

FOREWARD

"I come not to save Medicare but to bury it"

-Rich Reichard's satirical take on Paul Ryan's Medicare philosophy (with a bow to The Bard)

The Bibliography and Footnotes are available on sidem.org.

Broadly speaking, since the Great Depression our country has viewed itself as a national family. Just as we don't send our unemployed workers into a Dickensian market unsupported, we generally no longer send our sick, lame and old back home to fend for themselves with a loaf of bread, a bottle of water and a "Get Well Soon" card. In short, we decided 70 years ago that we would not abandon each other just because of fiscal hard times.

Medicare is a Democratic institution. Passed during the Johnson administration, it is a government insurance program that guarantees seniors financial access to quality healthcare in exchange for *affordable* premiums. The cost of the program is held low by a modest Medicare fee paid by a payroll tax. And it works!

Medicare now pays out more than it brings in. That has to be fixed. Most Americans love the program and want to save it with a few tweaks. Republicans hate Medicare, want to get rid of it altogether and see the fiscal problem as a means to that end.

The Republican problem, as noted, is that Americans love Medicare. To overcome this "minor" obstacle the GOP resorts to an old flim-flam that crashed and burned when tried by Coca-Cola: cheapen the product - keep the name - hope nobody notices.

That's what the Republicans' "Ryan Plan" is - a facetious scam to eliminate a popular program and substitute an inferior program under the same name - Medicare. Unlike real Medicare, the Ryan Plan does *not* pay for medical care. It gives seniors inadequate vouchers to partially pay premiums charged by private health care insurers -the same insurers who fill Republican coffers with political contributions.

Giving a senior, say, a \$6000 voucher toward a \$12,000 private insurance plan is a cruel joke. It will likely force that senior to forego insurance. The voucher cannot be used for anything else, and the senior will receive no benefit from this fraudulent scheme despite having paid Medicare taxes for many years. Perhaps worse, the Ryan plan will likely shift thrift-conscious seniors into low quality private plans, depriving some of needed care. (Perhaps the "Ryan Plan" should be called the "Dyin' Plan".)

As Democrats we cannot let that happen. This paper is drafted to fortify SIDA members and all caring people with an understanding of the issues and to express the association's position.

Medicare and Medicaid History and Information

In 2009 the United States spent \$2.5 trillion on health care, which represented 17.6% of GDP. Of that amount Medicare spending (care for the elderly) accounted for 20% of total health care spending and Medicaid (care for the poorest) accounted for 15% of the total health care spending. By 2019 it is projected that the nation's health care spending will be 19.3% of GDP.

The effort to address these fiscal problems resulted in the Affordable Care Act of 2010 which provides a framework within which everyone in the nation is in the pool of the health insured and that such insurance remains affordable and cannot be denied to an individual because they actually get sick.

Our healthcare expenditures will continue to go up because Baby Boomers, the largest cohort in our population, are getting ready to retire and will use Medicare because seniors simply use more health care. Furthermore, the recession has thrown millions out of work, some for over a year, which means that many of them will also be needing and using government medical assistance. Dealing with these increases in expenses is the issue.

When added to our present recession debt there is little disagreement between Democrats and Republicans that the current and projected rate of growth in the costs of the Medicare and Medicaid will eventually overwhelm our ability to pay for other government programs. However while those requiring health care will continue rise, refusing to alter our behavior or to consider global solutions to this natural increase in no way eliminates their illnesses nor our moral obligations to each other.

Since the Depression we have expanded our safety net to include not just unemployment support but healthcare support as well. The following is a brief history of our actions in this area, problems that arose subsequently, and where we ought to go from here.

Because we had increasing numbers of elderly and poor citizens unable to get health insurance burdening our states and embarrassing our citizens, the Social Security Act of 1965 was signed into law by President Johnson in 1965 creating Medicaid and Medicare Parts A and B.

