August 25, 2022

Xavier Becerra,
Secretary, Department of Health, and Human Services

Chiquita Brooks-LaSure,
Administrator of the Centers for Medicare & Medicaid Services
https://www.regulations.gov

Re: Request for information file code CMS-4203-NC

The National Retiree Legislative Association (NRLN) is grateful for the opportunity to offer input that might improve Medicare C, Medicare Advantage (MA) in response to your July 27, 2022 specific Request for Information (RFI) about aligning with the Vision for Medicare and the CMS Strategic Pillars (*https://www.cms.gov/cms-strategic-plan*).

The NRLN began its review of Medicare Trustee, MedPAC, HHS-OIG, GOA, CBO and other verifiable annual and periodic reports, and CMS records, beginning in the late 1990's and began publishing NRLN's annual position papers on the status of original Medicare and MA in 2017. Information supporting our RFI responses is available in the NRLN 2022 position paper at the end of our RFI document below.

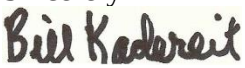
NRLN limited its responses to those RFI questions that relate to structure, policy, and performance improvements that we believe would set the stage for immediate overall MA improvement. Responses include our assertion that forty million in original (traditional) Medicare are being denied access to subsidized benefits afforded only to MA enrollees. We believe, that without disruptive change, MA will continue to milk the federal budget and eventually MA beneficiaries will shoulder major healthcare cost increases.

Recently, we developed a preliminary analysis of the evolution of CMS innovations and trials from the 2012 ACO 1 to ACO NextGen in 2016 and then from 2019 – 2022 - DCE GEO, DCE Global, DCE Professional, DCE Global and Professional. We are comparing 2023 ACO REACH final business structure, rules with MA to determine, if possible, improvements in ACO REACH might answer MA questions in this RFI. Unpublished ACO-REACH changes will delay our final analysis. however we will publish our initial 2022 review soon.

We ask CMS to be more forthcoming with all ACO REACH details ASAP as we would appreciate the opportunity to compare its rules with MA and to offer improvement suggestions. We request that you issue an ACO REACH RFI ASAP this Fall before the beginning of trials in 2023.

If you or your staff have questions or comments, please email or call.

Sincerely



Bill Kadereit, President
National Retiree Legislative Network
Email: president@nrln.org Phone: 972-722-5928

August 25, 2022

National Retiree Legislative Network (NRLN)

Re: Response to RFI file code CMS-4203-NC.

NRLN General Response, how to improve Medicare C, MA Plans:

Our more than two-million retirees served by Medicare deserve a full review and assessment of MA as a direct competitor with Medicare FFS. However, without full disclosure of how ACO-REACH policies and rules will compare with MA we cannot be sure that ACO REACH, an FFS benchmark model, might not be a better model than MA.

This confluence of solutions deserves more comparative analysis, congressional oversight, and a delay of ACO REACH trials, otherwise, three offerings at the same time (original Medicare A&B, original Medicare A&B ACO REACH, Global or Professional, and MA) may create confusion and misunderstandings during the 2022 Medicare Fall enrollment.

MA Capitation benchmark and bid and Quality Bonus Plan (QBP) features have created legislated discrimination within Medicare that impedes the desired outcomes of the six (6) CMS Strategic Pillars.

MA plans have received unwarranted rebates that have subsidized the funding of Medicare beneficiary cost sharing and the payment for extra healthcare benefits for 37 years. These rebate subsidies, funded by general revenue, have yet to reduce the avowed MA healthcare cost objective - to provide better healthcare at a lower cost per enrollee than original Medicare. That has not happened in any year since 1985. Such subsidies (rebates) create an unfair competitive disadvantage that disguises the fact that MA policies and rules increase the cost of healthcare at taxpayers' expense and that someday soon this subsidized cost may be shifted to unsuspecting beneficiaries. MA has not been a **"responsible good steward of public funds"** as required under the **CMS "PROTECT PROGRAMS" Strategic Pillar**.

The legislation enabling MA Capitated bids and Quality Bonus Plan (QBP) rebate bonuses has created discrimination within Medicare. Over $450 billion have distributed to MA plans over these 37 years, with $50 billion expected in 2022 and $100 billion by 2030. In 2022, cost-sharing and extra benefit payments on behalf 24.7 million MA beneficiaries will be $1,980 each. The remaining 39 million in Medicare get $0. **CMS Strategic Pillars "Advance Equity" (subsection A)** and **"Expanding Access" (subsection B) are severely discredited** by the granting of cost-sharing and extra benefit payments for a subset of younger, near age 65 retirees that are denied to those also in Medicare but who are older and more in need of these same benefits, and further, as a class, have effectively prepaid more dollars for such benefits than younger recipients.

Our proposed MA General improvement recommendation is that Congress and CMS immediately create a level playing field where private insurers' risk capital, and taxpayers' (income and payroll tax dollars) compete with Americas public plan, Medicare.

The NRLN's attached MA paper lists five (5) proposed improvements that could create a level playing field.

