LA TORRE WAS A DARLING of Massachusetts liberals. In 2008, shortly after taking the helm of the small hospital group that would become Steward, he invited the then-chair of the health care division of the Service Employees International Union to organize the hospitals. After former state attorney general Martha Coakley approved his sale to Cerberus, he thanked her by hosting a massive fundraiser at his house featuring Barack Obama. He and his wife Wing gave more than $43,000 to Massachusetts Democrats during the decade before his 2018 move to Dallas, including $1,000 to Maura Healey's campaign that year for attorney general. In 2012, he defended the state's "individual mandate" that had been the blueprint for Obamacare in *Bloomberg Businessweek*; the following year, the magazine profiled de la Torre in a piece that described Steward as "the business model for the Obamacare era."

The premise of Steward as the poster child for Obamacare was its embrace of a business model called the "accountable care organization," a virtuous-sounding structure through which doctors and patients were supposed to "coordinate" care to save money by keeping patients out of the hospital. De la Torre called Steward an "ACO on steroids," and he promoted the model heavily in Massachusetts. With the help of a former Steward executive named John Polanowicz who was named the state's health and human services secretary in 2014, de la Torre even convinced the health department to issue an amendment exempting ACOs from a 2008 building moratorium on cardiac catheterization labs, allowing Steward to build one at a hospital in Fall River, making way for one of the more profitable revenue streams in health care.

But as with the HMO before it, the ACO's appeal to for-profit operators like Steward seemed mostly to stem from the "fraud and abuse" waivers ACOs receive from the Centers for Medicare & Medicaid Services, exempting doctors and hospitals within their systems from "certain specified fraud and abuse laws." Four whistleblower lawsuits filed in Texas and Massachusetts allege that Steward executives abused those exemptions to the point of fostering a culture of fraud. In the Massachusetts case, physicians whose practices affiliated with Steward claim that they were punished and ostracized for allowing so-called "leakage"—that is, referring patients to specialists outside Steward's hospitals, even if Steward offered no comparable services itself, like partial kidney removal or something called "high dose transperineal radiation iridium therapy" developed for late-stage prostate cancer patients.

Shortly after Steward bought an interest in a high-profile orthopedic surgery practice in Melbourne, Florida, its nearby Sebastian River Medical Center was one of just two hospitals in Florida to receive a grade of "F" from the Leapfrog Group, which monitors statistical

outcomes to grade hospital safety. A few months later, two Steward executives and a former Cerberus executive named Jim Renna invited the CEO and CFO of the surgery practice to dinner at a local yacht club to discuss "actions that could be taken to benefit the partnership," according to one whistleblower complaint; the surgeons got the message and started moving their joint replacements to Steward's hospitals. Two other doctors recruited to work for Steward hospitals in Texas described in a separate lawsuit being "rocked by a disorienting array of schemes, self-referrals, upcoding, and greed … almost immediately" upon starting the job. One lawsuit filed by a prominent urologist that Steward recently paid $4.7 million to settle alleged that "Steward and Cerberus have wholly corrupted the ACO model."

These days, many Steward hospitals have neither the staffing nor the necessary supplies to accommodate many profitable surgeries, according to a Florida physician who practices near several Steward hospitals. The physician forwarded an email from an HMO executive who said the hospitals lack even basic supplies like needles and linens, because "vendors won't give them anything on credit."

In January, I received an unsolicited email from a Steward nurse. "This company puts patients at risk on a daily basis," it read. "This hospital is full of good doctors, nurses and other staff that genuinely care about patients and quality care but Steward makes it impossible to provide an environment that's safe … I can't in good conscience see this happening and not continue to do anything possible."

A third doctor who previously worked with Steward and confirmed that the company pressured physicians to violate the Stark Law, said he had been contacted last year by an assistant U.S. attorney about Steward's finances. Steward, he explained, "collect[s] money on a monthly basis from Medicare for [a program called ACO-REACH] and they're supposed to on a monthly basis pay providers with that money, but they haven't done it in years as far as I know. I'm not sure who's holding the money, but from what I understand the person on top of Steward has a mansion in Costa Rica, two yachts and two planes … This particular group seems to be immune from consequence."

Editor's note: *An earlier version of this story identified by name one of the former Steward physicians who spoke to the Prospect. At the request of the physician and their current employer, we have removed the physician's name.*

MAUREEN TKACIK

Maureen Tkacik is investigations editor at the Prospect and a senior fellow at the American Economic Liberties Project.

