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Week 32

Medicare Solvency Without Benefit Cuts — The Platform Math

"The program is not going broke because Americans are too old. It is going broke because we overpay for drugs, tolerate \$60 billion in annual fraud, and let middlemen extract profit from every transaction. Fix those three things first."

1. The Problem

Medicare spent approximately \$1.2 trillion in 2025. Payroll taxes and premiums brought in about \$568 billion. The gap — roughly \$630 billion — is covered by general federal revenues, meaning deficit spending. Medicare has run a cash shortfall in nearly every year since 1965, totaling approximately \$8.49 trillion over that period. The Medicare Part A hospital trust fund is projected to be depleted in 2033, at which point hospital payments would be cut by approximately 11%. Parts B and D have no trust funds — they are billed directly to the deficit every year. The political response to this for 60 years has been to either raise taxes, cut benefits, or change the subject. This platform does none of those things.

2. The Governing Principle

Medicare does not have a demand problem — it has a price problem and a theft problem. Americans are not using too much healthcare. The program is paying too much for drugs, losing too much to fraud, and routing too much money through private intermediaries who add cost without adding care. The policies already in this platform — Weeks 3, 14, 16, and 25 — each attack a different piece of that cost structure. This week adds them up, shows the math, and states the governing commitment: Medicare solvency will be achieved by reducing what the program pays, not by reducing what beneficiaries receive.

3. The Gap and What Closes It

The annual Medicare cash shortfall is approximately \$630 billion. Four platform policies attack that shortfall from four different directions. The following estimates are policy projections, not CBO-scored figures. GAO is directed to produce an independent scored analysis of the combined effect of Weeks 3, 14, 16, and 25 on the Medicare structural deficit within 18 months of enactment.

Source of Savings	Platform Week	Estimated Annual Reduction	Basis
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Drug price reform — international reference pricing	Week 3	\$75–120 billion/yr	Medicare spends ~\$180B on Part B/D drugs; international reference prices average 40–60% lower than U.S. prices
Fraud, waste, and abuse elimination	Week 14	\$30–60 billion/yr	Senior Medicare Patrol estimates \$60B lost annually; recovering 50–100% through AI-assisted detection and prosecution
Government-owned pharmacy and direct drug purchasing	Week 16	\$20–40 billion/yr	Eliminates PBM middleman markup and negotiates at GOCO cost-plus pricing; applies to Medicare Part D formulary
Public health insurance option — market competition	Week 25	\$30–60 billion/yr	Federal insurer competing on price drives down provider rates across Medicare Advantage and traditional Medicare through market pressure
Combined estimated annual reduction	Weeks 3, 14, 16, 25	\$155–280 billion/yr	Addresses 25–44% of the \$630B annual cash shortfall without raising taxes or cutting benefits

4. What the Four Weeks Each Contribute

Week 3 — Drug Cost Reform: \$75–120 Billion Per Year

- **Medicare spends approximately \$180 billion per year on prescription drugs** across Parts B and D combined. The United States pays 2–4 times what other developed countries pay for the same drugs from the same manufacturers. Week 3 establishes international reference pricing — Medicare pays no more than the average of what Canada, Germany, France, the United Kingdom, Japan, and Australia pay for the same drug. At a 40–60% price reduction, Medicare drug spending falls by \$72–108 billion per year. This is the single largest lever available to address the Medicare deficit without touching benefits.
- **The pharmaceutical industry argument** is that lower prices reduce R&D; investment. The counter: the United States currently subsidizes drug R&D; for the entire world by paying inflated prices while every other developed country pays market rates. Aligning U.S. prices with the rest of the developed world does not eliminate pharmaceutical profit — it eliminates the American premium on top of it.

Week 14 — Medicare and Medicaid Fraud Prevention: \$30–60 Billion Per Year

- **The Senior Medicare Patrol estimates Medicare loses \$60 billion every year** to fraud, waste, and abuse — phantom procedures, ghost patients, upcoded services, durable medical equipment billed but never delivered, home health visits that never happened. Week 14 deploys AI-assisted claims analysis to flag anomalous billing patterns in real time before payment rather than after, mandatory prepayment review for high-risk provider categories, and significantly increased criminal prosecution and asset recovery for Medicare fraud. Recovering 50–100% of the estimated fraud loss saves \$30–60 billion per year.
- **The current recovery rate on Medicare fraud is approximately 10 cents on the dollar.** The government pays first, investigates later, and recovers a fraction of what was stolen. Reversing that sequence — flag before payment, investigate before release — does not require new legislation. It requires the political will to slow down payments to bad actors even when those bad actors have

lobbyists.

