



MEDICARE ADVANTAGE PLANS – SPEEDING TOWARD PRIVATIZATION

\$350 BILLION WASTED ON SUBSIDIES TO PRIVATE INSURERS

May 15, 2019



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Executive Summary

Ted Sidle owner of Benchmark Financial Services, Inc. wrote in April 2019 that “We are on the precipice of the greatest retirement crisis in the history of the world. And that makes perfect sense because, first of all, **we have the largest elderly population in the history of the world.**” Just focusing on the United States: our elderly are woefully unprepared to retire. And in the decades to come we will witness millions of elderly American's, Baby Boomers and others, slipping into poverty. **'Too frail to work, too poor to retire'** will become the new normal for many elderly Americans.”

We are aware of the savings crisis and that 10,000 Americans turn age 65 a day (3.6 million a year); by 2035 there will be 75 million and then 100 million by 2060.

This paper illuminates the Congressional and Executive branches 30-year flight from budgetary accountability for funding our Medicare program to what they have been convinced is the best solution, privatizing Medicare. Our evaluation of this flight reveals that so far over \$350 billion of federal taxpayer money has been paid to insurance companies, wasted on subsidization of Medicare Advantage (MA) plans in an effort to privatize Medicare.

Health Maintenance Organization (HMO) plans pioneered the private health care provider model in the 70's but the model has yet to succeed.

The Medicare Payment Advisory Commission (MedPAC)¹⁷ reported that that MA plan insurers made a five-percent (5%) margin in 2016, twice the average of Medicare plans overall. That's 25% better than the industry's overall four-percent (4%) margin reported by Standard and Poor's.

MA plan bonus payments to insurers under the suspect Star Rating System were \$3.5 billion in 2012, and \$6.3 billion in 2018. Yet most ratings reported by customers don't reflect that there has been much quality improvement. Benchmark settings, plan risk adjustments and star quality ratings bonuses have all come under fire as being mismanaged and run by those who turn in the paperwork.

Private plan market share has grown proportionally as federal subsidies are baked into monthly payments to insurers. MA plan providers lobbied their way into the Medicare market. MA plans have been the Trojan horse lobbied for by insurance companies and promoted by Congress to deliver privatization of Medicare.

Medicare Fee for Service (FFS) traditional plans could purchase products and services at double the volume levels of MA plans; Medicare FFS operates with 2% overhead vs the 15% overhead and profit of insurers.

Instead, Congress authorized Centers for Medicare Services (CMS) to give \$16.5 billion of our tax money to MA insurers exclusively so they can market new unproven benefits that are not available to the 39 million traditional Medicare FFS enrollees (3.4% of \$266.3 Billion or \$9.1 billion in 2019 and 2.53% of \$292.5 billion or \$7.4 billion in 2020 was approved to buy food consulting, home delivery of groceries, transportation, home services and safety devices, etc... that lure new healthier MA enrollees when FFS enrollees may need them more.) **THESE TWO-YEAR PAYMENTS TOTALING \$16.5 BILLION WILL FUEL THE CMS AND MA INSURER 2019 and 2020 MARKETING HYPE!**

The Congressional Budget Office's (CBO's) October 5, 2017 Analysis of Illustrative Options¹⁰ states clearly that under privatized regional exchanges and using the 2nd lowest bid option "Without Grandfathering" (a 2018 decision that eliminated those age 55 or older from being grandfathered as promised in 2017) that results in:

"Net Federal Spending for Medicare Parts A and B for Affected Beneficiaries" that would be lower by	-15%
"Premiums Paid by Affected Beneficiaries" that would be higher by	35%
"Total Payments by Affected Beneficiaries (premiums, deductible" co-pay and co-insurance) that would be higher by	18%
"The Combined Net Federal Spending for Total Payments by Beneficiaries" that would be lower by just	-7%

Without grandfathering, enrollees must pay 18% more for health care payments and the federal government saves only 8% (\$419 billion) in 2024. Seniors should be informed that grandfathering may be out, and MA plans may be discontinued by 2022.

Clearly, privatization will not lower the cost of health care, instead it will shift 18% of the federal tax burden and health care costs to seniors while protecting the health care provider and pharmaceutical industries. If the MA plan is the Trojan horse for privatization, then the CBO October 5, 2017 analysis has crippled it. It's time to have an honest discussion about the efficacy of privatization.

In 2019, as a result of the 2018 passage of the “Bi-Partisan Budget Act of 2018” (BPBA), Congress has delivered a low- blow that confirms our assertion and declares Congresses intention to privatize Medicare and Medicaid. The BPBA created more subsidies to pay for more MA plan unsubstantiated benefits that are NOT available to Original Medicare plan A&B beneficiaries.

The Senate passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act then Congress amended it to the BPBA in 2018. The CHRONIC Act granted the inclusion of long-term services in private plans (MA Plans). Today long-term care is not covered by Medicare! These new MA benefits are labeled MA plan managed-care benefits.

Other new actions announced and written about in April of 2019 are:

- 1) a healthcare insurer (UHC) has announce a private plan that will combine Medicare and Medicaid.
- 2) MA insurers are working with the housing industry to include home - based care delivery in senior housing.
- 3) in April of 2019, HHS Secretary Alex Azar announced that experiments with plans to introduce changes in the primary care payment model that will strike at the heart of the Original Medicare Fee-for-Service model. Ironically, maybe HHS now sees that MA can never compete with Original Medicare and that changes to it will bring the necessary solutions to high cost provider products and services.

