



Protecting Medicare and Trimming the Deficit

2/1/2017

Executive Summary

Over 2,000,000 NRLN retirees from 131 U.S. corporations and public entities urge Congress to avoid reductions in Medicare expenditures that could negatively impact the care that current and future retirees receive from doctors, hospitals and other health care services. Medicare benefits and Social Security income payments have become an inextricable part of American retirees' retirement planning and critical to their sustaining a livable economic base in retirement. The NRLN recommends below ways to reduce Medicare and health cost inflation, generally without cutting benefits or quality of care.

Medicare is not a welfare program; it is a covenant with the American people that is consistent with the democratic principle of an elected government choosing to provide for its constituency. There is an obligation to meet, not run from this covenant. We believe that cutting benefits is not appropriate as long as there is genuine and obvious waste to remove from the federal budget.

The 2012, current and future debates regarding whether or not Medicare is affordable prospectively is far more complex than the debate regarding Social Security income payments. The "X" factor in the Medicare debate is the fact that health care costs in general are rising at double the Consumer Price Index (CPI). It's not just Medicare that is at stake: the impact of rising health care costs on all middle income families, and especially on fixed-income retirees, is undermining sales of other products and services, choking off new jobs and our economic future.

Former Congressional Budget Office (CBO) Director Rudolph G. Penner wrote in a recent study for the Urban Institute that Social Security benefits are "not keeping up with inflation, and for those retired a long time, the real value of the net benefit can erode significantly."

Looking ahead, Penner said in the study, "The rapid growth in healthcare costs is leaving the entire population with relatively less to spend on non-health goods and services, and the elderly are affected the most because so much more of their income goes to healthcare."

The May 2011 Medicare Trustees report indicates that spending for the program will increase faster than either workers' earnings or the economy over all. Medicare spending is growing at a 7.2% annual rate—far faster than the economy. The Medicare Trustees report also states that from 1985 through 2010 Medicare expenditures grew at a rate of 8.2%. The trustees predict that average Medicare spending per beneficiary will increase from \$12,042 in 2011 by more than 50%, to nearly \$17,000 in 2021. Given rising costs and an aging population, Medicare's unfunded liabilities over the next 75 years would amount to about \$31 trillion. In 2012, the Trustees reaffirmed these trends. At the heart of Medicare spending is the increasing cost of health care, not the U.S. budget or deficit but the cost of prescription drugs, wheelchairs, insurance company overhead and profit, hospital and doctor care.

While this may lead some to conclude that Medicare is unsustainable, a more rational and ethical conclusion is to address the root causes of the high costs and take adequate steps to eliminate them. For example, there is an enormous Medicare fraud problem that requires immediate attention. Centers for Medicare and Medicaid Services (CMS) estimates that \$48 billion of Medicare's total outlays of \$509 billion in fiscal 2010 (Trustee report says \$523 billion) went to improper payments, including fraudulent ones. According to the FBI, between 3% and 10% of all health spending is lost to health care fraud.

Adding to the complexity, as the 2007 recession deepened, the Medicare program's financial health deteriorated. Higher unemployment levels drove payroll tax revenues precipitously lower, from 62.2% of Medicare revenue in 1990 to 38.9% in 2010, a nearly 40% decline. If health care costs are not curbed by 2020, it is estimated that Medicare payroll taxes and premiums will only cover 33% of Medicare costs.

General tax revenues covered 27.9 % of Medicare's costs in 1990, but due to the shortfall in payroll tax revenue, health care cost inflation and the onset of baby boomer eligibility for Medicare, the share covered by general revenue rose to 44.0% in 2010, and is predicted to rise further to 45.9% by 2020, according to the Trustees report. This pressure on general revenue is increasing despite the fact that participant premiums used to cover costs increased from 9.8% in 1990 to 13.2% in 2010, a 35% increase. Premiums paid by participants are predicted to cover 15.1% of Medicare's cost by 2020. Under the debt ceiling bill passed in August 2011, Congress is now forced to cut the federal budget elsewhere or trigger a huge automatic cut in Medicare spending. The Pork barrel syndrome must die. Congress must manage.