Week 16 — Federal Market Alternative, Government-Owned Pharmacy: \$20–40 Billion Per Year

- **Pharmacy Benefit Managers (PBMs) are the middlemen between drug manufacturers and Medicare Part D plans.** The three largest PBMs — CVS Caremark, Express Scripts, and OptumRx — control approximately 80% of the prescription drug market and extract profit at every point in the chain through spread pricing, rebate retention, and formulary manipulation. Week 16 establishes a government-owned pharmacy that purchases drugs at GOCO cost-plus pricing with no PBM intermediary. Medicare Part D beneficiaries who choose the government pharmacy pay the actual cost of the drug plus a transparent dispensing fee. The PBM markup disappears.
- **Direct Medicare Part D purchasing through the government pharmacy** eliminates the rebate system entirely — manufacturers cannot pay to have their drug preferred on the formulary; drugs are ranked by clinical effectiveness and cost. The savings accrue directly to Medicare, not to a PBM that retains the rebate and passes a fraction to the plan.

Week 25 — Public Health Insurance Option: \$30–60 Billion Per Year

- **Medicare Advantage plans — private insurers paid by Medicare to cover beneficiaries — cost the federal government approximately 6% more per beneficiary than traditional Medicare** while consistently over-billing through risk score manipulation and denying medically necessary care. Week 25's public health insurance option competes with Medicare Advantage on price and coverage, driving down the per-beneficiary cost the federal government pays across the program. A federal insurer with no shareholder returns and no executive compensation premium can price below private alternatives and still cover its costs.
- **Market competition from a public option also puts downward pressure on provider rates** in traditional Medicare by demonstrating what services actually cost when the insurer is not optimizing for quarterly earnings. The combination of direct competition and rate transparency is estimated to reduce per-beneficiary Medicare costs by 5–10% over a 10-year period.

5. What Remains After the Four Weeks

The combined estimated annual savings from Weeks 3, 14, 16, and 25 is \$155–280 billion per year — addressing 25–44% of the \$630 billion annual cash shortfall. The remaining gap of \$350–475 billion per year reflects the structural reality that Medicare is a program where spending will always grow as the population ages and medical technology advances. Closing the remaining gap completely would require one or more of the following, in order of preference for this administration:

- **Continue expanding the savings identified above as implementation matures.** The estimates above are conservative. Drug price reform alone, fully implemented with international reference pricing across all Medicare drug spending, could save \$150–200 billion per year. Fraud elimination at 100% recovery would save \$60 billion. First-year estimates are a floor, not a ceiling.
- **CBO directed to score the combined effect of all four weeks on Medicare solvency** within 18 months of enactment and publish a public report. If the scored savings fall short of closing the gap, the administration brings additional proposals to Congress within 30 days of receiving the CBO report. The commitment is to Medicare solvency by 2033 — before the Part A trust fund is depleted — without cutting benefits for any current or future beneficiary.

6. The Governing Commitment

No Medicare benefit will be cut under this administration. No Medicare eligibility age will be raised. No beneficiary will pay more out of pocket as a result of any policy in this platform. The path to Medicare solvency runs through drug prices, fraud, and middlemen — not through the wallets of retirees who paid into the program their entire working lives. That is the commitment, stated plainly, with the math behind it.

7. Year 1 Implementation and Measurable Result

Year 1 measurable result: international reference pricing legislation introduced within 30 days and effective for new Medicare drug contracts within 180 days; AI-assisted Medicare claims fraud detection deployed by CMS within 90 days; prepayment review expanded to all high-risk provider categories within 120 days; government pharmacy pilot operational in 10 states within 180 days for Medicare Part D beneficiaries; public health insurance option legislation introduced within 30 days; GAO commissioned to score combined Medicare solvency impact of Weeks 3, 14, 16, and 25 within 30 days; first annual Medicare Solvency Progress Report published within 365 days showing actual savings achieved against projections.