Our second MA General improvement recommendation is that CMS and Congress do not start ACO REACH trials until we can inform MA plan and other Medicare beneficiaries and the public about ACO REACH. Today, only those assigned to an ACO have knowledge of what an ACO is, and CMS has not produced an ACO REACH official plan to review! We are seven (7) weeks away from 2022 Medicare open enrollment. Congress should review ACO REACH to examine whether provider costs and overhead

expenses, cost sharing and extra benefits will be subsidized or if ACO REACH policies will create disparate treatment across different classes of Medicare beneficiaries within and across three (3) different Medicare part A and B plans.

NRLN - Response to II. Solicitation of Public Comments

A. Advance Health Equity

Response:

We responded to the Health Equity issue regarding the disparity of treatment between younger and older MA beneficiaries due to subsidies used to pay for cost sharing and new extra benefits in the General Response section of our submission, above. "The legislation enabling MA Capitated bids and Quality Bonus Plan (QBP) rebates has created discrimination within Medicare. Over $450 billion have distributed to MA plans over these 37 years, with $50 billion expected in 2022 and $100 billion by 2030. In 2022, cost-sharing and extra benefit payments on behalf 24.7 million MA beneficiaries will be $1,980 each. The remaining 39 million in Medicare get $0. CMS Strategic Pillars "Advance Health Equity" (subsection A) and "Expanding Access" (subsection B) are severely discredited by the granting of cost-sharing and extra benefit payments for a subset of younger, near age 65 retirees that are denied to those also in Medicare but who are older and more in need of these same benefits, and further, as a class, have effectively prepaid taxes for such benefits than younger recipients.

For the same reasons cited above, access due to disparate payments creates a second layer of access denial that is problematic in Advance Health Equity. Footnote 1 of your RFI highlights beneficiaries defined as affected by "social determinants of health (SDOH), defined as "the conditions in the environments where people are born, live learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Also included in this second layer of denials are those defined in Footnote 2 as living in "underserved communities" as "populations sharing a particular characteristic, as well as geographic communities, which have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life."

MA therefore divides Medicare A&B into the haves, by age (a younger class in MA that gets $1,980 in added annual subsidies) and the have nots (an older class in original Medicare who do not get a nickel). However, in picking winners and losers this way, older beneficiaries in original Medicare including those identified as affected by SDOH and those living in "underserved communities" are being denied access to the extra $1,980 bucket of coverage and care as defined in Pillar B Expanded Access.

This is a CMS Strategic Pillar weakness that may deny access to benefits to those designated in 1 below.

1. What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- **Enrollees from racial and ethnic minority groups.**
- **Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.**
- **Enrollees who identify as transgender, nonbinary, or another gender identity.**
- **Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.**
- **Enrollees with diverse cultural or religious beliefs and practices.**
- **Enrollees of disadvantaged socioeconomic status.**
- **Enrollees with limited English proficiency or other communication needs.**

The NRLN MA improvement suggestion is to discontinue all MA bonus, rebate subsidies, and implement NRLNs 5-step recommendation and, improve and target communications to reach all beneficiaries in simple terms on how to access and utilize Medicare benefits.

We do not care to get into the weeds regarding specific studies needed to better define and utilize Medicare resources (2–11 below) to improve or fix MA details or tell the medical community how to keep seniors healthy, except to critique the list by editorializing that it is amazing how more studies are required after the fact, 12 years after the ACA was promulgated. Innovation can be healthy but only if efficient and accurate analysis takes place before implementation of change.

Questions reviewed:

2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work? **3**. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? [2] Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH? **4.** What have been the most successful methods for MA plans to ensure access to language services for enrollees in different health care settings? Where is improvement needed? **5.** What socioeconomic data do MA plans leverage to better understand their enrollees and to inform care delivery? What are the sources of this data? What challenges exist in obtaining, leveraging, or sharing such data? **6**. For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple organizations? Please provide examples of how MA plans and providers have leveraged MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships. **7.** What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes. **8**. What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? **9.** How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPSs), and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees? **10**. How have MA plans and providers used algorithms to identify enrollees that need additional services or supports, such as care management or care coordination? Please describe prediction targets used by the algorithms to achieve this, such as expected future cost and/or utilization, whether such algorithms have been tested different kinds of differential treatments, impacts, or inequities, including racial bias, and if bias is identified, any steps taken to mitigate unjustified differential outcomes. For MA plans and providers that do test for differential outcomes in their algorithms, please provide information on how such tests function, how their validity is established, whether there is independent evaluation, and what kind of reporting is generated. **11.** How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

B. Expand Access: Coverage and Care

CMS is committed to providing affordable quality health care for all people with Medicare. We seek feedback regarding how we can continue to strengthen beneficiary access to health services to support this goal in MA.

1.What tools do beneficiaries, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools? **2.** What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Response to 1 and 2:

These are two especially key areas for improvement! In order, for new enrollees (electing MA or Medicare plus Medigap) or those thinking about switching plans (MA to Medicare plus Medigap or back to MA) the cost, risks and how to evaluate options should be made clear and be communicated only through use of Medicare and You Handbook (the Handbook) changes and messages directly to prospective and existing beneficiaries.