Private insurers with 12-to-16% overhead and 4% plus profit margins could never improve upon Medicare as the low-cost provider when Medicare's total overhead is just 3-4%. They both purchase from the same health care product and service providers and Medicare has the larger purchasing leverage. The NRLN agrees with the CBO's analysis that concludes that adding of private insurance plans into the mix would raise administrative costs and would not keep medical inflation as low as traditional Medicare has done.

Philip Moeller, a writer for US News & World Report, in an article published Aug 19, 2011, noted that "[i]n most years, a significant portion of the cost-of-living increases received by most Social Security beneficiaries" is used to pay for higher Medicare premiums.

NRLN Recommendations:

- Eliminate waste, cut back federal budgets for projects, non-strategic grants and planned budget expenditures and stop authoring wasteful preferential bills and amendments.
- Attack Medicare fraud with the full force and effect of the government. Congress must enact laws that contain stiffer federal penalties including more prison time, for defrauding the Medicare system.
- Pass legislation that would compel safe importation, competitive bidding, funding to accelerate generic drug sales and eliminate non-competitive practices in the prescription drug industry.

- Set fair and equitable rate formulae for determining physician fees and make adjustments up or down annually. Examine costly referrals and redundant visit practices and disallow them.
- Finally, Congress must honor its covenant with the American people. The effect of unemployment on payroll tax revenue, the surge in baby boomer eligibility and rising health care costs can't be offset by slashing Medicare benefits without regard for this covenant. Congress must increase the Medicare tax on workers and employers until such time as taxes can again fund 60-65% of the Medicare budget.



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Medicare – Introduction

Medicare health care benefits and Social Security income payments have become an inextricable part of our culture and are indeed the third rail in American politics.

Liberals and conservatives in Congress know that Americans now plan their futures with Medicare and Social Security in mind, and that no matter what label you attach to these programs (paid-for benefits, earned benefits, promised benefits, entitlements, welfare, etc.), like it or not, there will be a price to pay for the sitting and prospective members of Congress and their respective political parties if they don't preserve these programs in a rational manner. More than one of every five voters in 2010 was age 65 or older.

Most seniors realize that the dynamics of adding baby boomers to the Medicare rolls and reducing Medicare benefit costs will require some changes. However, few realize just how much both political parties have been working toward eroding these benefits while Congress has been on notice for decades about funding concerns that weren't addressed. They fiddled for 30 years and now Rome is burning.

The 2011 and 2012 debates regarding the cost of Medicare and whether or not Medicare is affordable prospectively is far more complex than the debate regarding Social Security income payments. While the impact of 10,000 baby boomers turning age 65 each day for the next 19 years is a major factor to consider in the Medicare debate, it is virtually the only factor in the escalation of Social Security costs. The "X" factor in the Medicare debate is rapidly-rising health care costs. Health care cost inflation is even greater for private health insurance and Medicaid. It's not just Medicare that is at stake: high and rising health care costs among all middle-income families, and especially among fixed-income retirees, is undermining sales of products and services, and thus threatening to choke off new jobs and our economic future.

There are differing views in Washington that encapsulate the leading ideas, and ideologies, concerning how to address the problem of Medicare costs. The NRLN has examined these views and has formulated its own recommendations for addressing the root causes of concern about the program based on the experiences of its senior members and on its conviction that policy-makers need to be reminded about the roots of the program and basis of its funding. While our proposals are geared toward protecting current and future retirees who have paid into Medicare and believe in its promises, we firmly believe they are best for America's future economic stability. An assessment of political factors and realities are necessary to fully understand the relevancy of Medicare as an ingrained or institutionalized part of the American culture. The complexity that must be considered in arriving at solutions that are best for our country should exclude consideration for the success of political parties, ideologies and the Congressional office holders and candidates.

We believe that the American dream is best fulfilled when politics are set aside.

