Notes for Slides

Slide 2
The Bush budget for FY 2007 proposes to slow the growth of Medicare spending by $36 billion over five years, and by $105 billion over ten. The plan would cut payments to providers, specifically hospitals, hospices, nursing homes and home-health agencies. A lowering of Medicaid costs by $6.9 billion is proposed over the next five years, which will decrease benefits and raise out-of-pocket costs for the 47 million Americans.

Slide 5
After January 1st of this year, many states declared a health crisis emergency as they stepped in to pay for the drugs of "dual eligibles'" that were not being covered by the new Medicare Part D. Medicaid recipients have been transferred into the new system automatically and many have been unable to obtain their prescriptions at the promised discounted prices. The Bush administration's determination to write private insurers into the equation buys off a powerful interest group but at a very high cost to beneficiaries. By fragmenting the purchase of drugs among many private plans, the new program denies Medicare the ability to bargain for lower prices from the drug companies.

Slide 6
More than 40 choices are available for the beneficiary. Each plan covers different brand-name drugs. Seniors need the internet to effectively navigate the many options. Since the rollout of the plan, we have seen the complicated 2-stage sign up process for dual eligibles and the bungled transfer of beneficiaries from Medicaid to Medicare. Many dual eligibles found that drugs they needed are not covered under their new plans. Medicare officials repeatedly assured poor people that they would receive extra help- so they would not have to pay any deductibles and their co-payments would not exceed $5 a prescription. This did not happen and many low income people were not subsidized and were required to pay the full $250 deductible and co-payments far exceeding $5.There has been a slow take-up rate in the number of low-income Medicare beneficiaries who have successfully applied for subsidies. These are the very beneficiaries who stand to gain the most from the drug benefit.

Slide 7
In adding a drug benefit to Medicare, the Bush administration and allies in Congress paid more attention to the needs of the insurance and pharmaceutical industries. The administration insisted on the superiority of the private sector despite the public sectors demonstrably lower costs as evidenced by the Veteran's Administration health care model. The fact is that Medicare Part D is a program in which private insurance companies receive government subsidies to offer insurance.

Slide 9
The traditional Medicare benefit did not need extensive marketing because its basic structure (from the beneficiary's standpoint) was straight forward and its advantages clear. The new Medicare drug benefit fails this test.

Slide 10
The US health care system is more privatized than any other advanced country and we pay much higher prices for prescription drugs than residents of other advanced countries, including Canada. Yet Medicaid, and to an even greater extent the Veteran's Administration, get discounts similar to or greater than those received by the Canadian health system. The U.S. Government is stepping up seizures of cheap drugs ordered by Americans-who are mainly seniors- from Canada. While ordering drugs from abroad is illegal, many US Customs and Food and Drug administration officials have generally allowed the practice.

Slide 11
As Paul Krugman, the economist and columnist for *The NY Times* wrote, "this administration's idea of health care reform is to take what is wrong with our system and make it worse." Private insurers, for-profit hospitals, and other players may just be adding cost without adding value. Integrated systems like the Veteran's Administration that directly provide some health care as well as medical insurance suggest other models of delivering health care in the US are working and should be considered. In 2004, the US spent 16% of GDP on health care as compared to 1960 when spending was only 5.2%. The major factor associated with this growth has been the development and use of new medical technology. While it is true that we have found new ways to help people, the US health care system is extremely inefficient. As the health care sector becomes a larger fraction of the economy, the inefficiency associated with the health care system becomes a larger fraction of total costs. Private insurance companies try to carefully screen applicants to identify those with a high risk of needing expensive treatment. Such screening is very costly and tends to screen out exactly those who most need insurance. As mentioned earlier, the share of no elderly Americans with employment-based health insurance is in decline. This trend seems certain to continue, even accelerate, because the whole system of employer-based health care is under severe strain. Companies like GM are cutting their benefits to stay competitive. But in the new global economy this action may still not be enough.

Slide 13
Studies show that HMO plans with caps on drug benefits cause some beneficiaries to cut back on essential medications. It is likely that this will happen when seniors meet the "doughnut hole" in coverage. The new Medicare legislation prohibits buying insurance to cover this gap . The bill offers generous coverage to people with low drug costs, who have the least need for help. People will get small checks in the mail and think they are making out pretty good. Meanwhile the people who really need help were deliberately offered a very poor benefit. One bright spot, beneficiaries with incomes of $14,500 or less will save 90% in out of pocket cost under the new coverage. Millions of Medicare beneficiaries face a May 15 deadline for signing up. Current beneficiaries who decide to join after that date will generally have to wait until November 15 and will then pay higher premiums as a penalty for late enrollment.

