2022 - Time to End Taxpayer Rebates to the Private Healthcare Insurance Industry

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The National Retiree Legislative Network (NRLN) and most Americans support competition from private healthcare plans and we understand the financial challenges ahead for Medicare and the federal budget. However, we do not support bonus and 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 overage 65 U.S. **retirees will grow 25%, from 62 to 77 million between now and 2030 and to 100 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 3 million will remain. Medicare **healthcare costs will grow 101%,** from $796 billion to $1.7 trillion from 2019 to 2030**.** Medicare Trustees 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. **– MEDICARE HEALTHCARE COSTS PER 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, like prescription drug manufacturers. The character and global reputation of our democratic system is threatened by yielding to gain electability.

Four realities 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 43.1% (27.4 million enrollees)** in 2021 and generated **revenue of $370 billion, 3)** after 24 years, despite gobbling up over **$450 billion in rebates, t**he 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 2021, 4)** MA plan market share is at 43.1% and revenue is $370 billion; it's time to realize subsidized growth can no longer be justified!

Exposing the cause and effect of the facts is very revealing. In 2019, payments to MA plans per enrollee were 2% higher than for Original Medicare FFS. This **102%** performance was treated as insignificant by CMS, the industry lobby and some prestigious think-tanks, proving that averages can deceive. MA plan **Part A results were 91%** or 9% under original Medicare cost. However, the **Part B score was a pathetic 118%.** The combination of the two **was 102%.** The Medicare Trustee and MedPac reports cited that MA plan recruits are much younger and don't 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**!

Taxpayers are kept in the dark and duped into paying insurers for extra MA plan benefits worth **$41.8 billion this year to 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 40 billion beneficiaries in original Medicare**; a slap in the face and breech of moral and ethical character.

In 2020, over 75% 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's not chutzpah, it is betrayal. Many of the 40 million who are denied benefits by members of Congress elected them to represent public interests, theirs included, and to protect Medicare, not dissolve it. Just before the 2020 election, they ran for cover.

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's interesting that Joe Machin (D-WV), a moderate and Marco Rubio (R-FL) were on this list. Both of them and Senator Sinema must have many 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 (D-MI), Todd Young (R-IN), John Tester (D-MT), Jacky Rosen (D-NV), Angus King (I-ME), Jeanne Shaheen (D-NH), Deb Fisher (R-NE) and Mark Kelly (D-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 / yr.)** paid to insurers directly for 27.4 million MA enrollees. Total payments were up 19.1% from **$35.1 in 2020 to $41.8 billion** this year and the **2021 Medicare Trustee report warns us to expect 6-10% annual increases per enrollee, growing to $100.8 billion in 2030 ($668 billion 2021-2030),** making rebates a scandal as monumental as the Teapot Dome scandal in the 1920's. In one case, oil was the leverage, here it's campaign contributions that support personal and party electability.

FFS rules permit effective management of supplier pricing, quality and service. The healthcare insurance industry won when HHS and Congress agreed to switch from FFS to MA capitation payments that turned over the control and visibility of supplier cost, quality and service to middlemen **(**insurers**).** Insurers don't 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 your own business and get you fired.** The message is that congress is willing to cannibalize 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 larger, are awarded and are applied to boost benchmarks in combination with insurer plan bids used to determine rebates, that are paid under terms of a customized formula contrived in 2010, implemented in 2012 and revised in 2015.

This scheme uses a 5-star rating plan that on the surface is typical of what you might see if you were shopping for a washing machine, a household product or a car. However, this plan is called the Quality Bonus Plan (QBP). Close examination shows it is vehicle used to grease the skids, enabling rebate payments to private plan insurers.

Anyone who knows just a little about 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 prices, quality and service terms. Instead, they would remain on a preferred supplier list and/or may be awarded non-monetary gifts, maybe a small award or 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 their bids, they keep it all; they don't 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 (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), doesn't 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 exposes the scheme **aptly named the Quality Bonus Plan (QBP).** It serves to subsidize healthcare insurers - it's 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 plans that bid are awarded a 5% or 10% increase in the Benchmark if the plan's star rating is 3.5 or higher - we used 5%. Since ratings in the 1st two columns qualify, a 5% bonus of **$50** was added to the Benchmarks for both – 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 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 the same **2% risk factor was applied 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.

Every Plan wins a taxpayer subsidy – Merry Christmas!

There are numerous ongoing investigations and litigations regarding risk factor fudging. QBP bonuses and risk factor adjustments inflate the spread and 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 (insurers don't report costs) and leaves the QBP highly vulnerable to low

balling. Insurers and CMS staff now brag what a good thing it is that insurer bids are coming down. However, if bids are reduced and FFS benchmarks are constant or are increasing, the spread between them must increase rebates, therefore the cost per enrollee paid by CMS to private plans would be higher. So, **lower 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?

Congress, CMS, D.C think-tanks and some advocate organizations still advocate for congressional, industry and political rhetoric and that MA plans are good for retirees. However, they know instead that MA plans increase the cost of healthcare and are the vessel for Medicare privatization and increased expenditures.

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 reports!

So far, privatizing Medicare has led to higher costs and lower purchasing power with more of the same ahead of us when there are 100,000,000 overage 65 retirees (including our grandchildren). Lost purchasing power for 25% of our population will have a chilling effect on GDP and our overall economy.

The Trump administration decided to accelerate privatization by implementing pilot programs in a new privatization scheme called **Direct Contracting (DC)** a program from the Center for Medicare and Medicaid Innovation (CMMI) would effectively eliminate the more cost-effective traditional Medicare program designed to ensure that people with complex health conditions get the care they need.

DC adds a layer of cost that would manage health care providers and is aimed at privatizing original Medicare. It is a master MA plan on steroids. Nothing new here, ineffective value-based pricing is good-sounding spin of words and other reengineering attempted has yet to produce lower cost, better service or better quality than FFS. In reality, doctors, clinics, hospitals, and healthcare suppliers, especially the prescription drug industry, control pricing; while senior's demand for quality service is inelastic. Providers don't like Fee-for-Service because it works. Adding middlemen has only added more cost. Congresses' sole interest appears to be to get the financial monkey off their backs and to satisfy healthcare industry large campaign contributors.

Centers for Medicare and Medicaid Innovation (CMMI) programs burn tax dollars (for 10 years) and have made little tangible improvement in healthcare cost per enrollee or quality. It's not clear whether Congress will fund DC or that CMMI has the authority to go forward with the Direct Contracting experiment, however the White House and Congress have not killed the plan yet.

American taxpayers funded $41.8 billion dollars in rebates paid to healthcare insurance companies in 2021. The industry received $370 billion in CMS payments in 2021. Why should taxpayers be assessed a tax penalty equal to 11.2% of industry sales? Why should 37 million taxpayers on original Medicare not be equally eligible for these benefits along with the 24 million other taxpayers in private MA plans?

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":

Obtain Majority Political Support to Save Medicare – a symbol of American Democracy

Grandfather Benefits for all Current MA Plan Holders

Eliminate Bonuses and Rebates

Use Quality Control and Innovation to Reduce Costs and Award Contracts Using Competitive Bids.

Removing Original Medicare Competitive Barriers – Creates a Level Playing Field for Competing Plans