Background

Medicare is a government insurance program passed by Congress as an amendment to the 1935 Social Security Act and covers Americans who are 65 years of age and older. When President Lyndon B. Johnson signed the bill creating Medicare on July 30, 1965, close to 40% of America's elderly lived at or below the federal poverty line. Only half of the country's seniors had any health insurance. They simply could not afford the ever more sophisticated and expensive health care starting to come on line.

In 2011, Medicare covered 48.7 million Americans 65 years of age and older, as well as younger people with permanent disabilities. About half of Medicare beneficiaries live at or below 200% of the federal poverty line (i.e., \$20,800 annual income for a single person and \$28,000 for a couple). Over a third of the beneficiaries are afflicted with three or more chronic conditions.

Medicare has become one of the federal government's most popular programs. Beneficiaries rightly believe they have earned this benefit because they and their employers paid Medicare payroll taxes when they were working and they believe the health care services should be there for them when they are retired. Indeed, based on calculations by The Urban Institute, after accounting for inflation and compound interest, Medicare participants today could easily reap twice as much as they paid into the program.

With the passage of the Medicare Modernization Act in December 2003, which went into effect on January 1, 2006, seniors became eligible for Medicare Part D prescription drug coverage and gained the option to enroll in "Medicare Advantage" plans. Approximately 25% of Americans eligible for Medicare are enrolled in "Medicare Advantage" plans.

Medicare Cost Escalation

The Medicare budget has grown from \$3 billion in its first year, 1966, to \$549 billion in 2011. That represents more than one-fifth of the total spending for national health care. Medicare income in 2011 was \$530 billion. In 2010, according to the Kaiser Family Foundation, Medicare represented 15% of the federal budget and it is expected to reach more than 17% by 2020. Medicare is nearly 3.5% of the country's GDP (Gross Domestic Product).

Experts who analyze Medicare and members of Congress in both parties have long warned that Medicare's sharply rising costs are ballooning out of control as large numbers of baby boomers are becoming eligible for benefits. The percentage of the population over the age of 65, according to the Census Bureau, is projected to increase from 13% in 2011 to 20% in 2050. The trustees have forecasted that the number of Medicare beneficiaries in the coming decade will increase from the 48.7 million in 2011 to 58.8 million in 2018. By 2040, Medicare, if it operates as it does now, will cover 88 million people or more than one-in-four Americans.

Medicare trustees have reported that spending for the program will increase faster than either workers' earnings or the economy over all. Medicare spending is growing at a 7.2% annual rate—far faster than the economy. The May 2011 Medicare Trustees report states that from 1985 through 2010 Medicare expenditures grew at a rate of 8.2%. Report actuaries are projecting a 6% growth rate from 2011 through 2020, attributing most of the reduced rate of cost inflation to the Affordable Health Care Act. In the next decade, enrollment in Medicare will grow by a third, spending per enrollee will jump 50% and total spending is due to double in this period. And yet, Medicare only covers about 50% of seniors' health care costs. These cost dynamics must also be absorbed directly by those not on Medicare.

While some believe the obvious conclusion is to reduce Medicare benefits and add on to out-of-pocket costs to seniors, the problems can be addressed efficiently without decimating the program. Little can be done to stave off the baby boomer rush but costs can be attacked.

The Medicare trustees predict that average Medicare spending per beneficiary will increase more than 50%, to nearly \$17,000 in 2021, from \$12,042 in 2011. Given rising medical costs and the aging population, Medicare's unfunded liabilities over the next 75 years would amount to about \$31 trillion.

The Medicare Part A (Hospital Insurance) trust fund trustees reported on May 13, 2011 that the trust is now estimated to be exhausted in 2024—five years earlier than projected in 2010— a result of the sluggish economic recovery. The projection is a shift from the summer of 2010 when trustees, including Treasury Secretary Timothy Geithner and Health and Human Services Secretary Kathleen Sebelius, projected that the new health law extended the solvency of the program by 12 years from 2017 to 2029.