Ask your Senators if they voted for the CHRONIC Act and if they approved amending it to the 2018 Bi-Partisan Budget Act (BPBA)? Then ask if they believe that spending over \$350 billion on MA plan subsidies (taxpayer dollars) over 30 years has been the right thing to do?

The MedPAC, the independent congressional agency created by Congress to advise them on issues affecting the Medicare program reported to Vice President Pence, Speaker Pelosi and all members of Congress on March 15, 2019... “We project the base benchmarks (that is, excluding quality bonuses) will average 103 percent of FFS spending, and the payments, excluding, quality bonuses (and coding differences), will average 98 percent of FFS spending in 2019. According to MedPAC bonuses would add about 2.4 percent to the 98 percent. **This report said benchmarks without quality bonuses added would average 103 percent in 2019. MA plans are more expensive per enrollee than Original Medicare.** So why not fix Original Medicare, strip out the cost of subsidies and get rid of some people? HHS is wasting taxpayer’s money and cheating over- age 65 Americans?

FEDERAL SUBSIDIES PAID TO MA PLAN INSURERS ARE UNWARRANTED!

THEY SHOULD BE STRIPPED OUT NOW RATHER THAN LATER WHEN INSURERS WILL BE ABLE TO INCREASE PREMIUMS, DUDUCTIBLES AND COINSURANCE AT WILL IN ORDER TO MAINTAIN THEIR 5% + PROFIT MARGIN!

MA PLANS ARE HIGHLY SUBSIDIZED AND COST INEFFECTIVE BUT CHEAPER FOR THE HEALTHY WHO BENEFIT FROM THEIR ARIFICIALLY LOW PRICE. WE NEED TO PROTECT OUR RETIREES WHO OWN AN MA PLAN AND WE NEED TO DESERT POLITICIANS WHO SUPPORT THEM.

OUR CHIDREN, GRANDCHILDREN AND FRIENDS DESERVE BETTER!

The NRLN Asks Congress and the Executive Branch to:

- Grandfather and protect the 20 million seniors (34%), who have purchased MA plans in good faith, from future reductions in benefits and guarantee the protection of baked in subsidies as of December 31, 2019 and all future MA subsidies, rebates, rewards, bonuses and non-traditional Medicare plan benefits combined.
- Direct Government Accountability Office (GAO), CBO and the HHS Inspector General to investigate and report on MA and Original Medicare Part A and Part B independent financials and assess and publicly disclose the cost effectiveness of MA, with and without taxpayer subsidies (rebates, risk adjustments and star bonuses).
- Retract the 2019 and 2020 subsidies for home air filters and carpet shampooing for asthma patients, pay for heart healthy meals for those with heart disease and other services that represent a shift from services that prevented, improved or cured a patient's conditions, to services determined by what a chronically ill patient needs, or make them available to the original Medicare A & B, FFS enrollees who have the same health conditions and needs.
- Reduce the \$140 billion annual wrong and improper payments generated by all federal agencies (particularly the \$85 billion attributable to Medicare and Medicaid). Sequester savings and use them to eliminate the 75-year deficits of Medicare Part A and Part B, then Part D. Payroll tax increases are an option.



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THE EVOLUTION OF PRIVATE and MEDICARE ADVANTAGE PLANS

1970 - 1996 – Private plans, mostly HMO's, were alternatives to Medicare A&B

- HMO's languished due to inferior staffing, bad service and poor quality.
- Private plans did not compete well against Traditional Medicare

The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program to be "Medicare Choice" (MC). The insurance industry was taking on heavy losses they didn't want to absorb, and Congress wanted budget relief from baby-boomer expectations. President Clinton agreed to a 3% subsidy.

From 1997–2003 private plans were unable to compete, they carried a 12-15% overhead and profit burden VS Medicare's 3% overhead and were unwilling to risk insuring older, less healthy enrollees. A monthly capitation payment including subsidies was established that carried into the 2010 Affordable Care Act (ACA).

MC plan market share slipped from a 1999 high of 18% to 13% by 2003^{2a}

The 2000 Benefits Improvement and Protection Act (BIPA). The year 2000 drop in MA plan market share caused a "K" street rush to lobby for more subsidies that would help recoup market share. BIPA established a new sharply raised set of rural and urban floors for capitation payments in many counties⁵. Prior to BIPA, payments were based upon historical traditional Medicare per capita payments. Under BIPA county floors were set at \$525 monthly and rural county floors were set at \$475. Since insurers' plans in about 72% of counties received capitation payments below these floors before BIPA, their MA plans received immediate and sizeable monthly capitation increases, risk payments.

The Medicare Modernization Act (MMA) of 2003, intended to be the Medicare Part D prescription drug plan (Act), was lobbied by health care insurers who convinced Congress again to subsidize the privatization of Medicare even more. The MMA renamed MC plans to be Medicare Advantage (MA) plans, authorized them to include Medicare Part D and sneaked in federal subsidies of 12-17% by introducing a benchmark scheme that insurers later proved could be manipulated.

MA plans must offer Parts A & B, but not hospice services (Medicare pays for these). In addition, MA plans often cover vision, hearing, dental, and health and wellness coverage, sometimes for an added premium. They are required by law to have an annual out-of-pocket maximum beyond which the plan pays 100%. Insurers tossed in silver sneakers programs, low or no premiums, etc. Happy MA clients were mostly cherry picked (seamless conversion⁹) from among younger retirees in selected areas (manipulation). Healthy 65-year-olds don't always believe they need supplemental insurance (Medigap) or that they will use their out of pocket max coverage (not included in Traditional Medicare Part A or B).