Slide 14

Efforts to educate beneficiaries have been strong, but plagued by troubling glitches. The benefit represents choice overload at its worst. The CVS pharmacy **Show Me Guide** to the drug benefit runs over 24 pages and features a three-page glossary. *The NY Times* reported that pharmacists have been losing money under the new prescription drug benefit- because of slow payment and cash flow problems. Pharmacists are being asked to bankroll the program in some cases. The drug plans have contracts with pharmacies. Some pharmacists have had trouble enforcing the terms of these contracts. Even as pharmacists take on new duties under Medicare, they are discovering they will be paid less than they would receive under Medicaid.

Slide 15
The market-based design of the new plan will work temporarily until the federal government stops assuming much of the insurers' risk. If enrollment is robust, drug companies will compete to offer lower prices, premiums will remain relatively low, plans will stay in the market, and dissatisfaction with the program will subside. If enrollment continues to flag, premiums will rise, plans will collapse and the program will be in jeopardy.

Slide 16
When people are denied insurance coverage, some will qualify for Medicaid, others receive "uncompensated" treatment paid for either by the government for by higher medical bill for the insured. The lynch pin of the current private health insurance system is the hidden subsidies in the form of untaxed health benefits given to employees. Without this subsidy, millions of Americans would not be able to afford health care insurance at all. This tax subsidy may be as large as $190 billion per year. Yet, corporations are reacting to rising health care costs by dropping insurance, states are throwing people off Medicaid and people without health insurance are leaving chronic problems untreated, thus ending up in emergency rooms of hospitals or dead.

Slide 17
This chart shows the Congressional Budge Offices' baseline projection of spending over the next twenty-five years on the three big entitlement programs, Social Security, Medicare, and Medicaid, measured as a percentage of GDP. There is a demographic component to Medicare and Medicaid. Medicare only serves Americans over sixty-five, but a minority of the Medicaid population are elderly. This group accounts for most of this program is spending.

Slide 18
Private insurance companies spend large sums of money not on providing medical care, but on denying insurance to those who need it most. If you are part of the unlucky 5 percent of Americans who incurred almost half of US medical costs, your medical expenses will be daunting unless you are very well off or have good insurance. But good insurance is difficult to find because the bad risks drive out the good. Economists suggest the use of the counterfactual. Imagine if everyone was required to buy the same insurance policy. The insurance company would charge a price reflecting the medical costs of the average American, plus a small charge for administrative expenses. But if a company

would offer such a policy, it would definitely lose money. Why? Because healthy people, who do not expect high medical bills, would go elsewhere, or even go without insurance..and those who bought the policy would be a self-selected group of people likely to have high medical costs. And if the company reacted to this selection bias effect, it would raise premiums.. The rise in insurance prices would drive away even more healthy people, leaving a pool of people disproportionately in need of medical services.

Slide 19
In any given year, most people have small medical bills while a few people have very large bills. In 2003, about 20% of the population accounted for 80% of expenses. Half of the population had virtually no medical expenses, one percent accounted for 22% of expenses.

Slide 20
Our outmoded, employer-based, privately financed, multipayer health-care system is an anachronism in the 21st century. The worlds' richest and most powerful nation is unique in not sponsoring government-controlled Universal Health Insurance. UHI for the elderly otherwise known as Medicare has been a resounding success. This program is widely recognized as the most important investment and socioeconomic advance made in the last century. Paul Krugman has said, "one way to implement national health care would simply be to expand Medicare to everyone". We would need additional funds and an increase in taxes. But this would simply substitute an explicit tax for the implicit tax that companies and workers already pay in the form of insurance premiums.
If other countries experience is our guide, health care costs would actually fall and job creation would actually rise. Government can provide insurance **and** be involved in the provision of health care itself. Why is a national health care system deemed a political non-starter?

Slide 21
Inefficiency is evidenced in international comparisons. The table shows that the US spends far more on the health care than other advanced countries, almost twice as much per capital as France, almost two and ½ time as much as Britain. Yet we do considerably worse on basic measures of health performance, such as life expectancy and infant mortality. The Bush administration needs to think as globally about health as it does about the economy. Health care is an investment in our future and its returns will far outweigh costs if we pursue a national agenda that creates the social conditions to ensure good health, on equal terms for the entire population.