GRAY PANTHER RESPONSE TO WYDEN-RYAN MEDICARE PLAN: A POSITION PAPER

This Gray Panther position paper is presented as response to the Medicare plan of Senator Ron Wyden and Congressman Paul Ryan entitled "Guaranteed Choices to Strengthen Medicare and Health Security for All." It is the position of the Gray Panthers that the Wyden-Ryan plan would punishe Medicare enrollees for health care inflation – over which they have no control – while the real drivers of escalating health care costs remain unaddressed. Solutions to the actual causes of health care inflation are offered in this paper.

What is the Wyden-Ryan Plan?

The Wyden-Ryan plan is known as a "premium support option" plan. Starting in 2022, Medicare would, in accordance with the plan, no longer directly pay a major portion of health care enrollees utilize. Instead, Medicare recipients would be issued vouchers to help them buy health care in a "Medicare exchange" comprised of private insurers or from "traditional Medicare."

The Wyden-Ryan plan purports to be a solution to health care inflation. What is the claim of Wyden-Ryan in regard to inflation? As stated above, in 2022, enrollees would be provided an option of remaining in traditional Medicare or shopping in an exchange comprised of health care corporations. Nevertheless, insurance "shopping" must be undertaken with a limited amount of dollars. In other words, Medicare would be "capped."

This is how the cap would be implemented: The yearly increase in vouchers would be limited to the increase in the nation's GDP plus 1%, far below actual health care inflation. In effect, the overall budget for Medicare would be capped and limit the amount that seniors have available for health care. An assumption of the plan is that seniors would be more discerning in their utilization of health care, cut down unnecessary use, and force the market to reduce costs to meet a reduced demand and compete for customers.

The Dangers of the Wyden-Ryan Plan

A major danger of the Wyden-Ryan plan is that it would most likely drive healthy seniors out of traditional Medicare into low cost plans while less healthy seniors will be left behind in traditional Medicare or in a high cost private plan. Each year, the enrollment period for private insurance would renew the process. Eventually, traditional Medicare would become a program for treating the sickest patients. A negative feedback loop would occur in which Medicare inflation would continuously drive the premium costs for Medicare higher and eliminate any incentive for the healthiest patients to stay in traditional Medicare.

Why would Medicare be left behind with the sickest patients? The amount of dollars – or the amount of a voucher – will be based on a benchmark determined to be the second lowest cost plan in the "exchange of private insurers" or the premium for traditional Medicare – whichever is less. The premium for Medicare would be determined by the rate of inflation.

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If the cost of health care increased more rapidly than the increase in GDP plus 1%, the difference between these two measures of inflation would be folded into a premium for traditional Medicare. Hence, costs for inflation – the causes of which are discussed below – would be shifted to Medicare enrollees rather than the industries providing health care services and products. Furthermore, if enrollees purchased a plan costing more than the voucher, they would pay the difference out of pocket. Conversely, if they purchased a plan costing less than the voucher, they would receive a rebate.

This is an obvious incentive for the healthiest patients to apply their voucher to a low cost plan with high deductibles and copays while the sicker patients would most likely have no reason to purchase a low cost plan due to high out of pocket expenses. Rather than "cherry picking" by the insurer, the government drives the "cherries" into the arms of insurers. This perverse system would turn traditional Medicare into a costly program serving patients with most expensive needs.

The Efficient Market Hypothesis is Not a Reality in The Health Care Industry

Economic philosophy underpinning the Wyden-Ryan plan is based on a the belief that prices will be most efficiently set by "the market." However, the health care sector of the economy is not operating as an efficient and highly functional free market. Quite the opposite, the health care market is highly dysfunctional and characterized by legislative-industry collusion in development of anti-competitive practices. For instance, the pricing of drugs purchased under Medicare, Part D is not in accordance with the basic capitalistic economic principle of marginal cost pricing. Furthermore, the pricing of drugs in Part D plans do not reflect the negotiating power of the Federal government – as is the case with Medicaid and the Veterans' Administration.

A free market assumes rational actors in price negotiation with equal access to relevant information. It has been industry practice to lobby congress in an attempt to suppress information needed for rational decision-making and thereby unduly increase profits. For instance, hospitals have less than adequate information concerning the average and median price of medical devices and implants. Senate Bill 2221, introduced by Senators Spector and Grassley, would force manufacturers to disclose implant and device prices on a quarterly basis. Nevertheless, SB 2221 has been bottled up in committee since 2006.