APPENDIX D

HOSPITAL AND HEALTH CARE PRICING IS IMPENETRABLE — AND EXCESSIVE BECAUSE IT APPLIES FREE-MARKET PRINCIPLES [287]

THE AMERICAN PROSPECT

IDEAS, POLITICS & POWER

Fantasyland General

Hospital pricing is impenetrable to consumers and regulators alike. The result: increased costs and profits, and wasteful reliance on armies of middlemen.

BY ROBERT KUTTNER JUNE 13, 2024

In 2018, the Department of Health and Human Services issued a rule on hospital pricing transparency,[288] requiring hospitals to post prices in easily accessible form. This was done under a Republican administration, and it expresses free-market ideology: If consumers have more information, they can shop around for the best price. A better-informed

[287] The American Prospect, 2024.6.13 https://prospect.org/economy/2024-06-13-fantasyland-general

[288] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0

consumer will in turn discipline sellers, lead to more salutary competition, and restrain costs.

The rule was strengthened in 2021[289] to include sanctions for hospitals that failed to comply. What followed speaks volumes about the folly of attempting to use consumer market discipline in a profit-maximizing system that is opaque and manipulative by design. In practice, most people just follow the advice of their doctors and use the hospital where their doctor practices.

Suppose you are the rare outlier who would like to shop for the best deal. If you look at the website of Mass General Hospital,[290] you will learn that an "HC BYP FEM-ANT TIBL PST TIBL PRONEAL ART/OTH DSTL" will cost you $35,014.00. Even if you can decipher what that means, it's just the beginning of determining the real price.

Posted price lists give hospitals wiggle room by noting that the actual price will vary with the length of stay and the patient's condition. And a bill for a single procedure typically has multiple elements, from individual treatment aspects like sutures or anesthesia, to "facilities fees," which have of late been added even to routine outpatient care,[291] like consultations and ordinary screening.

Every procedure has a billing code. In recent years, there has been an epidemic of upcoding, in which the hospital bases the charge not just on the procedure that necessitated the current visit, but on every prior condition the patient has ever had.

Upcoding also undercuts one widely hyped reform that was supposed to restrain costs: so-called Prospective Payment Systems,[292] which were introduced in the late 1980s. The idea is to pay hospitals a lump sum for treating a given condition rather than reimbursing each specific task. This was supposed to give hospitals an incentive to use the most cost-effective treatments rather than the most profitable ones. But with upcoding, two patients in adjoining beds can receive identical treatments, and the one with a medical history that becomes the basis for upcoding is more profitable to the hospital than the other. HHS audits hospitals to limit extreme abuses of upcoding but cannot audit every charge, and the penalties for flagrant abuses are slaps on the wrist.

People are skeptical of giving their data to Big Tech platforms. But they trust their doctor. Clinically, the physician needs to know their entire medical history and is professionally bound

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[289] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/hospitals

[290] https://www.massgeneralbrigham.org/en/patient-care/patient-visitor-information/billing/cms-required-hospital-charge-data

[291] https://www.wsj.com/health/healthcare/hidden-hospital-fees-cost-patients-hundreds-of-dollars-0024cd95

[292] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195137

by an ethic of confidentiality. Patients expect their doctor to keep the information safe. Little do they know that this data is used to raise prices on them.

The airlines have multiple possible prices for the same seat, but hospitals have a practically infinite number of possible prices for the same procedure. Indeed, compared to hospitals, airline pricing is a model of transparency and simplicity.

ONE OF THE BIGGEST FALLACIES in treating hospital prices as consumer-determined—and why public posting is no kind of solution—is that most individual patients never actually do all the paying. Hospitals typically negotiate price schedules with insurers. Depending on the relative market power of the hospital and the insurer in a given area, the same hospital will make different pricing deals with different insurers.

In Boston, where I live, the Mass General Brigham conglomerate is both the most prestigious and the most economically powerful hospital system. Though insurers attempt to "manage" care, no insurer would dare tell a subscriber, or an employer who buys insurance for employees, that they are not allowed to use Mass General Brigham. That, in turn, gives the hospital more power to negotiate relatively higher charges with the insurer.

