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**The Expanding Costs of Health Care  
Center for American Progress Action Fund  
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**JEANNE LAMBREW, PH.D.:** Hello everybody. My name is Jeanne Lambrew. I am a senior fellow here at The Center for American Progress Action Fund and I welcome you all to this excellent event we have here this morning.

The event we have is entitled, The Expanding Costs of Health Care, which is intended to shed some light on what has been a critical problem in the U.S. We all know that the cost of health care is rising and is a severe risk to our economy. As the Federal Reserve Board Chair Ben Bernake recently said, "improving the performance of our health care system is without doubt, one of the most important challenges facing our nation."

There is a common agreement across the political spectrum that the health reform can improve the value in our system and we need to figure out how this is a priority. That said, we really have had more rhetoric than policy discussions and need to begin to dig into these differences.

I will note that tomorrow, colleagues of mine here at the Center for American Progress Action Fund, will be releasing a paper on the differences between the proposals on cost containment.

But, today, we are thrilled to have a superb panel to elucidate these issues. Among the three discussants we have on our stage today, we have two law degrees, two business degrees, and each one of them has at least one degree from Harvard. So,

they will help us figure out how we get into this health care cost crisis.

But, first let me introduce our moderator. We are thrilled to have Karen Tumulty. Karen is the National Political Correspondent for *Time* magazine since the year 2001 and prior to that, she worked for *Time* as their Congressional Correspondent. She has written or co-written more than 30 cover articles for *Time* magazine and has recently been following the candidates around the campaign trail.

She also has become a blogger, contributing to the Swamp Land political blog which has really taken off as a primary source of information on what is going on, on a day-to-day basis on the campaign. So, I will turn to Karen to introduce our panelists and thank you all for coming.

**KAREN TUMULTY:** Thank you Jeanne. I am really thrilled to be here today too with these two people, talking about health care costs which of course are such an enormous issue affecting not only society and people's lives but also one of the main drivers now in corporate America and in the federal budget. If health care costs continue to grow as fast as they are, it will not be too long. I think the estimates are something like 2050 before health care costs alone are taking up as big a share of the GDP as the federal budget does now.

So, here today, we have two experts on this issue who have advocated different approaches. On my left is Al Hubbard,

who was one of the architects of the plan that President Bush put forward last year that has been pretty much embraced almost in total by John McCain this year. He was Assistant to the President for Economic Policy and Director of the National Economic Council from January 2005 until December of last year. And before that, was Deputy Chief of Staff from '90 to '92. That is wrong.

**MALE SPEAKER:** That was with Bush 41.

**KAREN TUMULTY:** Okay, Bush 41. Okay, great. -to the Vice President of the United States and has served on a number of for-profit and non-profit boards including Well Point.

On my right is Jack Lew, former ONB Director in the Clinton years but somebody who I first got to know back in the day when he and I were both a lot younger and he was working on Capital Hill as Tip O'Neil's top policy aide. He was one of the architects of the Bipartisan Balance Budget Act of 1997 and the creation of AmeriCorps. So, I think we are going to have a very lively discussion here today.

Here is the way the format is going to work and I hope somebody is going to give me a high sign as we run into time issues. Al is first going to talk for seven minutes and Jack then will follow with another seven minutes and then we are going to have hopefully a good discussion between the two of them for about twenty minutes at which point we are going to

open up the discussion to your questions. So, I think I should get right to it and turn to Al.

**AL HUBBARD:** Thanks Karen. And thanks for the opportunity to be here. Thanks for sponsoring this. I consider health care to be truly are number one domestic issue and obviously if you ask the public today, they will say energy prices are the number one issue. But, I think the energy challenge is actually going to be easier to deal with than health care.

When you poll the American people, if you look over the last five years, when energy prices have not spiked, health care is always right at the top, one or two in terms of the biggest domestic problem that people see in the United States.

There are really two big problems in health care. One is cost and we all know that. It's amazing, 19 years ago, 1989, the cost of family provided health care in today's dollars was \$3,600, \$3,600 in today's dollars provided by an employer. Today, it is over \$12,000. So, we go from 3,600 to 12,000 and by the way, as we all know, employees contribute and their contribution has grown at the same rate or a little bit faster than it has for the employer. It is just at a non-sustainable rate as Karen said.