The history of Medicare is filled with unsuccessful efforts to rein in costs. "Medicare Advantage" plans were to cut 5% off costs, but ended up costing more than traditional Medicare. Private plans can offer more benefits than traditional Medicare. Taxpayers pay "Medicare Advantage" plan insurers an average of 13% more per Medicare beneficiary than paid under the government-run traditional Medicare program. Because it is hard to justify this extra corporate subsidy, especially since it is paid from the Medicare Trust, to the private plans, "Medicare Advantage" has been highly controversial among health policy experts and is scheduled to receive cuts in funding under the 2010 Affordable Care Act.

For decades, Congress has tried to limit Medicare spending on doctors' services, but the limits set have proved so unrealistic that Congress repeatedly intervenes to increase them. They kick the can on this issue when they pass an annual appeasement increase rather than develop a more rational formula.

Medicare Benefits Paid and Revenue – Economic Dynamics and Political Gridlock

The Medicare Act became law in 1965 and Medicare A and B began operation in 1966. Medicare benefit payments, the number of participants, sources of revenue and tax history data from the 2011 Medicare Trustees report, reported in billions of dollars and millions of participants, by selected years, are in the table below:

	1970	1980	1990	2000	2010	2011	2020e	2040e
Benefits Paid – A Hosp.	5.0	24.3	66.7	130.3	249.0	262.8	393.2	na
Benefits Paid – B Dr.	2.2	11.2	44.0	66.6	212.9	227.6	376.5	na
Benefits Paid – C Med Adv	12–17 % subsidies included in A & B (2.0 million enrollees in 1990, 12.4 2011.							
Benefits Paid – D PDP					61.7	66.8	156.2	
TOTAL BENEFITS PAID	7.5	36.8	110.0	221.8	522.8	557.5	932.1	
# Enrolled Participants (mil)	20.4	28.4	34.3	39.7	47.5	48.9	63.9	80.8
Payroll Tax Revenue %	61.8	68.0	62.2	59.8	38.9	38.3	33.3	29.9
Tax on Benefits %	na	na	na	3.6	2.9	2.7	4.0	4.6
Premium Revenue %	13.7	8.6	9.8	9.1	13.2	13.4	15.1	15.8
Brand Name Drug Fees %						.4	.3	.1
State Transfers %					.9	1.3	1.5	2.1
General Tax Revenue %	24.6	23.4	27.9	27.6	44.0	43.8	45.9	49.2
SURPLUS (DEFICIT)	.7	.2	15.3	35.3	(36.8)	(27.8)	95.8	na
Employee Tax %	.6	1.05	1.45	1.45	1.45	1.45	1.45	1.45
Employer Tax %	.6	1.05	1.45	1.45	1.45	1.45	1.45	1.45
The Self - Employed %		.6	1.05	2.90	2.90	2.90	2.90	2.90

Note: Starting in 2013, there will be an added Hospital Insurance (part B) payroll tax of 0.9% on income over \$200k for singles, \$250k for couples.

There is also an enormous Medicare fraud problem that requires immediate attention. CMS estimates that \$48 billion of estimated Medicare outlays of \$509 billion in fiscal 2010 (Trustee report says \$523 billion) went to improper payments, including fraudulent ones. According to the FBI, between 3% and 10% of all health spending is lost to health-care fraud.

The National Health Care Anti-fraud Association (NHCAA) estimates that \$68 billion (13% of \$523 billion in 2010) is lost to health care fraud annually. If Congress doesn't tackle this problem more aggressively, the total cost over a decade could easily reach more than \$300 billion.

Four Significant Conclusions that Can Be Drawn from Examining the Data Above

As the recession that began in 2007 deepened, the Medicare program's financial health deteriorated as higher unemployment levels drove payroll tax revenues precipitously, lower from 62.2% of total Medicare revenue in 1990 to 38.9% in 2010, a nearly 40% decline. By 2020, it is estimated that Medicare payroll taxes and premiums will only cover 33% of the Medicare costs.

