



Problem

Medicare Part A

The 2009 Medicare Trustees Report states the trust fund will be exhausted in 2017. At that time Medicare may turn into Maybe-care. There is no guarantee that after 2017 retirees will have access to full Medicare Part A benefits. The annual report implies three options listed below:

1. Medicare recipients may need to find hospitals who will receive 65% or less (81% x current 80%) of their normal fees.
2. Payroll taxes for employees and employers more than double or approve some other equivalent tax increase.
3. Some combination of the above.

Since Congress has been unwilling to fully address the issue above, the problem gets worse with each passing day. If congress continues to avoid the issue, there is no safety net in place for Medicare Part A.

Medicare Part B, C, and D

The vast majority of Medicare parts B, C, and D combined do not have designated funding. Therefore, much of the resulting shortfalls turn into deficits. The deficits turn into long-term national debt. In other words, our children and grandchildren are paying for seniors' benefits. They not only pay for many of the benefits, but will likely incur large amounts of interest payments. Our children and grandchildren count on us to make decisions in their best interest. Are we? What will they think when they fully realize what we have done?

Lastly, if lenders were to stop lending money to the U.S. Treasury, recipients of Medicare part B, C, and D would be at risk of losing benefits. Therefore, all forms of Medicare need reform.

Considerations

As a minimum, Congress should approve a safety net to protect seniors in the event a major reform package is not developed in time. However, even the safety net should consider deficits, cost effective health care methods along with preventative care.

Swift approval should allow America to stay proactive.

Objective

The objective of a solution is to sustain a high level of Medicare while minimizing the cost to our children and grandchildren. The solution should also assist in decreasing the overall cost of health care in America.

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Authorized and Paid for by: Volunteers for Steven J. Wilson
P.O. Box 7191 Rochester, MN 55903



Solution –*For Discussion Purposes Only*

A Medicare Safety Net (McSN) would be enacted when the Medicare Trust Fund is within 48 months of exhaustion as determined by the Medicare Board of Trustees Annual Report.

If at any time before October 1, 2020, the above trigger occurs, the Medicare Safety Net would be deployed within 24 months of the report. The Medicare Safety Net would be based upon the following assumptions:

- Government does not have unlimited resources to provide for or subsidize health care.
- People must take more responsibility for their own health.
- Preventative health care dramatically improves both quantity and quality of life.
- Success can and will occur after some degree of shared sacrifice of every American.

Elements of a Medicare Safety Net

Personal Responsibility Vouchers

These vouchers would replace Medicare Part A, B, C, and D in America and would be available to all those who qualify for Medicare. The vouchers would be used to purchase insurance by the recipient in the free market. The amount of the voucher would be the same for everyone. The amount of care that can be purchased with the voucher would be different for everyone. The federal government would not decide coverage; the personal responsibility of individuals would decide coverage. If individuals maintained healthy behaviors, individuals would be able to buy more coverage from private insurance companies with the same voucher. Secondly, insurance companies would be required to use a type of efficiency-based system such as Comparative Effectiveness Research for a portion of their coverage. Therefore, healthcare would be based on results rather than the quantity of service. The voucher plan would be funded within three years of enactment from three revenue sources 1) Current combined payroll tax of 2.9% and the current income tax on Social Security benefits. 2) Current funding from the general fund of the federal budget, however the budget could not contribute more than an amount equal to 20% of the discretionary outlays in that year. 3) Any other current revenue sources as designated by law. Insurance companies could not alter services to voucher recipients due to age.

Free Market

Free market approaches to the general public would not change and can supplement a voucher.

Prevention

A national preventative care plan would be set in place two years after the personal responsibility vouchers. Preventative care would likely assist in decreasing the overall cost of health care in America and eventually Medicare. Preventative services rated A or B by the U.S. Preventative Services Task Force will be chosen that provide a ten to one return on investment or more. These services could include physical exams, weight management and immunizations. These preventative health care services would be available to all Americans free of charge and would be paid in full each year by a two percent national sales tax on all new retail items. This high return on investment care would be available to everyone and would be paid by everyone. Access to preventative care to all Americans would improve, especially in rural areas.

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