MA plans added subsidized benefits such as eye care, dental plans, etc. and market share roared back from 13% in 2003 to 24% (with a 14% subsidy average) by 2010. Continued rebates and bonuses plus new subsidized benefits allowed MA plans to pre-market and cherry pick (the new cherry pickers) seniors even before they turned age 65, and by 2017 MA plan market share reached 33%^{2a}. Over this time period MA plans became extremely profitable, the best in the industry.

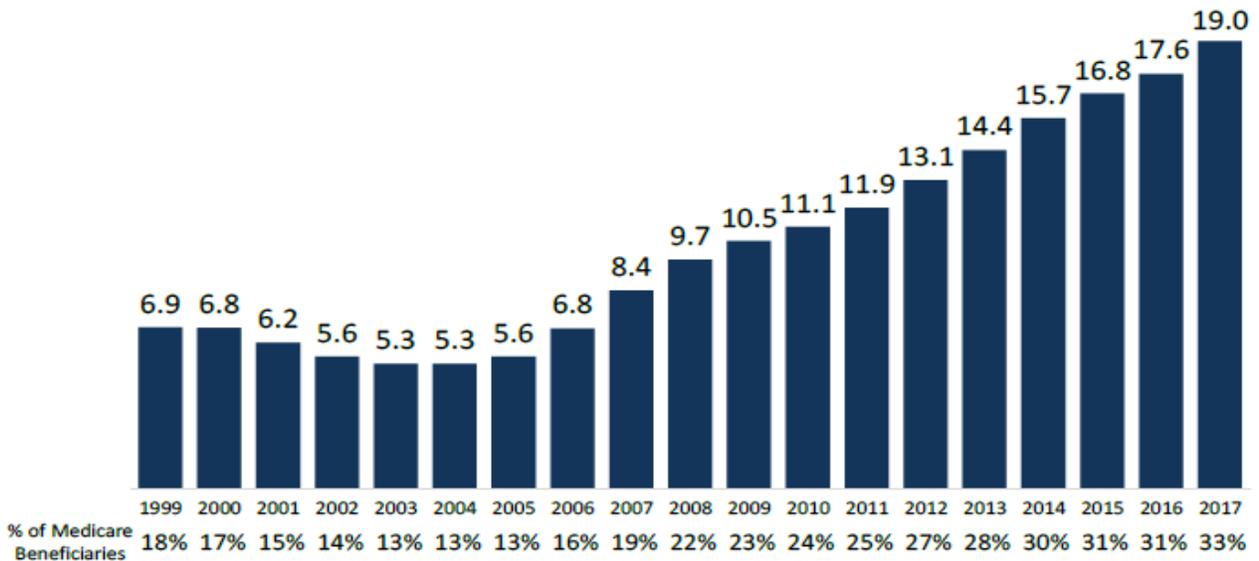
Since 2006, Medicare has paid plans under a bidding process. Plans submit "bids" based on estimated costs per enrollee for services covered under Medicare Parts A and B; all bids that meet the necessary requirements are accepted. The bids are compared to benchmark amounts that are set by a formula established in statute and vary by county (or region in the case of regional PPOs). If a plan's bid is higher than the benchmark, enrollees pay the difference between the benchmark and the bid in the form of a monthly premium, in addition to the Medicare Part B premium. If the bid is lower than the benchmark, the plan and Medicare split the difference between the bid and the benchmark; the plan's share is known as a "rebate," which must be used to provide supplemental benefits to enrollees. Payments to plans are then adjusted based on enrollees' risk profiles^{2a}. In 2018 and 2019 CMS has simply added 2.95% and 3.4% in new benefit subsidies that enable MA insurers to entice new enrollees.

Today, MA plan success hinges on the accuracy of cost / enrollee "bids", "benchmarks" set by someone's formula (but subject to change), if bids are too high enrollee pays higher premiums, if bids are low "rebates" are split but enrollee does not get any cash; "high risk profiles" boost payments to insurers and CMS tosses in billions more "unearned benefit dollars" to insurers for benefits they say we need.

Insurance companies gamed the system in 2003 when they successfully lobbied for and won changes and then from 2006 forward have accelerated market share growth by offering great low-cost deals subsidized by taxpayer dollars. See following graphic.

