Medicare: Some Facts Amongst the Fiction

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1 INTRODUCTION

The New America Foundation, a left wing think tank in Washington, has published a white paper entitled Realigning US Health Care Incentives. It is an attack on Medicare plain and simple. It also is a concerted effort by the managers of large Hospitals to drive the independent physicians out of business and to get them aligned with the hospitals. It is a move using those covered by Medicare to drive a wedge between their health care providers and their needs as patients. The speech today by the current President re-intensifies this attack.

The report starts by stating:

"*Health reform must make quality health care and health insurance affordable and accessible to all. In order to achieve the goal of quality, affordable coverage for all, we support: (i) Health insurance exchanges or new marketplaces to help consumers compare and choose the health plan that is right for them (ii) Reforms that end insurance discrimination based on age, sex, and health status, including: guaranteed issue, community rating, and a ban on pre-existing condition exclusions, (iii) Subsidies financed through broadly shared responsibility to ensure coverage is affordable, (iv) A requirement that individuals obtain coverage, once such coverage is accessible and affordable...*"

This appears as a broad statement suggesting that they intend to look at health care in general. However they soon target Medicare. Remember that in our previous analysis we have demonstrated that those receiving Medicare have more than paid for their care. They have contributed to the system for forty years and the contribution exceeds any draw that they will make upon the system. At no point do the authors ever take recognition of this fact. Why should they, they want to remove coverage from the elderly and just allow them to go their way despite having contributed to their care well in excess of any other group.

They start their attack by saying:

"*Over the next 10 years, we can reduce system-wide cost growth by far more than many think, enough to save $500 to $600 billion in the Medicare program alone. This level of cost growth reduction can be achieved while simultaneously improving the quality and patient-centeredness of care. Over time, this money could help fund coverage expansions, improvements to Medicare and Medicaid benefits and payment rates, and deficit reduction. We describe reforms that will make these savings possible in the remainder of this paper*."

Where is the focus on the obese 30 year olds who will cost many times more with their Type 2 Diabetes and resulting morbidities? Not a word of that. They continue:

"*Improving health care quality is consistent with reducing health care costs, which is essential to fund coverage expansion and make Medicare and Medicaid more sustainable for generations to come. To reach these goals, we must develop, pursue, and implement strategies to achieve greater value for the American health care dollar.* ***We will not control health care costs until we create clear incentives for providers – the people who deliver care – to focus on quality and efficiency. Likewise, patients must be encouraged to make healthier choices through changes to their incentives.*** *This will require exemplary and even courageous provider leadership and significant cultural change.*"

What does this mean? Simply they want quality. Frankly we have no idea what quality is. There is the Demming quality which applies to manufacturing, a term which means that we want to lower costs on production by reducing errors. However quality in health care is akin to pornography in law, you know it when you see it. The patient knows quality care by the way the patient is treated, not by whether they live or die. Death can be a quality experience if the human dignity is preserved.

If as this paper and the current Administration propose the dignity is removed and the costs are reduced. One may never again achieve even death with dignity and thus we would argue that quality is lacking. One view of quality is the Pirsig view, with its warts and all, where quality is a contradistinction to quantity, it is the opposite of the Demming model and akin to the legal world view we proposed. Value is another term for quality in the discussion as well and we have equally rejected the value metric as proposed by Porter.

They then look at the comparative clinical effectiveness model. They state:

"*We can identify overuse, underuse, and misuse and implement best practice processes....Comparative effectiveness research, best practice information, and decision support tools will enhance the doctor-patient relationship*."

We have argued that the CCE proposed here and elsewhere has the potential of being both a means to ration health care and also to push down costs on the providers in an attempt to eliminate the sole or small group provider.

They then address specific proposals:

"*Fee-for-service payment is unsustainable. Medicare will lead a concerted effort to end fee-for-service payments for individual services within five to seven years. Further, Medicare will cooperate and collaborate with private payers to transition the entire delivery system away from fee-for-service payment and toward outcome-driven bundled payments that encourage provider accountability through full and partial risk contracts within 10 years...*"

This means that the patient will lose any and all flexibility in selection providers. Thus if one has ovarian cancer or breast cancer and is covered by Medicare then they will tell you who to see and where even if say the best procedures are at Memorial Sloan Kettering rather than your local hospital. You the patient will be shelved and just allowed to die!

They then continue:

"*Providers will be held accountable to reasonable cost and quality standards at a specified date...More efficient, value-based incentives will lead to higher-quality, lower-cost care."*

The authors use quality and value dozens of times without ever addressing the definition. Is it the Pirsig definition, goodness, or the Demming definition, low failure rate. The patient knows.

They then start with the bundling argument:

"*Develop and transition toward bundled payment models. Medicare should begin a concerted and focused effort to develop and implement payment bundles to enable a widespread transition from fee-for-service payment....Eventually, all clinicians will have strong incentives to move toward more integrated models of care that allow them to accept full responsibility and reward for high-quality patient care and patient outcomes...1. Comprehensive services with shared risk....2. Complete chronic care....3. Ambulatory chronic care....4. Acute episode.*"

These four bundles are discussed. As we have argued before the bundling puts the hospital and the Government in charge It institutionalizes an old paradigm for delivery ensuring lower care quality, here I mean a Pirsigian goodness term, and higher costs. We have argued this in detail with financial models demonstrating the results.

They end with Medicare changes they feel are required:

"*Reform Medicare Advantage payments to drive quality and innovation...Improve the quality and patient-centeredness of end-of-life care through advanced planning and palliative care....*"

They seem to have difficulty with getting away from the use of quality, without ever defining it. The focus on end of life care is really warehousing the old and dying. Hopefully those on or soon to be on Medicare, and who have paid for what they are due, will understand this fact.

Why the attack on Medicare. Because the Government controls it. What does this mean for non-Medicare patients, well simply if the current Administration gets its way with a

Government plan, and then a single payer plan, namely the Government, then Medicare is just the training ground for doing this to everyone! It is the old adage; **first they came for the old, and I said they are old anyhow, then they came for the young and I said well no matter they are just young kinds anyhow, and then they came for me, and I had no say at all!**

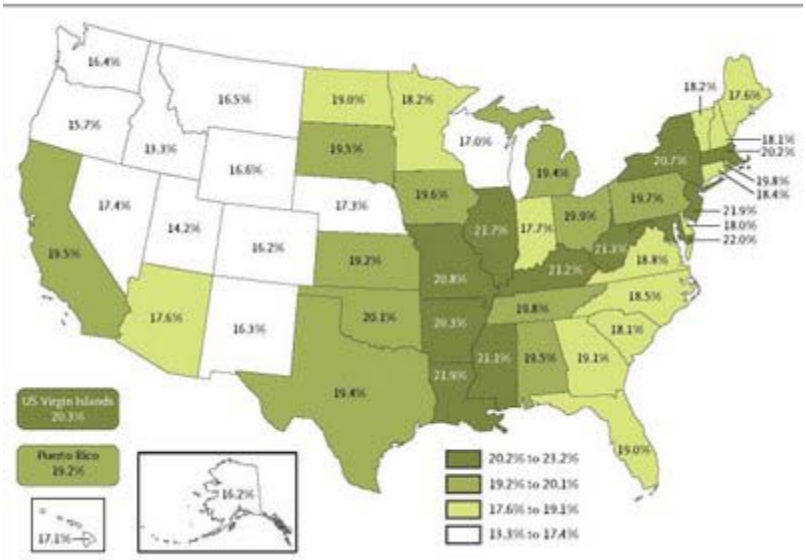
Why is this important, because entities like the New America Foundation are feeders to the White House, they create "policies" and give them a patina of acceptance. What happens when they come for their parents, then their children...but they are them!

2 MEDICARE DEMANDS

Now that I have been over 65 for a while and now that many of my friends are also, I read the paper in today's NEJM on the hospitalization of Medicare recipients with some surprise. The NEJM paper states that there were 13 million Medicare participants enrolled who were hospitalized in the year between 1 October 2003 and 30 September 2004. If one goes to the Medicare Site and look at the Medicare Trustee Report for that period one sees that there were:

"*In 2004, 41.7 million people were covered by Medicare: 35.4 million aged 65 and older, and 6.3 million disabled. Total benefits paid in 2004 were $303 billion. Income was $318 billion, expenditures were $309 billion, and assets held in special issue U.S. Treasury securities grew to $289 billion*."

This means that 32% of the Medicare participants were hospitalized at least once. That is one in three. That means that of the fifty or so friends in that age who I know and see somewhat frequently, enough so that if they were hospitalized I most likely would know, more than 16 of them should have been hospitalized! I can only think of one, and that one has been a chronic one for years. A closer look shows that of the 41 million only 34 million were 65 and older so it even gets worse, that is 38%! I wonder where all these sick old people are hiding out? The map in the paper shows a story which may or may not be correct. Clearly it reflects the data, no question there, but it may also reflect another tale. The picture is shown below from NEJM:



The question is, does the lack of higher hospitalizations in the low states reflect healthier people, or have the sicker people moved, and why? There is still the lingering question as to where all these chronically ill people are. They are hospitalized not just seeing a physician. Just some food for thought. There are times when these numbers really get confusing....I will look for the old people like me this week when I go to New Hampshire to work the farm, they are probably out tilling the soil!