It is not necessary to create two or three different sets of educational materials. Approved Medicare A & B benefits should be equally available to all Medicare beneficiaries in original Medicare, MA, ACO, DCE or ACO REACH plans. Plan sponsor premiums, deductibles, copay, and coinsurance should be the differentiators, not subsidies and rules that harbor age, SDOH or other clusters of discriminatory access and claim denials; especially those enabled by Congress.

The Medicare Handbook should be an AI driven source of information designed to be a Medicare "Alexa." Insurers and other participants and providers of all Medicare plans should be required to publish relevant non-proprietary information on this database. Audio/video tools should be used to simplify messaging.

A CASE for IMPROVEMENT: 20,000 retirees had their Supplemental health plan terminated and by law were entitled to enroll in new Medigap plans offered by a national Private Medicare Exchange (PME). PME offered plans were sold to retirees at 30-40% above many other plans of the same type in specific zip codes. When requested, both the state of TN and CMS denied responsibility for requiring that retirees be offered another Medigap Special Enrollment Period (SEP) and full disclosure offerings of all plans available by Zip Code, plan type (10 plans) and carrier. TN acknowledged that insurance sellers have special relationship deals with insurers to carry selected registered plans with premiums that maximize commissions. Florida publishes Medigap pricing by plan, price, carrier, CMS, and TN will not!

The NRLN asked CMS to make these prices available by plan type, by carrier and zip code online. This request was denied. Today, the Handbook publishes the price range for each plan by type only. Posting specific prices on the Db with the caveat that the buyer must get latest available pricing from the carrier or reseller before singing up would be extremely helpful.

There have been noticeable improvements to the website but there should be much more done to transform it to be a single authority for all 64 million Medicare beneficiaries and should be treated as a powerful tool to control non-conforming practices and behavior and to provide reliable Coverage and Care Access information and advice directly to Medicare beneficiaries in the insurers 4,800 MA plans, 500 independent ACO REACHES, etc. This is where misunderstandings, different motives and actions can lead to denial of coverage, poor care, loss of life and higher cost and fraud. Can do things: FRAUD

ALERTS; HOW TO ENROLL; HOW TO DECIDE: HELPFUL TIPS; HOW TO GET GOODRX or MARK CUBAN DRUG PRICES, and other aids. <u>This is important</u>, by 2060 100 million or 25% of all U.S. citizens will be over age 65 – must get there before chaos.

Be the advocate for 64,000 – CMS works for them, through, but not for insurers, doctors, drug manufacturers etc. Currently, 20,000 retirees in the above example and the NRLN member base do not believe you are their advocate.

It is disingenuous to say we are interested in improving access and care if we walk away when there is a chance to make a real difference. Tell Medigap insurers you want up to date Medigap premiums in effect transmitted in real time prior to the 2022 enrollment, then post them. This disruptive action should be a necessity.

<u>Questions reviewed</u>:
3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers? **4.** How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need? **5.** What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services? **6.** What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align? **7**. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits? **8**. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees' access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved? **9**. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)? **10**. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care? **11**. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

C. Drive Innovation to Promote Person-Centered Care

We strive to deliver better, more affordable care and improved health outcomes. Key to this mission is care innovations that empower the beneficiary to engage with their health care and other service providers. We seek feedback regarding how to promote innovation in payment and care delivery, and accountable, coordinated care responsive to the specific needs of each person enrolled in MA.

Response:

Beneficiaries have engaged with their service providers and other providers they recommend when they perceive they need help for years. Nothing changes this relationship by calling it an enrollee empowerment. People follow advice because they trust. That is precisely why retirees follow PCPs to ACOs

MedPAC, HHS-OIG, GOA, CBO, and other annual and periodic reports are uncovering an increasing level of unwarranted MA plan benefit coverage and claim denials (access problems). Either one of these denials lead to poorer care and more cost.

The words value-based care, value-based contracting and value-based pricing are over-used and hollow words like cost-sharing or lower bids which are also misnomers. New acronyms and jingles mean nothing. When true quality measurement and statistical quality control discipline is non-existent and quality and service measurable standards are not in place to compare performance with, there can be no rating of quality performance and no basis for awards. You cannot have value added products and services unless they are more valuable to the end-user and cost the same or less than previous solutions. And Innovations can become superfluous and increase the cost of healthcare.

Congress and CMS can improve MA by 1) improving credibility. Cost-sharing is a function of shifting cost to the user and has nothing to do with sharing anything good. MA rebates pay for beneficiary cost sharing, copays, and coinsurance, and new benefit subsidies amounting to $1,980 per year per beneficiary. CMS and insurers laud lower MA bids for Part A & B benefits, but lower insurer bids are not a good thing unless benchmark goals are cut by more than bids are reduced, otherwise they increase the spread between bids and the benchmarks which increases unearned rebates! Does it make sense to anyone that MA would award a 50% rebate to a 1 - 3.5-star product or service provider? These suggestions might help to correct misleading claims – apply the decisive test, measure cost improvement success only by the ratio of CMS payments per enrollee for original FFS, MA plans, each ACO REACH, the total payments per enrollee for all CMS payments. Compare each of the four aggregate measures and focus innovation that jettisons losers until there is one winning model.

