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American Retirees Education Foundation

NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

A 23-YEAR ATTEMPT TO PRIVATIZE MEDICARE HAS FAILED
MEDICARE ADVANTAGE QUALITY BONUS PLAN IS A HOUSE OF CARDS

June 5, 2020

Executive Summary

The National Retiree Legislative Network (NRLN) fully supports competition from private healthcare plans and understands the financial challenges ahead for Medicare and the federal budget. However, we lobby against subsidies and legislated restrictions placed on original Medicare Fee-for-Service (FFS) just to preserve the notion that private insurance plans are inherently more effective.

The NRLN's primary concern has always been for its members and all seniors who see the Joe Namath TV ads about Medicare Advantage (MA) plans and good deals that are "FREE!" You can't argue against facts. Congress has authorized MA insurers to pay for portions of deductibles, copays, and drug plans, vision, hearing, silver sneakers, etc. and out-of-pocket maximum protection.

However, it is also a fact that all Medicare enrollees must pay $144.60 monthly for Medicare A & B benefit and it is a fact that every American who pays income taxes is paying for this list of so-called benefits. Congress pays MA insurers rebates of $122 a month per enrollee, $35 billion this year, paid directly to them to pay for their lists of extras. For perspective, a prescription drug plan including a deduction and co-pays might cost $50 a month of the $122.

This whitepaper exposes three realities: 1) healthcare costs are rising four times faster than the number of new Medicare enrollees, 2) after 23 years and over $350 billion in rebates paid to MA plans, their annual payments per enrollee are higher than for enrollees in the original Medicare FFS plan, and 3) MA plan privatization has already failed; we believe public opinion and mounting costs will lead to pressure to end MA plan rebates.

The Medicare Payment Advisory Committee (MedPAC) and the Medicare Trustees have projected that as MA plan enrollees age they will use even more healthcare products and services per capita and large MA plan increases in premiums, deductibles, co-pay and coinsurance costs are expected. The Congressional Budget Office (CBO) in its 2017 report to the House Budget Committee projected a minimum of 35% in premium increases by 2022.

The NRLN wants to be sure that Congress demands that all the facts be on the table when those entering Medicare choose between FFS or one of the 4,000 private MA plans in 2020. It is critical that prospective enrollees fully understand that if an MA plan is chosen and 12 months elapse, that while they can switch to Medicare FFS, they must meet pre-existing conditions and other underwriting requirements to qualify for Medigap supplemental coverage. Those who do qualify with restrictions may have to pay excessive premiums.

The 2020 Medicare Trustees report projects the number of Medicare enrollees to grow by 25% from 2009 – 2029. Healthcare payments grow by 101%, 4 times faster than the number of enrollees who use the benefits. It is evident that healthcare costs are out of control! By 2029 costs per enrollee will rise 60% from 2019, consequently, costs per month grow by $600! Cost must be reduced, not just shifted to those over age-65. We must ensure that Medicare is there for our children, grandchildren and great grandchildren.

This whitepaper includes NRLN's 1997-2020, 23-year roadmap of when and how Congress approved the use of taxpayer dollars to pay bonus and rebate payments to MA plan insurers. MA market share of the Medicare market has grown mostly due to the awarding of quality bonuses and rebates that are used to fund and market new benefits.

While Congress legislated quality bonuses and rebates that heavily favor MA plans in competition with FFS, it tipped the scales even more by enacting restrictive legislation that prohibits FFS from establishing provider networks or implementing new innovations and seeking competitive supplier bids for healthcare products or services. For example, FFS can't accept competitive bids for prescription drugs or replacement seat cushions for wheelchairs.

Congress passed legislation mandating that 19 new supplemental benefits be offered to MA plan enrollees only - to be paid for with more rebate money. The 44 million enrollees in original Medicare FFS have been denied access to these new benefits, however all MA plan enrollees are eligible. The NRLN asserts that this denial of benefits is discriminatory and breaks President Trump's promise not to cut Medicare benefits.

Two facts speak so loudly that seniors and taxpayers alike should immediately learn the intent of this MA privatization policy: 1) the acronym QBP does not mean Statistical Quality Control (SQC) as the rest of the world might recognize a quality program - QBP is named the Quality BONUS Program, a system to payoff insurers; and 2) the QBP boasts that its 5-star rating program is a valid aid for seniors to use in selecting plans and it could be, however one fact destroys this myth - **a 1-star quality rated MA plan earns a 50% rebate payment!**

MedPAC warned Congress in 2018, 2019, and 2020 that QBP MA quality standards are mythical and unprofessionally derived and administered. The Health and Human Services (HHS) Inspector General has disapproved these payments, calling them Wrong or Improper Payments. This QBP program is a house of cards and the achilleas heel of privatization!!

We conclude that current MA plan enrollees must be protected from loss of coverage and cost shifting and that the QBP must be professionalized to protect seniors. It must be validated by Quality Control industry experts and be stripped of the ability to award financial bonuses and rebates for simply delivering quality promised in bids.

Four million enrollees in company or union MA–PPO plans are not as affected by rebates as MA–PPO plans. PPO plan benefits are usually not network restricted and premiums are negotiated and less dependent on rebates. More expensive PPO-like benefits can be negotiated and purchased through private insurance companies and are widely accessible.

Congress is more focused on shifting healthcare costs to seniors rather than reducing costs.

NRLN Proposals

- Immediately suspend MA plan bonus and rebate awards and order MedPAC, the Government Accountability Office (GAO), Congressional Budget Office (CBO) and the Health and Human Services (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 quality and cost effectiveness of MA, with and without taxpayer financial subsidies (rebates and star bonuses).

- Grandfather and protect the 26 million seniors (36%), 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.

- Make original Medicare A & B FFS enrollees, who have the same health conditions and needs as those in MA plans, eligible to receive all "new" benefits offered to MA plan enrollees, or retract the 2019 and 2020 "chronic" disease benefits e.g. home air filters and carpet shampooing for asthma patients, payments 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. As it is, Congress has legislated highly discriminatory benefit access rights that picks winners and losers in the same universe or class.

- 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,

- Centers for Medicare and Medicaid (CMS) and Congressional Operational Priorities:

  CMS must focus resources on refining FFS Benchmark fees and costs based on county and / or regional market costs for goods and services by focusing on a prioritized list of treatments for life threatening and/or high cost end results criteria. Rename QBP to Healthcare Statistical Quality Control (HSQC) plan (or anything but QBP) and establish measurable supplier process and end results standards, audit and report on supplier performance results. Motivate Affordable Care Organizations (ACOs)-like supplier delivery and wellness systems and create a focused FFS cost reduction plan.

  Congress has a duty to amend or create legislation that enables Medicare FFS free-market authority to seek competitive bids and buy healthcare products and services directly without artificial constraints or obligations to buy through middlemen. Also, current legislation that prohibits Medicare FFS from innovating with new programs or to form networks that would lower healthcare costs and better serve seniors' healthcare needs must be abolished. Congress has afforded MA plans an unfair competitive advantage – it must eliminate this preferential treatment!