Just after completing the entry preceding this one I read the speech by the current President on how he would fund his Healthcare plan. Specifically he states:

"*Since making this proposal, the Administration has worked with Congress on other ways to offset fully the cost of health care reform through additional savings and revenues. To that end, the Administration is detailing today savings proposals that will contribute another $313 billion over 10 years to paying for health care reform, bringing the total scoreable offsets put forward by the Administration to nearly $950 billion over 10 years. Together, this would extend the solvency of Medicare's Hospital Insurance Trust Fund by seven years to about 2024, and reduce beneficiary premiums for physician and outpatient services by about $43 billion over the next 10 years.*"

He specifically will use Medicare in the following manner to reduce expenditures by taking more money from Medicare. Specifically he proposes:

"*1.* ***Incorporate productivity adjustments into Medicare payment updates.*** *Productivity in the U.S. economy has been improving over time. However, most Medicare payments have not been systematically adjusted to reflect these system-wide improvements. We should permanently adjust most annual Medicare payment updates by half of the economy-wide productivity factor estimated by the Bureau of Labor Statistics. This*

adjustment will encourage greater efficiency in health care provision, while more accurately aligning Medicare payments with provider costs.....

2 ***Pay better prices for Medicare Part D drugs.*** *In its meeting with the President and subsequent communication, the pharmaceutical industry has committed itself to helping to control the rate of growth in health care spending. There are a variety of ways to achieve this goal. For example, drug reimbursement could be reduced for beneficiaries dually eligible for Medicare and Medicaid. The Administration is working with the Congress to develop the most appropriate policy to achieve these savings.....*

3. ***Reducing Medicare overpayments to private insurers.*** *The establishment of a competitive system where payments are based upon an average of plans' bids submitted to Medicare would save taxpayers close to $177 billion over 10 years, as well as reduce Part B premiums....*

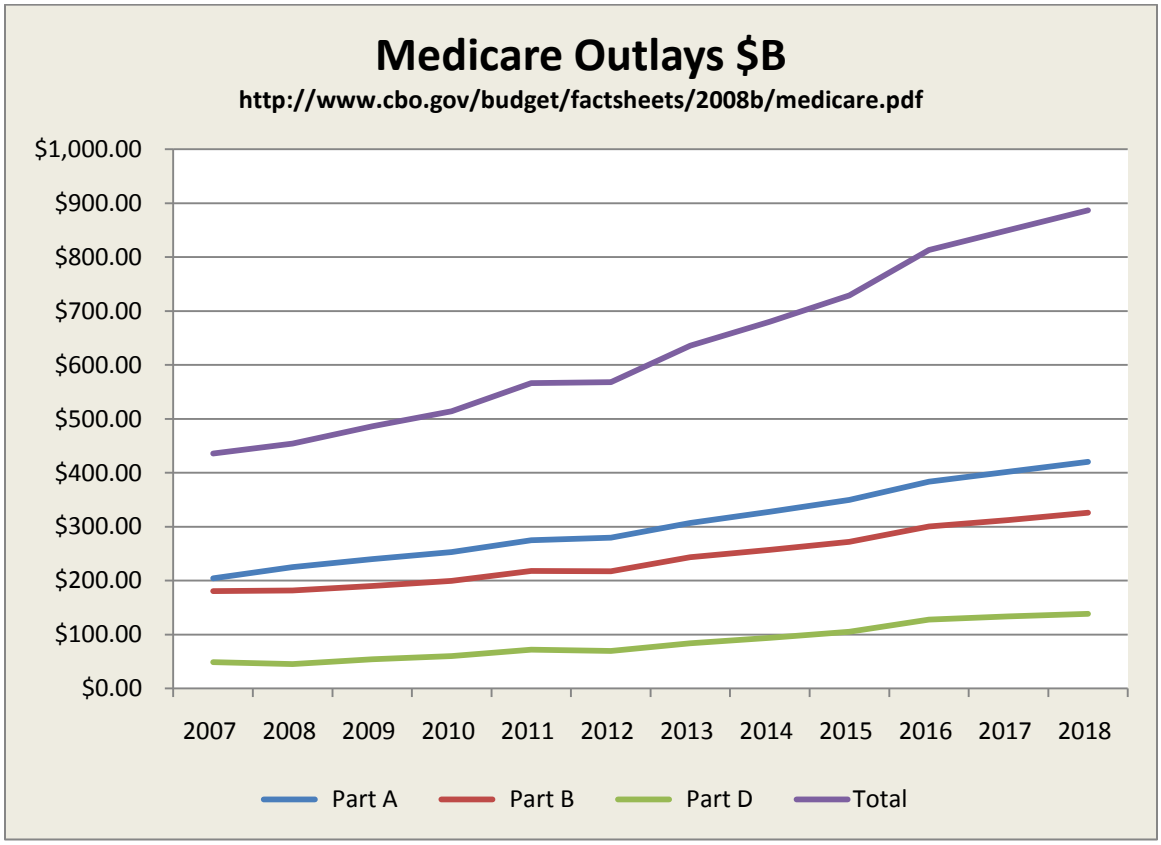
4. ***Improving Medicare and Medicaid payment accuracy.*** *By strengthening program integrity efforts, the Centers for Medicare and Medicaid Services (CMS) will address vulnerabilities that have led to billions of dollars in overpayments and fraud each year. ...*

5. ***Expanding the Hospital Quality Improvement Program****: By linking a portion of Medicare payments for acute in-patient hospital services to hospitals' performance on specific quality measures, quality of care for beneficiaries will improve, and Medicare will save approximately $12 billion over 10 years....*"

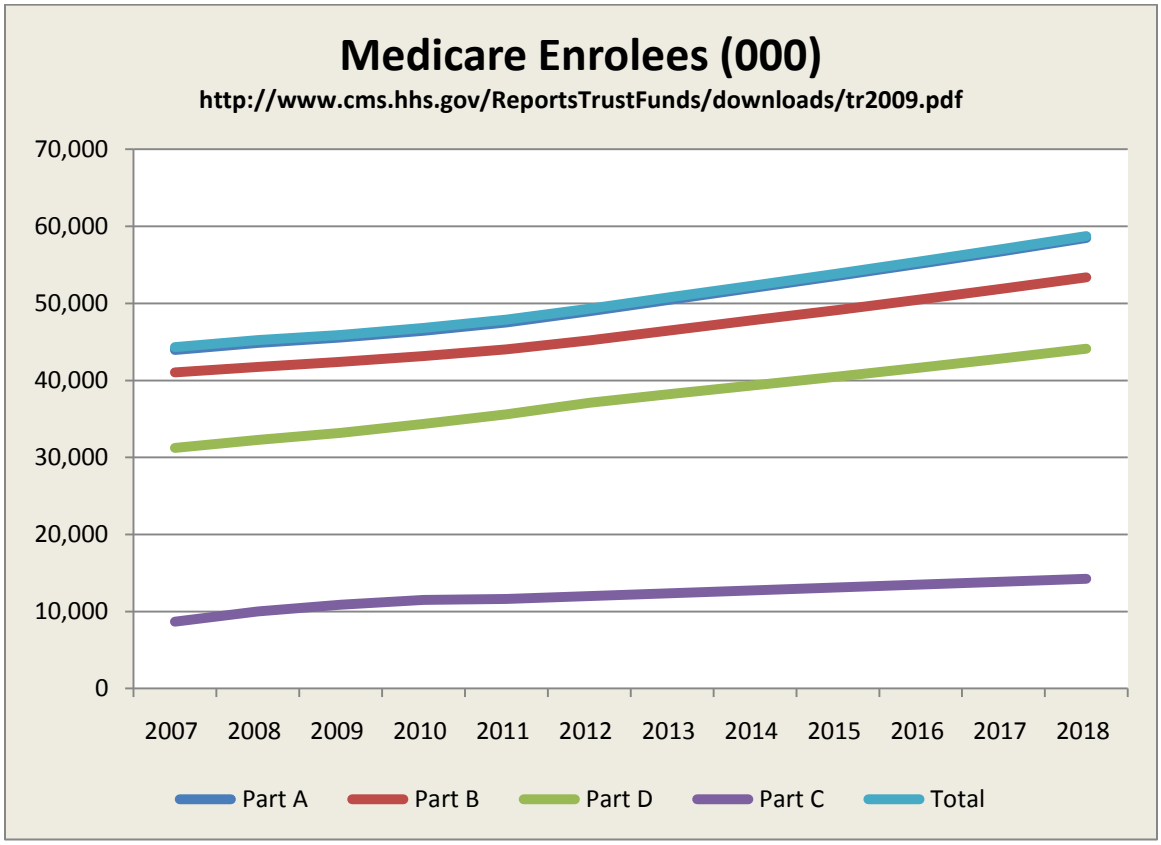
I have demonstrated that Medicare more than pays for itself for those who have worked during their lifetime and then seek Medicare after 65. There are those obtaining Medicare who have contributed nothing. Frankly they should be covered by a separate plan. The assumption of the current President is that Medicare is a gift from the taxpayers to those retired. It frankly is not, it has been bought and paid for several times over! Thus the intent is to again burden Medicare and the Medicare recipients with this cost reduction. Perhaps they should just let them all just pass on, as I suggested earlier. After all the gang in the White House will be exempt due to age for another twenty years.

The following data are three further facts on Medicare. We present the CBO estimated costs, the HHS estimates of participants and the cost participant per year.