One can only imagine the disadvantage of Medicare enrollees as they undertake negotiations with corporate conglomerates to obtain the best prices for health insurance with their vouchers. They will have little information about medical/loss ratios, denial of claims, and other matters of importance in determining the advantage of one price over another.

Health Cost Issues of Gray Panther Concern:

The following drivers of health care cost inflation and blame placed on the 65+ population for that inflation are discussed in the following sections of this paper along with Gray Panthers solutions for addressing them:

1. Suppression of free-market practices in the health care sector of the economy caused by industry/professional lobbying and congressional collusion in suppression of marginal cost pricing, withholding of pricing information, lack of regulation designed to protect consumers, unjustified patent protection, and failure to maintain a database/registry of medical devices and implants, and other practices, which undermine a healthy free market economic system.

2. Congressional-industry relationships described as a revolving door between congressional staffs and lobbying firms representing the health care industry.

3. Marvelous, but costly and ever-advancing, medical technologies.

4. Citizen engagement in irresponsible lifestyles and dietary habits promoted by corporations and condoned by – indeed often endorsed by – the U.S. government – that lead to costly chronic diseases such as diabetes, cancer, and heart disease.

These issues must be recognized as the main drivers of health care inflation. Unfortunately, policymakers have avoided discussing these as the causes of both the U.S. budgetary crisis and the unsustainable growth in health care costs. It is delusional to blame the senior population for "out of control" health care costs while ignoring the actual causes listed above.

First Things First, Let's Get the Facts Straight: The Elderly are not the Cause of Health Care Inflation

Amongst health policy researchers, it is overwhelmingly accepted that an aging population presents only a minor, and certainly manageable, problem in health care inflation while advancing medical technologies account for an unsustainable level of inflation in the health care sector.[1]

Furthermore, the most expensive technologies such transplantation, implantation, neo-natal intensive care services, and cancer treatments – to name a few – are, for the most part, provided to patients prior to age 65. As genomics, transplantation, drug innovations, and other future – some near future – technologies come on line, an acceptable level of health care inflation will become increasingly unattainable. Unfortunately, the dominant narrative in the health care debate these days ignores this 2000 pound gorilla in the room.[2]

Blaming & Scapegoating the Elderly

The facts concerning aging and health care costs presented as justification for the Wyden-Ryan plan are repeatedly misstated. For instance, the +65 share of total hospital costs are claimed to be 2 ½ times greater than the under 65 population demographic. It will be demonstrated below that this is not factually correct.

Furthermore, the following statement (on page 5 of Wyden-Ryan) would lead readers of the plan to believe that the increase in the 65+ segment of the U.S. population will be the major driver of health care inflation in the future: "With more than 10,000 baby boomers turning 65 every day for the next two decades, and with health costs increasing at unsustainable rates, reform is now essential to ensure that Medicare will remain a guaranteed, affordable lifeline for seniors and taxpayers for decades to come." The disconnect between such an implication and scholarly research could not be clearer. Aging of the U.S. population occurs at a glacial rate while health care inflation increases at a rate of nearly 10% per year. One only need consider the per capita expenditures of countries with a much higher rate of aging such as Japan, Germany, and Italy to debunk the belief that a gradual increase of

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the 65+ U.S. population from 13% of the population to 21% by 2035 (and then level off into the foreseeable future) is a fiscal crisis.

Objective Analyses for Debunking the "Elderly as a Driver of Health Care Inflation" Myth

The Gray Panthers advocate an end to blaming and scapegoating of the elderly population or any other age group for rapidly rising health care costs. It is not the less than 1 year old group of U.S. citizens that determines who receives marvelous lifesaving neo-natal intensive care services. Babies weighing less than 750 grams, born at 23 weeks, rarely left the hospital a mere 20 years ago. Today, nearly ¾ go home and most grow into healthy adults.[3] This is how it should be. This is how it must be. And we support this technology and believe the United States can afford to save our grandchildren.

Neither does the 45 year old patient decide who receives a heart, liver, lung, pancreas or other transplant that would have been unthinkable a couple of decades ago. The most costly of all hospital procedures are in the NICU and the transplantation units. Transplants are not generally available to the 65+ age demographic. We understand that decisions over scarce resources must be made in this manner.

We accept those decisions. Nevertheless, we also expect policymakers to understand that technology is shifting major medical costs from the plus 65 age demographic to younger age demographics. In fact, most of the most costly medical procedures will happen to patients before the age of 65.