Celebrate whenever there is a breakthrough that either significantly improves healthcare service or cost and or longevity. Celebrate by awarding trophies or cash to individuals whose ideas prove successful. Acknowledge ideas and progress but reward breakthrough successes. Implement the Examples everywhere.

Questions reviewed:

1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare, and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why? **2**. What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements? **3**. What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas? **4.** How are providers and MA plans incorporating and measuring outcomes for the provision of behavioral health services in value-based care arrangements? **5**. What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an Accountable Care Organization (ACO)? How could MA

plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care? **6**. Do certain value-based arrangements serve as a "starting point" for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost? **7.** What are the key technical and other decisions MA plans and providers face with respect to data exchange arrangements to inform population health management and care coordination efforts? How could CMS better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data? What approaches could CMS pursue to advance the interoperability of health information across MA plans and other stakeholders? What opportunities are there for the recently released Trusted Exchange Framework and Common Agreement [3] to support improved health information exchange for use cases relevant to MA plans and providers? **8**. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes? **9**. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum? **10.** Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID Model that would test how to address social determinants of health and advance health equity? **11.** What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID Model? What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits? **12.** What issues specific to Employer Group Waiver Plans (EGWPs) should CMS consider?

D. Support Affordability and Sustainability

We are committed to ensuring that Medicare beneficiaries have access to affordable, high value options. We request feedback on how we can improve the MA market and support effective competition.

Response:

The healthcare insurance industry had a level playing field when it was granted rural and big city subsidies in the 1980's and then a 3% subsidy with the signing of the 1995 BBA. Since 1995 however, they have begged, lobbied, and won more taxpayer money than they deserve by Congress. In 2022, 15% of all CMS payments to MA plan insurers are non-productive cost and profit subsidies. Insurers MA plans have achieved a 43% market share but incurred payments per enrollee in 2022 were 104% of FFS Medicare payment per enrollee. In 2022 the playing field is tilted 45º towards MA.

Congress and CMS can improve MA by 1) improving credibility. Cost-sharing is a function of shifting cost to the user and has nothing to do with sharing anything good. MA rebates pay for beneficiary cost sharing, copays, and coinsurance, and new benefit subsidies amounting to $1,980 per year per beneficiary. CMS and insurers laud lower MA bids for Part A & B benefits, but lower insurer bids are not a good thing unless benchmark goals are cut by more than the bid is reduced, the spread between bids and the benchmarks which increase unearned rebates! Does it make sense to anyone that MA would award a 50% rebate to a 1 - 3.5-star product or service provider? These suggestions might help to correct misleading claims – apply the decisive test, measure cost improvement success only by the ratio of CMS payments per enrollee for original FFS, MA plans, each ACO REACH, the total payments per enrollee for all CMS payments. Compare each of the four aggregate measures and focus innovation that jettisons losers until there is one winning model.

The NRLN MA improvement suggestion is to discontinue all MA bonus, rebate subsidies, and implement NRLNs 5-step recommendation

Unless current implementation plans are improved, ACO REACH will include a 3% risk adjustment cap and shared cost reduction savings. Stop there, do not allow the MA plan poisons of capitation payment models, quality or service financial rewards or other unjustifiable subsidies or credits to become a part of ACO REACH trial models!

Force a three-way, four-year competition (original FFS, ACO REACH and MA) pick a winner and make it work. Do not give in to those looking for subsidies. COST IS THE ENEMY!

Questions reviewed:
1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees? **2**. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH? 3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus? 4. Are there additional considerations specific to payments to MA plans in Puerto Rico or other localities that CMS should consider? 5. What are notable barriers to entry or other obstacles to competition within the MA market, in specific regions, or in relation to specific MA program policies? What policies might advantage or disadvantage MA plans of a certain plan type, size, or geography? To what extent does plan consolidation in the MA market affect competition and MA plan choices for beneficiaries? How does it affect care provided to enrollees? What data could CMS analyze or newly collect to better understand vertical integration in health care systems and the effects of such integration in the MA program? X 6. MERGE OOP with MEDIGAP – SET 90%. Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care? 7. How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks? **8.** What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?

E. Engage Partners

The goals of Medicare can only be achieved through partnerships and an ongoing dialogue between the program and enrollees and other key stakeholders. We request feedback regarding how we can better engage our valued partners and other stakeholders to continuously improve MA.

Response:
Managing three venues FFS, ACO REACH and MA) is inviting a major communications and control problem. Add portal(s) with hyperlinks on the Medicare .gov website (control point) for enrollees and stakeholders' organizations as needed to achieve direct control of official communications. Share solutions, resolutions, examples, rules, etc. Primarily, make it clear to all stakeholders that only CMS will communicate federal policy directly to enrollees. Then manage it well or it will manage you.