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2017



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

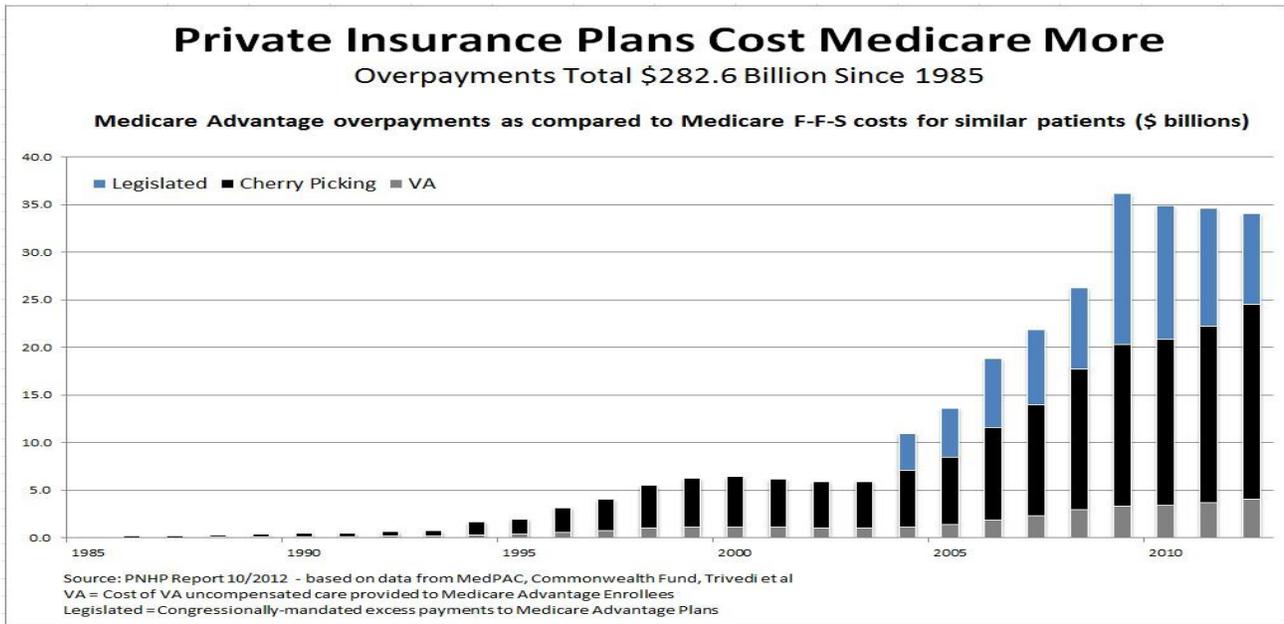
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.



From 1985 – 2004 insurers gamed CMS by keeping \$41 billion in overpayments from “old cherry-picking”; they enrolled healthier seniors. Congress mandated subsidy payments in the 2003 MMA that added \$84.4 billion in overpayments through 2012. Also, when Medicare set 70 medical diagnoses as part of a new risk-adjustment scheme in 2004 it opened the door for insurers to out-fox CMS again by enrolling persons who had mild versions of medical conditions that determined higher payments; the result was \$122.5 billion in overpayments from 2004 – 2012^{8a}.

There has been a near sinister alliance between Congress and HHS / CMS to tell the public on one hand that Medicare won't be touched, while every day HHS / CMS has the green light to sabotage Medicare with the MA Trojan horse and taxpayer dollars. A small but important example occurred when the “Seamless Conversion” (SC) Section 1854 was added to the Social Security (SS) Act to cover Medicare Choice plans, then was modified by Reg. 422.66 to include MA plans. SS must provide MA insurers with personal contact information of seniors about to turn age 65 who, if they fail to make a plan choice during enrollment, are auto-enrolled in a MA plan. There is an opt-out option, not opt-in. SS must provide information to insurers 90 days before age 65 arrives; an opt-out option is sent 60 days before an auto-enrollment event⁹. Result, insurers save billions in marketing expense and feast on 10,000 low risk prospects who turn age 65 daily.

An example of how inconsistent things are run, insurers paid a fixed monthly amount (capitation) for every enrollee to cover benefit payments whenever Veterans Administration (VA) eligible enrollee receives care from the VA rather than through their MA plan, insurers keep the monthly capitation payment. From 1985-2012) over \$34 billion, was up to 6% overpaid^{2a}. A breakdown of 1985-2012 overpayments by type are shown on the table below.



In fiscal year 2017, Medicare Advantage (Part C) overpayments were \$14.4 billion or 8.3% of program outlays of \$172.8 billion³.

The Medicare Payment Advisory Commission (MedPAC) determined Medicare was paying private plans 14% more per enrollee under the subsidized “benchmark system” than the cost of care in traditional Medicare and recommended subsidy reductions^{1a}. These data opened the door for the introduction of subsidy changes in the 2010 Affordable Care Act^{2a}!

The Affordable Care Act of 2010 changed things for MA plans. The ACA statute phased out MMA subsidies (14% average¹) over a five-year period, but replaced them with a new four-star rating system that pays rebates to MA plan insurers and opened the door to other incentive programs that continue to subsidize MA plan insurers⁶.

By 2014, the MMA subsidies were down to 6% over traditional Medicare⁴ and were expected to be completely phased out by 2017 but were not. Instead, MA plans with certain star-ratings were allowed to retain up to 6% of these remaining subsidies.

2018-2028 CONGRESSIONAL ACTION TO MINIMIZE ORIGINAL MEDICARE:

There is a significant difference between this 2019 version of NRLN's Medicare Privatization whitepaper and last year's Trojan Horse analogy that depicted a sneak attack to eliminate Medicare through privatization over time. This year, as a result of the 2018 passage of the "Bi-Partisan Budget Act of 2018" (BPBA) Congress has delivered more of a bad thing, federal government subsidies to prop up insurers who can't compete without them. The BPBA created more subsidies to pay for more MA plan unsubstantiated benefits that are NOT available to Original Medicare plan A&B beneficiaries.

It has been obvious since 2012 that Congress has wanted to privatize Medicare and has invited insurance companies to take over their work. Now it appears they want to fully privatize Medicare as evidenced by the Senate passage of Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act that was amended to the Bi-Partisan Budget Act of 2018" (BPBA), and that approved of added benefits to MA plans using federal tax revenue:

2018 - CMS plan payment increase of 2.95% - increased to reflect plan changes

2019 - CMS plan payment increase of 3.40% - for added coverage trips to fitness centers, doctors, pharmacies, over-the counter meds, eyedrops, vitamins, compression stockings; house calls by doctors and other help providers and home health care assistance such as dressing, eating, chores and light housekeeping; shower grab bars, home delivered meals, wheelchair ramps and A/C units for asthma sufferers.