The insurers, in turn, have also been merging, in order to maximize their market power with hospitals. The wave of mergers in the health industry has nothing to do with greater "efficiency" and everything to do with the quest for greater pricing power.

But there is one area of convergence for these behemoths fighting over price. Both the hospital and the insurer gain to the extent that they can offload costs onto patients.

For instance, if a given procedure is not covered by insurance, the "self-pay" rate is typically several times that of the hospital's negotiated rate with the insurer. This has nothing to do with the hospital's costs; it simply reflects the fact that the individual patient, unlike the insurer, has no bargaining power and has not negotiated a discounted rate in advance.

Two patients in adjoining beds can receive identical treatments, and one is more profitable to the hospital.

I encountered one of the games hospitals play when my mother had an emergency admission to Mass General Hospital after a bad fall. She was admitted and treated by specialists, and was an inpatient for three days. But she was placed in a category invented by hospitals called "admission for observation." That misclassification, for billing purposes, technically made her an outpatient.

Under Medicare, an outpatient is responsible for a 20 percent co-pay. An inpatient is not. But why does Mass General care if Medicare saves money? Because under a Medicare policy instituted under George W. Bush's presidency, hospitals are punished if they bill Medicare

under inpatient rates when they might have charged outpatient rates. So the government created an incentive for hospitals to make patients pay more.

Shifting costs to patients is a major source of profit maximization for both hospitals and insurers. Many insurers have a variety of complex requirements for authorizing treatment. The purpose is partly legitimate—to avoid medically unnecessary care—but it has the handy side effect of tripping up patients who fail to comply with some arcane technicality.

Having written numerous pieces on health care for the *Prospect* and having served earlier in my career as national policy correspondent for *The New England Journal of Medicine*, I am more sophisticated than the average patient trying to navigate the system. But in trying to determine what I needed to do to be sure that Blue Cross would cover a pending minor surgery, it took me upwards of ten hours on the phone with Blue Cross and staffers in two doctor's offices to avoid getting caught in a trap that would have substantially increased my costs.

Blue Cross insisted that under my PPO plan, my treatment by a specialist did not require a referral from my primary care doctor. But after I saw the specialist, Blue Cross refused to pay his bill for the initial consultation, or to authorize further procedures. On what grounds? They had not heard from my primary care doctor.

After numerous calls and emails, I finally figured it out. Blue Cross has its own terminology and I wasn't using the right words. Blue Cross does not require a *referral* to a specialist; but before it will approve payment, it does require *pre-authorization* based on a communication from the primary care doctor on the medical condition that necessitates the treatment.

If I hadn't figured this out, I would have been liable for the specialist's entire bill. At best, I would have to engage in prolonged wrangling with Blue Cross after the fact. The terminology game serves as a trap to confuse the consumer of health care.

None of these needless complications apply when the insurer is Medicare, an island of efficient socialized medicine amid an ocean of sharks. No referrals or "pre-authorizations" are required; there is no such thing as in-network versus out-of-network. The money saved from this endless gaming and counter-gaming goes to patient care.

Medicare Advantage is a whole other story. Despite the misleading branding, Medicare Advantage plans are run by private insurers. They are a kind of HMO, related to Medicare only in the sense that if you qualify for Medicare, the government will pay premiums on your behalf to the Medicare Advantage plan.

These plans are aggressively marketed to older Americans on the premise that they offer lower-cost and better coverage. Traditional Medicare does have some deductibles and co-pays, though they can be covered if you purchase a relatively inexpensive Medigap policy. But

Medicare Advantage has no co-pays, and special perks like gym memberships and wellness programs.

That's the theory and marketing pitch. In practice, cost-shifting to patients, gaming the Medicare program, and reducing treatment are the central components of the business model.

Medicare Advantage plans often decide that a proposed treatment, test, or medication is not medically necessary. So the patient either absorbs the entire cost or goes without. Unlike traditional Medicare, the private plans also stringently limit which doctors and hospitals a patient may see. All of this makes Medicare Advantage plans highly lucrative to insurers, at the expense of patients.

In this sense, sticker prices and promises of cheaper coverage have no relationship to what the plan actually pays, or doesn't pay, the doctor or hospital on behalf of the patient.

SURPRISE BILLING IS ANOTHER AREA where there is an endless cat-and-mouse game between insurance industry profit maximization and attempts to protect consumers. The most common sort of surprise billing comes when a patient gets treatment from a medical provider who turns out to be out-of-network, and charges an exorbitant bill.