Of course the other big problem is access. We talk about the 45 million and the 50 million, the 47.5 million uninsured and why do we have the 47.5 uninsured? There are a

number of reasons. I am sure we will probably get into it some more. Although, I think the focus is supposed to be on cost. But, the reason people do not buy insurance is one, it costs too much. Number two, they are "uninsurable". They have a health care problem that is chronic and so it is a predictably high cost and they have trouble getting insurance or they cannot get insurance.

Three, there are the bullet-proof crowd; the 30-year-old's who think they are never going to get sick. And again, I am sure I am leaving out a group, but there are those who are just ignorant of what is available. There are 10 to 15 million who are actually eligible for some government program but have not signed up for it.

Fundamentally, the biggest problem facing the country is the cost. And that is why most people are very concerned about health care, it is the cost and that fear of losing their employer provided insurance and not being able to get affordable insurance outside of the employer network.

So, why are costs out of control? Some people suggest it is technology. Some people suggest it is demographics. I happen to believe that overwhelmingly, it is the third party pay system. And I would like to illustrate to you why and I think most economists would agree with this. When a third party pays for a service or product, we consume it as if it

were free. We never ask what the price is and we over consume because we consume it as if it were free.

When is the last time you asked your doctor what it was going to cost? When is the last time you actually shopped before you consumed health care? Like you shop before you consume other things. When is the last time you asked the hospital what it was going to cost? We do not do that. And by the way, the health care system is not set up to provide that kind of information and the reason they are not set up to provide that kind of information is because we do not demand that kind of information. Suppliers do provide what we demand and we do not demand that.

It is interesting, if you would think about, if employers, rather than providing health insurance, provided food insurance. So, every time you go to the grocery store, you just take out your food insurance card and you give it to the cashier and she scans it and you are out of there. Pretty soon, you would start buying caviar, the most expensive steak, and you would start buying more than you needed.

Also pretty soon the supermarket would discover that you did not really care about price. So, the supermarket would remove price because it really does not affect your decision about what to buy and what not to buy. And if I am the supermarket operator, I am going to raise the price because you do not care what the price is. And guess what happens? All of

the sudden the employer that has estimated you are going to spend X dollars a month, you are spending X times 1.1, X times 1.2, X times 2, X times 3. And that employer is going to say to the insurance company, you have got to get this under control.

So, the insurance company is then going to tell you, you cannot buy caviar but once a month. Then, you are going to come back and say that is very unfair you insurance company, you are a bad person or you are a bad entity. Then the insurance company is going to tell you because it is responding to the employer, you can only go to X supermarket, not Y supermarket. And you will have the same dynamic in the grocery business as you do today in the health care business; it will be broken. And that is what we find today in the health care business.

Well, you do not have third party pay in the health care business, Lasik surgery, in vitro fertilization, plastic surgery, where people actually pay for it out of pocket, the marketplace works. The cost of Lasik surgery has dropped from \$2,500 to less than \$1,000 an eye over the last 15 years. Had that been an insured item, it would probably cost 5 or \$6,000 today.

In vitro fertilization has become much less expensive and now you are offered in vitro fertilization, if it does not work, you get your money back. That was not true twenty years

ago when I had my twins through in vitro fertilization. So, the marketplace can work if we allow it to work. And we are at a tipping point.

We are going to go one of two ways; the American people are not going to accept the current broken system. The quality of our health care, when you get it, is very, very good. That is why people come from all over the world to get it. But, the cost and the access is broken and it has got to be fixed and we are going to one of two ways.

We are either going to go a government system like exists in Canada and Great Britain and France and the results of that will be price controls and rationing. Or, we are going to a more consumer-directed health care system where people do have a vested interest in what the cost is so they do shop where we basically harness the marketplace to drive down costs in prices. The— hold on, let me just check my notes here. Sorry. I hope I am not taking too much time.