Nevertheless, the health care narrative these days includes a disturbing ageist element. Blaming the +65 demographic group is pervasive in the mainstream media and amongst politicians engaged in policy discussions. The preamble to the Wyden-Ryan proposal, taken from a 1959 congressional committee report, states the following:

"Older persons have larger than average medical care needs. As a group they use about two-and-a-half times as much general hospital care as the average for persons under the age of 65, and they have special need for long-term institutional care."

Regardless of health care reality in 1959, this quote from a half-century old report of the House Ways & Means Committee perpetuates and reinforces the widely believed elderly health care related misinformation, misperceptions, and, consequently, scapegoating that dominate the health care narrative in America today. Fallacies abound in comparisons of average costs for plus 65 hospital patients versus average costs for under 65 hospital patients.

Not the least of the fallacies in the invidious comparison of the over and under 65 dichotomy is the aggregation of all patients above into a single group and all of the patients under 65 into a single group. Analysis of hospital discharge data clearly indicates that length of stay and hospital charges cannot be adequately described by comparing "old and young" in accordance with the assumption that "over 65" is old and "under 65" is young.

Data presented in Table 1 and illustrated in Figure 1[4] clearly debunks the myth that the 2 ½ times as much is spent on the 65+ U.S. age demographic (2009: the latest U.S. hospital data available from the U.S. Agency on Health Quality & Research, Health Cost & Utilization Project). When hospital costs are disaggregated by 5-year age categories, a refined picture of expenditures by age groups emerges.

AGE CATEGORY	AVERAGE CHARGE	PERCENT OF TOTAL
Less Than 5	$4022	11.3
5 to 9	$12,503	.8
10 to 14	$15,242	.8
15 to 19	$12,717	2.6
20 to 24	$11,764	4.5
25 to 29	$12,051	5.2
30 to 34	$13,313	5.1
35 to 39	$14,744	4.3
40 to 44	$18,590	4.4
45 to 49	$20,640	5.6
50 to 54	$22,514	6.5
55 to 59	$24,270	6.5
60 to 64	$25,329	6.8
65 to 69	$25,822	7.1
70 to 74	$25,162	6.8
75 to 79	$24,394	7.0
80 to 84	$22,763	6.7
85 to 89	$21,078	5.0
90 to 94	$18,834	2.3
95 to 99	$17,567	.6
100+	$15,831	.1

Table 1

It is clear from the data in Table 1 that the cost per patient and total percentages of expenditures decline rather precipitously beginning at age 80. Furthermore, it can be noted from the data that the 65+ demographic is not significantly more responsible for overall costs than many younger patient age groups.

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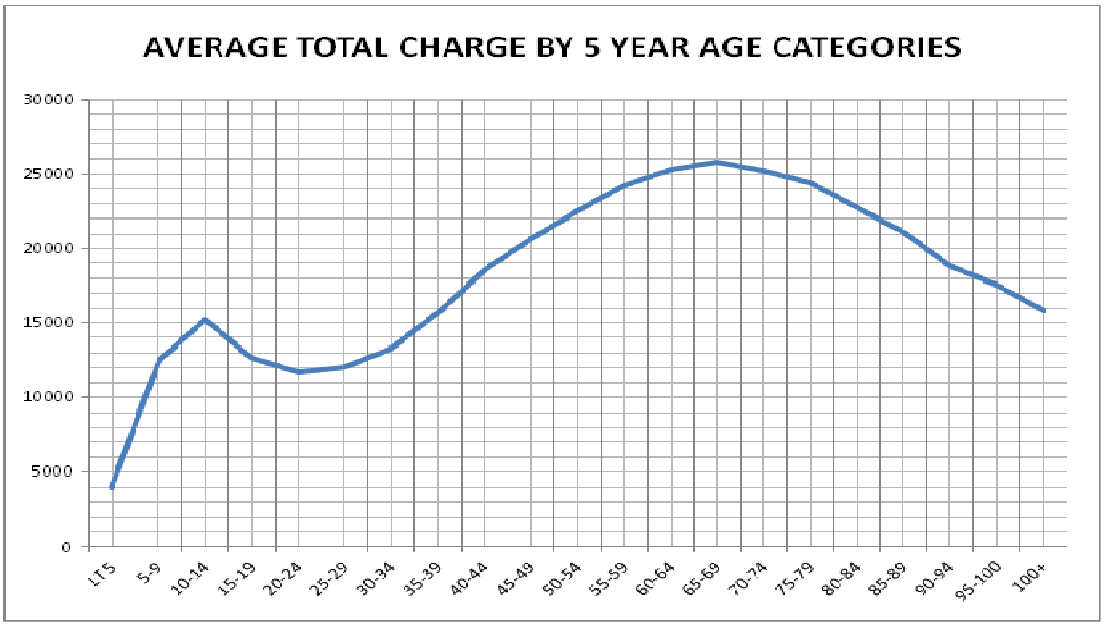