The No Surprises Act of 2021 prohibits the most extreme forms of surprise billing. Typically, that occurs when a medical provider whom the patient did not select, such as an anesthesiologist in a surgical procedure, turns out to be outside the insurer's approved network, and the patient is billed after the fact for the full, nondiscounted fee.

The federal government found that 16 percent of in-network hospital stays involved at least one non-network provider.[293] The act says that hospitals and other providers must not bill patients for more than the in-network rate if it turns out that someone on the medical team was out-of-network.

But the whole concept of in-network versus out-of-network is worth a closer look. It began in the 1970s with the arguably legitimate premise that the entire team of doctors who worked for an HMO were in close communication on a patient's comprehensive needs. This supposedly improved care and reduced costs. The patient, therefore, needed to use a specialist who was in-network.

As HMOs grew from so-called staff-model systems into networks whose only common feature was that participating doctors agreed to accept the HMO's treatment protocols and payment schedules, providers on the "common team" treating a given patient had often never

[293] https://www.kff.org/affordable-care-act/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022

heard of each other. The point was not better communication; it was restraining the HMO's costs and increasing its profits.

Today, in-network versus out-of-network is a pure game of gotcha. If I happen to misunderstand the complex requirements and get treatment from a doctor who is considered out-of-network by my insurance company, there is no clinical difference. The only difference is that I am stuck with a larger co-pay.

Insurers and hospitals have used the issue of which doctors are in-network to play chicken with each other, as they bargain over what the insurer will pay the hospital. In New York, UnitedHealthcare has repeatedly threatened to remove Mount Sinai Hospital and its affiliated doctors from its network of approved providers. UnitedHealth has done this because Mount Sinai was bargaining for rates more in line with what the insurer pays other New York hospital systems. Had UnitedHealth carried out its threat, tens of thousands of New Yorkers would have had to pay out-of-network charges or switch doctors.

The hospital and the insurer finally came to terms[294] in March, but only after UnitedHealth had already classified Mount Sinai inpatients as non-network, disrupting treatment of cancer patients, among others. As part of the deal, that cynical move will be reversed. Note that this battle had nothing whatever to do with using networks to ensure quality of care. On the contrary, it degraded care. It was purely about money.

IN THE LATE 1960S, A PHYSICIAN and public-health researcher named John Wennberg began doing systematic analysis of clinically unwarranted variations in medical interventions and their costs. The results, updated annually in what became the Dartmouth Atlas of Health Care, were shocking. Wennberg's studies, among the most widely replicated findings in health research, found that hospitals in comparable cities performed medical interventions at absurdly divergent rates and with wildly divergent costs, based not on medical necessity but on market power and profit maximization.

Wennberg died earlier this year, at 89[295], and his work continues. A recent summary of his findings,[296] spanning five decades of research, reports: "Where there are more hospital beds per capita, more people will be admitted (and readmitted more frequently) than in areas where there are fewer beds per capita. Economically, it is important for hospitals to make sure that all available beds generate as much revenue as they can, since an unoccupied bed costs nearly as much to maintain as an occupied bed. Similarly, where there are more specialist physicians per capita, there are more visits and revisits."

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[294] https://www.nytimes.com/2024/03/19/nyregion/united-healthcare-mount-sinai-hospital-deal.html

[295] https://geiselmed.dartmouth.edu/news/2024/legendary-healthcare-researcher-john-e-wennberg-who-shaped-efforts-to-reform-the-nations-healthcare-system-dies-at-89

[296] https://www.dartmouthatlas.org/faq

In other words, supply generates demand. And it gets worse. The summary adds: "Studies by Dr. Elliott Fisher et al[297] have indicated that there is *higher* mortality in high-resourced, high-utilization areas than in low-resourced, low-utilization areas. One explanation for this phenomenon is that the risks associated with hospitalizations and interventions—hospital-acquired infections, medication errors and the like—outweigh the benefits."

One of Wennberg's most consistent findings was a crazy quilt of pricing disparities. Despite decades of supposed reforms, that pattern keeps worsening. A 2022 study of pricing for cardiovascular procedures published in JAMA Internal Medicine[298] found: "Across hospitals, the median price ranged from $204 to $2588 for an echocardiogram and from $463 to $3230 for a stress test. The median price ranged from $2821 to $9382 for an RHC [heart catheterization], $2868 to $9203 for a coronary angiogram, $657 to $25 521 for a PCI [treating a blocked coronary artery], and $506 to $20 002 for pacemaker implantation."