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This white paper was researched and written for the American Retirees Education Foundation (AREF).
The AREF expands the research and education reach of the National Retiree Legislative Network (NRLN).
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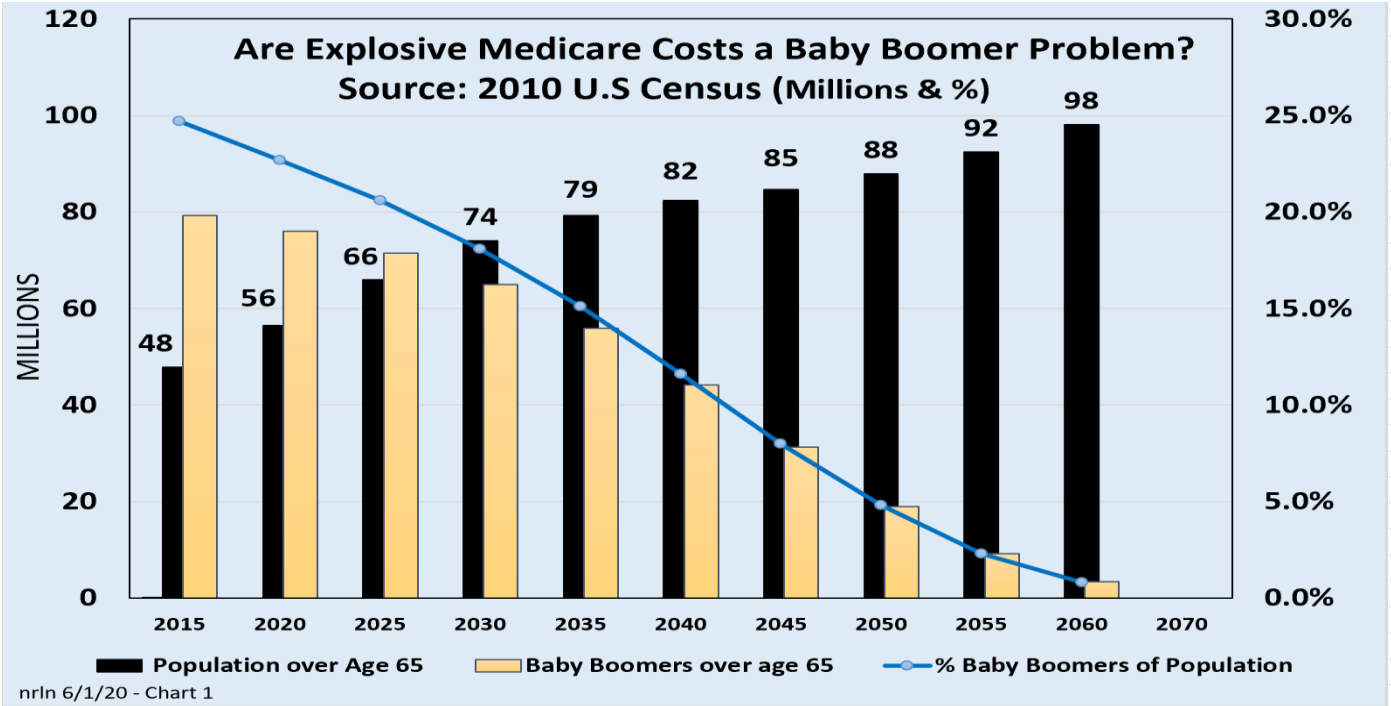
The Medicare Financial Crises

Congress has been aware that 10,000 Americans would turn age 65 every day for over 35 years, but did nothing to prepare for this evolution. Instead it bet on privatizing Medicare long ago. Now, in 2020, it is doubling down on subpar– Medicare Advantage (MA) plans!

Data from the 1990, 2000 and 2010 U.S. Census reports have revealed that baby boomers would start to overwhelm the over age 65 population by 2010 and they would all be over age 65 before 2030. If the 2010 Census Bureau actuarial calculations in **Chart 1** below are correct, by 2060 there will be fewer than 4 million baby-boomers alive, less than 1% of the U.S. population but nearly one fourth (25%) of the U.S. population will be over age 65.

The growth of the over age 65 group from 2030 forward will be our children, grandchildren and great grandchildren, turning age 65 and living longer. Congress must act, save Medicare, so post baby-boomer generations won't struggle with healthcare economically and socially.

Chart 1



2010 U.S. Census	2015	2020	2025	2030	2035	2040	2045	2050	2055	2060	2070
Population over Age 65	47,830	56,441	65,920	74,108	79,232	82,345	84,712	87,995	92,471	98,165	
% Population over age 65	14.9%	16.9%	19.0%	20.6%	21.4%	21.7%	21.8%	22.1%	22.7%	23.6%	
Baby Boomers over age 65	79,310	76,096	71,512	64,977	55,875	44,254	31,286	18,971	9,218	3,356	
% Baby Boomers of Population	24.7%	22.7%	20.6%	18.1%	15.1%	11.6%	8.0%	4.8%	2.3%	0.8%	
Total Population	321,369	334,503	347,335	359,402	370,338	380,219	389,394	398,328	407,412	416,795	

One notable bit of data not shown in the chart is that from 2020 to 2035, total population growth slows from 3 -4% to 2.7% in 2040 and from 2045 forward to around 2.3% annually

Politicians tend to limit their vision and the need to plan and act to the time frame between elections. Retirees are more concerned about their future and the futures of their children, their successors. We who are already in or close to entering the over-age 65 group should make it our business to support our family's futures by holding Congress accountable.

Current 2020–2029 U.S. Budget Projections for Medicare Expenditures

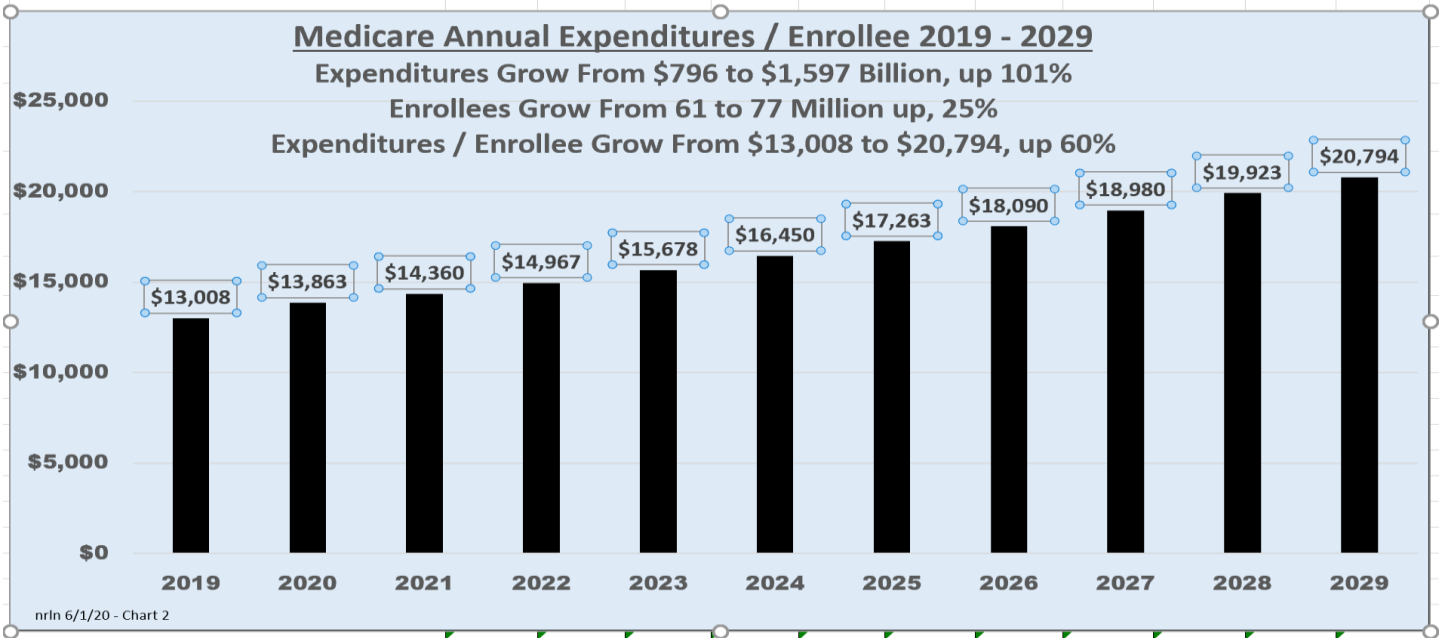
Chart 1 revealed that total growth of those turning age 65 is more alarming than baby boomer growth. This issue is one of two factors driving up healthcare costs. The other is the out of control escalation of costs per unit. The combination of these two factors drive the Medicare expenditure budget from $796 billion in 2019 to $1.597 trillion by 2029.

