

**AEI's Health Policy Double Feature:
Promoting Health Insurance for Children and All Americans
American Enterprise Institute for Public Policy Research, the
Heritage Foundation and the Galen Institute
April 24, 2007**

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CHRIS: It is a great pleasure to have Secretary Mark Leavitt at the American Enterprise Institute this afternoon for this address that we're delighted to be sponsoring along with the Heritage Foundation and the Galen Institute.

He has been Secretary of Health and Human Services since the beginning of President Bush's second term, having served as head of the Environmental Protection Agency during the first term and before that as the highly successful and popular three-term Governor of Utah.

Among his many accomplishments at HHS he has overseen the implementation of the Medicare prescription drug benefit program, promptly enrolling tens of millions of seniors and disabled people and fashioning a highly competitive market for their business, providing them with variety, good service and good prices that sets a new standard for further health care reforms.

At a time of sometimes over-the-top partisanship and overheated and inflamed rhetoric, Mike Leavitt stands out as a model of energetic public service and enlightened public leadership, and in the Galen and Heritage AEI think-tank world he is particularly admired for being studious, brainy and adamantly devoted to the public interest.

His talk this afternoon is on promoting health

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insurance for children and all Americans, and he promises to give us all exact details on all of the health care legislation which the Congress will be enacting this year.

Please give a warm welcome to Secretary Mike Leavitt.

[Applause]

SECRETARY MIKE LEAVITT: Chris, thank you. I'm appreciative of having this distinguished forum and the trio of distinguished organizations that have collaboratively put it together today. Thank you.

Some of you know that I have recently become a grandfather. It's been a wonderful experience. I was boorishly going on, I suspect, with one of my friends who explained to me why it is that there is such a close bond between grandparents and their grandchildren. He said it's because they have a common enemy. [Laughter] That may well have been on my mind yesterday. I had a chance as a Trustee of the Social Security and the Medicare Trust Funds to meet in our spring trustee meeting, and I know you have a report from Rick in some detail about that meeting, but may I say as an American and as a grandfather, it was a sobering experience for me. It always is.

You acknowledge, I am sure, that we now measure this one government program that we call Medicare as a percentage of the entire Gross Domestic Product. I think that fact in and of

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itself is tough. It became clear as I looked through the charts that we provided that as the unfolding scenes of life take place, and when my grandson becomes 25 years old, it will have gone from three percent of the Gross Domestic Product to almost seven, and when he becomes my age, which I might add has seemed to happen very quickly, it will amount to 10 percent of the Gross Domestic Product.

This is a very serious problem and one that we have to deal with. Yesterday we issued for the very first time a financial warning, a warning required by Congress. Congress indicated to the trustees at any point in time that you project forward that in a five-year period for two consecutive years that it will have exceeded 45 percent of the total support coming from general revenues, we as Congress need to know it and the American people need to know it.

Well, I believe that was a very important warning yesterday. The trustees of the system issued that warning. It happened last year. It's happened again this year. Likely it will happen again next year as things unfold.

This story and the report that doesn't tell it all is certainly accurate and actuarially sound, but I suspect there are a couple of things you may not have read in the report. One involves the fact that the report was based on the law, and the law includes the need for adjustments in physician

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reimbursement rates. Some years ago Congress passed a law that required that the rates be adjusted downward whenever expenditures go up to a certain level, simply stated.

Well the problem is every time we reduce the rates just magically there are more procedures, and the total amount just continues to go up. It's a vicious cycle, and the reality is this is exactly what happens when the government is setting prices. Every year we have the same debate over the so-called doc-fix [misspelled?]. How will we fill in the gap?

The way it's now set up, next year we'll have to reduce doctors' rates under Medicare by 10 percent, and then every successive year after that for the next nine years, we'll have to reduce it by five percent, the cumulative effect of which would be about 41 percent reduction in physician rates. Now if you believe that Congress will do that then you can assume that in fact we'll reach that trigger level in 2013. If you think that's not likely to happen as it hasn't happened for many years in the past, then we'll reach the threshold in 2010, roughly.

Now at that point what changes? Well, it's just a continuation of what's happening today. Medicare is not simply eroding the trust funds. It now begins to erode the capacity of the federal government to meet all of its other needs because every basis point it erodes it takes away our capacity

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to deal with national defence or any of the other things that we call upon government to do.

Now I suggest I'm sure that you were told that there were some rays of good news in this report. One is that the trust fund last year indicated that we would essentially become insolvent in 2018. Now it's 2019—a one-year reprieve. I think what is more important than that fact is why.