Correspondingly, general revenue funds were used to cover 27.9 % of Medicare's costs in 1990 but rose to 44.0% in 2010, an increase of 57% that is predicted to rise further to 45.9% by 2020. This pressure to pay from general revenue funds is despite the fact that participant premiums used to cover costs increased from 9.8% in 1990 to 13.2% in 2010, a 35% increase. Participant premiums are predicted to cover 15.1% of Medicare's cost by 2020. Under the debt ceiling bill passed in August, 2011, Congress is now forced to cut the federal budget elsewhere or trigger a huge automatic cut in Medicare spending.

In 2010, there was a net-add of 7.8 million enrollees or 20% over the year 2000. By 2020 the number balloons to 63.9 million and then to 88.3 million by 2040, or 86 % more than the 47.5 million enrollees in 2010. It is alarming that over the past forty (40) years, trustee reports have been provided to Congress and, for the past 10-to-15 years, trustees and actuaries have been telling Congress to fix the rising health care cost problem and to find ways to raise revenue or cut benefits in order to accommodate the impending baby boomer problem. Failure to raise the Medicare payroll tax and to attack Medicare fraud with a vengeance 10 years ago were colossal missed opportunities and demonstrates how political parties and past and present members of Congress have been more concerned about how a tax increase would affect their personal status than they have been about America's future. A Medicare payroll tax increase may be unavoidable.

Finally, Medicare fraud must be more aggressively attacked with the full force and effect of the government and Congress must enact laws that contain stiffer federal penalties and prison time for defrauding the Medicare system. This alone could save nearly \$100 billion a year by 2020.

Medicare – U. S. Representative Paul Ryan's Proposal

On April 5, 2011, U.S. Representative Paul Ryan (D-WI), Chairman of the U.S. House Budget Committee, unveiled "The Path to Prosperity: Restoring America's Promise," a 2012 proposal which outlines a strategy for reducing federal spending and reducing the national debt over time. The proposal would eliminate the government-run Medicare program for Americans now under age 55 and replace it with means-tested subsidies for private insurance that would push more costs onto Medicare recipients. Medicare spending would be sharply reduced by switching to a system in which seniors would receive "premium support" (or "vouchers") in order to choose among competing private health care plans offered in their area through a new Medicare Exchange.

Plans offered through the Medicare Exchange would be required to enroll any Medicare beneficiary who wishes to enroll, without regard to health status or income. Plans would be prohibited from varying premiums based on the health status of enrollees, and would be required to charge the same premium to individuals in the same age group.

Americans currently age 55 or older, a group that includes a large portion of the postwar baby boom, would remain in the traditional Medicare plan. However, their benefits would decline, mainly because Chairman Ryan's plan would repeal parts of the Affordable Care Act, much of which is already in jeopardy due to recent court decisions. Those grandfathered into traditional Medicare would have the option of switching to the new private system, and health policy experts say the healthiest individuals might opt for private plans.

The CBO has analyzed Chairman Ryan's plan and estimated that by 2030, the government would pay just 32% of the health care costs, less than half the share that the federal program currently pays. The other 68% of the plan would have to be shouldered by the retiree. The CBO estimated that if traditional Medicare stayed in place, the government would pay 70% to 75% of the costs.

Under Chairman Ryan's proposal, the payment made to Medicare participants to apply toward private plan premiums would be based on projected average per capita Medicare spending in 2022, adjusted for health status, age, and income. According to the CBO, net federal "premium support" payments for a typical 65-year old in 2022 would be \$8,000 per enrollee. The CBO analysis indicates that the total cost of providing health care benefits (premium and other costs) to a typical 65-year old in a private plan would be about \$20,500 in 2022. The remaining \$12,500 would be paid by the Medicare participant.

The CBO projects that out-of-pocket costs for the typical 65-year old would be more than twice as large under Chairman Ryan's proposal as under traditional Medicare (\$5,630) in 2022. A typical 65-year old who comes under Medicare in 2022 could expect to spend half of his or her Social Security income for Medicare under Chairman Ryan's plan. This would be double the amount a retiree would pay under traditional Medicare.