Chart 2 budget data shows the change in the number of people added to the Medicare enrollee base is rising by less than 2.3% a year or 25% over ten years, while the change in expenditures will rise at over 7.2% a year or about 101% over ten years, 2019 – 2029.

The most important ratio for policy makers to consider is the 4:1 ratio of rising costs to rising number of enrollees who use the benefits (101 / 25). **Medicare expenditures are rising four times faster than the number of enrollees.**

You can make these numbers very relevant to us, our kids, grandkids or great grandkids by looking at the annual cost per enrollee as a percent of our personal estimation of after-tax income. In other words, how big of a chunk of the money we will spend must go to pay for healthcare expenses, considering that seniors over age 65 do require more medical attention.

Chart 2



2020 Medicare Trustees Report Data	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
A+B+D $'s (TT'S REPORT PG. 171 V.B1	$796	$862	$922	$986	$1,059	$1,137	$1,221	$1,309	$1,403	$1,502	$1,597
Annual Expense % Change		8.2%	7.0%	7.0%	7.3%	7.4%	7.4%	7.2%	7.2%	7.1%	6.3%
A+B+D Enrollees TT'S REPORT *PG. 176 V.B3*	61,207	62,142	64,207	65,892	67,516	69,111	70,751	72,367	73,914	75,404	76,797
Annual Enrollee % Change		1.5%	3.3%	2.6%	2.5%	2.4%	2.4%	2.3%	2.1%	2.0%	1.8%
Medicare Annual Expenditures / Enrollee	$13,008	$13,863	$14,360	$14,967	$15,678	$16,450	$17,263	$18,090	$18,980	$19,923	$20,794
Annual Expenditure/ Enrollee % Change		6.6%	3.6%	4.2%	4.7%	4.9%	4.9%	4.8%	4.9%	5.0%	4.4%

In 2019 the annual amount per enrollee spent by Medicare averaged $13,008. This amount will grow by over 5% a year to $20,794 by 2029, a total change of 60% or $7,786 ($648 a month) in nine more years. Medicare FFS plan expenditures per enrollee are projected to be lower than MA plan projected expenditure per enrollee over that time frame.

Past members of Congress were provided these projections of enrollee and expenditure growth. The cost of prescription drugs, hospital and medical care were projected to grow 3-4% a year. By 2003, those prices were projected to rise faster than anticipated. Congress then ducked having to deal with holding costs in line and gave in to insurance companies that promised private plans could do a better job as long as Congress would help by paying them subsidies to help offset their overhead and profit requirements.

Also, included in the privatization deal were rules that would prohibit Medicare from seeking competitive bids for drugs and durable medical equipment that could make Medicare Fee-for-Service (FFS) plans even more competitive against private plans than they are today.

This was the beginning of what has been a 23-year disappointing experience. Here we are in June of 2020 and Medicare is prohibited from competitive bidding, including for such things as seat cushion replacements for wheelchairs and unpatented prescription drugs. Congressional rhetoric assaults higher prices, but accommodates industry lobby pressure; go figure!

The 23 -Year (1997-2020) History of the Great Privatization Deception

Table 1 is the 1997-2020 history of Congressional and regulatory MA bonuses and rebates. History shows that **MA plan market share has never grown except when associated with unsubstantiated quality bonus and rebate increases used to prop up plan performance.**

Further, never in 23 years and nearly $400 billion in bonus and rebate payments have private plans ever been able to complete a year where the expenditures paid to MA plan enrollees has been lower than 100% of expenditures paid per enrollee in the Medicare FFS plan. The 2020 MedPAC projection is that MA plan expenditures per enrollee will be 103% of FFS.

Comments about the 2010 Affordable Care Act (ACA, aka Obamacare) are very significant. After being chastised for wrongful spending on bonuses and rebates by the HHS Inspector General and MedPAC in 2009, the 2010 ACA mandated a 5-year roll back (elimination of these payments) but the ACA retained the quality plan and reduced 4.5 star rebates to 70% and 3.5-star to 4.5-star rebates to 65%, but did not abolish them.

Preserving the quality plan and bonus and rebate components was a monumental win for the health insurance lobby and a capitulation by Congress. Had the Obama administration abolished the plan and financial award components, it would have meant the end for private plans, namely MA plans.

In 2016, the Trump administration froze the rollback at 8% to retain rebates for plans that met the “revised” 5-star Quality Bonus Plan (QBP) criteria that today continues to generate bogus payments to health insurance companies that sell MA plans.

MedPAC’ s June 2019 report cited that 71 contracts covering 7 million enrollees had plan administrative measures (called insurance function ratings) that averaged a 4.5-star rating or higher but when measured by outcome results were less than 3.5 stars. A 4.5-star rating is rewarded by a 5% bonus reward and a 70% rebate. **In 2020 rebates will average $122 a month for 25 million MA plan enrollees.**

Table 1

The 23 - Year (1997-2020) History of the Great Privatization Scam	
1974	Private insurers strived to enter the Medicare market during the 1974-1997 period. HMO's evolved as a competitive model but industry overhead and profit hindered the ability to compete with Medicare's low-overhead non-profit model.
1997	The Balanced Budget Act (BBA) - Medicare "Choice" plans were created; Congress Created Rural Pay floors; and president Clinton granted the 1st rebate, 3%.
2000	The Benefit Improvement and Protection Act (BIPPA) Enabled the adding of Urban Pay Floors & higher Rural County Payment Floors. Market share reached 18% by 2000 then lost ground, falling to 13% entering 2003.
2003	The Medicare Modernization Act (MMA - Med D) - "Medicare Advantage" (name change) was born. Congress approved a major 12-17% bonus and rebate package.
2006	Congress revised the bidding process which boosted rebates. Tax money flowed freely to insurers and market share exploded from 13% in early 2003 to 24% by 2010.
2010	MedPac and the HHS Inspector General lashed CMS and Congress for subsidizing 14% rebate payments (billions of $) and labeled rebates as "Wrong or Improper Payments" & they cited Cherry Picking younger / healthy retirees as unfair.
2012	The 2010 "ACA" mandated a 5-Yr. rebate phaseout, reducing 4.5 star rebates from 75 to 70%, 4- star to 65% and 1 - 3.5 star to 50%. But, it retained quality rebates!
2016	CMS halted the "ACA" 5-Year Rebate Phaseout, allowed plans with higher star ratings to keep 8% in 2016. With the door reopened, Congress, CMS began to liberalize quality rebates again, starting in 2017. Private plan insurers won again.
2017	CMS began to increase rebates resulting in the laundering of more taxpayer revenue through the quality plan scheme to subsidize insurance companies. CMS also proposed approval for authorizing "chronic" disease benefits for private plans only.
2018	2018 Balanced Budget Act (BBA) passed - Added 19 "Chronic Benefits" and approved rebates, to be authorized at CMS discretion if approved by CMS Director of Budget.
2019	Congress cheated 40 Million original Medicare enrollees by adding 19 new "Chronic" benefits, paid for with rebates (for 20 million enrollees in MA plans only). All taxpayers (including 20 year old workers) are footing the bill. This is a desperate preconceived marketing effort to boost market share of MA plans. Denying 40 million access to these same benefits is discriminatory; it is the same as cancelling benefits.
2020	75% of House and Senate members are "Champions" of the MA insurance industry financed BetterMedicareAlliance.com (BMA). This unprecedented bias along with misleading Joe Namath type advertising of free benefits, the upcoding and granting of record high rebates of 13% of $271 billion or $35 billion are all improper and a shameful waste of taxpayer money.