2020 - CMS plan payment increase of 2.53%, is a shift from services that prevented, improved or cured a patient's conditions, to services needed by specific patients, like for those with chronic pain. Plans may pay for home air filters and carpet shampooing for these with asthma, or pay for heart healthy meals for those with heart disease and other services determined by what a patient needs, and not just what is on an allowable list. In 2019, these 2010 added benefits will NOT be available to same-aged traditional Medicare enrollees who have the same health conditions and needs. WHY?

These benefits are a product of the establishment and funding of a CMS Innovation Center in the 2010 ACA, aka Obama Care. Our current administration has kept it alive but so far many if these added benefits have not been proven to cost effectively solve health problems, according to numerous articles including one in The New England Journal of Medicine, November 2018.¹⁷

If these new services (benefits) are proven to help reduce Medicare C (MA) program costs, then for what reason would CMS exclude 66%, the traditional Medicare A & B enrollees?

Currently, several MA plan insurers have been sued by six or more states seeking to recover hundreds of millions of dollars for allegedly defrauding Medicare and Medicaid by gaming individual health care ratings of enrollees, and the federal government has warned the industry after looking into similar activities. It appears that there has never been an incentive bonus program installed that smart people who benefit from them can't game. Cheating has migrated from simple "up coding" and "cherry picking"^{8b} to more sophisticated schemes and bigger payoffs.

Across the country, MA plan networks have been found to include 51% of all hospitals and 46% of the physicians in the U.S.⁶. In 2015, 35% of MA plan enrollees were in plans with narrow physicians' networks. These networks included less than half (46%) of all physicians in a county on average⁷.

Using these services out of network leads to enrollee benefit payment claims being denied. This is mostly an HMO problem that can lead to critical economic problems for enrollees. PPO plans are not as restrictive as HMO plans. In 2017, 63% (12 million enrollees) of all MA plans were HMOs. PPOs were 26% (5 million enrollees), Regional PPO's 7%, PFFS plans 1% and other 3%^{2a}.

Inadequate hospital and physician networks and claim denials have prompted HMO enrollees to search for less restrictive PPO coverage, but they have found it to be comparatively expensive. One example is that Medicare plan average HMO out-of-pocket maximums were \$4,928 compared with \$5,862 for PPO's in 2017.

WHY SHOULD SENIORS and PROSPECTIVE SENIORS BE CONCERNED?

Members of Congress and political parties are just now facing, but not owning up to the truth, that they dug a deep hole. Medicare Trustees annual reports for years included warnings that the over-age 65 population would grow to 75 million by 2035 and 100 million by 2060¹². Not taking action to fund mandatory programs over a 35-year period and now lowering tax rates has put enormous pressure on economic growth and the ability to fund these programs, particularly Medicare.

As usual, the drumbeat from Congress is that "entitlement" benefits must be cut or the nation will suffer because of mandatory programs.

It is obvious that Medicare privatization is not just a potential risk, it is alive and rapidly proceeding. The House Budget Committee 2018 budget for "A Brighter American Future"⁶, in spite of politicians who say they won't touch Medicare, pledged to:

Fully Support a Patient-Centered Program that Enhances Quality and Choice in Medicare. Under a Privatization model, traditional Medicare – which would always remain an option available to future beneficiaries – and private plans providing the same level of health coverage would compete for seniors' business, just as Medicare Advantage does today. By adopting a

competitive structure, the program would also deliver savings for seniors in the form of lower monthly premium costs. Today, only Medicare Advantage offers seniors the opportunity to choose from a selection of comprehensive coverage plans. Not surprisingly, Medicare Advantage enrollment has tripled in the past decade and currently serves 20 million individuals.

CBO determined that a Medicare program following this policy would result in savings for both beneficiaries and taxpayers. Moreover, health plans that participate in this new option would not be able to deny coverage to any Medicare recipient. This proposal would guarantee better health, improved value, and increased choice for America's seniors.

“Under a Privatization system, health plans would compete for enrollees and people on Medicare would choose among plans for their coverage – an approach that sounds similar to the current system, but is not the same. A key difference is that payments for services provided to beneficiaries in traditional Medicare would be capitated rather than the current approach that generally ties payments to the specific services that beneficiary’s use.”^{2a}

In 2017, there were 19 million Medicare C (MA) plan enrollees or approximately 32.7% of 58 million covered by Medicare. The total number of MA plans available has been relatively flat since 2011 and was at 2,034 in 2016, down 796 or 28% from a high of 2,830 in 2009^{1a}.

The perpetual argument over the validity of claims that Traditional Medicare Fee-For-Service plans (Parts A & B) are not competitive with private plans and the growth of Medicare C private plans has led to major concerns by America's seniors. These concerns have extended to be a genuine fear for what might happen to the economic well-being of their 40-to-55-year-old children and 20- to-35-year-old grandchildren and indeed some great-grandchildren.

Seniors are perplexed by the complex choices they have to make today. The BPBA and new CMS plan announcements camouflage the complex options they will have to choose from in the 2019 enrollment.

In 2018, 34% of Medicare enrollees depended upon MA plans.¹⁸ It is critical that we understand whether or not the privatization of Medicare, the goal of many in Congress, has been fully planned for and includes protection for the 34% who believe in what they have been sold and that there is hope for the other 66% of 58.8 million enrollees who have been told they can keep traditional Medicare. About 94% of all private plans today are MA plans and federal spending on MA plans will nearly triple, to \$584 billion in 2028 from \$210 billion in 2018.