The level of the "premium support" payments would grow over time with inflation. The program would be means-tested, so poorer Americans and those with catastrophic illness would get more money. Chairman Ryan's plan would give people with incomes below the federal poverty level an extra supplement that would cut their average out-of-pocket cost to about \$4,700 a year—or about 43% of their average income. Yet under the current system, poverty-level Medicare beneficiaries pay little or nothing for their health care.

In addition to converting Medicare from a defined benefit plan to a system of defined "premium support" payments, Chairman Ryan's proposal would gradually raise the age of Medicare eligibility from 65 to 67 by 2033. Also, the proposal would repeal provisions of the 2010 Affordable Care Act. The provision designed to close the Medicare Part D prescription drug benefit's coverage gap (doughnut hole) would be revoked. Over time, prescription drugs would not be offered separately through private stand-alone plans but would presumably be covered under private plans, along with other medical benefits. The health care reform law's Independent Payment Advisory Board (IPAB) which is yet to be formed would be abolished. IPAB is tasked with making recommendations for Medicare spending cuts to Congress if Medicare spending exceeds GDP+1% in 2015 or later years. Also, the law's general requirement that most Americans carry insurance or pay a fee would be eliminated, again, a provision of the Affordable Care Act which is in jeopardy from recent court decisions deeming those mandates unconstitutional.

On April 15, 2011, the U.S. House of Representatives passed the Fiscal Year 2012 Budget Resolution proposed by Chairman Ryan by a vote of 235 – 193. Republicans voted as a bloc to pass the budget. Of the 239 House Republicans, only four voted against the budget, joining 189 Democrats who voted against it.

Would Chairman Ryan's plan help reduce the federal government's deficit? Yes. According to the CBO analysis, if the plan were to be adopted, the government by 2030 would be spending only about 6% of our nation's Gross National Product (GNP) on health programs, including Medicare and Medicaid. If the current system stays in place, government spending on health would total between 8.75% and 9.75% of GNP in 2030. Overall health spending, both public and private, would be higher with more of the cost coming out of seniors' pockets.

The CBO's analysis also assumed that adding private insurance plans into the mix would raise administrative costs and would not keep medical inflation as low as traditional Medicare has done.

Medicare – President Obama's Proposal

On April 13, 2011, President Obama called for cutting the nation's budget deficits by \$4 trillion over the next 12 year, offering what he said was a more balanced approach that relies in part on tax increases for the wealthy as well as on spending cuts.

Under the President's outline, Medicare would not be changed to a "payment support" or "voucher" program as Democrats call it. President Obama proposes broad reforms that he says would save hundreds of billions of dollars over the next 12 years and more than \$1 trillion in the following decade. The Affordable Care Act that the President helped push through Congress contains a number of pilot projects and other efforts intended to rein in spending.

President Obama says that he wants to slow the increase in drug costs by giving Medicare the ability to use its purchasing power to "*drive greater efficiency.*" The President maintains that changes he is proposing could result in Medicare savings of \$340 billion over the next ten years.

In his remarks on April 13th, the President stated that the goal of his proposal is to make Medicare more efficient and facilitate bringing generic drugs into the market place faster. It would also incentivize doctors and hospitals to prevent injuries and improve results, and it would also bring down costs through the IPAB. Concerns about the President's proposal have been that it does not have specifics about how these goals would be achieved and what real dollars would be saved. However, if a detailed plan were proposed, including a more aggressive plan for reducing Medicare fraud, there would be a greater chance of maintaining the benefits that America's seniors rely upon and partially paid for through their taxes. The White House plan would set a new target of reducing the growth of Medicare's cost per beneficiary in line with the growth of Gross Domestic Product (GDP) per capita plus 0.5%, compared with the current law's target of holding Medicare spending growth to the pace of GDP expansion per capita plus 1%.

The White House plan also would cut spending on prescription drugs in Medicare and Medicaid by speeding availability of certain generic drugs. In addition, the President's strategy relies on additional tactics that have less certain results, including redoubled efforts to ferret out abusive or fraudulent Medicare, and stronger incentives to reduce medical errors and unnecessary hospital readmissions.