Congress' Shocking Action to Add Chronic Benefits Only to MA Plans

In 2018, Congress funded legislation earmarked to be spent to improve wellness, through somewhat unproven ideas about lifestyle changes and alleviation of "chronic" illnesses.

The 2018 Bi-partisan Budget Act legitimized 19 new benefits (see **Table 2** below) and authorized continued study that might add more of these benefits later. Unfortunately, CMS and Congress, at the insistence of the MA insurance lobby, declared that only those enrollees in MA plans could be eligible to receive these special benefits when offered.

This action effectively declared that 44 million ineligibles in Medicare FFS are disposable and that FFS is being targeted. Taxpayers of all ages are paying the bill for these MA plan legislated payments. President Trump campaigned on the promise his administration would not reduce Medicare benefits. Denying original Medicare enrollees' access to benefits while granting them to MA plan participants is reducing benefits. Saying otherwise is dishonest.

Denying access to a person in FFS who is homebound due to a chronic asthma condition, while granting a neighbor with the same health condition on an MA plan the benefits of free HVAC air filter changes, carpet shampooing, plus free transportation to doctor appointments is stupefying. Can Congress justify this discriminatory action to their constituents?

Table 2

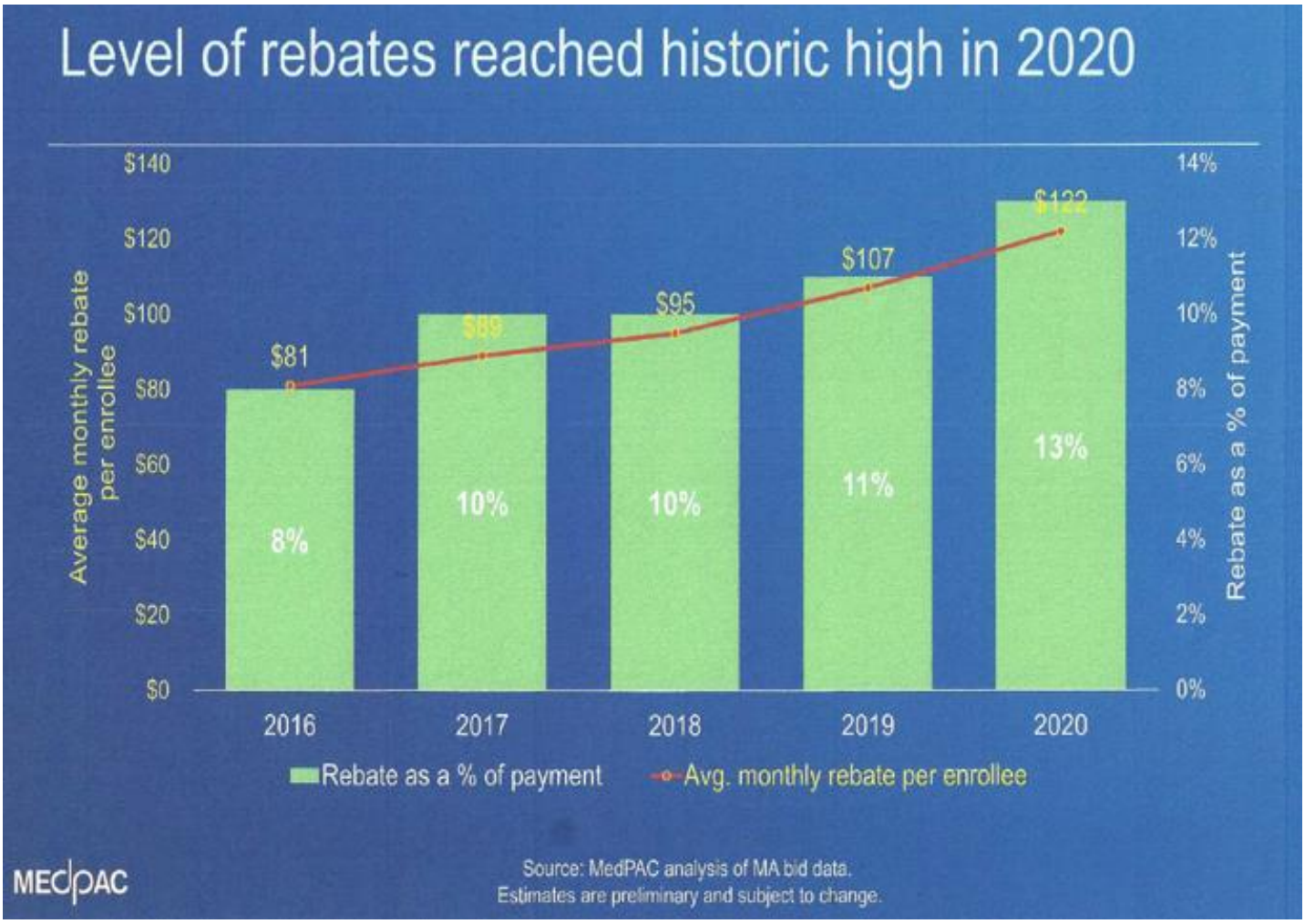
BONUS AND REBATE INCENTIVES PAID FROM 1997-2018 AND NEWLY AUTHORIZED BONUSES AND REBATES PAID TO INSURANCE COMPANIES UNDERMINE 40 MILLION OLDER MEDICARE ENROLLESS AND THREATEN THE FUTURE OF MEDICARE			
		20 Million MA Enrollees	40 Million Medicare FFS Enrollees
1997-2018 14%; Bid/Benchmark + Star Rebates (Benefit Payout = only 54% NEJM)		$400 Billion	Original FFS Medicare
Vision Plan	1997	YES	NO
Dental Plan	1997	YES	NO
Silver SNEAKERS	1997	YES	NO
Pay Insurer to Reduce Premiums, Deductibles & Copays.		YES	NO
2019 & 2020 CMS Insurer Gifts (Chronic Disease Care) $16.5 billion / Yr for 10 yrs.		$165 Billion	$0.00
Pay for Transportation to see Doctor	2019	YES	NO
Pay for Transportation to Fitness Center	2019	YES	NO
Pay for Transportation to the Pharmacy	2019	YES	NO
Pay for Over the Counter Medicines (eyedrops, vitamins etc.)	2020	YES	NO
Pay for Compression Stockings	2020	YES	NO
Pay for House calls by Doctors and other Providers	2020	YES	NO
Pay for Home Dialysis	2020	YES	NO
Pay for Telehealth Information Services	2020	YES	NO
Pay for Personal Safety Devices and Services.	2020	YES	NO
Pay for Grab Bars for Showers	2020	YES	NO
Pay for Wheelchair Ramps	2020	YES	NO
Pay for Assistance (Dressing, Eating, Housekeeping)	2020	YES	NO
Pay for Home Delivered Meals	2020	YES	NO
Pay for Changed Air Filters for Asthma Patients	2020	YES	NO
Pay for Shampooing Carpets for Asthma Patients	2020	YES	NO
Pay for Delivery of Heart-Healthy Meals	2020	YES	NO
Pay Affordable Care Organizations (ACO) - $20 / Service	2020	YES	NO
Pay to Waive Geographic Limits - fro Renal & Stroke Ttreatment.	2020	YES	NO
% 2018 MA Plan Expenditures of Reginal Medicare FFS Expenditures.		103.9%	100.0%

In February 2020, 403 members of the House and Senate, from both parties, signed a letter asking the Administrator of Centers for Medicare and Medicaid (CMS) to add "chronic" benefits only for MA plans in 2021! Today, 360 of their names and pictures are posted on the insurance industry's K Street Lobby website, www.BetterMedicareAlliance.com. They are hailed as MA plan "Champions." We believe this is a conflict of interest. Leading insurance companies that sell MA plans are financiers of the K Street Lobby.