Essentially two parts: The first is that Part D, there was a lower than expected level of expenditure on Medicare Part D; and the second was that there are hospitalization rates that have fallen for reasons that we simply don't understand. Now this will make Rick cringe a little when I say it, but let me just say I have some hope and some optimism that there's a correlation between the fact that we have seen for the first time prescription drugs in the hands of seniors with the idea that there may be heart operations that we would have paid for during the last year that we haven't had to because we gave them prescription drugs. We'll see as this unfolds whether that trend continues or not.

For those of you who are not as close to Part D, let me just give you a brief reminder of how this program is constructed. There was, of course, for many years a desire on the part of the people of this country to have a prescription drug program for the reasons I've just outlined. The plan had

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always been to say we'll have a one-size-fits-all government program like we did with Part A and Part B, but that was resisted.

The Republic Congress and the president indicated that we're going to have prescription drugs but instead of using compulsion we're going to use markets. Instead of using one-size-fits-all, we'll have the market, and allow prices to be established, and we'll allow competition and innovation. And that's exactly what happened, and the market responded—responded robustly. And today we stand with 92 percent of all of those who are eligible having a plan.

The better news is 80 percent by virtually every estimation are happy with their plan. Why are they happy? They're happy because they could choose a plan that fit them. If they had one-size-fits-all you can bet there would be a lot of people who wouldn't be happy. And the 20 percent who aren't can now choose a plan that will help them become more pleased in the future. We're all going to get better at this.

And the price: Originally the estimate was \$37 a month per beneficiary. This year it will be delivered for about \$22 a month. Why? Because of competition primarily—saving the taxpayers money as well, over \$200 billion dollars.

I believe that this difference between the good news in the report and the bad news in the report frame a very

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important question, and that is: What is the role of government in health care? Why is it such a good illustration? Well, fundamentally Part A and B demonstrate one philosophy and Part D demonstrates another. There are two very divergent views as to the role that government ought to play in health care. The first is that government ought to be the proprietor. We ought to define the benefits. We ought to set the prices. We ought to bear the risk. There are others of us who believe that government should be an organizer. As an organizer our task is to set the rules, to remedy the inequities and to subsidize the needy—two very divergent points of view.

Part A and Part B are excellent examples of the way these two philosophies play out. On Part A and B Congress very clearly establishes the benefit. There's no innovation to speak of in a larger framework. Second, government sets and regulates the prices. Taxpayers bear the risk. Future generations bear the risk. And the system is very clearly on the road to insolvency, and we are sowing the seeds every day that will produce an insurmountable weight to our prosperity.

Part D, on the other hand, is a model of what happens when government serves as an organizer. Congress set rules. It allowed the private sector to innovate, to respond to solutions that consumers would want, and respond they have. The market set the prices and continues to. The government has

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provided extra help for those that are poor. And the result I've already mentioned—falling prices, happy consumers, the government saving money, and hopefully a healthier population.

During a recent debate in Congress I had a conversation with a member of Congress about should the government negotiate drug prices? Essentially the conversation was: Well, how do I explain that the government set prices on doctors and hospitals and medical advisors but not prescription drugs? Well the answer—the government in making those decisions is producing the greatest financial mess in the history of our country. The answer isn't to change Part D. The answer is to change Part A and B.

The first rule of getting out of a hole is to stop digging, and we need to. I'm happy to say we are in various ways, part D included. Medicare managed. We now have 20 percent of the Medicare population that has chosen a private plan. We've gone from 4.7 million to something over 8 million now of those who have made a selection. They're getting extra benefits; they're getting better care. We're also beginning to implement competitive bidding on Parts A and B, but those are different stories for a different day, but they illustrate the need for us to decide if government is going to be a proprietor or an organizer.

When the government acts as a proprietor the same thing

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happens every time. I have traveled in my role as Secretary and before all over the world looking at health care systems. It doesn't matter if it's Europe or if it's Asia or if it's Latin America or if it's here in the United States. The same thing happens when government acts as a proprietor.

People talk about the concept of universal care, but closer examination makes clear that there's not much universal about it. In virtually every system a budget is set, it's granted to the provider of the care, and essentially they provide all they can for what they can. And the reality is that when you support institutions most of the time the institutions get taken care of but the people don't always get taken care of. Where are they? Well, they're generally in a waiting line.

Now my observation is in looking at all of these systems no matter what continent it's on, the same thing is generally true. Physicians typically will practice a part of the day in the public system and then they'll almost always have a private practice where they care for private patients. So the reality is if you are in the public system then you wait and wait and wait. You've got the money then you're very capable of being able to go to a doctor and getting it there. Universal care is not always universal.

