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Medicare, the Federal Budget, and the Deficit

Medicare Private Plan Rebates Created $1.5 Trillion of 10-Year Deficit

The data forecast in the June 2025 Medicare Trustees Report and March 2025 MedPAC report told Congress that:

- Over the ten-year budget period 2025-2034, Medicare Advantage (MA) plan rebates will add over $1.5 trillion to the deficit. Examples: $89 billion 2025, $111 billion 2027, $155 billion 2030 and $240 billion 2034.
- After 53 years, private MA plan insurers have failed on their promises to be competitive with Medicare Fee-for-Service (FFS). MA rebate-to-bid ratios grew from 10.1% in 2015 to 19.9% in 2025. Trustees projected 24.2% by 2034. Rebate dollars include 15% insurer overhead and profit.
- The average cost for each of 35.5 million enrollees in MA in 2025 is 120% of the cost of Medicare FFS enrollees. MA plans hold a 51% share of the Medicare market but fail to deliver better quality or service, and insurers have delayed, withheld and denied Medicare payments, and are repeatedly cited for upcoding and risk adjustment payment practices.
- Private plan competition with original Medicare FFS is welcomed but it is time for members of Congress and the Executive Branch to recognize that $1.5 trillion of the proposed budget deficit is on them for passing statue language that mandates subsidies they brand as rebates.
- The 2006 Medicare Modernization ACT (MMA) authorized unjustified subsidy payments of 15% that the HHS Inspector General called Wrong and Improper in 2008 and 2009.
- A Capitation Payment plan passed by the 1972 Congress and subsidies that were added through 2005, plus the 2006 MMA Wrong and Improper payments of 15%, opened the door for the 2010 ACA and new rebate legislation, the nefarious Medicare Shared Savings Plan (MSSP), Quality

Bonus Plan (QBP) and Innovation Team (IT) were added to the ACA.

- If Medicare were a public company subject to the Financial Accounting Standards Board (FASB) and Security Exchange Commission cost and financial standards, Congress, as its Corporate Officers, could be fined or jailed for creating the MSSP, QBP, and ACO rebate subsidy schemes.

Medicare Advantage Chronic Disease Rebates Triggered a Crises!

The 2018 Balanced Budget Act added 19 new Chronic disease benefits for those over age 65, purportedly to improve care and control Medicare costs. CMS records show that 85% of total Medicare payments made are paid to 25% of those in original Medicare who are the older and more chronically ill.

However, Congress had no intention of funding chronic benefits for those in Medicare who were well beyond 65 years old and in need of such benefits. Instead, Congress wrote the Act to mandate that only MA plan enrollees would be eligible for these paid benefits. This was a colossal mistake!!!

Before 2018, rebates had been paid to MA plans to subsidize Medicare D drug plan premiums, deductible, and copay costs. Rebates could also be used to pay for portions of enrollee cost for eyecare, hearing, and dental.

MA insurance companies selectively included the 2018 chronic rebates in MA plans and marketed them to eligible enrollers. Joe Willy Namath ads touted get your MA plan and free rides to your doctor, if you have asthma, get your furnace filters changed, carpets cleaned, get dental and over-the-counter drugs paid for. It is all FREE!

2018 BBA Chronic Rebates Broke the Congressional Integrity Mold:

- From 2017-2025 MA plan enrollment grew from 19.8 to 35.5 million, up 79%. Total Medicare enrollment grew from 58.78 to 69.5 million, up just 18%. MA plan enrollee market share grew from 33.7% to 51.0%!
- MA total rebate payments ballooned from $21 billion in 2017 to $89 billion in 2025, up 424%. Rebates drove MA market share and profit. Congress pays 74% of Medicare B and D rebate payments from general revenue.
- The 2025 MedPAC report shows that MA plans received chronic rebate payments $40 billion higher than Medicare would have paid for younger

enrollee benefits after adjusting out higher costs built into rebates for older retiree risks. MA plans benefit from this “Selection Bias.”

- Congress approved Chronic benefits for the 2025 younger class of 36 million in MA plans but denied the same benefits to 34 million more deserving and much older FFS enrollees, creating a smoldering liability.