Once again, these extreme pricing disparities had nothing to do with hospital costs. The fees increased in line with the hospital's power to do so.

THE MORE COMPLICATED THE SYSTEM GETS, the more its participants rely on middlemen to shift costs. We see this with pharmacy benefit managers and group purchasing organizations, which claim to save money on drugs and medical supplies for insurers and hospitals, but which raise costs throughout the system because of the profits they skim off the top. My Blue Cross policy uses an outside vendor to review all claims and payments, and find reasons to deny some after the fact.

One cost-containment firm called MultiPlan has attracted extensive private equity investment and a position of dominance in the practice of determining out-of-network pricing. The firm's algorithm, Data iSight, is marketed to insurers,[299] and recommends ways to cut reimbursements and shift costs onto patients or doctors. Sen. Amy Klobuchar (D-MN) has accused MultiPlan [300]of being a form of algorithmic collusion, gathering payment data from across the industry and using it to inform its low reimbursement rates. "Algorithms should be used to make decisions more accurate, appropriate, and efficient, not to allow competitors to collude to make healthcare more costly for patients," Klobuchar wrote in a letter to the Federal Trade Commission and the Justice Department.

Another middleman comes in the form of electronic medical records. These were supposed to revolutionize medical care by making it easier for doctors to access patient histories. What some would call a natural monopoly of hospital patient data was quickly taken up by Epic, a

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[297] https://doi.org/10.7326/0003-4819-138-4-200302180-00006

[298] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2794202

[299] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-private-equity.html

[300] https://static01.nyt.com/newsgraphics/documenttools/1d00c48c7634f677/0d0d8490-full.pdf

for-profit product sold by an outside vendor. But although numerous hospital systems now use Epic, doctors affiliated with one hospital typically cannot access patient records at another.

That's because the Epic system only pretends to be mainly about providing access to computerized patient records; it's primarily about maximizing billing. All of the upcoding I talked about earlier is facilitated through Epic. When patients are asked about their prior medical history, each keystroke can enable hospitals to add a code and raise prices. And for clinicians, it is more time-consuming than a purely clinical data system.

The more complicated the system gets, the more its participants rely on middlemen to shift costs.

Obviously, patients suffer from this in the cost of medical care. Even if they don't feel the direct cost in co-pays and fees, they eventually have it passed through to them in higher insurance premiums as well as frazzled doctors. And that brings up another cost: how it affects the quality of care.

I see an eye doctor twice a year for a condition that requires monitoring. When my ophthalmologist retired, I was referred to a new one whose practice had been bought by the hospital. He spent about ten minutes with me, skimmed my chart, did not bother to take a history, and did a cursory examination. He had two waiting rooms, and raced between patients, almost as if he was on roller skates.

When I sent him a very polite note to express some concern, I received back a plaintive letter going into great detail about his economic situation. His net earnings were about half of what he had expected. He lived in a small apartment, and drove an old car. The only way he could make a decent living was to see what he acknowledged were too many patients. And the hospital, which took a cut of his caseload, put no limits on how many he saw.

The abuse of medical professionals is especially extreme in the area of mental health. Each insurance company has its own protocols, its own payment scales, and systems for clawing back payments if its consultants can find some excuse. Too many clinicians find the system too much of a hassle with too much personal risk, and decide not to take insurance at all. Their patients are typically rich people who can afford to pay out of pocket, while far needier people, both economically and clinically, struggle to find someone who will treat them.

NEEDLESS TO SAY, NONE OF THIS GAMING and counter-gaming around prices operates in national health systems, either in the comprehensive systems of socialized medicine on the British model, or the tightly regulated systems of true nonprofit insurers and hospitals on the German model.

In the British National Health Service, there are no prices for procedures at all. Each hospital in the system is given a global budget to serve a population of patients. The hospital allocates

its budget as efficiently as it can. Doctors are salaried, based on the size and age of their patient panel. Specialists are also salaried.

We've seen global budget reforms attempted in the U.S., but only on a limited scale. The entire system of insurers here is parasitic on the provision of actual health care, and the industry of middlemen is a parasite on top of a parasite. Each hapless attempt at price reform only creates new openings for gaming and more opportunities for middlemen.