Figure 1

Results of analyses presented in Table 1 and illustrated in Figure 1 are not news to health policy researchers. In spite of myths about excessive, aggressive, and expensive ICU services provided to the elderly at the end of life, most ICU services are consumed by patients under 65 and most certainly by patients under the age of 80. Furthermore, per patient average charges peak, on average, between ages 65 and 70, and then decline throughout older age groups.

Extremely costly technologies are not likely to be provided to patients past the age of 70. Indeed, most expensive heart procedures, transplants, and highest cost ICU services will be directed to patients under the age of 70.

Gray Panther Solutions

The Gray Panthers believe all parties – citizens, corporations, professionals, and legislators – rather than only the elderly are responsible for reducing an unsustainable level of health care inflation. Individuals must be responsible for the choices they make; corporations and professionals desiring a free market system must operate in accordance with free market principles; and legislators must stop collusion with professional organizations and corporations in subverting the free market facets of the U.S. health care system.

Recognizing the unsustainability of the current rate of health care inflation, the expanding "technology bubble," lack of emphasis on primary prevention and preventive medicine, and anti-competitive market practices due to industry-congressional collusion, the Gray Panther approach to government-sponsored health care would preserve the dignity of enrollees by continuation of an adequate payroll tax and other dedicated taxes designed to insure needed, affordable health care, while at the same control inflation through market reforms and corporate and citizen responsibility.

It is the position of the Gray Panthers that the "premium support option" proposed by the Wyden-Ryan plan would force enrollees into a "corporatized," "privatized," and "financialized" health care system, which has been shown by past history to operate inefficiently and wastefully. The history of

the medical-industrial complex has been one of anti-competitive practices, rent seeking, lack of marginal cost pricing and refusal to disclose implant/device average and median prices.

Here is What We Want:

The Gray Panthers want to see a shift in focus from unfair blaming of the 65+ population to a focus on the following: (1) a dysfunctional free market system, (2) collusion between legislators and lobbyists in health care policy favorable to the industry but detrimental to citizens, (3) an expanding technology bubble, and (4) appropriate funding sources for meeting future health care needs in the context of extremely costly technology.

A Thorough Review of Anti-Free Market Practices in Privatized Medicare

The Gray Panther plan would strengthen traditional Medicare through reform of currently privatized sections (i.e. supplemental or Medigap, part C, and part D). A thorough review of anti-competitive and wasteful inefficient practices on the part of insurers, manufacturers, and other providers of services paid for with enrollee and taxpayer dollars is needed and must happen (it is important to keep in mind that general revenue accounts for only 23% of the total Medicare expenditures, the remainder are supported by payroll tax and premiums).

Medical devices and implants have become a major driver of inflation. However, lax regulation of these products and the marketing of them have introduced major waste and inefficiencies into the health care system. A database of implants and devices would be a good beginning – one meaningful step perhaps – in control of implant quality and costs. In addition, competitive pricing of these products could be achieved through reprise of Senate Bill 2221 – introduced by Senators Spector and Grassley – which has been bottled up in the Senate Finance Committee since 2006.

Amongst other things, the innovations and advancements in organ transplants along with neo-natal intensive care services account for the most expensive hospital procedures and will become increasingly expensive as the technology advances. These technologies will not, for the most part, be provided to patients past the age of 65.

Primary Prevention & Preventative Medicine Is One Necessary Solution

It has been well established scientifically and widely reported in scholarly medical-health policy literature that the primary driver of health care inflation is medical technology and continuous technological advancements in treatment of diseases. While the efforts at reduction, through preventative health, of major diseases such as heart disease have been anemic, extremely costly advances in treating them and prolonging life have come on line at a breathtaking rate.

In just a few decades, the medical field has developed advances in treating heart disease that would have been unthinkable as recently as the 1960s. Such procedures as open heart surgery, angioplasty, and even the implanting of heart pumps (e.g., left ventricle assist device implanted in former Vice

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President Cheney), now prolong life at an acceptable quality for years, perhaps decades, beyond what would have been possible prior to these innovations.