Ryan- Wyden 2012 Medicare Proposal

In January of 2012 U.S. Representative Paul Ryan (D-WI), Chairman of the U.S. House Budget Committee and Senator Ron Wyden (R-OR), unveiled what they hailed was a bipartisan plan, a revised Ryan Plan.

While this plan is very much like Representative Ryan's April 5, 2011 Medicare proposal included in his budget proposal titled *The Path to Prosperity: Restoring America's Promise*. It contains unique differences. Ryan and Wyden tried to head off partisan attacks on Medicare in advance of the 2012 elections. However, there has not been a bi-partisan rush to adopt it and 2012 politics have, if anything, muddied the waters more than expected.

The very first part of the Ryan-Wyden plan is called "Choice". Prior to Congress enactment of the 2003 Medicare Modernization Act (MMA), health care insurance companies lobbied for more privatization of Medicare and lobbied for what we know today as Medicare Advantage Plans which have since captures about 25% of the Medicare market, thanks to subsidies paid directly from the Medicare fund. Prior to that time, Congress under pressure from the insurance industry enacted privatization and labeled these plans Medicare Choice plans but these plans were to be truly competitive plans, there were no approved subsidies.

The "Choice" feature of Ryan – Wyden, not too subtly, offers the throwback term "Choice" but in fact proposes to add back and increase Medicare Advantage subsidies to insurance companies. The motivation appears to be to pay insurers off for taking on Congress's obligation to fund Medicare. This ruse simply shifts more cost of health care increases and corporate overhead and profit to the retiree plan participant. Further, the plan does not state whether or not subsidies will be paid directly from the Medicare trust, which of course would mean that there could be no cost savings!

The "Affordability" feature of Ryan-Wyden retains "premium support" aka "vouchers" but would set support levels determined by the 2nd lowest cost among private plans as well as traditional Medicare. In addition, a new out-of-pocket maximum would be set to avoid catastrophic risk and those eligible for Medicaid or on low income assistance would get ongoing coverage at no additional cost. What is not said is that Medicare would be declared the winner if insurance company premiums, deductible and copay cost to retirees are higher after netting out federal subsidies!

This plan proposal also includes a "Protecting the Guarantee" feature beginning in 2023 that limits cost growth to 1% over Gross Domestic spending, plus inflation. Increases over the cap will reduce premium support levels for providers, drug companies and means tested premiums (the split is not specified).

Medicare - NRLN's Summary Analysis and Conclusions

The NRLN's position on Medicare has been and continues to be that Congress must guard against reductions in Medicare expenditures that negatively impact the care that current and future retirees receive from doctors, hospitals and other health care services. The NRLN is opposed to proposals that would end Medicare as it has been known; replacing it with federal payments for private insurance for people born after a certain date when those Americans become Medicare eligible. Private insurance has failed to significantly contribute to lower the cost of health care and does not have the tools or market clout to solve cost problems as individual firms.

Private insurance companies would add on yet another layer costs for administration, marketing and profit. Private insurers with 12-to-16% overhead and 4% plus profit margins could never improve upon Medicare as the low-cost provider when Medicare's total overhead is 3 to 4%. They both purchase from the same health care product and service providers and Medicare has the larger purchasing leverage. The NRLN agrees with the CBO's analysis that assumes the adding of private insurance plans into the mix would raise the cost of administrative and would not keep medical inflation as low as traditional Medicare has done. Recent data suggests that rising deductibles and co-pays and the current level of annual and lifetime benefit limits are as much of a concern as premiums. These factors are just the measurements of the elephant in the room, which are sky-rocketing health care costs. Health care costs grow unabated and the political will to control prescription drug costs, Medicare fraud, medical doctors and hospital fees and other costs is weak at best.

Philip Moeller, a writer for US News & World Report, in an article published Aug 19, 2011, noted that "[i]n most years, a significant portion of the cost-of-living increases received by most Social Security beneficiaries" is used to pay for higher Medicare premiums.