The fact that universal socialized systems have no counterpart to the U.S. system of price manipulation, with all of the money spent on administration and gaming, goes a long way toward explaining why the U.S. spends upwards of 17 percent of GDP on health care and the typical OECD country spends about 11 percent.[301]

That difference—6 percent of GDP—is about $1.5 trillion a year. Just imagine what else we might do with $1.5 trillion a year. The only solution is to get rid of prices entirely by treating health care as the social good that it is.

ROBERT KUTTNER

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[301] https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022

APPENDIX E

APPLYING VERMONT UPDATE TO NEW YORK STATE

NYS Bills Addressing For-Profit Ownership & Management of Facilities

2023-2024 Legislative Session

The LWVUS Privatization Position does not allow League support of any of these bills. The Vermont Update would change this so advocacy in support of these bills could be considered.

A05375 (Paulin)[302] *Corporate ownership & management of hospitals*

Sponsor's Justification: Under current provisions of the Public Health Law, a hospital cannot be established, or ownership changed, without the prior approval of the Public Health Council as part of an establishment process which includes a determination of public need.

These provisions do not apply to situations or arrangements in which a corporation exercises "passive" control over a hospital, but not direct day-to-day operational authority. Many of the recent, and pending, hospital merger, network and affiliation arrangements which have resulted in the reduction or elimination of certain health care services in a community are a result of these "passive" corporate arrangements.

This bill would clarify what constitutes operational authority over a hospital to include "passive" control corporate models. In so doing these arrangements, and their potential impact on the availability of health care services in a community, would be subject to an establishment review by the Public Health Council.

Jama Hospital Change in Ownership Associated with Adverse Events and Patient Outcomes December 26, 2023

[302] A05375 (Paulin)
https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A05375&term=2023&Summary=Y&Memo=Y

https://jamanetwork.com/journals/jama/article-abstract/2813379?guestAccessKey=92f16644-1af0-49be-a25c-eb82ee839c05&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=122623&utm_adv= ama&utm_content=etoc&utm_t

Harvard Gazette: January 1, 2024 Healthcare Riskier for Patients at Private Equity Hospitals
https://news.harvard.edu/gazette/story/2024/01/healthcare-riskier-for-patients-at-private-equity-hospitals/

NY Times: Who Employs Your Doctor? July 2023
https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html

S6460/A6032 (Krueger /Paulin)[303] *Prohibits for-profit hospices*

Sponsor's Justification: An article recently published by *ProPublica* and digitally released in *The New Yorker*, titled "**Hospice Became a For-Profit Hustle**" shines a light on multiple instances of fraud targeting the Medicare hospice benefit. It illustrates how patient care suffers when bad actors are able to manipulate its original intent and purpose. An earlier article published in the *Journal of the American Medical Association** found that "for-profit compared with nonprofit hospices provide narrower ranges of services to patients, use less skilled clinical staff, care for patients with lower-skilled needs over longer enrollment periods, have higher rates of complaint allegations and deficiencies, and provide fewer community benefits, including training, research, and charity care. For-profit hospices are more likely than nonprofit hospices to discharge patients prior to death, to discharge patients with dementia, and to have higher rates of hospital and emergency department use."

For-profit organizations have a duty to their owners to generate as much profit as possible and distribute net income to the owners. Their obligations to the people they ostensibly serve are secondary. This is especially troubling in the case of hospice. The mission of hospice, providing compassionate end-of-life care, should not be subservient to providing profit to investors. New York is uniquely situated to prevent the deterioration of end-of-life care described above, as **currently only two of 41 hospices in New York** are for-profit, compared to a national average of two-thirds as of 2017. Now is the time to place the care and safety of persons who are dying first and foremost over profit.