Let me just say that one of the things I worry about is

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that unless we change, Medicare and Medicaid will become the same thing. Many doctors have stopped taking Medicare patients. Others make enough in essence on their other practice they continue to do so. It's the same proposition. When government acts as the proprietor the same things apply—long lines, lower quality and higher taxes.

What we need is a system of competition — competition where value is the currency. For that to occur, every person needs to have access to a basic insurance policy. Now there are a lot of good reasons why that's true. One is it helps them stay healthy. The truth is people who do not have insurance don't get preventative care. They don't get the care they need at the time they need it. Generally they go to an emergency room, which is great if you have an emergency, but it's not good if you're looking to get basic primary care.

The second reason it's valuable is because it creates a social and personal stability. It's a way in which societies can organize to share the worry and to share the risk, and it also creates a systematic method for managing costs. One of the most profound pieces of information that's left out of this debate is the fact that people in America who don't have insurance for the most part get care. It may be ineffective; it may be unequal; it may be inconsistent, but they're getting care. And we can do better than that.

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What's not widely understood is that while we don't have a kind sounding name like Medicare or Medicaid or SCHIP, between federal and state and local budgets we spend over \$30 billion dollars a year in sending payments in lump sum to hospitals to pay for those who don't have insurance. One has to wonder if it doesn't make some sense at least to spend at least part of that money, rather than perpetually paying the bills of people who don't have insurance to just help some of them get insurance. But nevertheless we are doing so today. They're getting care.

So very quickly you come back to the very basic proposition. What is the role of government? Should we be a proprietor or should we be an organizer? Now some would have the role of the federal government as a proprietor expanded. They'd like to expand our business as a proprietor. Others believe there's a move forward that we need to become an organizer, as I've said. Clearly, we have been headed in the direction of those who believe it ought to be a proprietor. We're headed for more government—at least that's the trend.

Medicaid enrolment is up 50 percent from over a decade ago. Today the federal government provides health insurance for 45 percent of all children. Half of all the births are paid for by the government. In the next few months we will see a debate ensue in Congress about the ongoing future of SCHIP,

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the State Children's Health Insurance Plan.

SCHIP was meant to be for low-income children who are not eligible for Medicaid, those that are earning less than twice of the federal poverty level. There are some who would raise it to 400 percent, or \$82,600. What that would mean is that 71 percent of all American children would be on public assistance.

Now there are those who would expand it to cover adults. In fact, there are already three states that cover more adults than they do children. SCHIP is being proposed in the spirit of expansion of health coverage, but that isn't the reality. The reality is that 60 percent of Americans who are newly enrolled in public programs like SCHIP were formerly insured by private plans. For every 10 people who go on a publicly funded plan six of them leave a private plan. This is called crowd-out[misspelled?].

We need to reauthorize SCHIP. Let me be clear about that. It's a very important tool. But we need to stick with what it was intended to do, and that is to help low income children have health insurance. Besides, that really ought not to be, however, our objective. Our objective ought to be for every American to have access to basic insurance at an affordable price. The solution to this dilemma isn't to incrementally put one more car to the train of government-

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funded or government-run health care. The solution is for every American to have affordable basic insurance, including children.

Now those who understand the dangers of the trend need to engage. If there is a single message I hope that I will convey today it is that. Those of us who understand the flaws of government-run care need to step forward. We need to step forward with genuine plans that accomplish that task. The old saying in politics that you can't beat a candidate with no candidate, the correlate of that is you can't beat a bad plan with no plan.

Plans need to be based on a very simple core philosophy. It would surprise nobody here that I believe that philosophy needs to be government as an organizer. It needs to be a uniquely American plan. The plan needs to have a core strategy. Let me offer a very simple one. If you're elderly, if you're poor, if you're disabled government ought to provide coverage to you, and we ought to pay for most of it. But if you're everyone else, you deserve to live in a state where your government has organized a private marketplace where through your employer or on your own or through methods that have been organized you have access to a choice of basic plans that are affordable.

In the State of the Union the president made clear that

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he believes that as well. He instructed the Secretary of Health and Human Services to go out to the states where he said that's where the action is. See what you can learn. Find out what's happening. See if we can't harness some of that energy and innovation.

Since that time I'm happy to report to you that I have met with over 40 governors and state legislatures all over the country. I can report to you that there is a torrent of activity going on. We're currently working directly with almost two dozen states that are working to develop plans—plans that would cover every citizen of their state or that would allow every citizen to have access to a basic plan of insurance on a level that's affordable.