The 2019 and 2020 combined MA benefit increases of \$16.5 billion signals an abrupt departure from services that prevented, improved or cured a patient conditions, to

services needed by specific patients, like for those with chronic pain and in fact constitutes a denial of benefits to current original Medicare FFS beneficiaries who have the same illnesses.

Average Incurred per Beneficiary* Cost 2018 and 2028:

	<u>\$ Average</u>	
Medicare A (HI or Hospitalization)	2018	\$5,241
	<u>2028</u>	<u>8,018</u>
	% Chg.	153%
Medicare B** (SMI or Physician Services)	2018	6,253
	2028	11,194
	% Chg.	179%
Medicare D (Prescription Drugs)	2018	2,171
	2028	3,333
	% Chg.	153%
Total	2018	13,665
	2028	22,546
	% Chg.	164%
Medicare A (HI) and B (SMI) combined	2018	\$11,494
	<u>2028</u>	<u>19,212</u>
	% Chg.	167%

* Total Beneficiaries grew from 59,920 in 2018 to 76,734 or 28% in 2028.

**General revenue funded 74% of SMI benefit in 2018.

Source: 2019 Medicare Trustees Report Data (Page 185, Table V.D1:

This data indicates that from 2018 to 2028, the # of beneficiaries will grow by 28% while costs per beneficiary will balloon by over 50% across all categories. So far (2018), MA plans have not proven they can compete with traditional FFS let alone reduce costs.

FINANCIAL ANALYSIS:

This paper addresses the question of whether or not Medicare “Privatization” through the implementation of a Medicare Advantage (MA) plan model (the Trojan Horse) has proven to be a financially viable alternative for current and future seniors over the age of 65 and if not, what alternatives might be pursued.

There is no consensus among studies where data has convinced many that MA plans are more cost effective than traditional Medicare. It is provable that MA plan federal subsidies in the form of incentives, rewards, bonuses, rebates and new but exclusive MA benefits have made them appear to be competitive with traditional Medicare, but only marginally and only from the perspective of government funding.

No complete set of Medicare C financial records exist. There are few details of fully absorbed enrollee costs (premiums, deductible, copay, coinsurance etc.). CMS's 2017 financial report discloses MA cost of operations of \$206 billion¹¹. The Medicare Trustees 2018 report disclosed that 2017 private plan expenditures per enrollee were \$10,593¹³. This per enrollee expenditure compares with \$10,051 per enrollee in Traditional Medicare A&B in 2017; see pg.17. MA plans costs were 5% higher!

Trustees Annual Reports do not disclose Medicare C (MA) plan standard financial information on revenue, subsidies, rewards and incentives directly incurred and/or allocated to Medicare C. There are no cash flow or balance sheet reports. Part A & B payments are made from one bucket of co-mingled payroll tax and income tax cash.

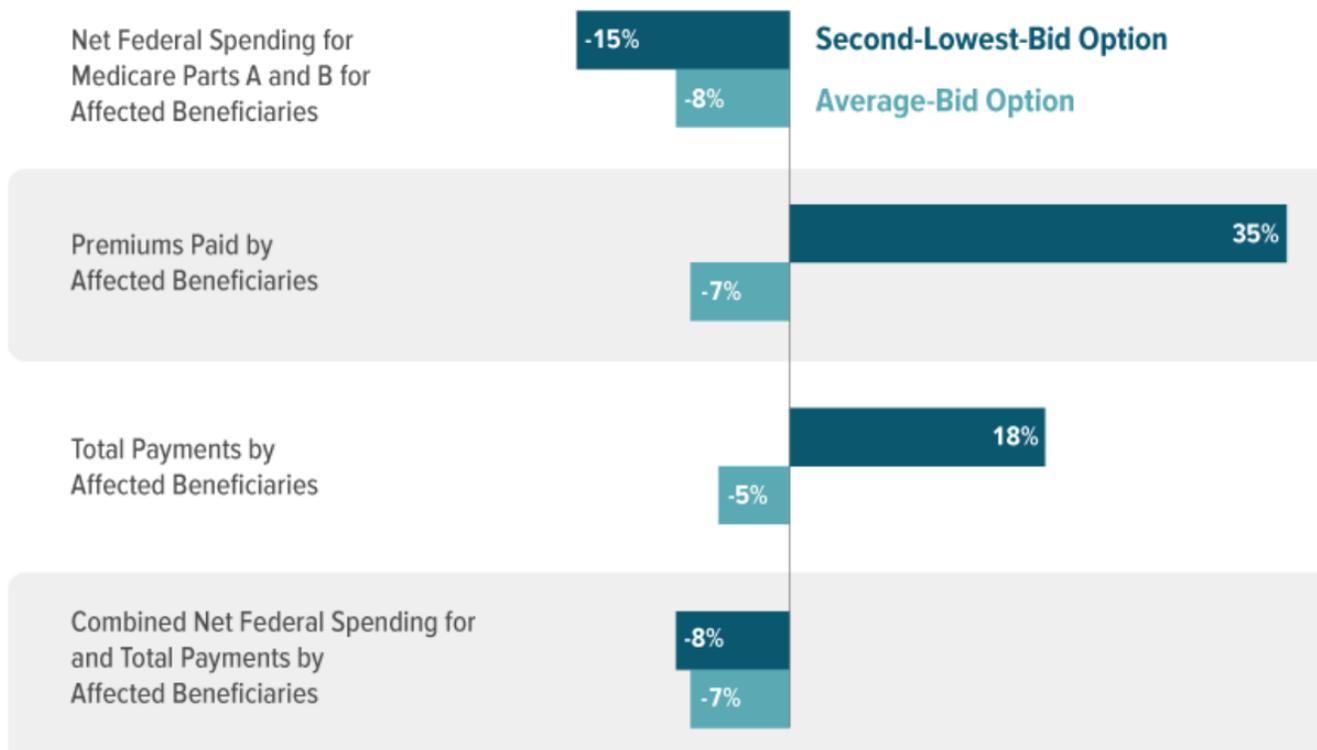
Most of the recent privatization proposals would include traditional Medicare to be part of privatization and thus would be treated in a similar manner as private plans. This means that the federal government would make a capitated payment on behalf of each beneficiary enrolled in traditional Medicare, just as it would make to a private plan. This would be a significant change from the current system under which traditional Medicare generally makes payments to hospitals, doctors and other health care providers generally based on the services provided^{2b}.