The Medicare Crises:

- Chronic disease rebates paid to MA insurance companies since 2018 have inflated insurer financial performance to levels that cannot last.
- Aging of 36 million MA enrollees each year and higher cost of healthcare per enrollee due to annual inflation threaten future insurer net income and shareholder value. Without more rebates, insurers would increase MA enrollee deductible, copay, and premium costs to avoid financial losses.
- Deficient performance and broken promises made by MA plan insurers to compete with Medicare FFS are evident. At 51% market share and 20% higher cost per enrollee than FFS, Congress would be foolish to ask taxpayers to pay even higher rebates to protect insurers.
- In 2024, three (3) of the five (5) MA insurance company market leaders terminated MA plans and the 1.1 million beneficiaries in them on January 1, 2025, blaming rising MA costs. Only some retirees were notified of a Guaranteed Issue Right (GIR), as required by federal law (see detail on page. 6 below).
- IBM in 2023 and AT&T from 2022 through 2024 terminated Medigap coverage, replacing it with United Healthcare MA plans asserted to be replacements for company reimbursed Medigap (supplement) plans. Both refused to offer their retirees notice of GIRs. Tennessee Valley Association (TVA) and Avaya retiree GIR notifications were also not sent.
- In May of 2025, United Healthcare (UHC) declared serious financial problems, blaming higher MA costs. Medicare Trustees data and MedPAC and NRLN reports to Congress have warned that MA “Selection Bias” and poor cost, quality and service performance would doom MA. UHC holds about 25% of the MA market, about nine (9) million beneficiaries. Only more rebate bailouts can save insurers.