Heart disease – strongly related to lifestyle – is the biggest acute care expense in the U.S. and has a major impact on Medicare. The age at which this disease has its greatest impact on the health care system can be pinpointed in the age group of mid to late 60s. In essence, the natural history of the disease tends to reach an end stage at approximately the time an individual is eligible for Medicare.

However, it has been known for some time that the pathogenesis of the disease has its primordial roots in atherosclerosis, which has been noted through autopsies in children and young adults. Although not clinically significant in childhood and young adulthood, heart disease is beginning and developing throughout the life span.[5] Therefore to dichotomize disease as young (under 65) and old (over 65) is fallacious. Furthermore, the impact of chronic diseases peak in the 60s and early 70s and begins to drop precipitously during the mid to late 70s.

There is no doubt that heart disease, like many other major diseases, could be greatly reduced – if not nearly eliminated – through preventative health practices. Rather than reducing Medicare benefits, the government should take action to hold parties causing the disease accountable – namely corporations, medical professionals, and consumers. It has been well established scientifically that diets high in animal fats and low in plant fiber and nutrients are major causes of the most costly and yet preventable diseases.

Raise Health Care Revenue in a Manner That Promotes Responsibility

Unfortunately, efforts at preventing these diseases are anemic at best while costly treatments with ever increasing sophistication are coming on line at a breathtaking rate. Unless, the growth in disease and costs due to irresponsible behavior are brought under control, constant reduction in health care benefits and therefore access will be necessary to sustain the system in the face of untenable inflation.

It would not be bio-ethically or morally tenable to deny treatment or otherwise penalize patients because of presumed irresponsible behavior on their part. Furthermore, it would be scientifically impractical to attempt to lay the etiology and pathology of a disease at the doorstep of behavior rather than genetics.

Nevertheless, those irresponsible behaviors known to cause self-inflicted disease should be costlier to the parties engaged in the behavior than they now are. A dedicated tax on high fat, low fiber foods such as those distributed in multi-billion dollar fast food industry is necessary for offsetting the economic impact of a disease-inducing diet on the health care system. The only way to hold consumers and corporations accountable for lifestyle-caused diseases is to make them pay for it at the point of purchase. Otherwise, responsible citizens will bear the burden of the behavior through lower health care benefits, higher health care costs, and, consequently, less access to health needed health care. Less access will increase overall health care costs.

Summary

While it has been well-established that the elderly have a minor impact on health care inflation, the Wyden-Ryan plan shifts responsibility for rapidly escalating health care costs onto Medicare enrollees. Given that health policy researchers generally agree that current and new technologies are

the major driver of health care inflation, it is unjust to continue the narrative of elderly as a "silver tsunami," as "a crisis," and as the cause of the U.S. fiscal crisis in the form of budget deficits and federal debt.

In our view, it is time for congress to recognize what has been discussed with a fair amount of alarm in medical and health policy journals for some time: advances in and cost of medical technology leading to a "technology bubble." Unlike other recent "bubbles" such as those in housing and tech stocks, the medical technology bubble continues to expand at an unacceptable due to infusion of dollars from tax payers, patients, and premium payers.

In addition to costly advancements in medicine, inflation is pushed upward by the medical-industrial complex, which engages in economic activities that suppress competition and dampen what is claimed to be free-market practices in the privatized segment of the health care industry. In view of a suppressed free market in health care, it is difficult to understand how shifting Medicare from a defined benefits program to a defined contribution program would be anything but a penalty for enrollees and an escape of responsibility for providers.

Funding a futuristic health care system is indeed a crisis that will not be solved through benefit cuts for Medicare enrollees. Not all costly-to-treat diseases are caused by dietary and other personal habits. Nevertheless, lifestyles leading to diseases such as diabetes, heart disease, and other chronic ailments have been shown conclusively to be caused in large part by dietary and other habits and environmental toxins. Hence, it makes sense to expect corporations producing and individuals consuming unhealthy products to pay a tax dedicated to providing resulting health care.

Plans such as the Weyden-Ryan plan will end Medicare. Future enrollees will be placed at the vicissitudes of the health care market and drivers of health care inflation such as advancing health care technologies. This would be the end of one of the crown jewels of U.S. policy and certainly be an unjust end to a program for meeting the "actual health care needs of older Americans." In its stead, a program that limits the amount of health care a person receives to an arbitrary economic value unrelated to medical needs.

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Endnotes

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