The Labor Movement Must Call the Question on Medicare Privatization

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The passage of the publicly funded and administered Medicare Act in 1965, due in large part to the grassroots mobilization of the labor movement against the extraordinarily powerful American Medical Association, guaranteed access to medical care for all seniors and is one of the U.S. labor movement's most significant victories.[1] Today, Medicare is increasingly privatized, and unions face growing pressure at the bargaining table to degrade retiree health benefits via Medicare Advantage (MA) plans.

For decades, unions have been fighting an uphill battle to hold the line against skyrocketing healthcare costs. Annual premiums for employer-sponsored family health coverage reached $25,572 in 2024, with workers on average paying $6,296 toward the cost.[2] Contributing to escalating costs, and compromising the quality of care, private equity (PE) firms have spent half of a trillion dollars since 2018 buying up hospitals, nursing homes, and medical practices. PE firms drive up costs by charging hospitals unaffordable rents for facilities they once owned, by pulling doctors out of insurers' networks, encouraging doctors to perform unnecessary procedures, and demanding high prices by cornering the market. Prices increase typically by 20 percent when PE firms buy a clinic or doctor's practice. When PE firms finish their asset stripping, some medical facilities are forced into bankruptcy and many are required to cut staffing and services to enhance profits for their PE owners.[3]

Bargaining for union retirees brings an additional set of challenges. A Supreme Court ruling in 1971 prevents unions from negotiating benefits for existing retirees unless the employer voluntarily agrees to bargain, allowing sweeping changes in retiree healthcare benefits outside of bargaining.[4] Bankruptcy laws allow courts to put retiree health benefits at the bottom of the list of creditors to be paid, opening the door to wholesale termination of benefits for both current and future retirees.[5] And significant changes to accounting for the cost of future benefits for retirees added "new stresses at the bargaining table."[6]

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Every day, unions face tough decisions and weigh concessions as a direct result of health care costs. Wage increases are traded off against benefit cuts, increased worker premium contributions and out-of-pocket costs, and two-tiered benefit structures for new hires. And the interests of active members are pitted against those of retirees. In 2024, only 24 percent of large employers offered retiree health benefits. That is down from 66 percent in 1988.[7]

An increasing number of employers that still offer retiree health benefits are pushing retirees onto MA plans as a way to cut costs. MA is now the only choice offered by 53 percent of those companies. In the public sector, state and

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municipal government retirees in 13 states now have MA as the only option.[8]

MA is attractive to employers because it costs less than the supplemental, or Medigap (coverage for traditional Medicare's out-of-pocket costs including co-pays and deductibles), plans that unions have negotiated. The cost savings are possible because the federal government is subsidizing the private MA plans by using funds from traditional Medicare and because plans restrict access and deny claims. In essence, MA insurers are draining the public Medicare system and limiting access to care while passing some of the "savings" to employer and union plans.

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Under pressure from employers seeking to limit their costs and their postretirement medical liability, an increasing number of employer plans and union trust funds have begun to use the MA option as the "base" plan for calculating costs, requiring retirees to pay all or part of the difference to retain traditional Medigap coverage. According to one union health plan director, some retirees are paying up to three times the cost of their union MA plan to retain their Medigap plan. This cost differential will only widen as Medigap costs escalate as a result of being chosen by the sickest retirees.[9]

"Medicare Advantage can look like an easy way to address skyrocketing retiree healthcare costs, avoid concessions, and make some wage gains. But the concession—and it is a concession—is likely much bigger than we'd like to acknowledge," says Mark Dudzic, long-time leader of Labor Campaign for Single Payer Healthcare (LCSP). "That said, unions are between a rock and a hard place. In some situations, there are no other alternatives." When we look a little closer, it becomes clear that the MA benefit claims are a wolf in sheep's clothing, and the federal subsidies are a Trojan Horse to privatization of the public Medicare program that labor fought so hard to win. Labor can fight back both at the bargaining table and by supporting anti-privatization efforts like the "Level the Playing Field" proposal to redirect MA overpayments to improving traditional Medicare.

What Is MA?

MA is another Wall Street privatization scheme, raiding public funds for private profit much like the attacks on public schools, water systems, and even parking meters. With support from both Democrats and Republicans,[10] the dismantling of the public Medicare system is just the latest target. And if the supporters of Project 2025 are successful, the privatization will happen even more rapidly. It calls for making MA the default option for all Medicare enrollees, pushing the United States toward a future of fully privatized Medicare.[11] "If this system of skimming funds were extended to all seniors, the Medicare trust fund would immediately begin deficit spending, leading to insolvency within five years," writes Dr. Diljeet K. Singh, president of the Physicians for a National Health Program (PNHP). "It would cost $1.5 trillion more than real Medicare over 10 years."[12]

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Congress opened Medicare's door to private insurance companies in the 1980s during a wave of privatization legislation pushed by business interests. It officially became MA in 2003. As part of the persistent insistence by free-market idealogues that the private sector can magically do "it" better, more efficiently, and at lower cost, MA was billed as cost-saving and quality-enhancing.