States are convinced they can do this if they have the tools. Every state has to solve some problems that they have in common. I'd like to talk about what those problems are and the process through which each state must go. There are essentially three problems that states must organize a solution for. The first is a basic plan. What do we mean in our state by a basic plan? The second is: How are we going to pool risks to assure that the hard-to-insure and chronically ill can be covered as well? And lastly: How do we solve the puzzle of affordability for those who can't afford it on their own?

Let's talk for a few minutes about the basic plan. Let

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me suggest that I believe every state needs to answer a question for themselves, and that question is: Is there more virtue in having 1,000 people with a basic plan of insurance or having 500 with a comprehensive plan and 500 without?

Well, I believe that across the country states are acknowledging the virtue in having a basic plan available to all of their citizens. Now one barrier to that in many states has been the action over time for reasons that were noble and understandable, the accumulation of a large series of mandated coverages. Now those coverages have in total created an atmosphere where some people simply are priced out of the market. They can't afford it.

Each state, then, needs to deal with that question. States approach it differently. When I went to Vermont, it won't surprise you, in Vermont I found a highly comprehensive plan. And frankly the state was willing to step up and tax their citizens to accomplish it. Now I might not have, Governor Leavitt might not have proposed that, but at least they put forward a plan, and defined the word "basic" and created a plan of affordability and a plan of pooling.

I went to Tennessee. Governor Bredesen has a much different approach. He's defined a very simple plan, very basic, has a relatively low limit of liability, but it's \$150 a month, and the deal is \$50 for the insurer, \$50 for the

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employer and \$50 for the state. I predict thousands of people who currently don't have insurance will because of that basic plan. It's not a comprehensive plan but it fits the needs or the capacities of Tennessee.

We've all seen this in other states. Michigan: Governor Granholm has put forward a plan that would cover 1.1 million uninsured people in the state of Michigan. It's a basic plan. It has a limited liability of around \$35,000. It has basic preventative benefits. She has a plan that is able to be worked out to be able to afford it.

Illinois: Governor Blagojavich. You can go to Missouri. Missouri has been completely reorienting under Governor Blunt their system. There is a lot of action going on right now. As I indicated, we're working with almost two dozen states.

Some say well Congress ought to establish a basic benefit package. Congress will not have the capacity to constrain itself. The reason a state will have that capacity is because states have to deal with one factor that the national government does not—they have to balance their budget and they have to find some way to balance those scales between affordability and benefits. It's a virtue of this system.

Now let's talk about risk pooling. How do you go to the second part of the puzzle they have to solve? How do we

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assure that the hard-to-insure can be part of this? There are at least five ways that I can think of that states can choose from and that states are beginning to choose from to solve that problem. The one that's had the most conversation recently has been the individual mandate. Massachusetts chose to use it. It's being discussed in California. It's being discussed in Illinois.

But it's not being discussed in a lot of other places that are solving the pooling problem in a different way. Some are choosing to use their Medicaid population as a pooled population. Others say we'll use our state employee benefits as a means of being able to create a pool sufficient to solve that problem. Others are using uninsured pools that they're creating to allow the market to operate and then allow tax dollars to focus on those who need subsidies in that area.

Others are looking for reinsurance arrangements that will allow that to be solved. Almost all of them are talking about a connector system that begins to allow that to occur. There's one thing I believe. We'll look at Massachusetts over time as having piloted, or at least tried, is this concept of a connector. It's not just important in being able to pool risk, it's also a very important tool in being able to aggregate different contributions to a premium to make it affordable.

Let's talk about affordability. What does

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affordability mean? Well, it might mean different things to different states because at the root of that question is who do we subsidize? It may be that some states choose to subsidize to a high level. Others may have a more constrained reaction to that. The beauty of a federalist system, the laboratories of democracy, is that we'll find a lot of different ways, and states will learn from one another.

But there are two parts of the affordability question that have to be dealt with in every state. The first deals with the problem that the Congress has to solve, that the federal government is in charge of, and that's this blatant discrimination that occurs between those who purchase health insurance through an employer and those who purchase on their own. It's the problem of the teacher's aid that works in the school but not enough hours to get insurance, who's married to a construction worker. They make a pretty good living together but neither of them has an insurance policy offered through their employer. Consequently they are forced to go out and buy it on their own and to buy it after they have paid their taxes, and it's just too heavy a lift.

