# Champaign County Health Care Consumers

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***Grassroots organizing for health care justice since 1977.***

## Principles for Medicare Reform

### By the Medicare Task Force of the Champaign County Health Care Consumers

### About the CCHCC Medicare Task Force

The Medicare Task Force is a group of Medicare beneficiaries and concerned individuals in Champaign County dedicated to making consumer-driven improvements in the Medicare Program. Champaign County Health Care Consumers (CCHCC) organized the Medicare Task Force in 2005 to give Medicare beneficiaries a voice in the health care system.

### About Medicare

Since 1965, Medicare has guaranteed coverage to all seniors and to people with disabilities regardless of their income, health status, or where they live. Today, 47 million Americans receive Medicare benefits. Medicare is a social safety net that has helped to reduce poverty among the elderly by nearly two-thirds since it was created. With a very low administrative cost of 2-3 percent, Medicare is cost-efficient and spends taxpayers' money responsibly, unlike private health insurers' administrative costs, which are at least 3 times as high. Medicare is affordable because it creates a large pool of beneficiaries, which spreads the risks and the costs of the program among millions of people – something private insurance companies cannot do. Medicare is widely accepted by health care providers. Medicare beneficiaries simply present their red, white, and blue Medicare card to receive the services that they need. Medicare is an excellent benefit for millions of Americans and has broad support among the people it helps everyday. This history of success should guide all Medicare benefit changes.

### Principles to Improve and Expand Medicare

While Medicare has a lot of successes to build on, reform is needed to make Medicare work for the changing needs of current and future Medicare beneficiaries. The Medicare Task Force is advocating for Medicare to be improved and expanded to:

1) **Include all necessary health services including hospital, doctor visits, dental, vision, mental health, prescription drugs, and durable medical equipment and assistive devices, such as eyeglasses and hearing aids.** All physician-prescribed procedures, medications, and equipment should be covered. Preventive care, including annual physicals and physician-prescribed diagnostic tests, should be covered as well.

2) **Include a Medicare-administered drug plan.** Medicare currently relies on private insurance companies to provide Part D prescription coverage for Medicare beneficiaries. Each state has numerous private plans with different co-pays, premiums, and deductibles, making it very confusing for Medicare beneficiaries to choose a plan. A Medicare-administered plan would allow Medicare beneficiaries to simply present their red, white, and blue card at the

pharmacy and receive the drugs that they need. A Medicare-administered drug plan would also be able to use the bulk-buying power of Medicare beneficiaries to negotiate for lower drug prices and save enough money to eliminate the harmful and costly Donut Hole.

3) **Have predictable and affordable co-pays, premiums, and deductibles.** Traditional Medicare requires monthly premium payments and currently covers 80% of approved health care costs while the beneficiary is responsible for the remaining 20%. For many Medicare beneficiaries on a fixed income, the 20% co-insurance is frequently unpredictable and unaffordable. A better alternative would be smaller co-insurance or a system of co-pays to lessen the out-of-pocket costs for Medicare beneficiaries.

4) **Eliminate use of taxpayer dollars to subsidize Medicare private health plans.** Because Medicare does not cover several important health care services (i.e. dental, vision, prescription drugs), Medicare beneficiaries often have to sign up for private Medicare Advantage plans to fill in the gaps. To make these plans more affordable for Medicare beneficiaries, Medicare subsidizes the cost for these plans using taxpayer dollars. In 2008, taxpayers paid private insurance companies $8.5 million in Medicare Advantage subsidies. These were health care dollars paid to private insurance companies, whether the Medicare beneficiaries were using health care services or not. Traditional Medicare only pays out when the Medicare beneficiary has used health care services. These tax dollars going to pay for Medicare Advantage subsidies would be much better spent expanding and improving Traditional Medicare to cover more services. If Medicare used this money to expand coverage and lower out-pf-pocket costs for Medicare beneficiaries, it would eliminate the need for expensive private health plans that drain Medicare and provide little extra care for Medicare beneficiaries.

5) **Eliminate the waiting period for people with disabilities to be eligible for Medicare.** After proving they are permanently disabled and cannot work, people with disabilities must currently wait two years before they can receive the health coverage they need. These people should be eligible for Medicare as soon as they are approved for their Social Security Disability benefits.

## For more information

For more information about CCHCC's Medicare Task Force or about the principles for which the Medicare Task Force is advocating, please contact:

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