Traditional Medicare is a shining illustration that those market-based claims are baseless. Year after year, Medicare spends only 2 to 3 percent on administrative costs. Comparatively,

15 percent of MA spending goes to administrative expenses and profit.[13] MA "has never generated savings relative to traditional Medicare. In fact, the opposite is true,"[14] according to the health policy organization KFF, formerly known as the Kaiser Family Foundation. However, Project 2025 leaves no doubt that privatization of the public sector, including Medicare, the Veterans Administration, and Medicaid, is the ultimate goal of the billionaire class.

Why Are So Many Insurers in the MA Business?

"When the notorious bank robber Willie Sutton was asked why he robbed banks, he replied: 'Because that's where the money is.' It would seem PE, billionaires, and Wall Street view our healthcare system the same way. And the federal government is paving the way," says Rose Roach, LCSP National Coordinator and former Executive Director of the Minnesota Nurses Association.

The MA business model is based on: (1) maximizing funding from the federal government to private insurers via a rate structure that invites overpayment and (2) minimizing these companies' expenditures by restricting or delaying access to care. Instead of reimbursing doctors and hospitals directly for care provided, the federal government pays the MA insurer a lump sum, based roughly on the average cost of a traditional Medicare beneficiary. This offers a huge incentive to game the system to attract the healthiest, youngest enrollees (and the least expensive to cover) through "favorable selection" or "cherry picking." This sometimes includes offering a "sweetener" such as a free gym membership to attract healthy enrollees. There is also evidence that "lemon dropping" occurs when less healthy and more costly individuals become frustrated when care is delayed or denied and disenroll.[15]

MA insurers also use "upcoding"—making patients appear sicker than they are—to receive higher reimbursements. Since they rarely deliver any related care, the lump sum payments to MA insurers enable them to pocket the excess payment. As a result, Medicare spends at least 22 percent more per patient on MA plans than if they were enrolled in traditional Medicare. These overpayments, from public Medicare to private MA, total between $88 and $140 billion per year.[16] If DOGE is really looking for waste, MA would be a great place to start.

Why Has MA Become So Popular?

Traditional Medicare remains user-friendly, cost-effective, and popular. It pays healthcare providers directly without involving insurance companies. It is accepted by most doctors and hospitals without narrow networks that limit access to care. Traditional Medicare "Part A" covers hospital care and "Part B" covers care from doctors and other healthcare providers. However, traditional Medicare charges a monthly premium for "Part B" and for drug coverage, has gaps in coverage—dental, hearing, and optical, for example—and has no cap on out-of-pocket costs.

Seniors without employer-sponsored retiree health benefits may opt to purchase a Medigap plan, if they can afford it, to cover the gaps. These plans typically cost more than $200 a month. Seniors with fewer resources see MA as a better deal. MA plans cover many of the gaps, often with additional benefits like limited vision and dental, and often with little or no premiums beyond the "Part B" cost.[17] As a result, enrollment in MA has skyrocketed. By 2024, MA plans covered 54 percent of all eligible Medicare beneficiaries, compared to 26 percent of seniors in 2011.[18]

The choice for most seniors, therefore, is all about cost—not better-quality care. "Many seniors realize," says Jim McGee, Executive Director of the Transit Employees Health & Welfare Plan,

> that their Medicare Advantage plan was not a good decision when they get sick and need medical care outside the network, or face delays and denials of coverage. By this point, they are not in a good place, often too sick to change plans or to fight the insurance company.

Wolf in Sheep's Clothing

Restricting access, particularly to expensive care, is fundamental to maximizing profit in MA. Unlike traditional Medicare—which is accepted by most doctors and virtually all hospitals in the United States—MA restricts beneficiaries to healthcare providers within limited insurance networks. Narrow networks are especially difficult for retirees who live outside the coverage area for part of the year. And networks can change from year to year. The impact on care is significant: as many as 11.7 million people in MA plans are in a network so narrow that more than 70 percent of the physicians in their county are excluded. Many MA providers advertise "ghost networks," or lists of providers that are either inaccurate or unavailable.[19] And because MA plan networks often block patients from seeing the best cancer doctors and hospitals in their area, death rates after some cancer surgeries are double the rate of traditional Medicare.[20]

Project 2025 . . . calls for making Medicare Advantage the default option for all Medicare enrollees, pushing the United States toward a future of fully-privatized Medicare.