In her 2022 veto message 149, Governor Hochul says she will direct the NYS Master Plan for the Aging (MPA) "to assess the services offered by for-profit hospices" and "to include a recommendation on their continued need." It is important for the MPA to consider these issues, however we already know from

[303] S6460/A6032 (Krueger /Paulin)
https://nyassembly.gov/leg/?default_fld=%0D%0A&leg_video=&bn=S6460&term=2023&Summary=Y&Memo=Y

the experience of patients, the advocates working on their behalf and the experiences described in the articles referenced above that New York should take the proactive step of prohibiting new for-profit hospices.*

The New Yorker, Nov 2022: How Hospice Became a For-Profit Hustle: https://www.madinamerica.com/2022/12/hospice-became-for-profit-hustle

JAMA May 2021 Hospice Tax Status and Ownership Matters to Patients and Families https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2779070

S2929/A7186 (Rivera/Hermelyn)[304] *Prohibits for-profit nursing homes*

Sponsor's Justification: In recent years, **for-profit nursing homes in New York** have grown from about one-third of the market to two-thirds. National data shows that for-profit nursing homes score worse on staffing, infection control and other quality indicators. They have higher rates of patient deaths and cost more. The State Attorney General's 2021 report documents that dubious real-estate and service-contract transactions divert funds from patient care and had a hand in increasing COVID-19 risks to patients. This bill prohibits granting of new for-profit nursing home licenses or expanding the capacity of existing for-profit nursing homes.

Public Citizen: **For-profit Nursing Homes**. September 2022 https://www.citizen.org/news/nursing-homes-often-do-not-report-private-equity-firms-among-their-owners

Public Citizen: Private Equity: lapses in safety, price-gouging across a dozen kinds of health care March 2023 https://www.citizen.org/news/action-on-predatory-private-equity-in-health-care-needed-stat-says-public-citizen

S7800/A8470 (Rivera /Paulin)[305] *Repeals MLTC provisions for Medicaid recipients*

Sponsor's Justification: New York State transitioned home care from a traditional fee-for-service model to a Medicaid managed care program or MLTC Plans in 2011, under direction from then Governor Andrew Cuomo's Medicaid Redesign Team. Under this model, New York State began paying for-profit insurance companies to manage and coordinate healthcare for

[304] S2929/A7186 (Rivera/Hermelyn) https://www.nysenate.gov/legislation/bills/2023/S2929

[305] S7800/A8470 (Rivera /Paulin). https://nyassembly.gov/leg/?default_fld=%0D%0A&leg_video=&bn=S7800&term=2023&Summary=Y&Memo=Y

several Medicaid services, in an attempt to improve care by coordinating between doctors and to save money by creating financial incentives to keep patients healthy and out of high-cost hospitals and nursing homes. The original intent was that MLTC plans would develop into fully capacitated plans over time. This has not happened.

Instead, the majority of the services for-profit insurance companies currently provide are solely home care. Because of this "care coordination" is limited, and the insurance companies' administrative costs and profit are a drain on the Medicaid system. These resources could be reinvested to support the delivery of care through fee-for-service and fully capitated models ensuring more uniform care for residents of the state, as well as more adequate reimbursement to providers to support wage increases. This will help to assist providers in addressing health- care workforce challenges facing the state.

In the past 3.75 years, New York State has **given $5.9 billion to the 24 for-profit insurance** companies managing home care in administrative costs and profit. In 2021 alone, the latest full year of data available, **private insurance companies posted $722 million in profits, twice the national average**.

To address this, the "Home Care Savings & Reinvestment Act" would repeal the partially capitated MLTC program and instead provide appropriate long term care benefits under a fee-for-service model or through a fully capitated model where appropriate.

This bill is estimated to generate significant annual savings, which can be used to reinvest and support the Medicaid program while addressing healthcare workforce issues.

Politico: Managed Care hasn't lived up to its promise

https://www.politico.com/newsletters/weekly-new-york-health-care/2023/12/11/home-care-coalition-pitches-major-medicaid-payment-reform-00131026

A7393/ S7477 (Darling /Rivera)[306] *Redeployment of excess reserves of certain not-for-profit HMOs*

Sponsor's Justification: This bill is necessary to ensure the continuation of specific laws of critical importance to the Commissioner of Health relating to not-for-profit managed care organizations in order to avoid the expiration of those laws. Through

[306] A7393/ S7477 (Darling /Rivera. https://nyassembly.gov/leg/?default_fld=%0D%0A&leg_video=&bn=S7477&term=2023&Summary=Y&Memo=Y

these sections, the Commissioner is able to check the organization's reserves and ensure that they are in operating order and authorizes the Commissioner to make regulations related to an organizations reserves.

Health Affairs, June 2023: Nonprofit hospitals: Profits and Cash Reserves Grow, Charity Care Does Not

https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01542

APPENDIX F
GLOSSARY