NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK

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February 24, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Brooks-LaSure:

Thank you for inviting our response among the many I'm sure you will receive regarding CMS-2023-0010-0001.

The National retiree Legislative Network (NRLN) endorses holding the line at the 1% payment increase earmarked for Medicare Advantage (MA) plans, and Prescription Drug plans, Medicare Part D for 2024.

Sources for information reviewed and used in this response:
Major sources for data used herein are MedPac annual reports to Congress, including its January 2023 status report on Medicare Advantage plans, and Medicare Trustees reports published from 2010 forward which include current and the past nine years on record and projection forward for 10 years or more.

In addition, several past and recent sightings in HHH Office of Inspector General (OIG), Government Accounting Office (GAO), Congressional Budget Office (CBO) reports and other sources were researched and used where appropriate.

Beneficiary Health and Economic Consequences:
Beyond other MA financial consequences, payments to MA plans have not been used to create some needed improvements, as

pointed out in independent studies that reference commonly validated and widespread benefit access and claim processing delays and benefit denials, risk assessment and upcoding cheating, and spurious healthcare insurance industry marketing and sales tactics that confuse and mislead prospective beneficiaries.

Financial Consequences of MA Bonuses and Rebates:
In addition to MA plan insurance company risk and coding profiteering problems, MA plan rebates or subsidies in 2023 will be $75 billion, 17% of payments made by CMS to MA plans, 20.5% of gross margin over cost, before rebates. CMS payments to MA plans have averaged 4% more than FFS payments made per enrollee made to healthcare providers that serve original Medicare beneficiaries. This unnecessary added payment loss to CMS adds another $14.6 billion ($441 billion total payments to MA plans - $75 billion in rebates to be paid in 2023 x .04).

These subsidies and insurance industry inefficiencies created a combined waste of $89.6 billion and MA plan market share, buoyed by rebates rose 3%, reaching 52% in 2023. It's time to drop subsidies (rebates) and to tell insurance industry providers to compete with their cash, not taxpayer's general revenue. It's time to improve performance, not to increase payments.

Comments thus far have intended to primarily address Medicare Parts A and B but are equally applicable to cost improvement, pricing practices and government indirect subsidies paid from General Revenue to insurers of Medicare Part D Prescription drug plans. Over 75% of Medicare D payments are made from general revenue. Over 70% of Medicare Advantage plans include a prescription drug plan. MA plans pay their beneficiaries' monthly Part D premium payments and copayments for Tier I and Tier II drugs. We hear about the low-ball marketing of drug plans every day at dinner time – as Joe Namath and others preach on TV, sign up now while it's FREE!

While Congress' goal is to privatize Medicare through competition, there is evidence that subsidies restrict MA plan competitors from competing on a level playing field. Congressionally legislated and funded subsidy payments, serve to restrain trade and create artificial market entry barriers for companies like Mark Cuban's Cost Plus Drug Co., GoodRX or the latest competitor to enter the fray Amazon Prime. MA plan cost-sharing subsidies of about $36 a month in premium payments and an estimated $4 a month for Tier I and Tier II generic copays are hard evidence that competitors must overcome a $40 a month barrier to enter the market for the 30 million MA plan customers. Contrarily, Rx industry channels are awash in gross margin and net profit. Who suffers most? Retirees on low income.

Medicare Part D 2024 CMS payment increases should be $0!

Funding highly questionable cost-sharing and benefit enhancements enacted by the 2018 Balance Budget Act (BBA) simply have not worked.

We support a phase out of unearned rebates that subsidize 20 or so benefits and cost sharing worth $2,352 to every MA enrollee only. The $2,352 x 31,880,000 MA enrollees = $75 billion. It is time for insurance companies to bear the risk of competing with original Medicare. Take the burden off the backs of original Medicare beneficiaries and taxpayers.

Highly relevant to both payments and the Medicare projected budget of $1.6 trillion or more by 2030 are the consequences of Congress adding and funding the 20 benefit enhancements for MA plan beneficiaries only – see 2018 BBA.

Some of the consequences are readily discernable by examining the rise in rebate payments across the years, especially from 2018 to 2023, the years following passage of the 2018 BBA:

- While MA **enrollment rose by 58%** from 2018 to 2023 **rebates increased by 106%,** from **$95 to $196** per MA beneficiary, a record.

- Rebates as a percent of total payments made to MA plans **rose from 10% in 2018 to 17% in 2023**.

- Total payments made by CMS to MA plans rose from $230 billion to $443 billion, **up 91%**.

- The 2003 Medicare Modernization Act (MMA) authorized new rebates that were implemented by 2006. From 2006 – 2023, **18 years,** rebate payments were $398 billion, an average daily rate of **$61 million** – the **2018 daily rate was $63 million** but by **2023** the total jumped to **$75 billion**, a **daily rate of $205 million!** The total and daily rate more than tripled from 2018 to 2023!

Quality bonuses that suborn rebates and resulting rebate payments are unjustified, are no longer sustainable, especially now that MA plans hold a 52% share of the Medicare market! In 1985 private plan insurers begged for city and county rate floors – they wanted to prove themselves then – what now?

This MA perfect storm is the clash of the legitimate but unwarranted increases of 20 new benefits (2018 BBA), the annual increase of 2 million new MA beneficiaries and the inane premise that the difference between a bid and benchmark is “savings”, combined with the notion that a quality star or any other quality rating should be used as the basis for cash rewards, has put our Medicare and economy in jeopardy!

Please do not let the members of Congress who sign the annual letter to CMS begging for more rebate payments affect your better judgement – 1% is more than enough.

Other Consequences:
Medicare Parts A & B benefits are standardized benefits accessible by all Medicare enrollees (including those in MA plans). If subsidizing MA benefits that will improve the health of beneficiaries, improve quality and lower cost, is justified then isn't denying access to the 29 million other seniors over age 65 senseless? Why pass up savings, better health, and lower cost for 29 million more seniors?

Also, cost-sharing subsidies are not standard across MA plans (but should be), thus creating a bridge to far. For example, an individual with asthma, beneficiary "A" in a MA plan #1, can get subsidized HVAC air-filter changes and Stanley Steamer carpet cleaning if his/her plan offers the benefit. However, an original Medicare A & B beneficiary "B" not in a MA plan is denied this asthma treatment. Not good! The bridge too far is when beneficiary "A" in MA plan #1 also lives next door to beneficiary "C" who is also in MA but in plan #2, a different offering, but his/her plan does not cover this asthma benefit. And we wonder why retirees are confused during enrollment. Too much innovation by inexperienced people.

Please stay the course and don't bend from industry pressure or succumb to letters from members of Congress asking for more than MA deserves!

Sincerely,

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