There have been noticeable improvements to the website but there should be much more done to transform it to be a single authority for all 64 million Medicare beneficiaries and should be treated as a powerful tool to control non-conforming practices and behavior and to provide reliable Coverage and Care Access information and advice directly to Medicare beneficiaries in the insurers 4,800 MA plans, 500 independent ACO REACHES, etc. This is where misunderstandings, different motives and actions can lead to denial of coverage, poor care, loss of life, higher cost, and fraud. Can do things: FRAUD ALERTS; HOW TO ENROLL; HOW TO DECIDE: HELPFUL TIPS; HOW TO GET GOODRX or

MARK CUBAN DRUG PRICES, etc. <u>This is important</u>, by 2060 100 million or 25% of all U.S. citizens will be over age 65 – must get there before chaos.

Be the advocate for all 64,000 the 2022 Medicare beneficiaries – CMS works for them, through, but not for insurers, doctors, hospitals, clinics, drug manufacturers or other third parties.

<u>Questions reviewed</u>:

1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program? **2.** How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers? **3.** What steps could CMS take to enhance the voice of MA enrollees to inform policy development? Disclose all REACH details and get Congressional approval for subsidies **4**. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

Scroll down for NRLN Talking Points and Position Paper on Medicare Advantage

AREF
American Retirees
Education Foundation

NRLN
NATIONAL RETIREE
LEGISLATIVE NETWORK

IMPROVING MA – Eliminate Rebates – Reduce Costs – Equalize Benefits

Talking Points – August 17, 2022

MEDICARE COSTS / ENROLLEE 2019-2030 and BEYOND ARE OUT OF CONTROL:

Healthcare Costs are a **"Hungry Tapeworm,"** Eating Away at our Economy!

Medicare Costs of $796 Billion in 2019 Grow to $1.7 Trillion by 2030 **UP 101%**

Medicare Enrollees Projected to Grow from sixty-two million in 2020 to 77 million by 2030 **UP 25%**

Medicare Costs are growing Four (4) Times Faster than Medicare Enrollees 4:1

WE ARE AN AGING COUNTRY - CAN WE MANAGE IT?

The U.S. Census reports the over-age 65 population will be 75 million by 2030, 100 million and 25% of the population by 2060, but only three-million baby boomers will be alive. Who will kill the tapeworm?

GOVERNMENT BONUSES and REBATES INFLATE MEDICARE COSTS PER ENROLLEE:

CMS has paid MA Insurers **$450 Billion in Rebates** since 1985; **$53** billion in 2022; 2030 view is **$100.8** billion!

Forty-One percent of rebates paid subsidized MA cost-sharing, 59% subsidize extra benefits that lured three million enrollees into MA plans in 2022. Market share is now 27 million, 46%. Without subsidies, MA plans fail.

MedPAC' s 2022 Annual Report States: "Aggregate Medicare payments to Medicare Advantage plans have never been lower that FFS Medicare spending". "Medicare payments for extra benefits have increased by 53% since 2019." Further, "indirect subsidies" ... "account for 15% of payments made to MA plans, yet we have no data about their use nor information about their value". MA payments per enrollee were 104% of FFS in 2022.

MA CAPITATION PAYMENT and QBP SCHEMES ARE UNPROFESSIONAL SCAMS:

Profit and non-profit product and service business owners would never divest the supply side management of purchasing costs, quality, or service. But that is what Congress did when it legislated the capitation payment model. MA plans have no obligation to disclose actual incurred costs and are free to low-ball bids to maximize rebates and profit. Capitation and the QBP have led to denial of services and higher Medicare cost than FFS.

The MA Plan Quality Bonus Plan (QBP) is an unprofessional taxpayer scam. U.S. businesses do not pay supplier rebates for expected quality or service agreed to – by contrast, **QBP pays 50% rebates for 1-star ratings!** MedPAC' s 2022 Annual Report claims that **"The current state of quality reporting is such that the Commissions annual updates can no longer provide an accurate description of the quality of care in MA".**

REBATES CREATE UNFAIR COMPETITON and DISCRIMINATORY BENEFIT ELIGIBILITY:

MA Rebates **of** $1,980 per enrollee, **$53.4 billion** ($1.980 x 27.4 million) this year, is up 17.9% per enrollee from 2021! Congress passed legislation that excludes thirty-six million older Original Medicare taxpaying enrollees from being eligible for these extra benefits – **statutory age discrimination?** Low-income and non-MA enrollees who do not qualify for Medicaid and those in Medicare who buy Supplemental plans are denied these extra benefits!

NRLN PROPOSES "Exposing the Truth and Holding People Accountable"

- The **truth** is published in Medicare Trustee, MedPAC, GAO, CBO, CMS, and OAG reports.