Medicare Part A: Medicare coverage was intended for those 65 and over and in 1973 its benefits were extended to individuals under 65 with long-term disabilities. Initially it was funded by a .375% payroll tax collected from employers, employees and the self-employed. Over the ensuing years this tax and the income brackets paying it have increased slightly. It is used to fund the Medicare HI (Hospital Insurance) Trust Fund (Medicare Part A) which pays for inpatient hospital care, home health care, skilled nursing facilities and hospice care for the aged and disabled.

From 1966 through 1990 there was a maximum taxable salary for the HI payroll tax, but in 1991, 1992 and 1993 that maximum was increased, and in 1993 that maximum taxable salary cap was eliminated.

With the passage of the Patient Protection and Affordable Health Care Act of 2010 high income workers will pay an additional 0.9 percent of their earnings above \$200,000 (single) or \$250,000 (married) to fund HI.

However, the increasing use of these funds by Baby Boomers, is not a sustainable solution over time. "The financial status of the HI trust fund is substantially improved by the lower expenditures and additional tax revenues instituted by the Affordable Care Act. However the HI trust fund is now estimated to be exhausted in 2024, 5 years earlier than was shown in last year's report, and the fund is not adequately financed over the next 10 years."(3)

Medicare Part B pays for physician and outpatient services and Part D covers prescription drugs. The Supplementary Medical Insurance (SMI) Trust Fund covers Part B and D.

“Payments from the General Fund finance about 75 percent of SMI Part B and Part D costs, with most of the remaining costs covered by monthly premiums charged to enrollees.” (4) States paid about 7% of the cost of Part D in 2010 to compensate the federal government for assuming responsibility for paying the drug costs for those eligible for both Medicare and Medicaid.

Medicare Part C was created by the Balanced Budget Act of 1997 and established the Medicare+Choice program. Believing that marketplace competition could rein in costs, HMOs and other private health plans were offered to beneficiaries and for a short time they were able to stabilize costs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created something called the Medicare Advantage program that replaced Medicare+Choice.

These plans provide all Part A and B coverage. Most also provide part D, prescription drug coverage. For this, Medicare pays a fixed amount monthly from the HI and SMI trust funds for every beneficiary enrolled in a Medicare Advantage Plan. However, a June 2007 report by the Congressional Budget Office estimated that the average payment to Medicare Advantage plans was about 12 percent above the cost of traditional Medicare. Clearly, this was not a solution that reined in costs.

And to address this problem, the 2010 Affordable Health Care law will reduce payments to these Medicare Advantage plans by about 12% a year to bring their cost in line with traditional Medicare. Furthermore, the law also restricts the share of the premiums that Medicare Advantage firms can use for administrative expenses and profits.

Medicare Part D: The 2003 Medicare Prescription Drug, Improvement, and Modernization Act created Medicare Part D (prescription drugs). However, it left a huge gap in drug coverage for individuals and cost many seniors more than they could afford. This gap came to be known as the “donut hole.” Part D benefits went into effect on January 1, 2006, but the cost to seniors of that gap in coverage was so egregious that the 2010 Affordable Healthcare law was used to correct it by gradually eliminating it.

Medicaid

Medicaid provides coverage to the poorest of our citizens. However, Medicaid is not required to provide health care to all poor people -- only to those who fall under one of the groups established by federal statute. “Within broad national guidelines established by federal statutes, regulations, and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.”¹ Therefore a person may be eligible in one state but not in another and medical services may be provided in one state but not another.

Medicaid is jointly funded by federal and state governments. The federal share, “...known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. The FMAP cannot be lower than 50 percent or higher than 83 percent” of the state's average per capita income.²

Beginning in 2014 under the Affordable Care Act, the federal government will provide additional Medicaid funding to the state to cover those up to 133% of the federal poverty level, including single adults and childless couples. "New York already provides coverage above the 133% level and provides coverage of single adults and childless couples to 100% of the federal poverty level"³ The New York State Assembly has estimated that the state will receive an additional \$1 billion in 2014.

Under Medicaid, states pay providers directly and are given broad discretion by the federal government on how and how much to pay providers. However, providers participating in Medicaid must accept Medicaid payment rates as payment in full.