In order for states to solve the affordability problem Congress needs to solve that problem. The president put forward a proposal in the State of Union to make a uniform standard deduction for those who have health insurance. Now

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there are others who've made proposals. Bottom line is it needs to be solved if we're going to achieve an affordability plan in these states that are so interested in doing this.

The second problem is how do we close the gap beyond that for those who simply can't afford the basic plan? The president has proposed the idea of some affordable choice plans where under certain conditions the federal government can partner in the development of those plans. So I'm going to ask: Could this happen? Could we really see a system of insurance that would make it accessible to every American? I think the answer very clearly is yes from a financial standpoint.

As we work through these state plans—I won't take the time to go through any of them today individually—but if the states have the tools and the tax problems solved, and a partner in affordability they can solve these problems, and that's the reason these governors are proposing it.

Now how about politically? Is it reasonable to expect that we will see it in a political time like this? May I just tell you that this whole atmosphere is reminiscent to me of 1995-1996 in welfare reform, the time I was chairman of one of the governor's associations. I was deeply involved in this.

The government was divided: the White House in one party, the Congress in another. There were different opinions

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about welfare reform not only between the administration and the Congress, but different opinions in between the two houses of Congress, and different opinions within parties. However, the states were highly engaged in this problem. Why? Because they were dealing with this on the line every day. They were desperate to find a solution to this.

The states came forward in a bipartisan way and said Republican and Democrat, here are the problems we have to have solved if you want us to take care of this. We won't all solve it in exactly the same way, but give us the choice, get out of our way, and give us the tools, and we'll get it done. Ten years in retrospect it's pretty clear now it worked. But the atmosphere is eerily reminiscent of that. I'm aware that the governors are in fact working right now to develop a list of tools.

Let me just say in summary that I believe the picture of a nation with every person having access to a basic insurance policy at an affordable price looks a lot more like a 21st century network of PCs than it does the clunky, inefficient mainframe computers of the 1960s, and the metaphor is intended. Government has a role. Government's role is to be the organizer not the proprietor. The poor, the elderly and the disabled need to be able to turn to Medicare and Medicaid and SCHIP as they have in the past. Every other American deserves

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to have the choice of basic plans, and those who can't afford even a basic plan, we have an obligation to step up. The result will be better health; it will be lower costs for all Americans. Thank you.

[Applause]

CHRIS: Secretary Leavitt has agreed to take questions. I will call on you. We have two roving microphones. Please wait until the microphone arrives. I would appreciate it if you would introduce yourself before asking your brief question. The floor is open. Who's going to break the ice?

MARTIN: Hi. Martin [inaudible] from Norelco [misspelled?]. Why didn't the president market his proposal as a universal coverage plan that would offer hope to all kinds of people? Why leave that idea basically for Democrats and for some states?

SECRETARY MICHAEL LEAVITT: I believe there is now a widely hailed aspiration for every person to have access to an affordable basic plan. We tend to use different terms in the way we use them. Sometimes the Democrats like the word universal. Republicans like the word everyone. But the reality is the proposal is the same. People need access to insurance.

What the president said in the State of the Union was we need to solve that puzzle and the place to solve it is where

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the innovation is taking place and that's in the states. He said two things: I want the Congress to deal with a problem that they uniquely can solve, and that is the blatant discrimination, the undefendable discrimination that occurs between those who buy in the private market and those who buy through their employer.

And secondly, he said I want the Secretary of Health and Human Services to go out and talk to the states, and let's begin to organize a plan at the grassroots level where the solutions will be found, and we can organize a plan, hopefully a plan that will have bipartisan participation in which we can say let's go together and find out a way to do it. We may not do it in Congress but we can do it across the country and we need Congress to cooperate and provide the tools. I believe that this may be a moment in history where that could happen. And at that point a lot of people would be saying let's solve this problem.

TOM ROBERTSON: Mr. Secretary, Tom Robertson with Health Care. How do you address the dilemma that some have articulated that even if there is universal insurance, the assistance is not strong enough to apply to universal access?

SECRETARY MICHAEL LEAVITT: Elaborate a little on that question. I'm not sure.

TOM ROBERTSON: Some say that the health care system is

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simply not comprehensive enough to provide the kind of care that people would need. It never would have been covered. It's a pretty comprehensive question.