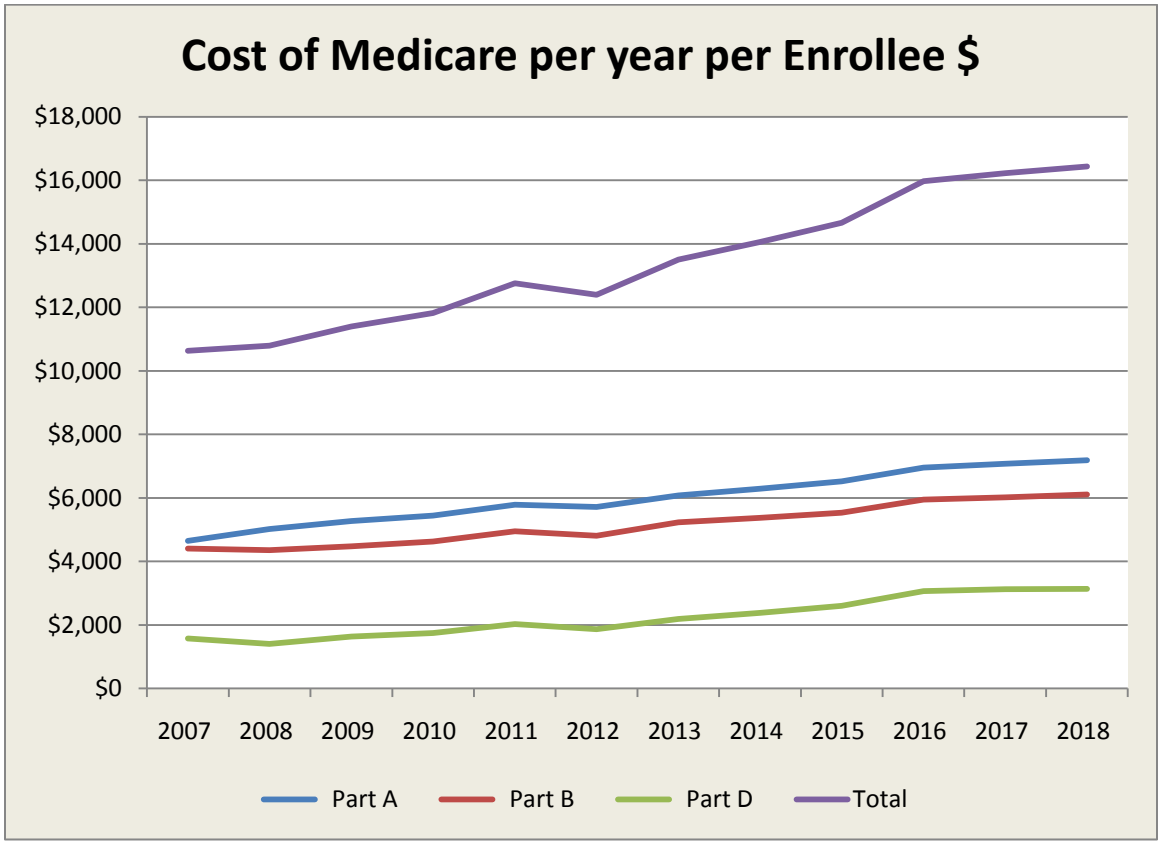
The CBO Cost Estimates are presented below. We show Parts A, B and D as well as the total. The growth in the total is substantial over the period to 2018 dominated by the inflow of the Baby Boomers.



The total participants are presented below. These are the Baby Boomers referred to above. One should remember that the enrollment starts at 65 and that the average life span for a male is about 75 and a female 79. Thus there will be a dominance of females receiving benefits even if many had not contributed as much as the males, although that is shifting as the younger group of working females is included. What that means is as we approach 2018 the females will have contributed equal to the males so the "free rider" status which may have been attributed before is no longer the case. All Medicare participants will have contributed as we have discussed before.



The cost per participant calculated from the above two is presented below. Given our previous analyses and the above comments regarding contributing participants, we see that the expenditures for the period thru 2018 are still less than the contributions from participants!



We thus argue that the Medicare participants will have contributed substantially in excess of their withdrawals by 2018 and that the excess has been spent by the Government rather than being used as specified. In addition we assumed in our earlier calculation a 20 year life for males and females post 65 and we know that it is substantially lower, only 10 for males and 14 for females. This makes the contribution excess even greater. This clear cold fact must become an element in the debate, and not a victim.

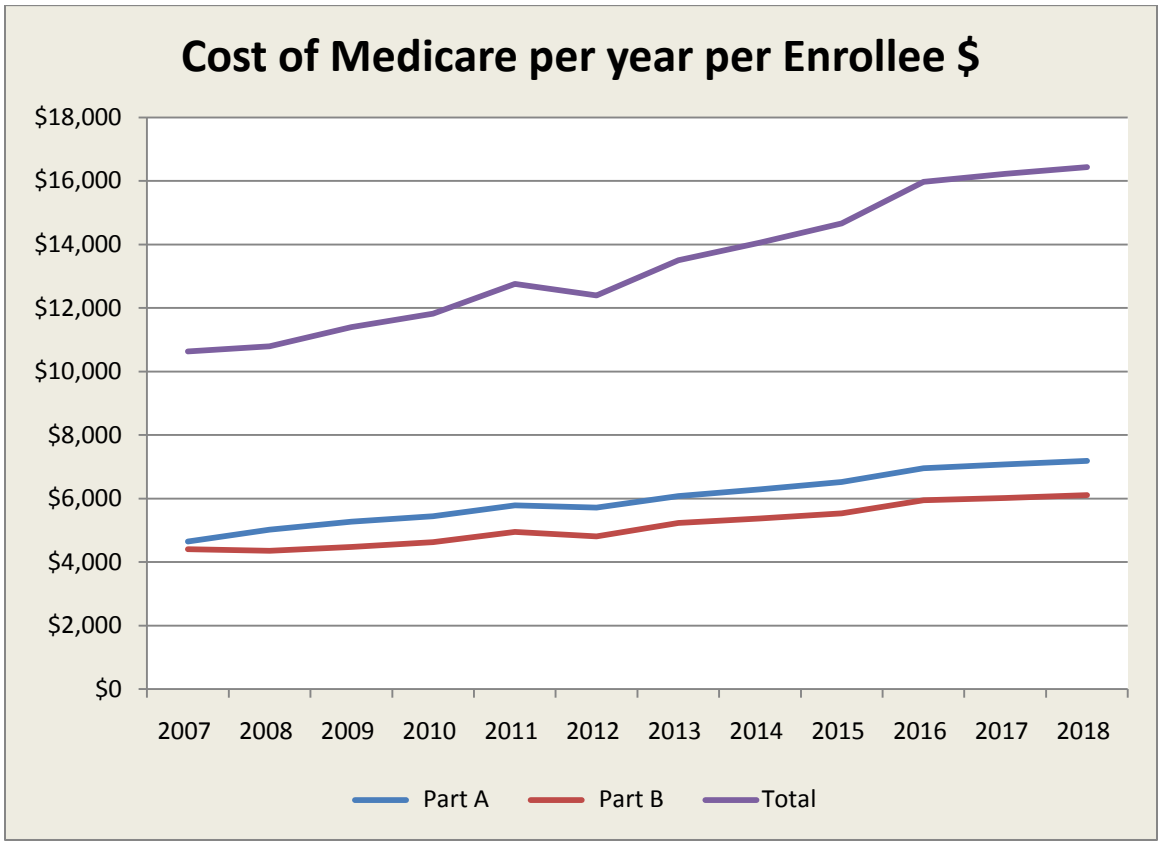
3 MEDICARE FINANCIAL ANALYSIS

There has been many arguments that Medicare is broken. We will show here that such a statement is far from the truth. Indeed Congress is broken and is literally stealing money from Medicare. We will do this with a simple example.

1. Assume that a person starts work in 1970 at the salary of $16,000 per year. They get raises of 5% per year until they retire at 65 in 2005. Their final salary is $107,000 per year..