- Grandfather benefits for current MA Plan enrollees or grant MA enhanced benefits to all in Medicare.
- Legitimize Quality Control at the doctor patient level and innovate to **reduce FFS costs**.
- Eliminate the Capitation Model - focus on setting more relevant FFS Benchmarks and require all **risk adjustments** and expected payments be actuarily assumed in CMS Benchmarks and Provider Billings.
- Eliminate **QBP Bonuses and Rebates and FFS competitive barriers**; create a Level Playing Field.

AREF
American Retirees Education Foundation

NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

IMPROVING MA – Eliminate Rebates – Reduce Costs – Equalize Benefits

The National Retiree Legislative Network (NRLN) and most Americans support competition among private healthcare plans, and we understand the financial challenges ahead for Medicare and the federal budget. However, we do not support bonus or rebate subsidies, or anti-competitive restrictions placed on original Medicare Fee-for-Service (FFS) just to preserve the notion that private insurance plans may be more cost effective or provide better care than FFS, when the record shows they are not and do not.

Warren Buffet recently commented that healthcare costs are like a “hungry tapeworm, eating away at us.” The cost of living for seniors, GPD growth, the cost of capital needed for growth and innovation and the strength of our democratic form of governance are threatened by the survival of this “hungry tapeworm”.

The number of over-age 65 U.S. **retirees will grow 25%, from 62 to 77 million between now and 2030 and to one hundred million by 2060.** We are an aging country. **Baby boomers are** a small piece of the puzzle; they will all be over age 65 by 2030 and by 2060 only three million will remain. Medicare **healthcare costs will grow 101%,** from $796 billion to $1.7 trillion from 2019 to 2030**.** Medicare Trustee and Medicare Payment Advisory Commission (MedPAC) reports show that healthcare costs are rising 101%, four (4) times the rise of Medicare enrollees (at 25%) from 2019 to 2030. **– HEALTHCARE COSTS / ENROLLEE ARE OUT OF CONTROL!**

Unfortunately, Congress and the Executive Branch, are surreptitiously feeding that tapeworm by yielding to private healthcare insurers and healthcare product and service providers. Medicare Advantage (MA) plans suffer from fatal business model deficiencies like the capitation payments model, the misuse of quality control as a cash award system (the QBP) and discriminatory benefit denials. All these perverse innovations are antithetical to the American competitive business model. Healthcare provider profits must be earned, not awarded / subsidized.

Facts that can’t be denied: **1)** healthcare costs are rising four times faster than Medicare enrollees**, 2)** private plan Medicare **market share rose by 2% to a 46% (27.4 million enrollees)** in 2021; **revenue was $350 billion, 3)** after 37 years (1985-2022) of dolling out over **$450 billion in rebates,** the Committee for Medicare and Medicaid Services (CMS) payments per Medicare Advantage (MA) plan enrollee increased to **103% of payments** made per enrollee for Medicare Fee-for-Service (FFS) enrollees in 2020 and **to 104% in 2022, 4)** it’s time to realize that subsidized growth can no longer be justified, Congress, CMS and Insurers must be held accountable!

Exposing the cause and effect of the facts can be very revealing. In 2019, payments to MA plans per enrollee were 2% higher than for Original Medicare FFS. This **102%** performance shortfall was labeled as insignificant

by CMS, healthcare insurance lobbyists and others in D.C. think-tanks, proving that averages can deceive even the "experts". In this case, MA plan **Part A results were 91%** or 9% under original Medicare cost. However, the **Part B score was a pathetic 118%.** The weighted average **was 102%.** Fortunately**,** Medicare Trustee and MedPac reports cited that MA plan recruits are much younger and do not often go to the hospital but as they age to match the profile average of original Medicare enrollees, **Part A costs for MA plan enrollees will skyrocket!**

Mark this point - MA plan subsidized cost-sharing and extra benefits are politically motivated and accessible mostly by healthier, nearer-age 65 retirees. As their average ages increases to the average age level of the other 50% of the Medicare population today, MA plan premium, deductible, copay, and coinsurance (out-of-pocket) costs will explode. This will cause a massive switch to original Medicare. If Medicare is not there for these younger retirees later in retirement, we can expect losses of purchasing power and increased personal bankruptcies among 25% of our U.S population, and macro-economic dilemmas such as lower GDP growth.

Congress duped taxpayers into paying insurers for enrollee cost-sharing and extra MA plan benefits worth **$53 billion this year that entice new MA plan enrollees**. They call these extra benefits "free" on TV commercials, flyers, and postcards. In fact, they are unjustified subsidies that enable privatization.

Congress authorized rebates to fund MA dental, vision, hearing, and prescription drugs and much more, and "cost sharing" but has repeatedly **denied these same benefits to forty million beneficiaries in original Medicare**: a slap in their faces and breech of moral and ethical character.

In 2020, nearly 50% of the Senators and Representatives from both parties agreed to posting their signatures as Champions for the Better Medicare Alliance www.bettermedicarealliance.org the healthcare industry funded lobbyist for Medicare Advantage Plans. That is not chutzpah, it is betrayal. Over three hundred elected members of Congress have denied access to these benefits to forty million beneficiaries in original Medicare.