In addition, states must make payments (called disproportionate share adjustments) to those hospitals that provide inpatient services to a disproportionate number of Medicaid, low-income or uninsured persons. To address the rapidly growing costs to Medicaid in 1991, 1993 and 1997, legislation was passed to cap the federal government's share of these "disproportionate share payments." Legislation increased federal payments for 2001 and 2002 which increased cost to Medicaid for those years.

Discussion of Proposals to Address Costs

Our health programs are under attack through the demographic changes brought about by an aging population followed by a much smaller cohort of workers, and by an economic downturn nearly as devastating as the Great Depression, compounded by a debt burden occasioned by two unfunded wars.

Proposals to address Medicare and Medicaid by President Obama's Commission on Fiscal Responsibility and Reform; by former Senator Domenici's and Dr. Alice Rivlin's Debt Reduction Task Force; by Congressman Ryan's "A Roadmap for America's Future," which the Republicans voted to back; and by a speech President Obama delivered on a vision for America's fiscal future 4/13/2011.

The Republican Plan

Let us look at the most radical of proposals: Beginning in 2022 the Republican Plan would move Medicare from a defined benefit plan to a voucher plan, which they call "premium support." In addition, this plan would gradually raise the Medicare eligibility age to 67 by 2033. It would change Medicaid from a cost sharing program to a block grant program.

Under this plan senior citizens would use these vouchers to buy insurance through a health insurance exchange. However, according to the Congressional Budget Office (CBO) a 65 year-old becoming eligible for Medicare in 2022 would have to pay \$12,510, while under traditional Medicare the same 65 year-old would only have to pay \$6,150 in out-of-pocket expenses.

Clearly, the Republican plan to control federal expenses achieves this by eliminating our communal relationship, making seniors individual mendicants of the federal government and by transferring the bulk of health insurance costs to individuals. They shift Medicaid costs completely to the states. No federal effort is offered to make medical care more efficient or less

expensive, and as we have seen during the 1980s and 1990s neither individual pressure nor the use of HMOs and private health plans were able to prevent an increase in costs.

Given the fact that most older citizens are unable to increase their income through work, it is unclear how the Republicans believe citizens will be able to make up this big deficit to purchase adequate insurance, and it pits elderly individuals against big insurance companies.

The CBO estimates that by 2022, under this plan, federal spending on Medicaid would be 35% lower than today and the amount of the federal block grant would generally not increase during times of economic downturns when Medicaid rolls may increase.

“Because of the magnitude of the reduction in federal Medicaid spending under the proposal, however, states would face significant challenges in achieving sufficient cost savings through efficiencies to mitigate the loss of federal funding. To maintain current service levels in the Medicaid program, states would probably need to consider additional changes, such as reducing their spending on other programs or raising additional revenues.”⁴

The Republican plan achieves its main goal, which is to off load the amount of money spent by the federal government on healthcare for citizens. It does so simply by destroying the contract made during the Great Depression that we would view ourselves as a large national family.

The Debt Reduction Task Force

The Debt Reduction Task Force also has a premium support proposal that would allow beneficiaries beginning in 2018 to purchase health insurance through an insurance exchange. However their proposal would allow beneficiaries to choose traditional Medicare as one of their plans.

The Task Force has also proposed raising the Medicare Part B premium over 5 years from 25% to 35% of total program costs. In addition, to address long-term health care spending to treat obesity-related illnesses such as diabetes and heart disease which are dramatically increasing, the Task Force has proposed an excise tax on beverages sweetened with sugar or high-fructose syrup.

The Democratic Plan

The Democratic Medicare Plan builds on the Affordable Care Act of 2010 by strengthening the Independent Payment Advisory Board.

This Act gives the President the power to make appointments to the 15 member Board and to expand its powers to control costs. Thus, any recommended cuts by the Board would take effect automatically unless Congress voted to block or change them. However, the Board cannot propose cutting benefits or raising taxes or premiums. The Board's recommendations could not be reviewed by the Federal courts, and he would like to further strengthen the Board's cost-cutting powers should the growth of Medicare spending exceed certain goals.