MA insurers often require "prior authorization" for specialized (and more expensive) care and for certain prescription drugs that can create "dangerous delays in care."[21] The higher the cost, the more likely it is subject to review. This process creates additional paperwork, waiting time, and other administrative burdens for patients. Care providers spend up to 20 million hours per year of wasted medical practice time dealing with prior authorizations from MA plans alone.[22]

In 2023, MA insurers fully or partially denied more than 3.2 million "prior authorization" requests.[23] A federal investigation into these denials found that 13 percent, or more than 400,000 requests, were denied necessary care that should have been covered—and would have been covered by traditional Medicare without prior authorization.[24]

An estimated 7.3 million people in MA plans are underinsured due to high out-of-pocket costs forcing them to avoid and delay needed care.[25] Approximately half of all MA enrollees leave their plans within 5 years, suggesting dissatisfaction with the program. MA enrollees may switch back to traditional Medicare during open enrollment. However, many seniors do not realize that it can be difficult, expensive, or impossible to purchase a supplemental or Medigap plan because in all but four states—CT, MA, ME, and NY—enrollees may be subject to medical underwriting. Insurers may deny coverage altogether for a pre-existing condition. The underwriting may justify charging so much more for available plans that many may find coverage out of reach, particularly as enrollees become older or get sick. Thus, most retirees leaving MA plans switch to a different MA plan.[26]

The Continuing Impact of the Profit Motive

MA is also playing a significant role in the consolidation and restructuring of the healthcare industry. The American Economic Liberties Project describes a "new frontier of consolidation," where insurers use excess capital gained in part from MA overpayments in "acquiring providers, gaining control of key points in the delivery system that enable them to capture greater government payments and minimize spending on patient care."[27] UnitedHealth Group, for example, is now the nation's largest insurer and the largest employer of physicians. Retail conglomerates such as CVS, Walgreens, and Amazon are "aggressively consolidating" the supply chain for prescription drugs.

With more seniors signing up for MA plans and pent-up demand for services post-COVID, some MA insurers have seen a decrease in what have been astronomical profits, resulting in further reduction or elimination of benefits and pulling out of geographic areas that the insurers deem not profitable enough.[28] UnitedHealthcare's stock plummeted by 22 percent in April 2025 when it announced that its first quarter earnings were down. UnitedHealthcare's then-CEO Andrew Witty

attributed the downturn to unexpectedly high and "unacceptable" MA utilization (profits for the quarter were a mere $6.4 billion).

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When profits are down, insurance companies like Cigna, Aetna, and UnitedHealthcare will simply ask Medicare for more money. And in response, the Trump administration's Centers for Medicare and Medicaid Services (CMS) granted a 5.03 percent rate hike ($25 billion)[29]—more than twice what the Biden administration proposed. "Medicare Advantage is simply an endless trough from which the insurance industry extracts public dollars," says Michael Lighty, President of Healthy California Now. "The very structure of the MA model guarantees that the insurance industry will always come back for more."

Fight Back at the Bargaining Table

Some unions have negotiated MA plans far superior to those available to an individual targeted by late-night televisions ads pushed by celebrities including Joe Namath, William Shatner, and Jimmie "J.J." Walker. However, even the best union-negotiated MA plan is based on the MA business model that requires limiting access to care—through narrow networks and prior authorization, for example—to make a profit.

Furthermore, the federal subsidies for MA plans—the very reason the plans are attractive both to unions and to seniors—could very well evaporate once all seniors have abandoned—or been forced off traditional Medicare. At the bargaining table, the pressure to drop Medigap plans altogether as older and sicker patients return to those plans is likely to increase.

Retirees across the country have soundly rejected and are organizing against MA. Washington State public employee unions beat back an attempt to force 53,000 retirees into an MA plan in 2022. The Vermont State Employees Association united with 6,000 retirees to defeat the state's attempt to force them into MA. In New York City, well-organized and determined retirees, in the face of some of their unions going all in for MA, took to the streets to protest. And they successfully sued the city numerous times to protect their benefits.[30]

Some union leaders are beginning to come together around a commonsense approach at the bargaining table to counter moves toward MA: (1) educate members and retirees about choices the union is facing; (2) fully understand the economics involved including how much it potentially saves the employer; and (3) study the MA contract closely to assess the impact on retirees.

"Medicare Advantage: What Union Leaders Need to Know,' a publication of the LCSP and the Debs-Jones-Douglass Institute, includes a checklist, "Questions to Ask at the Bargaining Table," to assist unions seeking transparency from employers about MA plans. Topics include prior authorization programs, customer service, network and benefit design, and broker/agent design. Because brokers and agents can receive fees and commissions to favor MA plans, unions need to demand full transparency and negotiate a flat-rate broker fee.