On October 15, 2021, 13 Senators led by Krysten Sinema (D-AZ) and Tim Scott (R-SC) signed a letter to CMS urging protection from MA payment cuts. It is interesting that Joe Machin (D-WV), a moderate and Marco Rubio (R-FL) were on this list. All of them and Senator Sinema must have thousands more constituents in traditional Medicare than in MA plans – who are not eligible to receive the subsidized benefits they support for their other constituents who are in MA plans! These members of Congress are true-blue privatizers. The others who signed are Senators Shelley Moore Capito (R-WV), Gary Peters (MI), Todd Young (IN), John Tester (MT), Jacky Rosen (NV), Angus King (ME), Jeanne Shaheen (NH), Deb Fisher (NE) and Mark Kelly (AZ).

CMS paid MA insurer rebates of $81 a month per enrollee in 2016. In 2021, rebate payments rose 14%, above 2020 to the highest level in history, $140 monthly ($1,680 / year /enrollee). In 2022 rebates are up 17.8% to $165 a month ($1,980 / year / enrollee. The 2022 rebate of $165 is up over 100% from $81 five (5) years ago and will cost $53 billion in 2022. The 2021 Medicare Trustee's report warned us to expect annual rebate increases per enrollee, growing to $100.8 billion by 2030. However, the current trend indicates we may reach that level by 2028.

MedPAC's 2022 Annual Report States: "Aggregate Medicare payments to Medicare Advantage plans have never been lower that FFS Medicare spending." "Medicare payments for extra benefits have increased by 53% since 2019." Further, "indirect subsidies," "account for 15% of payments made to MA plans, yet we have no data about their use nor information about their value." MA payments per enrollee in 2022 are 104% of FFS.

How did we ever get to a point where members of the Legislative branch can pass laws to award rebates to U.S. companies and then overtly endorse industry K street lobbyists that lobbied them for these subsidies, and further, then accept campaign contributions from them?

FFS rules permit Medicare's management of supplier pricing, quality, and service. The healthcare insurance industry won when HHS and Congress agreed to switch from FFS rules to MA capitation payments that turned

over the control and visibility of supplier cost and quality and service to go-betweens **(**insurers**).** Insurers do not provide value-added healthcare products or services but reap and keep unwarranted bonuses and rebates that include markups of 10-15% to recover insurance company overhead and profit! Medicare total overhead is less than 2%.

Congress tipped the scales even more by enacting restrictive legislation that **prohibits FFS from establishing provider networks or implementing new innovations and from seeking competitive supplier bids.** In normal for-profit and non-profit businesses, subsidizing a competitor and restraining your own management from competing would **cannibalize the business and get you fired.** Congress is cannibalizing its own Medicare business to avoid having to manage it - that might include having to raise taxes or doing anything else that might affect their personal or party electability.

Privatization works only because bonuses of 5-10%, or more, are enabled by a statute that increases FFS benchmarks that MA the plans bid against. When insurers bid lower than FFS benchmarks, they win and become eligible for huge rebates.

This scheme is a 5-star rating plan called the Quality Bonus Plan (QBP). QPB appears to be typical of what you might see if you were shopping for a washing machine, a household product, or a car. Closer examination reveals that it is scheme used to grease the skids, enabling rebate payments to private plan insurers.

Anyone familiar with how the product or service procurement process works in for-profit or non-profit business knows not to pay bonuses and rebates to suppliers of products and services who meet contracted-for price, quality, and service terms. Instead, they might earn a place on a preferred supplier list or be awarded a trophy. If they fail to meet buyer (Medicare) standards, they may well lose customers and sometimes go bankrupt. No subsidies for them. If they underrun costs and expenses in bids, they keep it all; they do not beg for subsidies!

If you saved $5,000 in a deal to buy a car, bought it at the price agreed to and with quality (a warranty) and service commitments would you pay the dealer a 70% or $3,500 rebate for meeting these commitments?

The Medicare Advantage Quality Bonus Plan (QBP) does not measure consumer healthcare product or service quality well. **Astonishingly, this 1-5-star plan awards 1-star rated plans a 50% rebate!** The Health and Human Services (HHS) Inspector General Office calls rebate payments “Wrong and Improper Payments.”

The table below and explanations below it exposes the scheme **aptly named the Quality Bonus Plan (QBP).** This plan serves to subsidize healthcare insurers - it is a fairytale, a taxpayer scam and is highly discriminatory.