SECRETARY MICHAEL LEAVITT: I believe that people are getting care today. As I indicated, I think it's the wrong kind of care in many cases. It's at the wrong place. They're charging the wrong price. But it's because we really do in many ways have a two-tiered system. We have those who have insurance and those who don't, and those who don't end up in a public system where they go to hospitals and wait in line in emergency rooms. We're paying for that care. We're paying for it in a lot of different ways. We're paying for it with inefficiency. We're paying for it with the help that ultimately we're missing. We're also paying for it in cost shifts from private employers into the system, and we're paying about \$30 billion dollars in public dollars going to support it.

Now we have the infrastructure in place and the restructuring of the business model. It's not going to happen overnight. It shouldn't happen overnight. We need public hospitals. We have to have hospitals that are able to cover those who for whatever reason don't have insurance. We've got to transition our way. People are better off with insurance.

I was in New Orleans a couple of weeks ago, and I walked through clinic after clinic after clinic, and I sat down

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with people who were uninsured. And I'd say to them: You've got this clinic. It's nice that you can come here. There's some people who I asked the question: Would you rather have these clinics or would you rather have insurance? And I didn't know the answer, but I suspected the answer. A gentleman said: "You just get treated better when you have insurance." Over and over I heard that message.

It's not only about their self dignity, it's also about having people in a system that begins to help manage the efficiency of the system. I believe we have the basic assets. I believe we have the money that's in the system already. We're paying 16 percent of our entire Gross Domestic Product on health care. It's impossible for me to understand the argument we don't have enough money in the system. And frankly, we're not producing health outcomes that are majorly better than those who pay substantially less. Could it be that our system isn't as efficient as it could be?

GRACE MARIE TURNER: Mr. Secretary, thank you so much for your coming today and for inspiring us about free market ideas for health reform. Grace Marie Turner, Galen Institute. I'm particularly interested in your comments about crowd-outs and the fact that John Matis' [misspelled?] work has shown so much that as you increase access to public coverage that especially to higher income levels that target SCHIP population

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that you crowd out private coverage. And obviously if Congress is thinking about spending \$75 million dollars on expanding SCHIP, you have to ask that question. But I'm interested in talking with the states what's their perspective on SCHIP expansion, because obviously they have to pay part of this bill if it were expanded to just one percent of coverage, and poverty and that may not necessarily add to the bottom line of the uninsured and the insured.

SECRETARY MICHAEL LEAVITT: Let me say I've been a governor and I understand the economics of the state, and it's not at all surprising that some governors view SCHIP as a means of being able to expand the roles of those who are insured. May I suggest to you that for the most part that is not an issue of expanding health care as much as it is a dispute between partners on who's going to pay the most, because I was there when SCHIP was passed (and by the way, SCHIP was passed in a divided government with bipartisan support) with the purpose of helping low income children, but it's now begun to be used, because of the enhanced mash [misspelled?] to cover other populations.

But again it comes down to how we're going to organize the vast majority of our system. We clearly have a system and continue to need a system where those who are needy have the capacity to get insurance, but the strategy I've laid out today

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says that as a compassionate nation we assure that if you are needy, if you are disabled or you're elderly, or if you're low income you have help and you have coverage. Everyone else needs to have access to the marketplace that will provide them with choices that will continue to drive costs down and quality up.

I might add that that's a phrase we ought to spend some time talking about, and I hope someone will ask me a little later in this conversation about the cost issues, because just having everyone have insurance is not going to solve the cost problem. We need to reflect market realities and create a system of competition based on value and transparency in the broad construct of our system, not just in access to health insurance.

BRUCE SMITH: Bruce Smith, George Mason University. We heard this morning, Mr. Secretary, in Part D only seven percent of those costs are covered by premiums—80 percent by the government. Now if as you suggested, and I think it would be a good idea to try to use Medicaid as a basis for getting states to offer universal coverage, but is there enough resources there to do it? I mean if you're going to subsidize things people will be glad to have insurance, but what part of the insurance bill could be paid by the people in the form of premiums if you did have a more universal type coverage, and

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how much would you have to subsidize, and how much could we afford to subsidize?

SECRETARY MICHAEL LEAVITT: Let me acknowledge that every state will be slightly different, but when you begin to model each state as we have done, you say to them let's start with the tools you already have and then let's add three new tools that you don't have. The one would be solving this tax dilemma because once you've solved the tax dilemma and you take the dollars that are currently going to people who are buying insurance through an employer and allow those who don't have insurance to have the same benefit, no matter how you go about it, you put dollars into the hands of a health insurance purchaser. And that goes a long way to close this affordability gap, a long way.