Adequate protection of retiree benefits would also include: (1) retaining a choice of at least one affordable Medigap plan; (2) a guarantee of return to the available Medigap plans without insurance underwriting; and (3) contract language that guarantees no loss in benefits to retirees. An excellent resource for member education that provides access to unbiased guidance on choosing health plans is the State Health Insurance Assistance Programs.[31]

"The good news is that a solution is at hand. This unfair competition can be corrected by leveling the playing field between Medicare and corporate health insurance, all at no additional cost to taxpayers," says Dr. Ed Weisbart, PNHP national board secretary.[32] The "Level the Playing Field" proposal takes back the public dollars now flowing to private insurance companies and redirects those dollars to

strengthen traditional Medicare by (1) capping out-of-pocket costs; (2) adding pharmacy benefits; and (3) adding dental, vision, and hearing benefits—at the same level as MA plans.

The total cost to level the playing field is $85 billion a year—well within the amount that MA is draining from Medicare (between $83 billion and $140 billion).[33] And public support for expanding Medicare is strong: 92 percent of voters—across party lines—strongly support or somewhat support expanding traditional Medicare to cover dental, vision, and hearing benefits.[34]

The Puget Sound Advocates for Retirement Action (PSARA) is one of the first labor-affiliated groups to sound the alarm against, and organize around, the growing impact of MA. PSARA's resolution to "level the playing field" was passed by the Washington State AFL-CIO as have the Minnesota and Maine state federations. LCSP and PSARA are calling on unions, state federations, and central labor councils to endorse as well.

On Capitol Hill, healthcare advocates including Social Security Works, Public Citizen, PNHP as well as a number of national unions are promoting the level the playing field proposal. But the tricky fact remains that unions, caught between that rock and a hard place, are bargaining for and offering MA plans. This can be seen as tacit support for MA and could result in undermining the anti-privatization fight.

"We know that the labor movement stands with us against privatization and for healthcare justice," asserts Alex Lawson, executive director of Social Security Works, a leading nonprofit working to protect and expand Social Security, Medicare, and Medicaid.

> But on Capitol Hill, we're hearing from lawmakers that unions love Medicare Advantage plans. Labor could have a huge impact if it made its opposition to privatization of Medicare loud and clear and joined the call for a level playing field. Labor is in a unique position of having negotiated better terms for Medicare Advantage plans, something most people can't do, and so have the ability to expose the deadly design that is standard operating procedure for privatized Medicare plans.

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"It's time now for the labor movement to stand up to the privatization of Medicare," says LCSP's Rose Roach. "Leveling the playing field will increase our options at the bargaining table by removing employers' incentives to move to MA."

A growing number of national unions are doing just that. At a briefing in April 2025 hosted by the LCSP and held at the AFL-CIO headquarters, union presidents Sara Nelson (Association of Flight Attendants/CWA), Matthew Biggs (International Federation of Professional and Technical Engineers-IFPTE) and Mark Dimondstein (American Postal Workers Union-APWU) sounded the alarm on Medicare privatization. They are joined by leading advocates National Nurses United (NNU) and the United Electrical, Radio and Machine Workers (UE) in the growing pushback.

Where To Go from Here

"As trade unionists, we must recognize that accessing healthcare, via an employer-based model, has become one of the largest transfers of our wealth as workers to the corporate bosses," says Rose Roach. MA is, of course, one more notch in the 45-year neoliberal assault on unions and working people as well as on the public sector, undermining our government's capacity to guarantee economic security for working people. The only long-term solution is to take healthcare off the bargaining table through a single-payer Medicare for All model or a national health system.

"Postal workers know the value of affordable, universal services, grounded in a

commitment to putting people over profits. That's the type of service we are committed to providing communities across the country, day in and day out," said Mark Dimondstein, president of the APWU at a rally reintroducing Medicare for All legislation in Congress.

> For too long, greedy corporations and their Wall Street investors have been able to deny the people of the country the quality, affordable, universal healthcare working people deserve. A healthcare system that works for working people, not the profits of the insurance companies, is long overdue. It's time for Medicare for All.[35]

The labor movement's fight in the early 1960s for passage of the publicly funded Medicare system can serve as a powerful reminder of both the values of and the power of the labor movement. With the broad attacks facing labor in 2025, taking on MA may seem politically impossible. But labor must call the question on the privatization of Medicare and take advantage of an excellent organizing opportunity to educate and engage both members and retirees, and to show our nonunion brothers and sisters that the labor movement is fighting for all working people.

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