Table – 1 Source: 2025 Medicare Trustees and MedPac Reports

NRLN June 19. 2025 Analysis of 2025 Medicare Trustee's and 2025 MedPac Reports Medicrae Advantage Plan Rebates Add $1.5 Trillion to U.S. Deficit over Ten Years 2025 to 2034										
A	B	C	D	E	F	G	H	I	J	K
		Total Medicare Enrollees (millions)	MA Plan Enrollees (millions)	MA % of Total Medicare Enrolles.	Medicare Spending 1970 2034 ($Billions)	MA CMS Monthly Rebates Paid / Enrollee	Total Annual Rebate Payments ($Billions)	MA Plan Rebate to Bid Ratios	% Rebate Payments of Total Medicare Spending	Total MA Spending 2015 - 2034 ($Billions)
2025 TT Report Page & Table		158 IV.C1	158 IV.C1	D/C	183, V.B1	165, IV.C4	(G*12)*D	164, IV.C4	H/F	162 IV.C2
1970	1965 Medicare Act	20,398	**Called FFS Plans**		$7.5	**Established Original Medicare Parts A & B Only**				
1975	1972 HMO Amend.	24,864	**Called Private Plans**		$16.3	**HMO contracts, Managed Care & Capitation Payment**				
1980	1982 TEFRA -	28,433	**Called Private Plans**		$36.8	**TEFRA - adds risk adj; results, 5-7% above FFS**				
1985		31,081	1,271	4.1%	$72.3					
1990		34,251	2,017	5.9%	$111.0					
1995	BBA Auth. Rebates	37,594	3,467	9.2%	$184.2	**1997 BBA Private Plans Renamed "Choice"**				
2000		39,688	6,856	17.3%	$221.8	**2006 MMA adds 15% subsidies, renamed C, MA**				
2005	2009 HHS Insp Gen	42,606	5,794	13.6%	$336.4	**2007-2009 HHS OIG-subsidies Wrong & Improper.**				
2010	MMA-ACA-MSSP+IN	47,720	11,693	24.5%	$522.9	**ACA Legalized QBP, MSSP & Rebates**				
2014	**1st Rebate Data Report**	**54,115**	**16,243**	**30.0%**	**$613.3**	**$12**	$3	**10.0%**	**0.41%**	**$159.2**
2015	**MMA-ACA-MSSP+IN**	**55,589**	**17,495**	**31.5%**	**$647.6**	**$77**	**$17**	**10.1%**	**2.62%**	**$174.6**
2016	**ACO1 & ACO2**	57,073	18,383	32.2%	$678.7	$81	$18	10.4%	**2.63%**	**$188.9**
2017	**Chronics Act**	58,683	19,817	33.8%	$710.2	$90	$21	**11.3%**	**3.01%**	**$209.3**
2018	**2018 BBA/Chronics Act**	60,020	21,338	35.6%	$740.8	$96	$25	**11.6%**	**3.32%**	**$236.0**
2019	ACA-MSSP-IN-Chronics	61,535	22,950	37.3%	$796.1	$111	$31	**12.6%**	**3.84%**	**$273.5**
2020	ACA-MSSP-IN-Chronics	62,887	25,075	39.9%	$925.8	$123	$37	**13.5%**	**4.00%**	**$317.1**
2021	ACA-MSSP-IN-Chronics	63,980	27,547	43.1%	$839.4	$141	$47	**15.9%**	**5.55%**	**$352.1**
2022	ACA-MSSP-IN-Chronics	65,165	29,840	45.8%	$905.1	$166	$59	**17.5%**	**6.57%**	**$406.4**
2023	ACA-MSSP-IN-Chronics	66,585	32,161	48.3%	$1,036.7	$209	$81	**21.1%**	**7.78%**	**$469.0**
2024	ACA-MSSP-IN-Chronics	67,601	34,114	50.5%	$1,122.1	$211	$86	**21.0%**	**7.70%**	**$505.1**
2025	**ACA-MSSP-IN-Chronics**	**69,537**	**35,494**	**51.0%**	**$1,206.9**	**$208**	**$89**	**19.9%**	**7.34%**	**$545.3**
2026	TT Report Projection	71,101	37,134	52.2%	$1,298.7	$208	$93	19.9%	**7.14%**	**$619.7**
2027	TT Report Projection	72,778	38,831	53.4%	$1,420.0	$239	$111	21.2%	**7.84%**	**$689.6**
2028	TT Report Projection	74,402	40,407	54.3%	$1,532.0	$257	$125	21.5%	**8.13%**	**$757.7**
2029	TT Report Projection	75,888	41,838	55.1%	$1,655.6	$275	$138	21.8%	**8.34%**	**$836.4**
2030	TT Report Projection	77,134	43,079	55.8%	$1,781.5	$299	$155	22.3%	**8.68%**	**$916.0**
2031	TT Report Projection	78,105	44,120	56.5%	$1,900.6	$323	$171	22.7%	**9.00%**	**$994.6**
2032	TT Report Projection	78,945	45,018	57.0%	$2,022.1	$347	$187	23.0%	**9.27%**	**$1,076.2**
2033	TT Report Projection	79,711	45,813	57.5%	$2,191.2	$373	**$205**	23.4%	**9.36%**	**$1,184.0**
2034	**TT Report Projection**	**80,520**	**46,554**	**57.8%**	**$2,340.3**	**$430**	**$240**	**24.2%**	**10.26%**	**$1,274.8**
10 Years 2015-2024					**$8,402.5**		**$421.5**		**5.02%**	**$3,132.0**
10 Years 2025-2034					**17,348.9**		**1,513.6**		**8.72%**	**8,894.3**
20 Years 2015-2034					**25,751.4**		**1,935.1**		**7.51%**	**$10,910.7**

IT IS TIME FOR CONGRESS TO BE TRANSFORMATIVE:

- time to junk rebates, time to pivot to a reenergized FFS with Managed Care and focus on reducing costs and funding cures for chronic illnesses, one by one, without duplicated research or other non-value-added costs.

- time to dump the capitation model, insurance intermediaries and ACO administrative costs. Instead, set fair benchmark pricing for front-line service providers and mandate that CMS send RFQs, get bids that package quality and service requirements for all healthcare products.

- time for insurance companies to offer competitive plan benefits, copays, coinsurance, and premiums, without rebate schemes. Time to compete with FFS on a level playing field or bow out.

- time for Congress to grandfather chronic benefits for the 36 million enrollees now in MA plans and include the 34 million also in original Medicare Parts A and B, reinforcing the need for chronic benefit cures.