The second tool would be what I referred to earlier as affordable choice grants where I believe it is not unreasonable for us as a nation and as a country to help the states close the affordability gap for the very needy. And lastly, there are a lot of states that are already spending billions of dollars to support hospitals, and they need to continue to support those hospitals, but one must ask the question: Isn't it reasonable to use at least a portion of that money that is perpetually being used to pay for the uninsured to buy at least some people a private health insurance policy? Now, not all of

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them. Not all at once. But doesn't it make sense as an ongoing strategy? Now, you start taking the tools they already have and you add those four tools, I believe every state can find a way if they can find a plan. They find a basic plan, create or select a solution for pooling, create a path of affordability, every state in this country in a relatively short time could enact this.

There's absolutely nothing unprecedented about this happening. Think about car insurance. There is no federal law about people having car insurance but in every state in America we have a financial responsibility law as well as a mandatory insurance law, and it happened because the states wanted to solve a problem. They all solved it slightly differently, but they solved it. And we have a network today that provides that benefit. The same thing can happen with the states. The finances are there.

JOHN GRAHAM: Thank you sir. John Graham from the Research Institute in California. The president has a goal of portability and that's one goal of the tax reform. If you allow the states or encourage the states to go off in all different directions with respect to organizing the private insurance market, Americans also like to move across state lines, so is there not a risk of having more friction in the individual American moving from one state to another, out of

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the commonwealth [misspelled?] connector and into Governor Schwarzenegger's connector when he moves from Boston to Las Angeles? How do we manage that scenario?

SECRETARY MICHAEL LEAVITT: Well I'm going challenge you to think a little differently here, all of you. I mentioned the fact that I thought the national system of insurance in the future would look more like a 21st century network of PCs than it will 50 mainframes. One of the things that might ultimately need to happen is to have some kind of interstate pooling of risk where by agreement people can not only pool risk but also begin to share portability. The virtue of that is that through the laboratories of democracy we learn.

The complexities of health care are legion and they are absolute. If we divide this problem in a way that will allow innovation and experimentation we'll find ways to solve it and we'll continually get better. That is the uniquely American way. That's what distinguishes our economy from virtually any other economy in the world, and yet we have failed to use that very simple philosophy in our health care system. Government needs to be an organizer of free markets and allow them to work, and when they do it can work in health care. We have seen it over and over again. People simply don't have access to information that allows them to make judgments on quality and cost.

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I'm continuing to tempt you to ask me about the cost question. [Laughter]

JILL WEXLER: Jill Wexler with the Managed Health Care Executive Magazine. This isn't exactly on costs, but more related to the previous questions. Some of the basic state coverage plans that you sort of described seem to have caps that might limit how much coverage a person would get, and I'm wondering what happens to individuals who have very high health care costs in a particular year? Would an appropriate role for the government be to provide some kind of catastrophic fallback coverage for high cost peak [misspelled?] individuals?

SECRETARY MICHAEL LEAVITT: Yes. A number of states that I have talked with have thought about that as an alternative. It's clear that some of the plans that I've looked at that have low limit of liability they will cover the basic needs for 99 percent of the population. The one percent, however, will produce 25 percent of the cost. And so in the same way that we have to have some way to pay for uncompensated care, we need to have a way to cover the underinsured. The important thing is that we get them into a system.

May I say, I don't think we have a health care system in America. What we have is a large, robust, rapidly growing health care sector. There is nothing about our sector that qualifies it for a system. It is not connected. It is

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completely diffuse, and I continue to invite someone to ask me about cost. [Laughter]

LAURA TRUMAN: Laura Truman with the Coalition for Affordable Health Coverage. One of the arguments made by people who are now in leadership roles in Congress, which has certain political appeal, is we just should offer people the kind of coverage that we have offered to us as members of Congress. Everybody should be able to have that kind of coverage. And so I wanted to hear your response and thoughts on that.

SECRETARY MICHAEL LEAVITT: My belief is that we go back to the question: Is there more virtue in having 1,000 people with a basic affordable policy than 500 who have what Congress has and 500 who have nothing? Would I like everybody to have that Congressional card? Yes, but let's not forget that one side says insurance and the other side says credit. Because ultimately the vast majority of the charges that go on that card go onto the credit of our future generations. This is about bringing a sense of balance, and one of the virtues of having a network the way I've described it is that the states have to wrestle with that dilemma and balance affordability with benefit. Now that does not preclude anyone from having more benefit if they want it. But having a basic plan for everyone would be a vast step forward, not just in the

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individual lives of those who lack having it, but it would be a major step forward in the context of a system of health care.

CHRIS: Secretary Leavitt, there are many more questions, but if I could interrupt with one of my own. I wonder—do you have any thoughts about the issue of costs?

