

Direct Contracting Entities: Scamming Medicare and you and bad for your health!

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On October 25, 2021 I wrote about 'Medicare Advantage, Direct Contracting Entities, and other scams to transfer your money to insurance companies'. In the interim, it has become clear that the impact, and even existence, of DCEs is not well known among Medicare recipients, physicians, members of Congress, and many policy analysts. Indeed, it involves a lot more than insurance companies, particularly "private equity" (a newish term for "venture capitalists" including hedge funds, that maybe sounds better). While DCEs are still an 'experimental' program by the Centers for Medicare and Medicaid Innovation (CMMI) it is significant that the Biden administration has continued this Trump-initiated policy. As, presumably, part of its experimental nature, it has not had much publicity; few Medicare recipients know about it and it is just getting known to Congress, particularly with Senate Finance Committee hearings on February 2, 2022. It is probably worth calling attention to again, even if this piece repeats some of what I wrote in October.

Medicare was established in 1965, and the first two cards were issued, by President Johnson, at the Truman Library in Independence, MO to Harry and Bess Truman, in recognition of Truman's efforts to pass national health insurance during his presidency. It meant that for the first time in American history, older adults would not suffer and die just because they could not afford medical care. It remains, along with Social Security, the most popular program in the US, in every poll, by almost everyone (except of course the rich elites, who believe the best programs are the ones that funnel money directly into their pockets, but more on that later).

Medicare has been a rousing success, but there are two problems. The real and serious problem, as seen from the point of view of Medicare recipients, or for that matter anyone who claims to be a decent non-narcissistic human being, is that it does not comprehensively cover health care costs. For starters, there are several important health conditions it does not cover, including vision, hearing, and long-term care. Also, even for the conditions (most hospitalizations and office visits) it does cover, it does not cover the entire cost. Generally, for hospitalization, it covers 80% of the Medicare-approved fee (which is always less than hospital charges, but which is in fact all the hospital can charge Medicare patients). This puts patients on the hook for the other 20%, which as anyone who has been hospitalized knows can be a lot of money.

The other problem, perceived as egregious by the small but powerful group of very wealthy investors (not regular people at all) is the same as with all effective government

programs: it doesn't put money in *their* pockets. Medicare is funded by different sources; Part A is for hospitalization and comes from the Medicare tax on your paycheck. Part B is for outpatient care and is funded from general revenue funds, plus a monthly charge to Medicare recipients (a minimum of about \$135 now, which can go quite a bit higher for high-income people and be waived for low income). Part D is the drug plan that each recipient is required to buy. We'll talk about Part C later.

Medicare, as a public (government) program that is in the business of paying for health care rather than generating shareholder profit operates very efficiently, with about a 2% overhead for administrative costs. As a taxpayer, I'd think this is good. But for the small number of powerful wealthy investors (for short, let's call them GNPs, for Greedy Narcissistic Pukes) it represents an opportunity; if they could control it they could reap profit from it!

So, of course, while the fact that it is not making rich people even richer is not a problem for most of us, the problem we have is the *solution* that the government has come up with in service to the GNPs. It has been regularly altering Medicare to help them make money from it. First Congress created Medicare Part C, or Medicare Advantage (MA), which, if you choose it, basically enrolls you in an HMO. You get everything paid for plus other stuff that traditional Medicare (TM) doesn't cover, like hearing and dental and maybe gym memberships. This is good for you provided you don't get sick. If you do, you don't have the choice of virtually all doctors and hospitals that you do with TM, just those "in network" (an even greater problem if you don't spend all your time in the same area, since those networks are geographic). Also, since, if you are sick, those MA programs would just as soon you left and went to TM so they don't have to pay your bills, and they have a variety of tricks to encourage you to do so. MA may be good for basically healthy seniors, unless they travel, until they're not healthy. MA plans also don't pay for long-term care – that's expensive and would cost too much; gym memberships are cheap. And they can – and do -- pocket overhead and profits of up to 15%. (The insurance term is that their "medical loss ratio" -- the amount that they have to spend on actually providing medical care – has to be 85%, while in TM with its 2% overhead, it is effectively 98%.) Medicare Part D, the required drug coverage was another gift, this time to big pharmacies and pharmacy benefit managers (PBMs) who make big profit from them.

But wait! A lot of people were and are still choosing TM, and not all of them are the high-cost really sick people that the MA plans don't want! While the insurance companies and GNPs are glad that they are in TM when they are sick and costly, there are still a lot of them who we could make money on. How can we do that? Well, let's get the Center for Medicare and Medicaid Innovation (CMMI), which is supposed to come up with innovative programs that improve quality and save the government money, to

implement an “innovation” that lets us pocket money from even those who chose TM! Cool! So they did, without even having to have Congress approve it. These are called Direct Contracting Entities (DCEs). If your primary care clinician is affiliated with a DCE, the DCE collects all your money from Medicare, and – this is a really good part – they only have a medical loss ratio requirement of 60%, so they can keep 40% if they can deny you enough care! A better deal (for them!) than even Medicare Advantage! And since most primary care physicians are now employees or part of large groups, the DCEs can just contract with the group, not with each physician. And even better, the DCEs, the majority of which are now owned by “private equity” (a particularly noxious form of GNP), can just buy the primary care groups! *Voilà!* The group is now owned by the DCE, your doctor is part of it, and you are part of it and being hosed. Your only recourse is to change your primary care doctor. Which you may not want to because you may like and trust your doctor...

Of course, the two problems I mentioned are mirror images of each other. Medicare does not pay for all your care because Congresspeople and Wise Policy Analysts say that would be bad because it would cost too much. They see it as much better to spend lots of money on further enriching the insurance companies, PBNs, DCEs, and other GNPs. Why? Because they contribute a lot of money to Congress, and because many congresspeople are heavily invested in these; often they are also GNPs, either before entering Congress or as a result of it (how they get so rich on a Congressional salary is another story).

By the way, in case I haven't been clear in what I think, these are all both bad and evil programs, taking money that should be spent on your healthcare. They are healthcare examples of the impact of “gangster capitalism”, or in another term I've heard, *Götterdämmerung* capitalism, which describes our current situation where the GNPs would rather destroy the world than stop acquiring all its wealth. And if they are willing to destroy the world, how much weight do you think your health and life have? These programs are not developed by accident; they are purposely designed to take what you have (as in the cost of health insurance premiums) or have previously been recognized as social benefits (as Medicare) and transfer them to the richest people in society.

The only – maybe, hopefully -- good news is that Congress has recently started holding hearings on DCEs, recently by the Senate Finance Committee, with outstanding testimony by many experts including Dr. Susan Rogers, current president of Physicians for a National Health Program (PNHP), whose [website](#) has lots of good information on DCEs. At the end of the hearing, Sen. Elizabeth Warren (D, MA) urged the Biden administration in the strongest terms to have CMMI end this “innovative experiment” (or perhaps you prefer gift or scam). Maybe they will.

Let your Congresspeople know what you think. And everyone else.