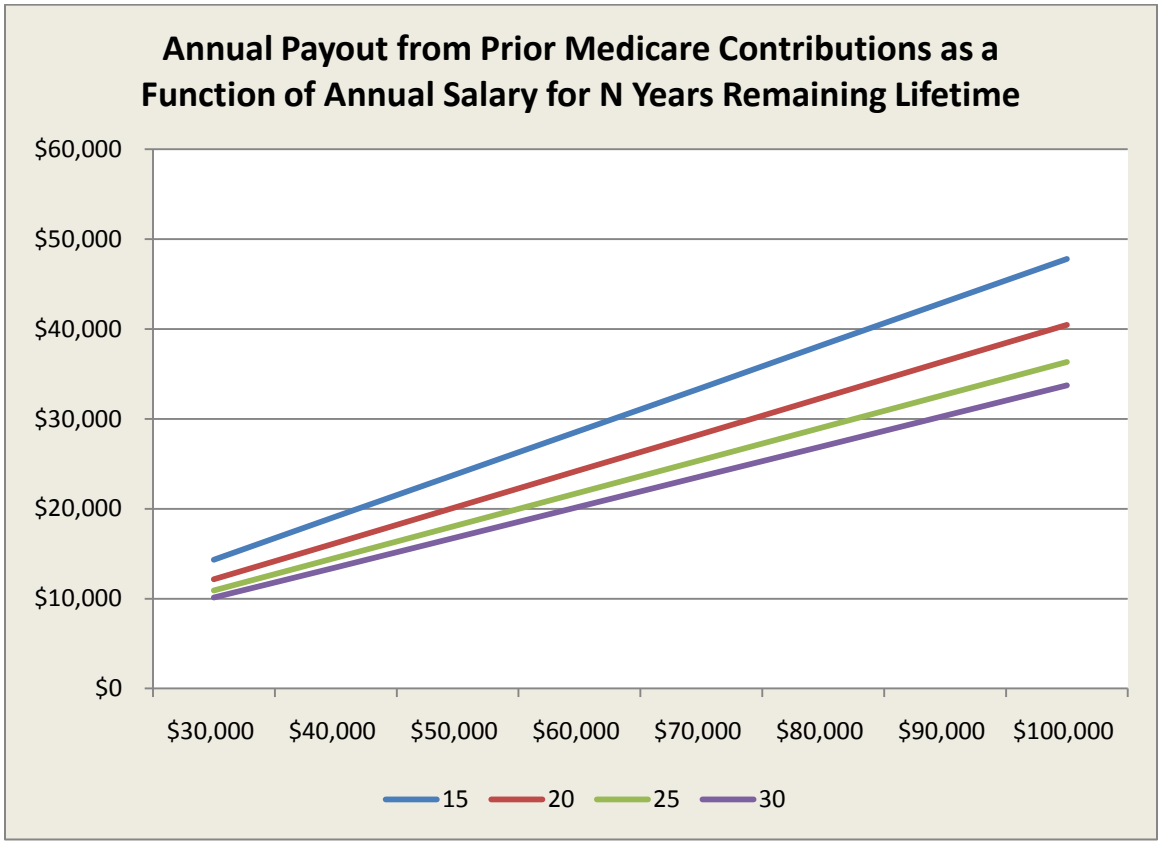
2. Each year they have contributed 3% of their gross salary to the Medicare fund. That is gross with no cap. Assuming the fund invests the contribution at an average 6% rate for that period and it is compounded then in 2005 they have $165,000.

3. Now they retire at 65 and they have an actuarial life of 12 more years. Medicare costs an average of $12,000 per year as we show below. The net present value of these 12 payments of $12,000 is $100,000.

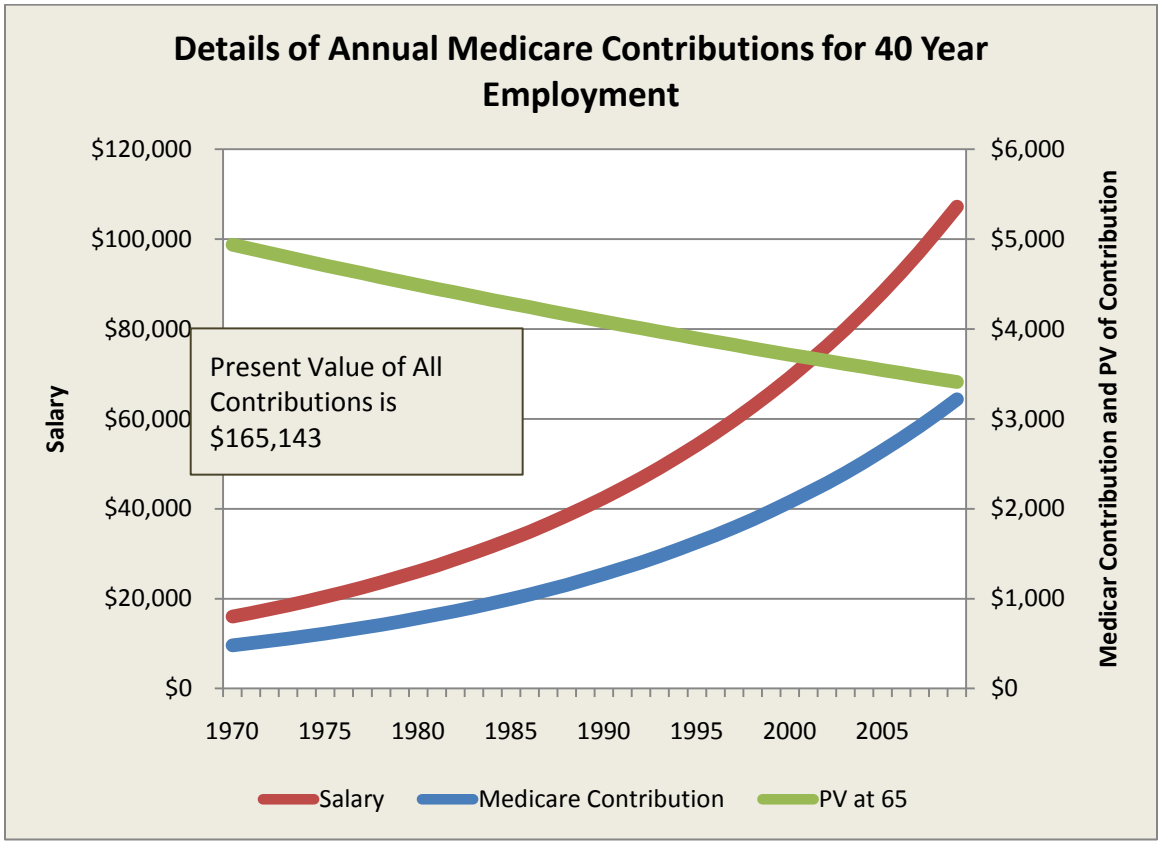


4. But, and this is an important BUT, they have contributed $65,000 more than they will ever collect! Where did the money go? Congress spent it!

5. This gets worse the more you make. In the following chart we show how the contribution explodes as salary explodes. Remember the costs are the 12 years times the $12,000. They are the same for everyone. The more you make the more the Government collects.



6. We finally show in the following some details on this payout. This is nothing more than the details of the contributions by year.



This is a rather powerful chart. It belies all the "facts" that those who maliciously attack Medicare present. Let us look at a person who works for 40 years. The typical American. This person goes to college and then starts work in 1970 at $16,000 per year and gets annual raises at 5% per annum. This is NOT some corporate executive and NOT some uneducated worker. It is in many ways the typical American. The engineer, the school teacher, the salesperson, the person on the GM factory line, the police officer and the like. They contribute 3% of their gross to Medicare. We assume it is saved and invested at say 6% per annum by the Government, a real bad assumption.

Then at 65 we add all of the savings up and we get a total of $165,143 in a lump sum amount. Now we assume that this person lives another 20 years and we ask what is the payout per assume that this person gets. It is $14,398, well in excess of their personal cost of an insurance plan even at the rate of today's private plans. Furthermore it is substantially less than any Medicare benefits.

Thus what is the problem with Medicare. This simple back-of the-envelope calculation, which can be performed by any high school student seems to be missed by the economic brains in the current Administration. Any VC, any entrepreneur, any banker, could do this calculation. Also the Medicare recipient pays an additional amount into

the fund on an annual basis and the Medicare payments typically cover at most 60% of the actual costs, thus leaving a substantial amount to be paid by the Medicare recipient.

The conclusions of this simple calculation are as follows:

1. The Medicare recipients who work a lifetime get much less than what they contribute.

2. The money is wasted by the Government, not by the Medicare recipient.

3. Those who run Medicare are doing what they are doing to establish a national single payer plan, which if Medicare is an example will end up costing people more for less and yield poorer health care.

4.Medicare has also become a dumping ground for many who have not reached 65 and have not contributed. It is an SSI dumping and loading ground.

One must ask why those who represent the elderly such as AARP would even allow such a plan to continue. It is outright highway robbery of the elderly. Does one suspect that the good Senator Kennedy gets his healthcare from Medicare, doubtful. It is essential to run the numbers and see the results.

4 BUNDLING

There has been a flurry of proposals for paying and reimbursing under Medicare. One of the strangest proposals is the Bundling approach which seems to have originated out of a Medicare advisor group. We look at that proposal briefly.

MedPAC is a Government policy panel formed under law to do the following:

"T*he Medicare Payment Advisory Commission (*MedPAC*) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program,* MedPAC *is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.*"

In a 2008 paper in the New England Journal by Hackbarth and others, all part of MedPAC, the authors propose a "Bundled" payment system. This bundled system simply stated is that

"*Under a bundled payment approach, Medicare would pay a single provider entity (comprising a hospital and its affiliated physicians) a fixed amount intended to cover the costs of providing the full range of Medicare-covered services delivered during the episode, which might be defined as the hospital stay plus 30 days after discharge. Bundling payments in this way should provide incentives to increase efficiency, coordinate in-hospital and post-hospital care, and, if combined with pay-for-performance initiatives, improve the quality of care*."

MedPAC published a detailed report in 2008 on bundled care. This report is in many ways the blueprint for Bundled payments.

This bundled approach of MedPAC assumes that if one needs medical care in a hospital that the patient in some manner stops dealing with their physician and then enters into some yet to be defined agreement with a hospital which in turn provides the full "team" and a bundled price. Thus if you require an aortic heart valve replacement, or breast cancer surgery, or prostate cancer surgery, you first get the hospital to tell you what bundle you get.

They choose all physicians and surgeons and they tell you the procedures and they set the price, somehow in accord with Medicare. You just show up and pray that the person or persons who treat you have some idea what they are doing. You choice, your responsibility, your freedom as a patient is destroyed for the better good, in this case the hospital, which in turn reports to the Government!