- time to use $500 billion of the $1.5 trillion over five (5) years to support Medicare chronic disease benefits for all 69 million in Medicare, support Medicare transformation funding, and to apply $1 trillion to offset annual cost inflation or to invest in targeted research to lower incurred future payments – $1.5 trillion of PayGO now in Medicare's 2026 budget!

- time for lower per patient fixed cost by consolidating shopping center imaging, dialysis, and other capital-intensive centers manage 24/7 instead of 5-Day 9:00 a.m. to 4:00 p.m. hours (see more patients). Time for physicians to be more productive: see more patients/day - work more days and hours a week to make more money. Need innovation, fair Medicare rates – but not rebates that waste taxpayer dollars.

- Dump the innovation team giveaway approach and thinking. Cost sharing is a sinkhole that makes no sense. The latest ACO - PCP for physicians pays a startup bonus an inducement to form a new ACO. A failed effort!

- Stop actuarial detail work and legitimize FFS market benchmarks. There is no reason to cheat if the FFS contract rate is fair.

Enforcing the Guaranteed Issue Right (GIR) and Medicare Special Enrollment Period (SEP) Standards (TVA, AT&T, IBM, Avaya, Medigap and 1.1 million MA Retirees)

CASE STUDY - FEDERAL AND STATE (NAIC) MINIMUM STANDARDS:
Employer group and Medicare Advantage (MA) and Medigap Supplement plan Insurance companies may terminate their plans.

Federal Minimum Standards require that terminated beneficiaries must be granted a Guarantee Issue Right (GIR) and a Special Enrollment Period (SEP).

The Social Security Act, Sec 1882[42 U.S.C. 1395ss] includes five (5) GIR and SEP Federal Minimum Standards that are replicated in Sec 12 of the National Association of Insurance Commissioners (NAIC) Model 650 regulations:

I – WHO IS ELIGIBLE? See Federal SEP and GIR Eligibility Standards – **Sec 1882[42 U.S.C. 1395ss] (s)(3)(B)(i).** (https://www.ssa.gov/OP_Home/ssact/title18/1882.htm)

II – WHO MUST NOTIFY THOSE ELIGIBLE? GIR and SEP Notification and Time Period Standard - **Sec 1882[42 U.S.C. 1395ss] (s)(3)(D).**

III – WHAT ARE THE GIR RIGHTS? – **Sec 1882[42 U.S.C. 1395ss] (s)(3)(A).**

IV – WHAT ARE THE MARKETING ACCESS AND SELECTION OBLIGATIONS? See **Sec 1882[42 U.S.C. 1395ss] (f)(1)(A) and (p)(3).**

V – WHAT ARE THE ENFORCEMENT STANDARDS? – **Sec 1882[42 U.S.C. 1395ss] (d)(1).** (a), … "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each prohibited act."

The **2024 NAIC form 651-ST** (https://content.naic.org/sites/default/files/model-law-state-page-651.pdf) shows that 20% of 50 states had not adopted NAIC's Model: 25% including D.C. and U.S. Territories. If states do not act, the HHS Secretary is empowered to decertify plans and fine or incarcerate violators for not enforcing **Sec 1882[42 U.S.C. 1395ss]**.

CASE STUDY VIOLATIONS OF MINIMUM STANDARDS I – IV ABOVE:

I – Did Not Declare Beneficiaries Eligible (Medigap) TVA, AT&T, IBM, Avaya
II – Did Not Notify (Medigap) TVA, AT&T, IBM, Avaya, 67% of 1.1 million (MA).
III – All who were not properly notified.
IV – TVA (Medigap) and 67% of the 1.1 million (MA).

REMEDIES:
Notify all affected they are Eligible, explaining clearly what GIR and SEP mean.
Standardize two mandatory Notification Letters to Medigap and MA beneficiaries.
Change SEP period from 63 Days to 12 months.
HHS Secretary sends letters to insurers, agents / PMEs, ordering compliance.
Enhance "Plan Finder'' to be Medicare online marketplace, use to educate users.
Stop MA plan misrepresentation of Medigap coverage and sales to MA enrollees.