How the Quality Bonus and Rebates Are Used to Subsidize Premiums, Deductibles, Copays, Coinsurance (Out-of-Pocket Maximum Protection), New Benefits and Administrative Expense and Profit.

History tells us rebates were 3% in 1997, 12-13% in 2003 and 10-17% by 2010. After they were declared to be Wrong or Improper Payments by MedPAC and HHS's Inspector General, rebates were reduced to 8% by 2016. Med Pac's **Chart 3** displays how congress has escalated monthly rebates per enrollee to 13% in 2020.

Chart 3



What changed? How could rebates increase by 50% (2016 to 2020) in four (4) years? Previously, Chart 2 revealed that expenditures per enrollee increase by 60% but that is prospective, over the next 10-year period! This Chart 3 data shows a 50% increase ($81 to $122) in rebates over four years (2016 to 2020)!

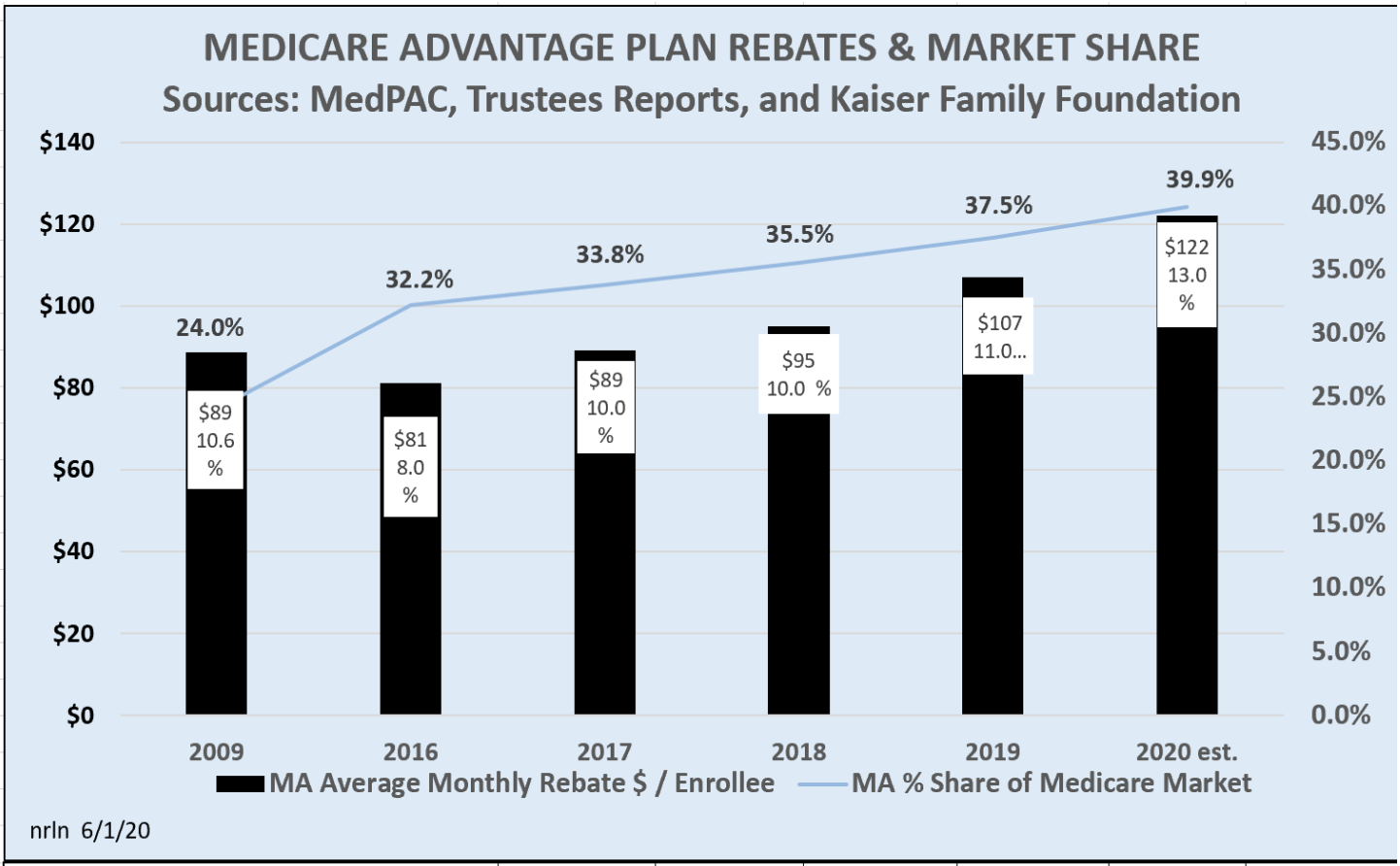
Those 19 new benefits that MA plans may offer starting 2019-2020 can't be offered unless they can be paid for. Since 44 million original Medicare beneficiaries are denied these benefits, FFS cost per enrollee should be even lower than MA's per enrollee cost (with rebate expenses included). The only way MA plans can avoid losing profits is to convince Congress to pivot taxpayer money though the QBP 5-star rating scheme.

A stated reason for needing more rebates is that more MA plans are earning 4.0-star and 4.5-star quality ratings. You will see a note on Chart 7 below that says in 2018, 74% of all MA plan enrollees

were in an MA plan rated at 4-star or higher. Thus, plan insurers would be paid a 5% benchmark bonus and either a 70% or 65% rebate for each enrollee, monthly. The projection is the 74% is growing rapidly! There are a few tricks to learn, like combining a 3.5-star plan with a 4.5-star plan to achieve 4.0-stars or better in one plan with more enrollees.

Chart 4 adds market share information to examine what happens to it when rebates are increased. MA plan market share growth has occurred during periods of increasing rebates. Adding MA plan payments for deductibles or co-pays, or paying for new "chronic" premiums marketed to prospective enrollees, age 65, are paid for with rebate dollars.