A detailed paper by Fisher et al called Fostering Accountable Health Care states that:

"*We then present a specific payment reform proposal for Medicare designed to foster the development of accountable care organizations (ACOs) and provide empirical evidence of the potential impact of this approach..."*

They continue:

"*We propose a voluntary and incremental program that would foster the development of ACOs. Our proposal builds on the current Physician Group Practice (PGP) Demonstration, a program in which large group practices are rewarded with a share of the savings they achieve in caring for their Medicare patients if they also achieve documented quality improvement. During the first two years of the program, the participating groups achieved major gains in quality and savings for the Medicare program overall*."

They conclude:

" *But other approaches to reducing the growth of health care spending and fostering integration face serious constraints and even stronger resistance. The political*

opposition to requiring all beneficiaries to join capitated health plans would likely be fierce.

Bundled payments reinforce the principle of shared accountability and encourage collaboration and coordination among providers but are unlikely to have much impact on the overall costs of care. Bundled payments will not discourage the provision of unnecessary services outside the context of the episode; nor do they necessarily reduce the provision of unnecessary or questionable episodes of care. And cuts in payment rates will be vigorously opposed as threats to providers' ability to provide care to Medicare beneficiaries. The tensions that have to be managed include the difficult physician-hospital relationships pervading some markets, the increasing need to slow spending growth, and the widely held perception that cost containment requires income loss for some providers.

A promising middle ground. In this difficult environment, we believe that a voluntary payment reform designed around ACOs and shared savings offers an incremental and promising middle ground that could meet the interests of providers, beneficiaries, and taxpayers better than the competing alternatives. And interest in the approach is growing....."

In effect their proposal is in contradistinction to the bundled plan. The above highlights their view that the bundled plan would not achieve its goals.

There is also a paper called the Long Term Care Quality Alliance which presents a comparison of the following approaches:

1. Accountable Care Organization (Shared Savings or ACO)
2. Primary Care Medical Home
3. Bundled Payments
4. Partial Capitation
5. Full Capitation

This paper views many negative aspects of the bundled care approach. The paper promotes the ACO model which it defines as:

"*The Accountable Care Organization (ACO) model establishes a spending benchmark based on expected spending. If an ACO can improve quality while slowing spending growth, it receives shared savings from the payers. This model is well-aligned with many existing reforms, such as the medical-home model and bundled payments, and also offers additional support (and accountability) to the provider organization to enable them to deliver more efficient, coordinated care. This approach has been implemented in programs like Medicare's Physician Group Practice (PGP) Demonstration, which has shown significant improvements in quality and savings for large group practices*."

This paper concludes on a positive note regarding the ACO approach:

"*The ACO model is receiving significant attention among policymakers and leaders in the health care community, not only because of the unsustainable path on which the country now finds itself, but also because it directly focuses on what must be a key goal of the health care system: higher value. The model offers a promising approach for achieving this goal without requiring radical change in either the payment system or current referral patterns. Rather, fee-for-service remains in place, and most physicians already practice within natural referral networks around one or a few hospitals. By promoting more strategic and effective integration and care coordination, the ACO model holds substantial promise as a reform that offers a potential win-win for providers, payers, and patients alike.*"

The unintended consequences of a Bundled approach are many:

1. The Patient and Provider lose a Nexus: The relationship becomes one with the hospital and not the physician. It breaks the fundamental bond that is the cornerstone of health care.

The patient and the physician are an important nexus. The only physicians who have little to no contact with a patient are the pathologist, radiologist, and anesthesiologist. The surgeon has contact as does the other specialists. It goes to the heart of practicing medicine. The hospital has the least.

In my experience, hospitals are run by managers who care less about patients and more about their bottom line. They are not professionals as are physicians. The only fear a hospital administrator faces is possible loss of accreditation, which only comes after gross negligence if even then. The hospital is run for the benefit of the management and not the patient.

Teaching hospitals may be different in that they are run to produce new physicians. Thus the teaching hospital may be further out on the risk profile.

By placing the hospital at the focus as is done in a bundled approach one creates a barrier between patient and physician and further places the worst possible party in a position of control, the hospital administrator.

Hackbarth et al state:

"*Bundling the payments for multiple providers would create incentives for providers not only to contain their own costs but also to work together to improve their collective efficiency. Providers accepting bundled payments would have the flexibility to develop entirely new approaches to organizing care and allocating payments among themselves*

in ways that could help them achieve efficient, high-quality care. They could then share in any savings gained by improving coordination, quality, and efficiency. "

There is no basis for this statement. They continue and state that perhaps some adjustments may be made. In fact by placing the hospital in the nexus one creates the most inefficient form as we have shown in our analyses.

2. It institutionalizes and memorializes the hospital **at a time when the role of the hospital may be at a massive turning point with genetic medicine.**

The Bundled approach places the hospital at the center of the model. We have argued that this entity is the most vulnerable to downsizing and change and is also at the heart of the explosion in costs. This is especially true for Medicare patients. Thus we see that placing such an entity at the core creates a tension for continuation of bad practices.

3. It creates massive problems with the issue of transfer pricing of services and creates the incentive for further padding by hospitals.

Anyone who has ever been in business, in a large multifunction company, has come to grips with the transfer pricing problem. Many business school doctoral theses have been written on the topic and many a corporate war has been fought over the issue. The price one unit charges another for a good or service is difficult to ascertain. This is difficult even when there is a market for the product. For the buying unit may easily say the internal price is too high and that they will go elsewhere. The hospital could do the same. They may say your physician is too costly so you must accept theirs or no surgery, just go home and die!

4. It drives good physicians out of the delivery of Medicare services further disenfranchising those on Medicare.

Physicians are opting out of Medicare in droves, as was reported by the New York Times. As the paper states:

"*Many people, just as they become eligible for Medicare, discover that the insurance rug has been pulled out from under them. Some doctors — often internists but also gastroenterologists, gynecologists,... and other specialists — are no longer accepting Medicare, either because they have opted out of the insurance system or they are not accepting new patients with Medicare coverage. The doctors' reasons: reimbursement rates are too low and paperwork too much of a hassle*."

This means that with the system as it is already, it is becoming harder for Medicare patients to find physicians which will take them. If one adds the burden of bundling then it becomes worse.

In our opinion, as we have stated many times in the past, the rearrangement of deck chairs, namely the many plans on how to cut costs via payment and control mechanisms miss the point. First, demand can be modulated, second, costs can be reduced by multiple means, third, genetic medicine will change the paradigm fundamentally and having the agent which will be changed the most in the middle will just delay this change, and finally, and only as the last step is the payment issue.

Let me pose a different issue, however. The plans discussed by Fisher, albeit well posed and meaningful, work for the majority of chronic and acute care problems, such as acute MI, heart valve replacements, and even hysterectomies. However, consider the following. A woman has a BRCA positive breast nodule which upon fine needle aspiration is determined to be a malignancy. She lives somewhere in New Jersey and she has the option, assuming that it still exists, to seek service through one of the Fisher like plans in the local hospital or she goes to Memorial Sloan Kettering in New York. Well, off to New York she would go! She may often have a greater chance of dying from nosocomial infection at some local hospital, I am not saying it would be the one in the town in New Jersey, before the cancer gets to her. The plans proposed by Fisher for Medicare would prevent her from going to a tertiary care facility, even if it could save her life.

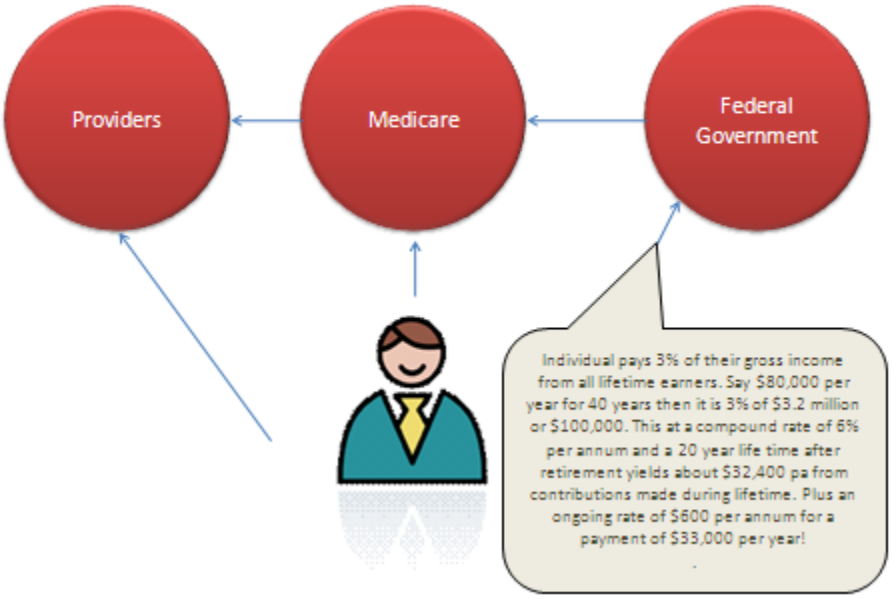
My concern is that the on the average approach works on the average. Yet there must always be room for exceptions, yet the exceptions are always what Government seems so unwilling to deal with, it is inherent in any bureaucracy. I strongly believe that as patients become more aware and as medicine has centers of excellence, that patient choice, albeit at a price, must be maintained. The abuse that Fisher in his many writings presents can and must be eliminated but not at the price of patient choice.

5 PAYMENT OPTIONS

There has been a great deal of talk about schemes for health care payments and the current Administration has used Medicare as the proposed scheme, namely a Government plan. We look briefly at some of the varying options herein.