For the uninsurable, they are going to need to be handled separately. What you are basically doing is insuring a house that is already on fire. You cannot expect insurance companies to step up to that. If they are forced to then they have got to raise rates on everyone else. My suggestion is, I am sure we will explore it more, is that the uninsurable, the people with chronic illnesses, predictably high cost, need access to insurance and the question is, how should that be

handled? And I think it should be handled outside the conventional insurance system.

Then, there is the uninsured, the people who cannot afford it and that is why Senator McCain has proposed, which is similar to what Karen pointed out, that President Bush proposed, a tax credit, a \$5,000 tax credit to make insurance affordable for people to buy family coverage. What he has also proposed is additional funding to the states to provide additional monies for whom that \$5,000 is not adequate.

In closing, let me just point out this recent debate about this Medicare bill that was just passed, vetoed and then the veto was overridden. I think that that is a great illustration of what will happen if we have a government-provided health care system. We now have a government-provided health care system for people who are over 65.

There were two big issues in that debate I would like to mention. One was the only way Congress could figure out how to keep Medicare costs under control, Jack knows more about this than I do, but they have a five year budget. So, they said next year we are going to cut physician fees and the year after we are going to cut them even more and that is a way to keep Medicare costs in line. Well then, when you have to pay the Piper and actually cut physician fees, nobody wants to cut physician fees.

So, that was the big debate, how do we not cut physician fees but that is what Congress will end up doing if they control all of health care, they will be deciding how much doctors, hospitals, and other providers get reimbursed. The other interesting little, and Secretary Leavitt wrote an op-ed in I think the *Wall Street Journal* or *New York Times* about this, there was another provision that was passed in '03 that made durable medical services subject to bidding, just like where people shop. So, Medicare was supposed to shop it to find the lowest quality provider.

And they did that in 10 different communities as a pilot program and it was time to take it national. By the way, doing it in these pilot programs, the average savings to the federal government was 26-percent. Well, now that they were going to take it national, guess what happened? All of these providers of the durable services started lobbying intensely Congress not to allow the law to take place.

Because what was going to happen is their reimbursements were going to drop. They were going to be subject to the marketplace just like your phone system is and just like the supermarket is and just like housing is and they did not want that. They wanted the higher reimbursements that Medicare was currently providing. And guess what Congress did? Congress caved and they gave in and those providers are going

to continue to get the 26-percent excess that they have been getting in the past.

Secretary Leavitt gave an example of this oxygen service that you can purchase for \$600 and the government, over three years, pays over \$7,000 for that oxygen service. And of course that oxygen service provider, if I were that provider, I would be lobbying Congress to not do that and that is just an example of the kind of problems we are going to have if the government takes over health care. Thank you.

**KAREN TUMULTY:** Jack?

**JACOB LEW:** Thank you Karen and I want to join in thanking the Center for American Progress for hosting this conversation. I think that in order to address a large problem, all sides have to begin by defining the problem and I think this is a contribution in that effort and I am delighting to be appearing with Al on this panel.

I think if you look at where we are in health care today, it would be a mistake to start and say the whole system is broken. As Al said, if you have access to health care in the United States, you have access to the best health care in the world. So, something is working very right in our health care system.

But, at a time when we have 47 million people who do not have proper access because they are uninsured and with costs rising as we have already discussed in an unsustainable

and an uncontrollable way, the status quo is just not going to be acceptable.

If you peel the onion a little bit and look underneath what the escalation of medical costs means for the private sector and for government, it is easy to find it a scary problem. Health costs have been rising four times the rate of wages. There is less and less room in an annual adjustment for wage increases because health care costs are just filling the space that is available for all incremental spending. That has a real impact on employers in terms of their expenses.

It has a real impact on workers in terms of how much they are taking home and how much they have available for all other purposes. The notion, as Karen mentioned in introducing the topic, that if we let the current trends continue, the health care spending by government alone will be equal to the total size of the federal government today is just an astounding fact. The government is roughly plus or minus 20-percent of the economy right now and that is what health care is projected to be if it continues to rise at 2.5-percent above inflation between now and 2050.

In contrast, if it were to grow at the rate of the overall economy, it would be 7-percent, 13-percent of GDP is enormous. If you think of the size of government as 20-percent of GDP and the difference between health care growing at inflation or 2.5 points faster than inflation as being 13-

percent, that just means there is nothing available for anything else. There is nothing available for education. There is nothing available for social security; there is nothing available for defense.