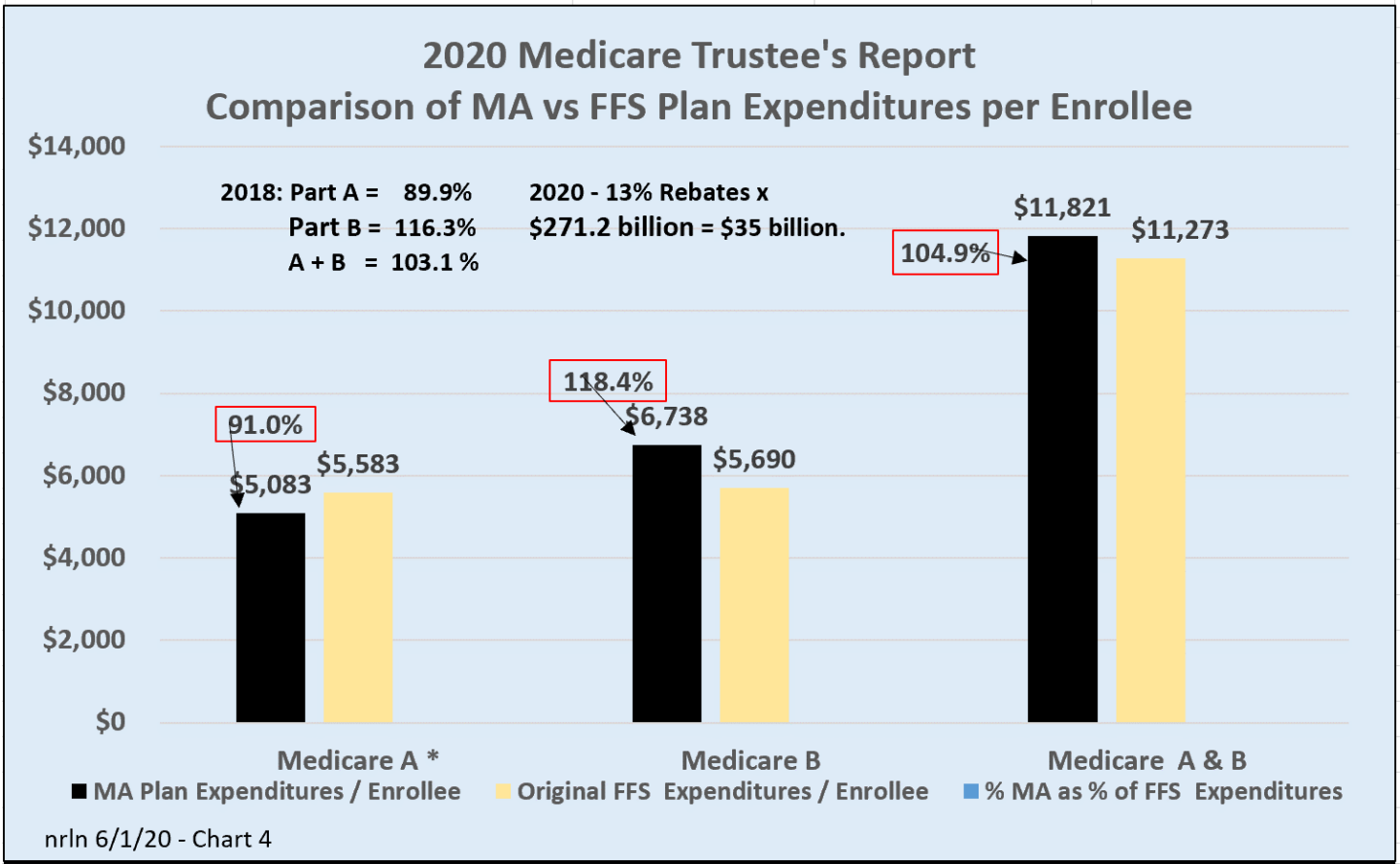
Chart 4



MA Plan Rebates / Enrollee	2009	2016	2017	2018	2019	2020 est.
MA % Share of Medicare Market	24.0%	32.2%	33.8%	35.5%	37.5%	39.9%
MA Average Monthly Rebate $ / Enrollee	$89	$81	$89	$95	$107	$122
MA Rebates as a % of MA Payments	10.6%	8.0%	10.0%	10.0%	11%	13.0%

The NRLN reviewed the expenditure per enrollee performance for FFS and MA plans from the Medicare Trustees 2020 report about 2019 and compared the results with 2018 results on **Chart 5** below. Note the inserted 2018 data shows MA plans lost ground from 2018 to 2019.

Chart 5



*** The Trustees Report noted that MA plans enroll younger, healthier seniors, thus spend less on Plan A, Hospital benefits than FFS plans do and expressed concern that if large #'s of older FFS enrollees switch to MA plans that MA plan premiums, deductibles and OOP limits will rise sharply.**

2019 Mediicare TTs Report for Plan Year 2019	Medicare A *	Medicare B	Medicare A & B
MA Plan Expenditures / Enrollee	$5,083	$6,738	$11,821
Original FFS Expenditures / Enrollee	$5,583	$5,690	$11,273
% MA as % of FFS Expenditures	91.0%	118.4%	104.9%

What can be seen is that MA plan expenditures per enrollee were 104.9% or 4.9% higher than for FFS when looking at Medicare Parts A and B combined – the far-right pair of bars on Chart 5. However, if you look at the next set of bars to the left you will see that MA plans were paid 118% of what FFS plans paid per enrollee for Part B medical services. MA plans did much better and were paid 9% less than FFS per enrollee for Medicare A – why?

The * note just below the chart states that MA plan insurers market to retirees turning age 65 (dangling free rebate benefits). Younger, over-age 65 enrollees are heathier and spend less time in hospitals than older retirees! So, MA Part A costs per enrollee are much lower.

The Medicare Trustees warn that if MA plan insurance companies convince older FFS retirees to switch to an MA plan that MA "premiums, deductibles and out-of-pocket limits will rise sharply". We agree but add that as time passes those new MA plan age 65 recruits will eventually also end up in hospitals which will trigger even sharper increases.

Patience, we are getting closer to the core issue, one that cannot be dodged. You may have noticed that everything points the QBP, the 5-star rating scheme and cash bonuses and rebates.

Financing and Paying Medicare FFS Claims and MA plan Capitation Payments

Before we define the steps and logic for determining bonus and rebate payments that are buried in capitation payments to insurance companies, let's delve into who pays for Medicare Parts A, B and D benefits and who pays and how for Medicare C, private MA plans benefits.

Medicare C is required to cover all Medicare A and B benefits only, all MA payments are paid from the same pot of money used to pay Medicare FFS Part A and B claims. No separate set of books.

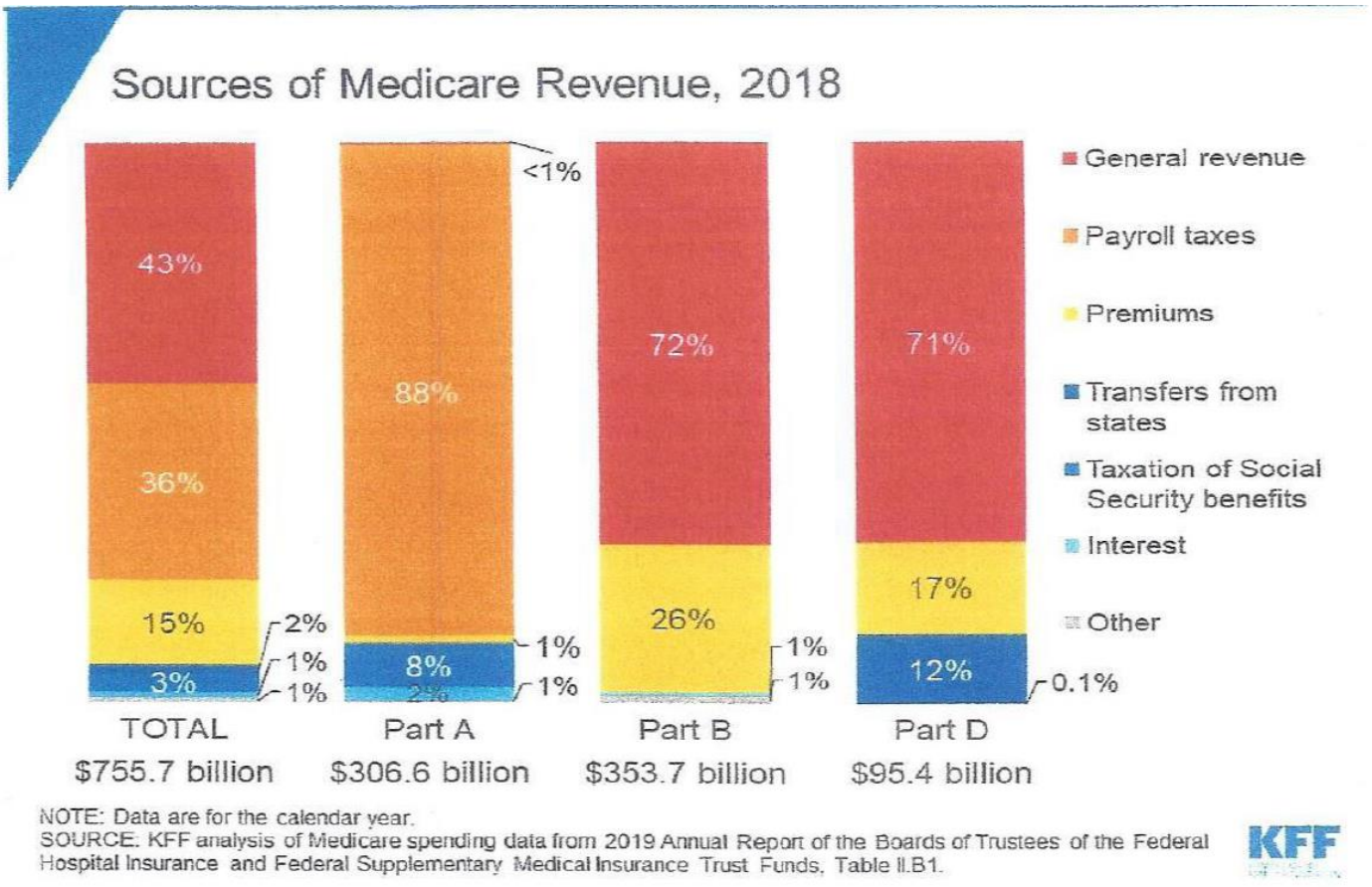
MA plans are not obligated to offer Medicare D, prescription drugs, or any other new benefit coverages. Medicare D and other benefits are offered and purchased separately by MA plans. There is a separate bonus and rebate scheme for Plan D plans.