Medicare Advantage QBP - Bid, Bonus and Rebate Study Calculate Three Plan Rebates - Use QBP 4.5, 4.0 and 1.0 Stars Using a $1,000 County Benchmark, a Plan Bid of $874 and a Neutral 2% Benchmark and Bid Risk Adjustment Factor		Rating - 4.5 + Rating = 5% Bonus & 70% Rebate	4 Star Rating - 3.5 to 4.5 Rating = 5% Bonus & 65% Rebate	1 Star Rating - 1.0 to 3.5 Rating = No Bonus 50% Rebate
STEP I	County Benchmark (for A&B Benefits) - FFS Based	$1,000	$1,000	$1,000
STEP Ia	4-Star Rating = 5%-10% Bonus (used 5% x Step I)	$50	$50	NA
STEP Ib	Benchmark for A&B Benefits - Plus Bonus (I + Ia)	$1,050	$1,050	$1,000
Step II	Standard A & B Bid (Cost+OH+Profit) = $874 /.98, The Combined Plan and Individual Risk Adjusted Bid.	$891	$891	$891
STEP III	Benchmark + Bonus Adjusted & .98% Bid Risk(Ib / .98	$1,071	$1,071	$1,020
STEP IV	Rebate Maximum (QBP Rebate Maximum, III - II)	$180	$180	$129
STEP V	Plan Rebate Award for - QBP Stars (70%-65%-50%) x IV	$126	$117	$64
STEP VI	Monthly Payment to Insurer / Enrollee (II + V)	$1,017	$1,008	$956
Insurers Monthly Rebate as % of Adjusted Standard Bid (V / II)		14%	13%	7%
* KFF (Aug 2021) reported 81% of MA Plan Enrollees were in plans awarded 5% or 10% bonuses (3.5 stars or higher) ** Prior to 2012 a CMS "rate book" was used to set benchmarks. FFS County benchmarks were implemented in 2012.				www.nrln.org

Step I - Benchmarks are the cost for the basket of Medicare A & B benefits and are set based on original Medicare Fee-for-Service costs in U.S counties. Our example **Benchmark is $1,000**.

Step I a.- MA plan quality performance can qualify for a 5% or 10% increase in the FFS Benchmark if the plan's star rating is 3.5 or higher - we used 5%. Since ratings in the first two columns qualify, a 5% bonus of **$50** was added to both Benchmarks – see Step I b ($1050). Plans rated 1 to 3.5 stars, are not bonus eligible

Steps II and III – In Step II plan bids are submitted to CMS and risk adjusted for health risks – In this case the bid was $874 but risk adjusted by 2% to $891. In Step III – Benchmark bids are also risk adjust – for example purposes we applied the same **2% risk factor to increase the Benchmark from $1050 to $1071**.

Step IV – The **Pot of Gold**, the spread between a bonus and risk adjusted Benchmark and the risk adjusted Bid – $1071 minus $891 or **$180 per month of "cost savings"** available to insurers for every enrollee in the plan.

Steps V – VII – The insurer of the 4.5-star rated plan gets a **70% rebate of $180 or $126**, equal to 14% of the plan risk adjusted bid for every enrollee; the 4.0-star plan gets **65% or $117**, 13% of the risk adjusted bid and the **1-star plan gets 50% or $64,** 7% of the risk-adjusted bid.

Most MA plans win a taxpayer subsidy of 50%; CMS rates about 80% of them at four-stars or higher.

There are ongoing investigations and litigation regarding risk factor fudging. QBP bonuses and risk factor adjustments inflate the spread, thus increases the size of the Pot of Gold.

The **abandoning of original Medicare product and service price setting and the control of market pricing** has sacrificed supplier cost visibility and leaves the QBP highly vulnerable to low balling of bids to maximize rebates. Insurers and CMS staff now brag what a good thing it is that insurer bids are coming down. However, if bidders artificially reduce bids and FFS benchmarks are constant or increasing, the spread between them increases so rebates increase and the cost per enrollee paid by CMS to private plans will be higher. L**ower bids mean nothing unless the net effect is a savings to Medicare and taxpayers – which has yet to be the case.**

Insurer 3.5-star or higher plan ratings inflate bonuses that inflate FFS benchmarks. Rebates are a percentage of the gap between benchmarks and bids (rebates average $140 a month, 14% of risk adjusted bids). Do you suppose it would cross the minds of insurers to win 3.5 star or higher plan QBP ratings, low-ball bids and walk away with 70% (4.5+ star), 65% (3.5 star) or 50% (1-star) of a larger spread between the benchmark and bid?

MedPAC's (Congresses watchdog for Medicare payment policy) March 2021 report to Congress states on page 385 that **"The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of the quality of care in MA."** This statement was reported to Congress by MedPAC in its 2018, 2019, 2020 and 2021 annual reports!

The NRLN advocates ending bonuses and rebates and allowing the two programs to compete head-to-head on a level playing field. Our nation cannot sustain paying subsidies or believing in a false narrative.

The NRLN PROPOSES "Exposing the Truth and Holding People Accountable":

- Rely on data from Medicare Trustee, MedPAC, GAO and CBO reports.

- Grandfather benefits for current MA Plan enrollees or grant MA enhanced benefits to all in Medicare.

- Use Quality Control and Innovation to reduce FFS costs.

- Eliminate the Capitation Model - focus on setting more relevant FFS Benchmarks and require all risk adjustments and expected payments be actuarily assumed in bidder pricing vs benchmarks.

- Eliminate QBP Bonuses and Rebates and FFS competitive barriers; create a Level Playing Field.