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NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

Time to End Taxpayer Rebates to the Private Healthcare Insurance Industry

Click this Link to See Our 2020 Video for More Details and Charts - https://youtu.be/0_cQc3f2xrs
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The National Retiree Legislative Network (NRLN) supports competition from private healthcare plans and understands 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 the 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.

Warren Buffet recently commented that healthcare costs are like a hungry tapeworm eating away at us. We agree whether referring to the cost of living (for seniors on fixed income especially), GDP growth, precipitous inflation, the cost of capital needed for innovation and growth or our democratic structure of governance, this tapeworm is a major threat to our country.

The number of over-age 65 U.S. **retirees will grow 25%, from 60 to 75 million between now and 2030 and to 100 million by 2060. Baby boomers are** a small piece of the puzzle; they are all over age 65 by 2030 and by 2060 only 3 million remain. Total Medicare **healthcare costs will grow 101%,** from $796 billion to $1.7 trillion from 2019 to 2030**.** We are an aging country. However, Medicare Trustee Reports and U.S. Census data reveals that, healthcare costs are rising four (4) times faster than Medicare enrollees. **– 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. Infusions of campaign contributions fuel inaction. The character and global reputation of our democratic system is threatened by this example of yielding to gain campaign contributions.

There are four realities that can't be denied: **1)** healthcare costs are rising four times faster than Medicare enrollees**, 2)** private **plan Medicare market share rose by 2% to a 43.1% (to 27.4 million enrollees) in 2021,** enough sales to reel in **$370 billion** revenue**, 3)** after 24 years, despite gobbling up over **$450 billion in taxpayer rebates,** the Center for Medicare and Medicaid Services (CMS) payments per Medicare Advantage (MA) enrollee increased to 103% of payments made to original Medicare FFS enrollees in 2020 and **to 104% in 2021, 4)** with MA plan market share at 43.1% it's time to realize **subsidized growth can no longer be justified!**

Even think-tanks "experts" and others who advocate for retirees make naïve assumptions about the data. For example, in 2019 a **102% overrun was lauded**, proving that averages can deceive. Data shows MA plan **Part A results were 91%,** 9% under original Medicare cost. But the **Part B score was a pathetic 118%.** 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 are likely to **skyrocket**! CMS and industry spin differs. Taxpayers are kept in the dark and duped into paying insurers for extra MA plan benefits worth **$41 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 taxpayer 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 million beneficiaries in original Medicare: a slap in the face and breech of moral and ethical character.

In 2020, nearly 50% of the Senators and Representatives from both parties agreed to posting their signatures as Champions for the Better Medicare Alliance, the healthcare industry funded lobbyist for Medicare Advantage plans.

That’s not hutzpah, it is betrayal. Many of the 40 million who are denied benefits by members of Congress elected them to represent their interests and to protect Medicare, not dissolve it. Just before the 2020 election, they ran for cover. Check the www.betteramericaalliance.org.

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 per year)** paid to insurers directly for 24.9 million MA enrollees. Payments were up 19.1% from **$35.1 in 2020 to $41.8 billion** this year. The **2021 Medicare Trustee report warns us to expect 6-10% annual rebate increases,** making rebates a scandal as monumental as the Teapot Dome scandal in the 1920’s. In one case, oil was the leverage, in this case it’s the desire for campaign contributions that support personal and party elections.

Under original Medicare, CMS manages supplier pricing, quality and service. Not so when HHS and Congress institutionalized MA capitation payments and 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 yet they 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 business, 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 that would affect their personal or party electability.

Privatization works only if rebates keep it alive! Rebates are calculated and awarded under terms of a customized formula contrived in 2010 and implemented in 2012. This scheme uses a 5-star rating plan, typical of what you might see if you were shopping for a washing machine, a household product or a car. The truth is ratings are used to grease the skids; they enable the payment of subsidies to private plans.

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 standards, they may well lose customers and sometimes go bankrupt. No subsidies for them.

If you saved $5,000 in a deal to buy a car, quality (warranty) and service commitments included, would you pay the dealer a 70% or $3,500 rebate for meeting these commitments? Not me.

The Medicare Advantage Quality Bonus Plan (QBP) doesn’t measure consumer product or service quality well. **This 1-5-star program 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. Star Ratings are a means to an end, not the be all, end all.

Medicare Advantage QBP - Bid, Bonus Rebate Study Calculate Monthly Rebate Payments - per Enrollee Basis Using a $1,000 County Benchmark and a Plan Bid of $891 Applied a Neutral 2% Risk Adjustment to Benchmark and Bid Calculate Three Plan Rebates - Use QBP 4.5, 4.0 and 1.0 Stars*		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 by the CMS based on original Medicare Fee-for-Service costs in U.S counties. Our example **Benchmark is $1,000**.

Step Ia.- MA plans that bid are awarded a 5% or 10% increase in the Benchmark if a 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 these two Benchmarks – see Step I b ($1050). Plans rated 1 to 3.5 stars, are not bonus eligible – see step 1 b (NA).

Steps II and III – In Step II plan bids are submitted and risk adjusted based on plan enrollee 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 our purposes we used the same 2% risk factor to increase the Benchmark from $1050 to $1071.

Step IV – The **Pot of Gold** is the spread between a bonus and risk adjusted Benchmark and a risk adjusted bid. A 4.5 and 4.0-star rating can get insurers up to $1071 minus $891 or **$180 per month per enrollee** and the 1-star rating can get insurers up to $1,020 - $891 or **$129 per month per enrollee**.

Steps V – VII – In this example, a 4.5-star rated plan insurer gets **70% or $126**, equal to 14% of the plan risk adjusted bid; the 4.0-star plan insurer gets **65% or $117**, 13% of the risk adjusted bid the **1-star plan insurer gets 50%, $64** and 7%. Rebates for every plan enrollee are paid directly to insurers and plan insurers are not required to disclose actual costs or profits during or at the end of the year.

Every private plan wins taxpayer rebates (subsidies) – Merry Christmas!

There are numerous ongoing investigations and litigations regarding risk factor fudging. QBP bonuses and risk factor adjustments inflate the spread and thus Pot of Gold and rebate payments.

MedPAC' s (Congress' 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!

Little is said but you have to wonder how many plan bids are low-balled to increase the Pot of Gold. The abdication from original Medicare product and service price setting and the cost visibility lost, leaves Medicare highly vulnerable to the low balling of bids. Insurers and CMS brag what a good thing it is that insurer bids are coming down, when in fact the cost per enrollee paid to private plans by CMS is higher than expenditure paid per enrollee in original Medicare. Rebate payments are projected to increase 6-10% a year, attributed to more plans achieving higher star ratings, risk assessment cheating and inflation. HHS and CMS seemingly ignore the dynamics of the rebate scam but MedPac and HHS Inspector General reports inform Congress about the details every year.

All initial risk-adjusted bids and all rebates, include recovery of insurer overhead and profit!

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 over-age 65 retirees (including our grandchildren). Lost purchasing power for 25% of our population will have a chilling effect on their livelihood, on GDP and our overall economic growth potential.

The NRLN advocates for the end of rebates now and to let the two programs (original Medicare and private plans) compete head-to-head. We cannot sustain paying rebates for a false narrative. If we don't act now, major cuts to Medicare will be necessary and ongoing.

<u>The NRLN PROPOSES:</u>

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