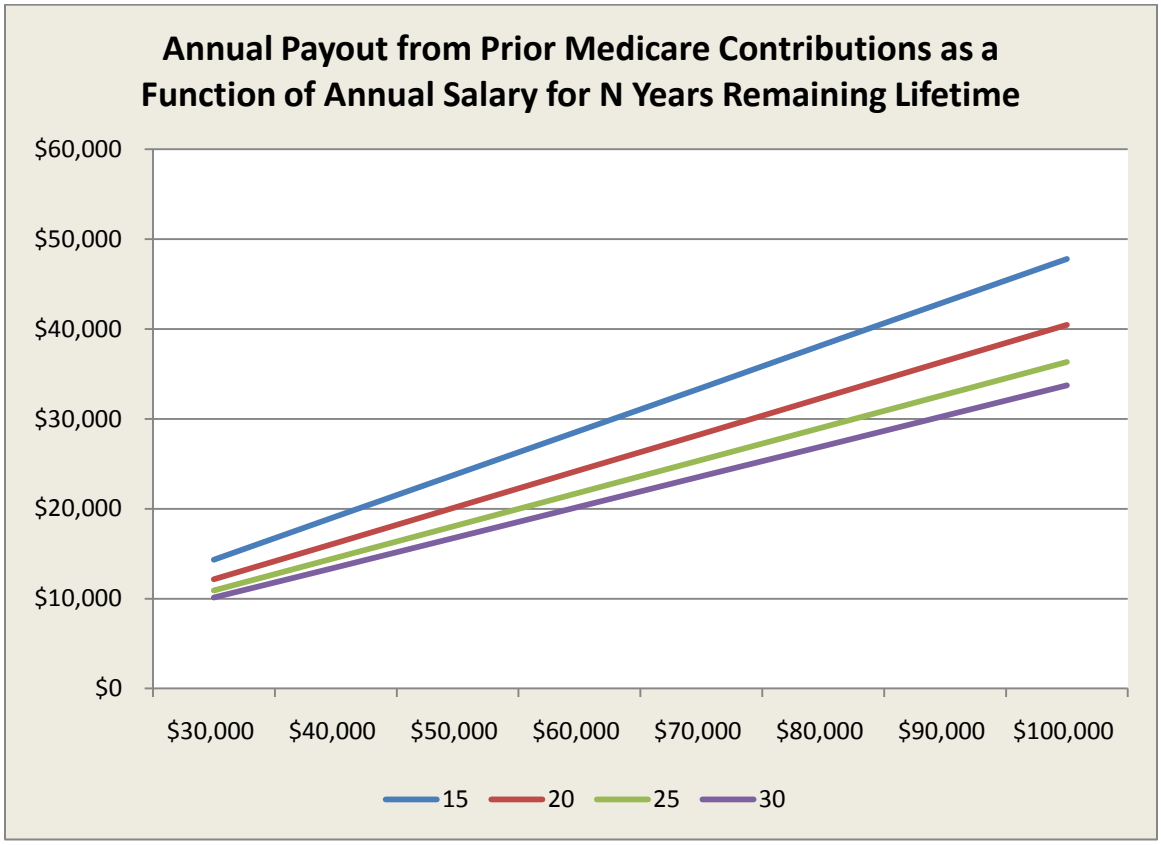
5.1 Medicare

Medicare is generally, but not always, for those over 65. It functions as shown below.



Namely a person spends their entire working life, say 40 years, contributing 3% of their gross pay, with NO cap as is the case for Social Security, and then at 65 they have the option of enrolling in Medicare. They pay about $50 per month per person. But what of the amount they contributed for those 40 years? Well, let us calculate what that may have been. We make some simple assumptions. We assume that they made $80,000 a year for 40 years and that the money gained a simple 6% per annum interest. Thus when they retire at 65 they have accumulated $370,000 which they now deduct a fixed amount for say their remaining 20 years of life. This equals to a payout of $32,400 from what they contributed and added to their current payment it is $33,000 per year! It costs about $8,000 per year to care for them. So what is the problem, First of course is that most people did not make $80,000, but we will account for that shortly. Second, the real problem is the Government already spent the money! Medicare really has no problem, Government does, it spends beyond what it has collected. If Medicare were say an independent fund non attachable by the Government then it would be self supporting.

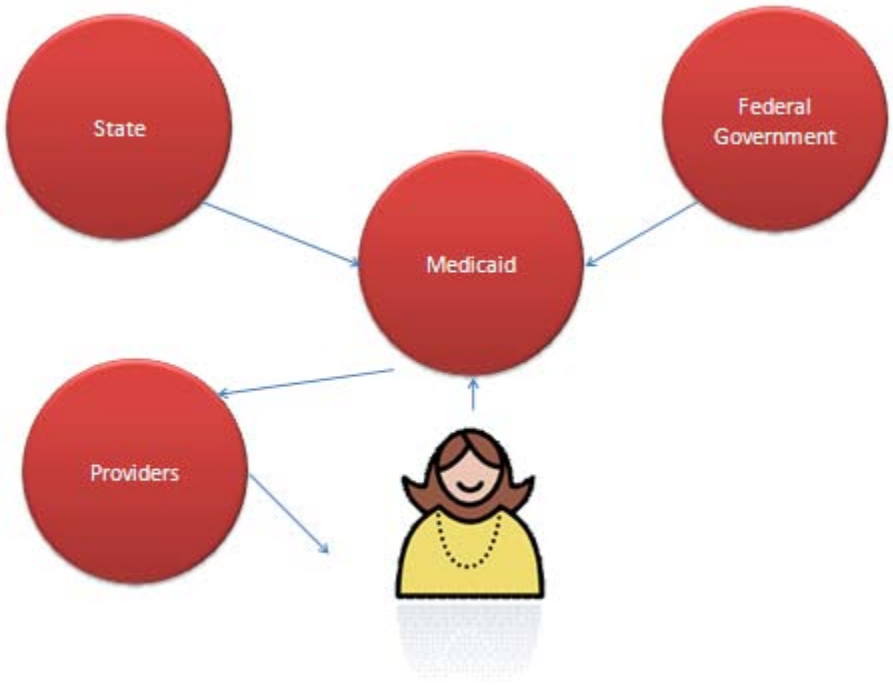
Now let us look at the sensitivity to this number. We show this in the following Figure.



Note that the number scales simply. That is we can calculate what the amount would be at say $30,000 per year, which would be $12,200 for a 20 year life span plus the $600 per month. This is still well above the cost! You would have to go even lower to get below cost but the average salary per working person is well above that number. Why has no one ever calculate this number? Because it demonstrates that the Government is the problem NOT the way the system works!

5.2 Medicaid

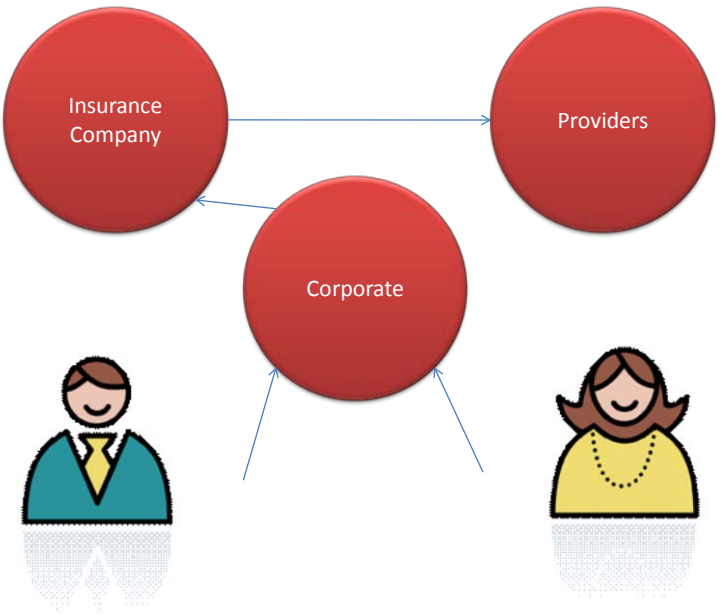
The next system is Medicaid. This is a problem because unlike Medicare there is no contribution. We show this in the following Figure.



This does cost money and this is something which gets supported by those of us who already contributed to Medicare! So don't punish us workers.

5.3 Corporate

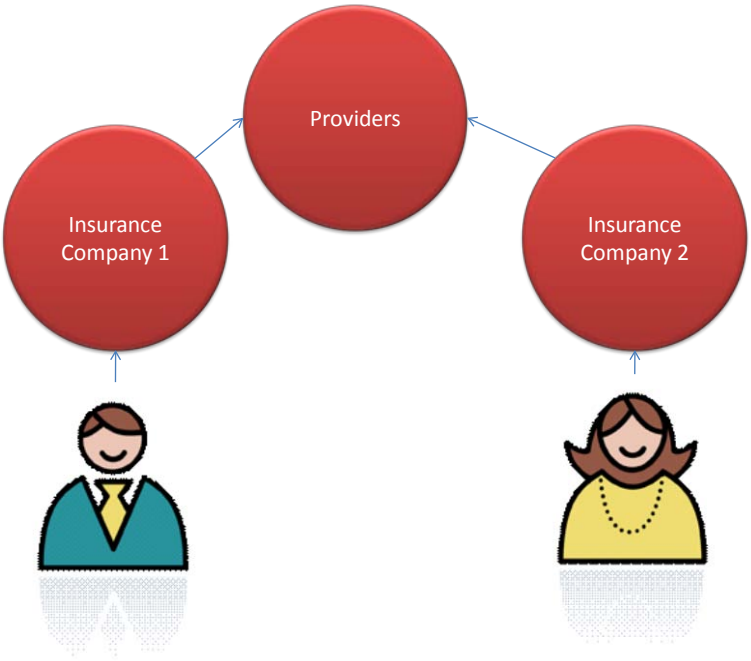
The next is the Corporate Plans. Remember that this is an artifact from when the Government regulated salaries. It was a way to give workers something when the Government denied pay raises. It is akin to the Wage Czar we have today. We show this below.