The CBO has said that including traditional Medicare as an option would increase federal savings because the rates that Traditional Medicare pays providers would help to hold down the rates paid by private plans and thereby hold down the bids of private plans^{2b}. It's ironic that privatization models need traditional plans' leverage to gain a cost advantage.

The House Budget Committee report wrongly cites the CBO pub/53077 dated October 5, 2017¹⁰ as justification for saying that "CBO determined that a Medicare program following this policy (the privatization model) would result in savings for both beneficiaries and taxpayers." This is simply not supported by the CBO pub/53077 report; see the graphic on next page.

Grandfathering as presented in CBO's 2013 analysis was proposed by Congress to allow seniors over age 55 to be grandfathered and thus protected from the effects of privatization and associated benefit cuts. Grandfathering costs under age 55 rule ruined the hope that privatization would save money. However, the 2018 House Budget Committee set grandfathering to game the financial calculation's so as to make it appear that privatization would be on more solid ground financially. Revising

Estimated Difference From Outcomes Under Current Law, Without Grandfathering, in 2024



A Premium Support System for Medicare: Updated Analysis of Illustrative Options,” *Congressional Budget Office*, October 5, 2017.

the grandfather protection threshold from age 55 to age 65 or older in 2022 when privatization is implemented could be grandfathered.

While 2018 would be the start date for privatization, according to the 2018 Budget Committee version of privatization the year 2022 would be the end of MA plans (1st year of full privatization and pricing of multiple of private plan choices within new regions) and the new grandfather rule would wipe out the 10-year protection window (from age 55 to age 65)! While there are no data to support a conclusion that those who lose grandfather protection as a result of this change will be harmed, it stands to reason that retirees who do not qualify for protection under the new grandfather rule will be at risk in a frenzied regional market where so far no rules have been defined.

The report does say that with grandfathering based on the 2nd lowest-bid option federal government savings would be \$50 billion over the 2022-2026 period, less savings than reported in prior years. This savings of \$10 billion a year on 2017 payments of \$720 billion is 1.4%; an extremely low pay off! Without grandfathering savings under the 2nd lowest bid option, over the same period the CBO projection

could be \$419 billion in savings, higher than the \$275 billion projected for the 2018-2023 period in CBO's 2013 report.

However, the report then addresses the beneficiary impact and states that the “CBO estimates that affected beneficiaries’ total payments for Part A and Part B benefits in 2024 under the 2nd lowest bid option without grandfathering would be 18% higher on average than under current law.” So, why would the House Budget Committee spin that privatization has been deemed a success by CBO? Under the conditions cited it sure looks like beneficiaries will pay more. The following are supporting data from Table 1 of the 2017 CBO report:

Table 1.

Estimated Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to Spending Under Current Law, 2022 to 2026						
Billions of Dollars						
	2022	2023	2024	2025	2026	Total, 2022–2026
Without Grandfathering						
Second-Lowest-Bid Option	-61	-80	-84	-91	-102	-419
Average-Bid Option	-14	-33	-41	-46	-50	-184
With Grandfathering						
Second-Lowest-Bid Option	-2	-5	-9	-14	-20	-50
Average-Bid Option	*	-2	-4	-6	-8	-21

A Premium Support System for Medicare: Updated Analysis of Illustrative Options,” *Congressional Budget Office*, October 5, 2017.

The MedPAC¹⁷ reported that that MA plan insurers made a five-percent (5%) margin in 2016, twice the average of Medicare plans overall. That’s 25% better than the industry’s overall four-percent (4%) margin reported by Standard and Poor’s.

MA plan bonus payments to insurers under the suspect Star Rating System were \$3.5 billion in 2012, and \$6.3 billion in 2018. Yet most ratings reported by customers don’t reflect that 80% improvement. Benchmark settings, plan risk adjustments and star quality ratings bonuses have all come under fire as being mismanaged and run by those who turn in the paperwork.

The goal of Congress has not been to lower the true cost of health care but instead it is to shift the federal tax burden and attendant health care costs they now must pay for onto the backs of seniors. And, they must do it before the growth of the over-age- 65 senior segment of our population explodes from less than 50 million in 2015 to 75 million by 2035 and to 100 million by 2060¹². Problem solvers? Not even close.

In areas with high medical costs, beneficiaries would pay more to stay in traditional Medicare than they would under the current system; in contrast, in areas with lower medical costs, beneficiaries would likely pay more to be in a private plan^{2b}.