MA plan Part C, new "chronic" and other benefits are paid for through premiums, deductibles, copays or co-insurance as cost sharing unless otherwise paid by the MA plan insurer.

Bonuses and rebates are calculated and paid to insurers who are supposed to use them to pay for benefits approved for payment by Congress (like "new" chronic benefits) but rebate money is also used to pay for incremental overhead and profit associated with new benefits.

Chart 6 shows 2018 data and that 88% of Part A revenue comes from the Hospital Insurance Trust (HI), with money paid in from the 1.45% tax on unlimited earnings. Over 72% of Part B medical services revenue comes from income tax payments from all taxable sources (general revenue). Similarly, 71% of Part D revenue comes from general tax revenue and in total 43% of all Medicare revenue expenditures are supported by general tax revenue.

Chart 6



NOTE: Data are for the calendar year.
SOURCE: KFF analysis of Medicare spending data from 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

We focus on general revenue here. While, payroll tax revenue is important, as you can see, Part B and D general revenue has the most impact on total revenue needed by Medicare. That's why we are so critical of MA plans inability to compete while at the same time 13% of MA plan expenditure paid out by CMS in 2020 as rebates, $35 billion dollars (13% of $271 billion) otherwise might be used to offset 10% of Medicare B or save Part A.

Medicare Advantage Plan Quality Bonus Plan (QBP) Bonus and Rebate Calculations

After investigating and interpreting Medicare Trustees and MedPAC data we believe the table calculation steps in **Table 3** are representative of how QBP calculations work.

We chose the starting benchmarks and bids used because they are close to the actual relationships between benchmark and bid data reported in the 2019 Trustees and MedPAC reports. Thus, the bid and the benchmark of $874 and $1,000 respectively, were selected.

The three different calculation columns (from left to right) use the same benchmark and bid dollars in all three columns but different quality ratings of 4.5-stars, 4-stars and 1-star. This will allow us to see how much a quality rating can swing rebate values.

Step I - CMS calculates Part A & B monthly county benefits we estimated $1,000.

Step I a - Plans with a star-ratings 4 or better are granted a $50 bonus, added to the plan county benchmark of $1,000.

I b - $50 bonuses are awarded to first two columns but not the 3rd example – rated 1-star

Step II - The insurance company bid to provide benchmark benefits is $874 but is risk adjusted up 2% to $891 to reflect risk in the pool of enrollees in the plan.

Step III – The $1050 benchmark is risk adjusted by the average risk score of bids - by 2% resulting in a bonus and risk adjusted benchmark of $1071 in the first two columns. The last column does not include the benchmark bonus, so the risk adjusted value is $1,020.

NOTES: The plan bid recovers Benefit Costs, Overhead and Profit. Also, the quality bonus is not a payment, it only increases the benchmark value. As you will see next, the name of the game is to maximize the difference between the adjusted bid and adjusted benchmark. Widening the gap and improving star ratings will maximize plan rebates per enrollee paid to insurers.

Step IV – The difference between the adjusted bid (Step II) and the bonus and risk adjusted benchmark (Step III) is the rebate pot of gold. In the first columns the opportunity is $180.

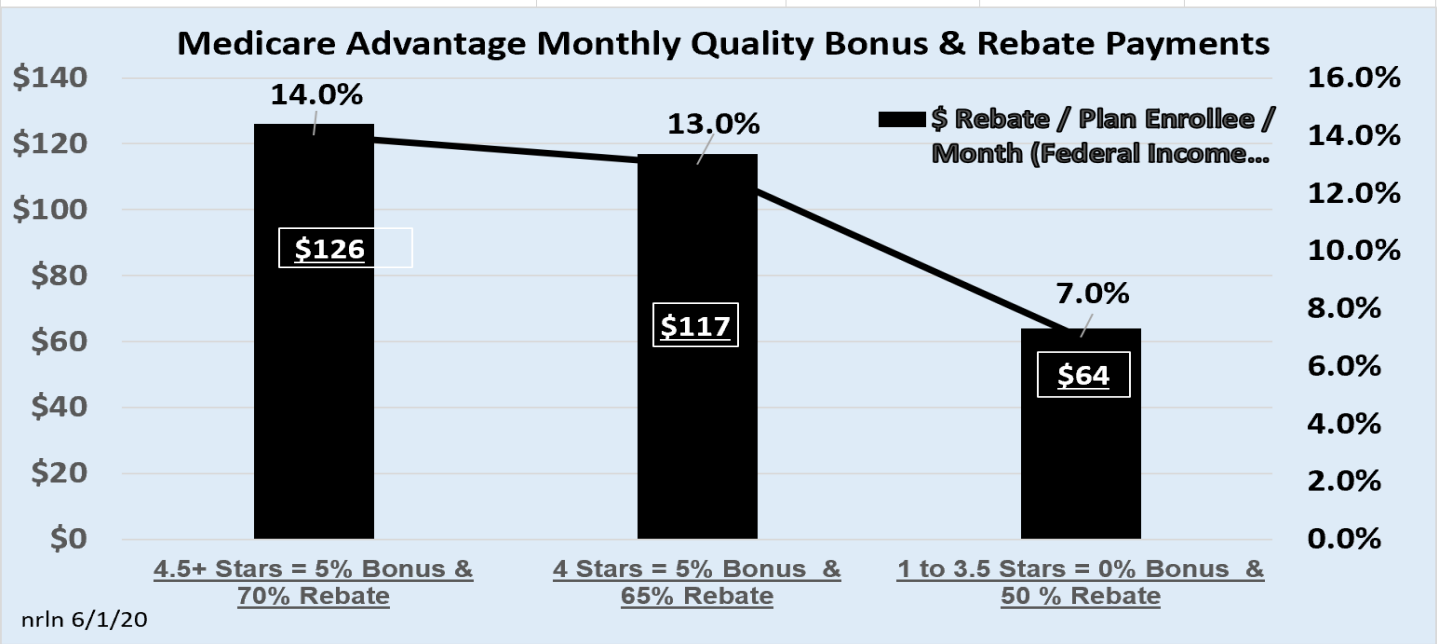
Step V – Plans rated 4.5-stars or higher are awarded a rebate of 70% of the Step IV opportunity, $126, those rated from 3.5 to 4.5-stars receive 65% or $117 and 1.0 to 3.5-stars are awarded 50% or $64. Only in the Medicare world would a 1-star supplier get a $64 monthly payment for every plan enrollee. Anywhere else they would be booted out the door!