The problem with the Corporate model is that for the 40-50% of those insured covered under this the Corporations have leverage and they drive down costs below what it costs to deliver. Thus the insurers will make it up on the individual insured persons and put pressure on the providers as well.

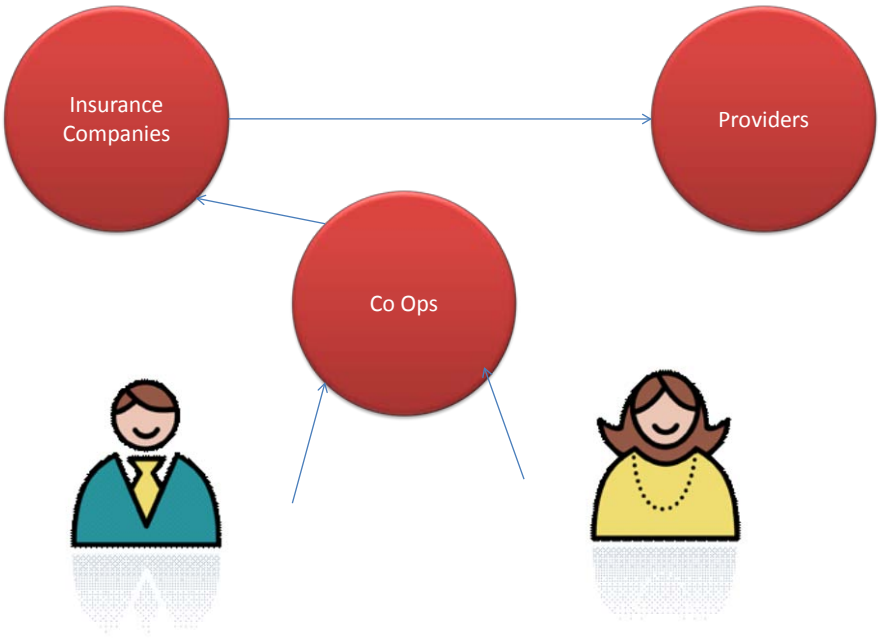
5.4 Individuals

This group really gets the burden. The insurers delimit it to low risk persons and then charge exorbitant rates.



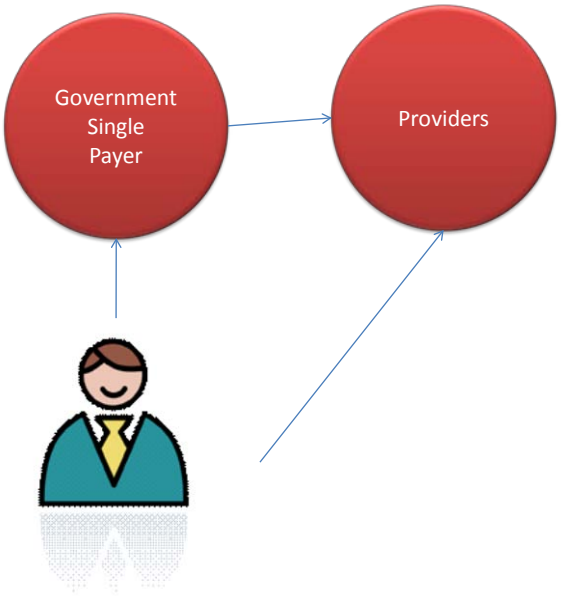
5.5 Co Op

The above individual model could be improved via the co-op plan which Republican have presented. This avoids a single payer Government plan as well as allowing for buying cooperatives which have some leverage with insurers. The problem is it adds another layer and the costs will reflect that.



5.6 Single Payer Government

The Democrats want a single payer plan with the Government being that payer. In many ways it is reminiscent to Medicaid with all of its problems. It does allow for a single buying pool which is a benefit but it also allows and would encourage delimiting service to reduce costs. It also begs the question of price setting and who pays whom in the process. The Government then takes away any market power that either the patient or the provider may have had, little if any now, and with this plan it would be zero.