[Laughter]

SECRETARY MICHAEL LEAVITT: Yes as a matter of fact I do. May I just say that we have a two part dilemma that is evident to all of you. One is that every American needs access to a basic insurance policy at a cost that's affordable. But we also have to access. It isn't enough to just have access to health insurance. We've got to be in a system that begins to create competition based on value. Now there are some who say competition doesn't work in health care. That is not true. We have seen it in Part D. We've seen it in many other areas. What we lack is the capacity for that information to be available.

I mentioned to you I've just become a grandfather. I had a birthday. I am not 56 years old, and I was reminded on my birthday that I needed to have one of those over-50 tests. I'm talking about a colonoscopy here. Now I want to just share with you my personal experience because [laughter] I think it illustrates in a very real way what the system looks like today and what a system of competition based on value ought to look

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like.

I had one of these over-50 tests when I turned 50. I gave them my insurance card and sat back to sort of endure the experience. That's all I can tell you about it. It all turned out okay. When I turned 56 and decided to get another one I said I'm just adding a little field trip on this. I'm going to call up and ask people when can you see me, and how much will this cost?

I called two places here in Washington, DC. Both places said to me: "I'm sorry we can't tell you." Well, that was unsatisfying to me [laughter] and so I called a couple of doctors at HHS and I said: "Let's do a little field trip on this and help me design, if you will, what you call in the business an "episode of care". That's a little bid spec on my colonoscopy. So I called back the doctors' offices and we went through each item. It really wasn't that hard. And it turned out that the first one was \$6,500. The second one was \$5,500. Now I have to tell you I was absolutely blown away by what they told me. I had no idea how much it cost, which of course demonstrates one of the real flaws in our system today. Nobody has a clue how much health care costs. And they have no way of finding out.

Well, I went home to my wife. By the way, I bought one of those health savings accounts. I have a serious interest in

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this now. I said to Jackie she needs to get one too. We're talking about two times \$5 or \$6,000. We're talking about serious money here. I said: "Maybe when we go home to Utah to see the kids, maybe they do them cheaper out there."

[Laughter] So I called up and sure enough went through my little episode of care. It was about \$3,000 out there. That's important, but then fascinating things started to happen. I started wondering. I wondered if there's some difference between the \$6,000 one and the \$3,000 one. You never want to cut any corners when you're talking colonoscopy. [Laughter]

Well, it occurred to me I was doing exactly what we don't want to happen in our health care sector or in our health care system. I was comparing quality with cost. In absence of any information about the quality of that procedure I was assuming the most expensive was the best. We all know that's not true.

I thought to myself that is a great example of what's wrong with the system. Wouldn't it have been a lot better if instead of having to design my own little episode of care if there were some standard episodes of care that every consumer could use and understand what the cost of that procedure I should expect? Wouldn't it be a lot better if rather than have to guess between the \$3,000 and the \$6,000 version that there was some kind of independent evaluation of the quality? So

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when I find out they're the same I'd be making a consumer choice.

Wouldn't it be a lot better if I didn't have to call around and make all these sort of embarrassing phone calls to figure this out? Now what I'm describing to you is good old fashioned competition, and what I'm providing you a vision of, I hope, is a system of competition based on value.

Now let me just tell you there are four things we have to do to get there. The first is we've got to have electronically connected medical records. You've heard a lot about it. I'm not going to go beyond that but it's clear that you can't go from a sector to a system without connecting them electronically.

The second: There's got to be some broadly accepted universally agreed upon standards that the medical community themselves have devised on what constitutes good health care.

Third: There's got to be episodes of care that have been defined so people know what goes into health care.

And lastly, the incentives have got to be right. Everyone in the system—everyone—has to have an incentive to provide high quality, low cost care including the consumer and the provider and the payer—everyone. It's a system of competition based on value.

And we don't have the time but I would love to tell you

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about what we've doing to create electronic medical records, what we're doing to define standards of quality, to define episodes of care. You've seen what's happening in Congress and other places with payers as we begin to wrestle with how to create the right incentives.

I believe based on what we're doing, within two years you'll begin to see fragments of this system of competition based on value. I think in five years the word "value" is going to be a regular part of the medical lexicon in this country. I think in 10 years this is the way the system will work, and when it does we'll look back on the last decade as a remarkably transformative event when we got better health and lower costs for all Americans. Thank you.

CHRIS: Secretary Leavitt, thank you for coming over this afternoon and for your terrific and very impressive presentation.

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