Table 3

Medicare Advantage Quality Bonus Plan (QBP) - Bid, Bonus & Rebate Study				
Monthly Payment per Enrollee to Insurance Companies - Calculations for Plan Bid of $893, Rated at 4.5, 4.0 and 1.0 QBP Stars		4.5 Star Rating 5% Bonus & 70% Rebate	4 Star Rating (3.5 to 4.5) 5% Bonus & 65% Rebate	1 Star Rating (1.0 to 3.5) No Bonus but 50% Rebate
STEP I	County Benchmark for Parts 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	ineligible
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 + 2% Risk	$891	$891	$891
STEP III	Benchmark Plus Bonus Adjusted & 2% Bid Risk(Ib x 1.02)	$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%
* See KFF 2018 Chart of CMS data shows that 74% of Enrollees were in plans rated at 4 stars or above.				www.nrln.org

The calculation in the last row is the percent that the rebate is of the Step II risk adjusted bid. We can compare the actual rebates in Step V of $126, $117 and $64 and with the $122 average from the MedPAC data reported on Chart 3 (see page 10 above).

Chart 7 displays Table 3 data but in chart format. Note the MedPAC* in last row.



QBP Bonus and Rebate Calculations of 1 Star, 4 Star and 4.5 Star Rated Plan Examples	4.5+ Stars = 5% Bonus & 70% Rebate	4 Stars = 5% Bonus & 65% Rebate	1 to 3.5 Stars = 0% Bonus & 50 % Rebate
Standard A&B Bid (Cost + OH + Profit) $874 + 2% Risk	$891	$891	$891
$ Rebate / Plan Enrollee / Month (Federal Income Tax Dollars)*	$126	$117	$64
Insurers Recover (Cost+OH+Profit) + ($126, $117 or $64)	$1,017	$1,008	$955
% Rebate / Insurer Bid	14.0%	13.0%	7.0%
*See MedPac 12/6/19 Chart - 2020 average rebates are $122 / enrollee, 13% of MA payments.			

Inspector General reports label bonuses and rebates to be Wrong and Improper Payments in the billions every year for at least the last several years. MedPAC has been highly critical of the unreliability and accuracy of treatment coding and the inaccuracy and effect of using it to determine risk data used in adjusting benchmarks and bids and states that error rates affect rebate payments by 2-4 %.

Worse yet, the very foundation of quality plans is often missing in many areas raising doubts that data is meaningful. Quality standards that determine what should be measured and what is good or bad quality can't be determined quite often, and in many cases can't be measured. Often there is little correlation between or among FFS quality standards or measurements and those implemented in MA plans. In other words, big differences exist in quality standards within FFS, covering 64% of all Medicare enrollees, and within and among the 3,500 MA plans covering about 36% of all enrollees. How do you know? Yet, the rebates keep flowing!

Having read dozens of technical data reports and articles every year and over several years, quality standards in hospitals for example seem to be moving targets when they shouldn't be. MedPAC in its 2020 report said an entire new hospital quality plan is needed. Yet the rebates keep flowing! You would think some quality standards like in nursing homes and hospice facilities would be easier to manage but results show ratings are frequently disputed and standards of quality are moving targets

This quote from Page 396 of the 2020 MedPAC report is very revealing: "Over the years, the Commission has discussed the flaws in the 5-star system and the QBP and the continuing erosion of

the reliability of data on the quality of MA plans (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting in MA is such that the Commission's yearly updates on MA can no longer provide an accurate description of the quality of care in MA. The Commission's March 2019 report to the Congress contains a detailed discussion of the difficulty of evaluating the quality of care within the MA sector and changes in MA quality from one year to the next (Medicare Payment Advisory Commission 2019b)." Not only do the rebates keep flowing but seniors are still relying on the 5-star ratings to make an enrollment selection!

QBP Bonus and Rebate Conclusions

The notion that any supplier would receive a rebate for delivering acceptable quality specified by any customer is an unacceptable and an unprofessional representation of quality engineering and World Class Quality management.

The QBP is merely an industry influenced convenient scheme to disguise the use of taxpayer money used to subsidize the underperformance of MA plans vs Medicare FFS and to ensure the continuance of the forward march of privatization.

The reward for good quality and service is an opportunity to earn or keep a customer.

Imagine choosing to buy a make and model new car selling at an average market price of $50,000 and you buy one for $45,000. One-year passes, the dealer calls to say he's a 4.5-star supplier, wants a check for 70% of your $5,000 savings. What would you do?

A new patient-oriented quality plan should be developed, certified and continued as proposed by MedPAC, but bonus and reward payments should be immediately discontinued.

Our conclusions are corroborated by MedPAC on page 396 of its 2020 report: **"Over the years, the Commission has discussed the flaws in the 5-star system and the QBP and the continuing erosion of the reliability of data on the quality of MA plans (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting in MA is such that the Commission's yearly updates on MA can no longer provide an accurate description of the quality of care in MA. The Commission's March 2019 report to the Congress contains a detailed discussion of the difficulty of evaluating the quality of care within the MA sector and changes in MA quality from one year to the next (Medicare Payment Advisory Commission 2019b)."** It would be virtually impossible to rate plan quality and pay cash rebates for star-ratings if you didn't know the desired results or how to measure them?

NRLN Proposals

- Immediately suspend MA plan bonus and rebate awards and order MedPAC, the Government Accountability Office (GAO), Congressional Budget Office (CBO) and the Health and Human Services (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 quality and cost effectiveness of MA, with and without taxpayer financial subsidies (rebates and star bonuses).
- Grandfather and protect the 26 million seniors (36%), 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.
- Make original Medicare A & B FFS enrollees, who have the same health conditions and needs as those in MA plans, eligible to receive all "new" benefits offered to MA plan enrollees, or retract the 2019 and 2020 "chronic" disease benefits e.g. home air filters and carpet shampooing for asthma patients, payments 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. As it is, Congress has legislated highly discriminatory benefit access rights that pick winners and losers.
- 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,
- CMS and Congressional Operational Priorities:

  CMS must focus resources on refining FFS Benchmark fees and costs based on county and / or regional market costs for goods and services by focusing on a prioritized list of treatments for life threatening and or high cost end results criteria.

  Rename QBP to Healthcare Statistical Quality Control (HSQC) plan and establish measurable supplier process and end results standards, audit and report on supplier performance results. Correct Wrong and Improper Payments. Motivate Affordable Care Organizations (ACOs)-like supplier delivery and wellness systems and create a focused FFS cost reduction plan.

  Congress has a duty to amend or create legislation that enables Medicare FFS free-market authority to seek competitive bids and buy healthcare products and services directly without artificial constraints or obligations to buy through middlemen. Also, current legislation that prohibits our own Medicare FFS from innovating with new programs or to form networks that would lower healthcare costs and better serve seniors' healthcare needs must be abolished. Congress has afforded MA plans an unfair competitive advantage – it must eliminate this preferential treatment!