The Affordable Care Act allows Medicare to pay more to hospitals that score well on a series of measures that gauge patient care and to **pay** less to those that don't hit the quality benchmarks,

thus providing an incentive for hospitals to provide the highest care at the lowest cost. It establishes a pilot program to test “bundled payments”: Medicare will pay doctors and hospitals a lump sum for all services in a course of treatment or an episode of care, which puts pressure on providers to be more efficient and to do a better job at the delivery of care.

The Affordable Care Act calls for the creation of accountable care organizations. These are networks of hospitals, doctors, rehabilitation centers and other providers that work together to cut duplicative tests and procedures, to prevent medical errors and to focus on keeping patients healthier and out of the ER.

The Affordable Care Act also improves and enhances prevention, detection and enforcement actions against fraud in Medicare, Medicaid and the Children’s Health Insurance Program as well as in private insurance.

National Commission on Fiscal Responsibility and Reform

The National Commission on Fiscal Responsibility and Reform has proposed giving Medicare additional statutory authority and increased resources to combat fraud. They have also proposed instituting a combined Part A and B deductible of \$550 and a 20% co-payment above the deductible. After \$5,500, the deductible would be reduced to 5% and eliminated once health care spending hit \$7,500. Again, these suggestions are an effort to curb the rate of growth and to spread the costs between the individual and the government.

Our Policy Position

The Republican plan’s supposed ‘virtue’ is its malign simplicity: it disposes of Medicare altogether and substitutes an inferior voucher program falsely cloaked in the label of “Medicare”.

This parlor trick is not a tribute to the true Medicare as the program itself is relegated to the junk heap of history all the while continuing to call it Medicare in their public utterances: Now you see it, now you don’t. It is a deceitful attempt to evade public outrage by hiding the truth. Why else would the GOP name the Ryan Plan after a quintessential Democratic achievement it so clearly abhors? If the Republicans like the Ryan Plan so much let them give it their own name. Like ‘Insurancecompanycare’ ”

Their plan throws the individual into an insurance market which has historically shown itself unable to provide health insurance at a cost affordable for most people and equally ineffective at curbing inefficiencies and/or fraud in the medical system. Such a plan makes no effort to improve delivery or outcomes in health care.

Furthermore, over time the Republican plan does nothing to control costs or fraud and transforms Medicaid to a block grant for the states; and it cannot help but become much more expensive. Moreover that expense will be born locally by citizens either through higher local taxes or through poorer communal health because it shifts that expense to the various states, which are much less able to cover those costs. Most damning is that it destroys the national commitment we have to protect each other in both good and bad economic times. It is a retrograde policy that undoes the moral commitment between the national government and the citizen.

Obama’s plan, which is contained in the Affordable Care Act, aims to slow down the cost growth of medical care while maintaining the current level of coverage for Medicare and Medicaid

patients. It expands coverage to citizens who are currently uninsured, among whom are the youngest and therefore healthiest members of our nation. Thus, the law maximizes the pool of people who will be insured, while at the same time squeezing out inefficiencies, duplicative care delivery, ineffective care etc. from the system as a totality.

The Club opposes any attempt to shift costs to beneficiaries, including raising the percentage of the Medicare Part B premium beneficiaries will be responsible for. On the other hand, the Club believes in personal responsibility and supports excise taxes on sugar or high-fructose corn syrup, tobacco and alcohol products -- all of which add to our society's health care costs -- because they are controllable by individuals and statistically or causally related to serious disease. Taxes should be dedicated to health care.

History shows us that leaving the individual to the mercy of the market without communal support as in the Republican plan actually raises the cost of health care in the long run, as well as the amount of sickness and death that we experience as a society. It isn't a solution to either providing healthcare or to keeping costs down. Over time this is not good for the individual, for businesses or for the nation, and it is not a moral stance.

SIDA presently supports the approach President Obama takes to address the Medicare and Medicaid cost issue. Choosing health care is not like choosing a new car: for some a brand new car is optional. For others, there are alternatives like a used car or a rented car for specific purposes. But health care insurance must be available to every member of a society, every day and at a reasonable level, because no one knows when they may become ill or what health calamity may befall them and because none of us is an island unto ourselves.