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"If you look at the numbers, Medicare in particular will run out of money, and we will not be able to sustain that program no matter how much taxes go up."

—President Barack Obama, July 11, 2011, The Washington Post

"But turning discussions of Medicare's future into the third rail of American politics does nothing to guarantee that Medicare will continue to be a lifeline for America's seniors."

—Commentary by Senator Ron Wyden and Congressman Paul Ryan, December 15, 2011, The Wall Street Journal

"If action is taken sooner rather than later, more options and more time will be available to phase in changes so that those affected can adequately prepare."

—2011 Annual Medicare Trustees' Report

The 2011 Medicare Trustee report estimates that the Medicare Hospital Insurance trust fund, for inpatient hospital and related care, will go bankrupt in 2024, five years earlier than estimated in the previous report. Also, in the 2011 report, the trustees estimated Medicare's unfunded liabilities to total \$24.6 trillion.

No doubt, we need to preserve and to protect Medicare, and to do that requires more than simply defending "Medicare as we know it." Members of Congress from both sides of the aisle clearly recognize that if we do nothing, "Medicare as we know it" will not be there for future

generations.

President Obama's health care law offers one solution. It empowers a panel of 15 unelected, unaccountable bureaucrats to unilaterally decide what Medicare will and will not cover. Specifically, the 2010 law proposes to control costs by granting this new bureaucracy — called the Independent Payment Advisory Board — the authority to cut Medicare payments to doctors and other health providers. But this approach of twisting screws on physicians, of relying on price controls to wring savings from a financially broken program, cannot work. Either providers will exit the system or seniors can expect to see access to health services severely restricted. Indeed, the nonpartisan chief actuary of the Medicare program predicts that under the president's health care law, 15 percent of hospitals will go bankrupt by 2019. This number rises to 40 percent by 2050.

I recently voted for an alternative solution to this top-down, one-size-fits-all approach. This approach, contained in the House-passed Fiscal Year 2013 budget proposal, puts patients and seniors in control of their health care decisions rather than bureaucrats and Washington technocrats. It combines strong beneficiary protections with the power of competition to help bring down costs while ensuring access to a guaranteed health care plan. These reforms are rooted in a long history of bipartisan support based on the idea that Medicare should fit the needs of patients rather than the needs of government.

The House-passed budget begins by making no structural changes for those who are currently enrolled in Medicare or will enroll in the next decade. Medicare will function exactly as it does today for those who are 55 and older. For younger workers, Medicare will provide a list of guaranteed coverage options — including the traditional plan that exists today — from which beneficiaries can choose the one that best fits their needs.

Medicare also will provide financial support in the form of premium assistance to help seniors cover the cost of their health care plan. This assistance is adjusted to reflect the individual needs of each Medicare enrollee: more for the sick and the poor, less for the wealthy. The size of the premium assistance would be tied to the costs of the insurance plans being offered to seniors. The second-least expensive approved plan or the traditional fee-for-service Medicare, whichever is least expensive, would establish the benchmark that determines the premium-support amount.

If a senior chose a costlier plan than the benchmark plan, he would be responsible for paying

the difference between the premium subsidy and the monthly premium. Conversely, if that senior chose a plan that cost less than the benchmark, he would be given a rebate for the difference. Payments to plans would be risk-adjusted and geographically rated. Private health plans would be required to cover at least the actuarial equivalent of the benefit package provided by traditional fee-for-service Medicare.

The critics of this plan will call it a voucher but this is exactly how federal employees, using a pre-approved list, choose their health plans.

By Rep. Mike Coffman

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