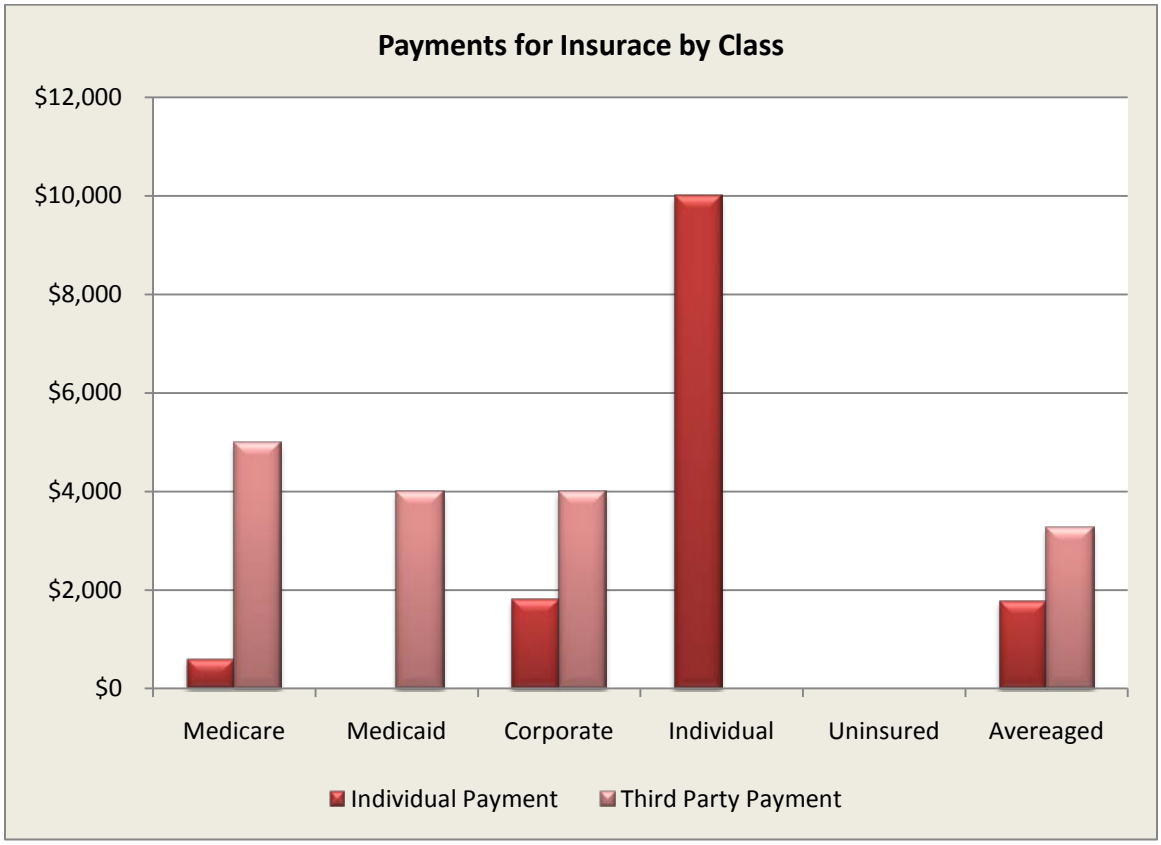


5.7 Cost Comparisons

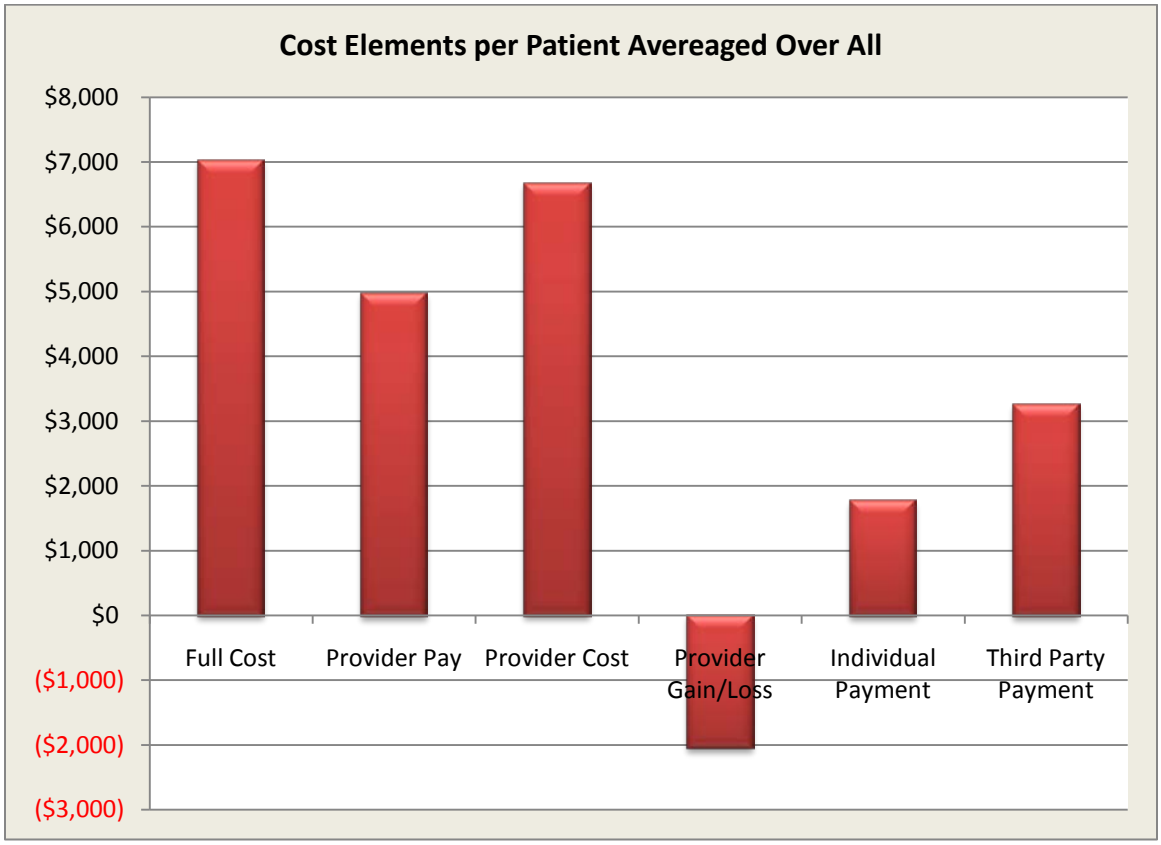
We now do some cost comparisons on these plans. First we show below a comparison table for all plans with assumptions which reflect the general numbers as are currently observed. Not what is contributed, what the costs are and that providers are almost uniformly getting a loss.

	Medicare	Medicaid	Corporate	Individual	Uninsured	Averaged
Percent Covered	**15%**	**8%**	**55%**	**7%**	**15%**	
Full Cost	**$8,000**	**$7,500**	**$6,500**	**$6,500**	**$8,000**	**$7,030**
Provider Pay	**$5,500**	**$7,000**	**$5,800**	**$5,800**	**$0**	**$4,981**
Provider Cost	**$7,500**	**$4,000**	**$6,500**	**$6,500**	**$8,000**	**$6,675**
Provider Gain/Loss	**($2,500)**	**($500)**	**($700)**	**($700)**	**($8,000)**	**($2,049)**
Individual Payment	**$600**	**$0**	**$1,800**	**$10,000**	**$0**	**$1,780**
Third Party Payment	**$5,000**	**$4,000**	**$4,000**	**$0**	**$0**	**$3,270**

We show below the costs by class.



Below we show the costs across all classes. These numbers show we believe that Medicare really is the most healthy based on those who contributed and that Medicaid is the worst. Perhaps a co-op system is better than a single payer for the obvious stated reasons. The Medicare is different in that people already paid and are still paying. One must remember that even Medicare places s substantial personal burden on the individual.



6 PUBLIC VIEW

In an op-ed in the NY Times, Tyler Cowen writes a piece entitled "*Something's Got to Give in Medicare Spending*". This title states his conclusion based on what at best can be said are a confused set of facts. Cowen is a faculty member in economics at George Mason University, one of the Virginia state schools in Arlington, VA. He clearly has done no work regarding Medicare if his analysis is to be believed.

First, as we have stated and we have shown on multiple and repeated occasions, Medicare is a program that supports those who have contributed in excess of what they ever hope to get returned and many more who have contributed nothing.

Now Cowen states:

"*It's not the profits of the drug companies or the overhead of the insurance companies that make American health care so expensive, but the financial incentives for doctors and medical institutions to recommend more procedures, whether or not they are effective. So far, the American people have been unwilling to say no*."

Frankly that may be part correct but it is not the provider alone who it fault. Providers perform tests to avoid legal problems. As has been noted, a 70 year old with back pain

may have metastasized prostate cancer, breast cancer, multiple myeloma, and a plethora of other problems. This the tests to determine what the problem is. The patient may not sue but oftentimes the family will. Thus to reduce the risk procedures are performed. How are you to control that. Multiple myeloma can be diagnosed by a series of blood tests seeking specific markers, PSA may help with prostate cancers but the CCE may not permit that if the patient if over say 70!

Cowen then continues:

"*Drawing upon the ideas of the Harvard economist David Cutler, the Obama administration talks of empowering an independent board of experts to judge the comparative effectiveness of health care expenditures; the goal is to limit or withdraw Medicare support for ineffective ones. This idea is long overdue, and the critics who contend that it amounts to "rationing" or "the government telling you which medical treatments you can have" are missing the point. The motivating idea is the old conservative chestnut that not every private-sector expenditure deserves a government subsidy.*"

Cutler is a health care mini-czar to the current President. Yes he was at Harvard but he has moved on, thus one should be honest at least with that biased disclosure. CCE has its problems as articulated herein many times. It, as proposed, is a Government, and not a professional, assessment group and as such it lags trends, delimits options and in the end will ration. Only those not on Medicare such as all Government employees will be free of the rationing. Is there no wonder that there are no objections from Congress, they are not affected. Cowen is missing the point and paying no attention to facts. Just look at how long a new drug takes to get through the FDA. Now compound that many fold and we have CCE procedure approvals. If the Government has its way the unapproved Medicare CCE procedures may be banned totally. Why don't we just burn the medical books, JAMA and NEJM to start!

Cowen then goes on to use the Dartmouth study:

"*Scholars have been applying comparative-effectiveness research to Medicare for years, and the verdict is not altogether pretty. It turns out that some regions spend more on Medicare than others — sometimes two or three times as much, as documented by the Dartmouth Atlas Project. Yet the higher-spending regions often fail to produce superior health care results*."

The problem here is in the details. Take a colonoscopy for example. If one does a colonoscopy in Florida the overhead costs are low and the patients may be somewhat homogeneous. Then take one done at Columbia Presbyterian in New York at 168th Street. In New York there are say 200 performed per day in a clinic setting which is akin to some industrial type surgery wards I have seen in Russia. People side by side and English not the main language. The staff performs one per 40 minutes and it is a true

assembly line. But the costs are higher despite the attempts to be more productive than any other location. Why? Good question. Dartmouth damns New York without asking why. Truth is found by answering the whys and not just mouthing the whats. One should remember that Dartmouth is in Hanover and it does not in any way present the real world. Columbia Presbyterian and other New York Hospitals are a cross section of humanity. Thus the Dartmouth group should really find the whys before they justify themselves on the whats!

Cowen then goes on:

"*Suggested ways to lower costs include an emphasis on preventive care, the use of electronic medical records and increased competition among insurers. But even if these are likely to improve the quality of care, they are speculative and uncertain as cost-saving measures. Keep in mind that while computers were remarkably powerful inventions, it took decades before they showed up in the statistics as having improved productivity in the workplace.*"

Frankly I have no idea where he is going here. It is a bit of on the one hand and then on the other. Yes we all agree the EMR will help, assuming it exists, it works, and it is used. We have addressed that issue in detail before.

Cowen continues:

"*One idea embodied in a bill sponsored by Senator Ron Wyden, Democrat of Oregon, and Senator Robert F. Bennett, Republican of Utah, is to finance new health care programs by taxing health insurance benefits. This makes sense in principle: why should insurance benefits be favored over salary by our tax system? But employer-supplied insurance is a mainstay of the current health care system, and there is no adequate replacement immediately in sight.....It sounds harsh to suggest that the Obama administration cut areas of Medicare spending, but, too often, increased expenditures and coverage are confused with good health care outcomes. The reality is that our daily environment, our social status and our behavior — including diet and exercise — have more to do with good health than does health care more narrowly defined....The demand for universal coverage sounds like a moral imperative to "take care of everybody," but in reality it would make only a marginal difference when it comes to the overall health of the American population. The sober reality is that universal coverage is another way to spend money, which may or may not be a good idea.*"

There are many ideas here with little justification. Let me address them in a more logical order:

1. Universal Coverage: Like auto insurance there are externalities. We have to take care of a sick person whether they have insurance or not. Opting out means moving the cost

to everyone who is in. The issue is coverage for what? Catastrophic, accident, chronic, acute. That is the debate.

2. Taxing Benefits: This is a question if and only is we assume that employer benefits remain rather than having a system where every person is insured in a manner akin to auto insurance. I recognize that such an approach is antithetical to the way we think but perhaps new thinking is necessary. Multiple providers, and individuals. Perhaps also the patient should pay the physician or provider and the patient should then get reimbursed by the insurer. Again like auto insurance in many cases. The nexus between the patient and the provider in terms of the payment is a critical connection to let both understand costs.

3. Medicare has some problems but they are too often Government based problems. The Medicare reimbursement system if used in global financial trading systems would collapse the world economy in just a few days. It is incompetently organized and operated. No business would have a billing and payment system like this. I remember my days developing and managing the cellular billing system twenty years ago. They were complex and if we had a problem we were soon aware if it and it was fixed. What takes Medicare so long, well it is the Government!

4. Back to Universal: If Universal is to work then all must be in the system, and if one looks at Medicare then that means Unions and Government workers and all politicians. They must have a dog in the hunt!

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