Former Congressional Budget Office (CBO) Director Rudolph G. Penner wrote in a recent study for the Urban Institute that as a result, Social Security benefits are "not keeping up with inflation, and for those retired a long time, the real value of the net benefit can erode significantly." Looking ahead, Penner noted, "The rapid growth in healthcare costs is leaving the entire population with relatively less to spend on non-health goods and services, and the elderly are affected the most because so much more of their income goes to healthcare."

The dangers of not protecting against inflation and in particular, for retirees, rising health care costs, are obvious. While Medicare specific costs should always be scrutinized for waste it will also be necessary to face up to the need for temporary or permanent changes to the Medicare payroll tax. Any evaluation of the role of payroll tax must include the possibility for increases or decreases in this tax. Given the current state of Medicare funding, an increase in the payroll tax for workers and employers would help fund Medicare to more acceptable levels until such time as reductions in health care costs and an increase in employment levels sufficient to stabilize Medicare funding materialize.

Insurance companies do not manage health care costs; they simply apply overhead and profit to rising cost and obtain rate approval state by state. Medicare overhead is 3-to-4%. Average insurance company overhead is 12-to-16% and after adding profit margin, 20% of the private insurer's price to their policy holders is non-cost related. The 2003 Medicare Modernization Act-created subsidies for Medicare Advantage plans brought insurers within competitive reach of Medicare. However, Medicare trust funds are used to pay the insurer's overhead and profit, escalating costs are passed to the Medicare Trust funded by taxpayers. Elimination of these subsidies is warranted.

The NRLN's position is that "premium support" or "vouchers" would be an unmitigated disaster for Americans who are now under age 55 when they become eligible for Medicare. The experience with "Medicare Advantage" suggest costs would rise far faster than inflation and, of course, a portion of the "support payment" or "voucher" would be siphoned into the insurance companies operating expenses and profits. Thus, even if the government payments appeared generous enough to pay for good coverage for an initial period of years, over time the cost gap would grow wider and wider – such that future retirees would have very high out-of-pocket expenses.

Some politicians have propped it would be a good idea to slow the increase in drug costs by giving Medicare the ability to use its purchasing power to “*drive greater efficiency,*” and by cutting spending on prescription drugs in Medicare by speeding availability of certain generic drugs.

For a number of years, the NRLN has advocated prescription drug solutions through the passage of legislation that: (1) Enables re-importation and importation of safe prescription drugs approved by the FDA; (2) Enables Medicare to develop formularies and take competitive bids for prescription drugs; (3) Staffs and funds the FDA to reduce the generic drug approval backlog; (4) Prevents drug companies from colluding to control pricing or subvert free market practices.

Medicare - NRLN's Specific Recommendations

- Eliminate waste, cut back federal budgets for projects, non-strategic grants and planned budget expenditures and stop authoring wasteful preferential bills and amendments.
- Attack Medicare fraud with the full force and effect of the government. Congress must enact laws that contain stiffer federal penalties including jail time, for defrauding the Medicare system.
- Pass legislation that would compel safe importation, competitive bidding, funding to accelerate generic drug sales and eliminate non-competitive practices in the prescription drug industry.
- Set fair and equitable rate formulae for determining physician fees and make adjustments up or down annually. Examine costly referrals and redundant visit practices and disallow them.
- Finally, Congress must honor its covenant with the American people. The effect of unemployment on payroll tax revenue, the surge in baby boomer eligibility and rising health care costs can't be offset by slashing Medicare benefits without regard for this covenant. Congress must increase the Medicare tax on workers and employers until such time as taxes can again fund 60-65% of the Medicare budget.

We believe that cutting benefits is not appropriate as long as there is obvious waste to remove from other parts of the federal budget. We will continue to advocate for health care cost reduction and the reduction of wastefulness in the federal budget. The NRLN will engage the full force of its grassroots network and its Washington, D.C. team to relentlessly lobby members of Congress and the President to protect retirees' earned Medicare benefits.