Without full disclosure, we can't see whether Medicare trust payroll tax income is being used to offset MA private plan Medicare Part B expenses, subsidies, rewards or other incentives or if all or part of these subsidies are paid for from federal income tax revenue. Either way, the federal government is using taxpayer money to pay for private insurance company benefits and is not disclosing all facts about whether private plans can compete on a level playing field with traditional Medicare FFS plans.

We assert this lack of reporting is on purpose and designed to delay disclosure until traditional Medicare is stranded.

CONCLUSIONS

Referring to premium cost alone is meaningless, usually a political stall. What counts is the annual total amount of premiums, and out-of-pocket cost for deductibles, copayments and coinsurance that is paid by the enrollee, plus the government cost paid to insurers for non-traditional benefits, subsidies, rebates and bonuses combined.

Traditional Medicare offers the best medical care, absorbs age risk, carries a low 2% overhead and owns a 66% market share. MA private insurers carry a 12-15% overhead and profit margin burden, own a 34% share of the same market and lack the volume that Medicare can leverage if it were allowed to obtain competitive bids and were better managed. Without taxpayer funded subsidies, how could private plans, the MA model, ever be as cost effective as the Medicare model?

There is no consensus among studies that has proven that MA plans are more cost effective than traditional Medicare. It is provable that federal taxpayer dollars are subsidizing insurers' MA plans and further that federal income tax and/or payroll tax revenue is being misused to pay MA plan extra benefits to 34% of those on MA plans to the exclusion of the 66% who do not receive them, but who have paid in 66% of the payroll and federal income taxes used to subsidize private insurers.

The CBO's bar chart on page 16 above shows that under privatization that in 2024 net federal spending on Medicare A & B would be 15% lower because of privatization. However, total beneficiary spending would increase 18% and that the combined net effect would reduce federal spending by just 8%. The net effect on payments would be a federal savings of 8% after 10% shifting the federal burden to taxpayers; a tax increase. Shifting the cost to consumers (seniors) lowers disposable income, slows economic growth, and increases the need for more federal programs.

On Sept 1, 2018 a Modern Healthcare article¹⁵ displayed a graph containing Kaiser Family Foundation (KFF) data from 2017 records indicating that Medicare A & B

payments to MA plan enrollees were 9.9% higher than payments made to traditional Medicare (FFS) enrollees. This data compares with 2018 Medicare Trustees report data cited on page 13 that reveals a 5% higher private plan cost per enrollee. It is time to derail privatization.

On February 11, 2019 the **Urban Institute released new data regarding national health expenditure growth from 2006 to 2017 for Medicare, Medicaid and Private Insurance. One of their three Key Findings was “Medicare and Medicaid spending per enrollee grew 2.4 percent per year and 1.6 percent per year respectively, compared to 4.4 per cent per year for Private Insurance.”** In its conclusions, the author states **“The larger cost containment problems the nation faces are in the private insurance markets.”**¹⁶

The Medicare Payment Advisory Commission (MedPAC)¹⁷ reported that that MA plan insurers made a five-percent (5%) margin in 2016, twice the average of Medicare plans overall. That’s 25% better than the industry’s overall four-percent (4%) margin reported by Standard and Poor’s.

MA plan bonus payments to insurers under the suspect Star Rating System were \$3.5 billion in 2012, and \$6.3 billion in 2018. Yet most ratings reported by customers don’t reflect that much improvement. Benchmark settings, plan risk adjustments and star quality ratings bonuses have all come under fire as being mismanaged and run by those who turn in the paperwork.

FEDERAL SUBSIDIES PAID TO MA PLAN INSURERS ARE UNWARRANTED!

THEY SHOULD BE STRIPPED OUT NOW RATHER THAN LATER WHEN INSURERS WILL BE ABLE TO INCREASE PREMIUMS, DUDUCTIBLES AND COINSURANCE AT WILL IN ORDER TO MAINTAIN THEIR 5% + PROFIT MARGIN!

The NRLN Asks Congress and the Executive Branch to:

- Grandfather and protect the 20 million seniors (34%), who have purchased MA plans in good faith, from future reductions in benefits and guarantee the protection of baked in subsidies as of December 31, 2019 and all future MA subsidies, rebates, rewards, bonuses and non-traditional Medicare plan benefits combined.
- Direct Government Accountability Office (GAO), CBO and the HHS Inspector General to investigate and report on MA and Original Medicare Part A and Part B independent financials and assess and publicly disclose the cost effectiveness of MA, with and without taxpayer subsidies (rebates, risk adjustments and star bonuses).

- Retract the 2019 and 2020 subsidies for home air filters and carpet shampooing for asthma patients, pay for heart healthy meals for those with heart disease and other services that represent a shift from services that prevented, improved or cured a patient conditions, to services determined by what a chronically ill patient needs, or make them available to the original Medicare A & B, FFS enrollees who have the same health conditions and needs.
- Reduce the \$140 billion annual wrong and improper payments generated by all federal agencies (particularly the \$85 billion attributable to Medicare and Medicaid). Sequester savings and use them to eliminate the 75-year deficits of Medicare Part A and Part B, then Part D. Payroll tax increases are an option.

This whitepaper was researched and written for the National Retiree Legislative Network (NRLN) by the American Retirees Education Foundation (AREF). The AREF expands the research and education reach of the NRLN.

MEDICARE ADVANTAGE PLANS – SPEEDING TOWARD PRIVATIZATION \$350 BILLION WASTED ON SUBSIDIES TO PRIVATE INSURERS

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