Now, that is obviously not an option. So, government would have to grow in order to pay all those bills to a point where I think we would have some pushback that that is not the size of government that Americans think they ought to have. I think that is one of the reasons we are having this conversation today. There has to be some action taken to step in.

The challenge when you look at health care from a public perspective is very different than with most government activities. If you were to give Al and me the assignment to solve the social security financing problem, we could go into a room, close the door, and if we put ideology outside, we could come out with a plan. We all know what the knobs and levers are. We all know what the choices are and we all know the consequences of the decisions you make.

The same is true in many other areas. If you decide to spend money on defense, you spend the money. If you decide not to, you do not. Health care is a little bit different. It is a lot different. It is an entire system out there and the government's role in health care is only a small part of the

overall economy, small is perhaps an understatement. It is about a little less than half of the overall health economy.

If you look at the rate of growth of government spending on health care and the rate of growth of private spending on health care, they are about the same. So, as someone who comes into the health care discussion thinking heavily about what it means in terms of public finance, I think it is first of all, a mistake to think about the public involvement in health care policy as principally being, we have to control Medicare and Medicaid spending because the budget is out of control.

The only way to control Medicare and Medicaid spending in a world where health care costs are generally rising at a faster rate is to reduce the amount of services we provide, reduce the number of people covered, reduce what we provide for those people. One can take different views of this but I would argue that it is just wrong at a time when health care costs are out of control, to say that it is a solution is to take the elderly and the disabled and reduce their basket of health care services to deal with the public finance problem.

So, what does that say? It does not say you can ignore it. It is just not an option to ignore it. But, you have to take a step back and say what do we do about the overall health economy because the only way to address the public side of

health care costs, is really to address the underlying problems in the health care economy overall.

If it were easy to sit down and say we have a white piece of paper, this is the system that would work for the United States; the problem would have been solved a long time ago. The problem is we do not have a system that anyone ever sat down and designed. Why do we have employer-based coverage? We have employer-based coverage because during World War II there were wage and price controls and employers wanted to give people raises and they gave them benefits of health insurance instead of wages to keep employers at a time when the labor market was tight.

No one sat down and said let us make a health care policy. Why do we cover children more than we cover other people? Because they are a politically sympathetic group. It is easier to pass a state child health insurance program than it is to extend health insurance to 50-year old, 30-year old apparently able bodied people who do not have health insurance. So, the political process, the economic process made a series of decisions over the year that leave us where we are.

I think when you look at the solutions; I take a different view than Al does. I think a pure market solution is not likely to work. If you look at the structure of how the healthcare economy works, very large players in the health care economy, Fortune 500 companies, governments, have a horribly

difficult time negotiating with health insurers and health providers to get packages with the defined benefits that are desired at a price that is affordable with access that is guaranteed. It is very difficult.

The leverage in this system is heavily weighted towards the insurance companies. The economics of the insurance industry are overwhelmingly defined by a desire to shed risk, to avoid insuring those who are going to be most costly. I do not usually cite USA Today as a source document, but if you pick up the cover of the USA Today this morning, below the fold, there is a story that I think kind of encapsulates what the challenge is.

A family that's self-insured, going out in the private market, a child is below the normal height limit, the fear is it is glandular disease, they're denied coverage, they appeal, they finally win the appeal, the period for appeal is told they still cannot get coverage. That is the bind that individuals find themselves in in the current market place.

I think we have to look at the options and say what will work, what will not work? I do not think pure unfettered competition will work. There needs to be a kind of pooling that does a number of things.

First, it has to pool risk and I think there is always going to be a role for public subsidies for those who are most uninsurable, for those who are most in need of help. But, there

is a large group that is between uninsurable and able bodied, healthy, safe to insure who without some kind of large, mandatory pooling, will have a problem in the free marketplace because insurance companies are always going to look for the people who will use less, not more health care.

There are a variety of ways to create those kinds of pools but unless we have those kinds of broad risk-sharing arrangements, I do not think we are going to materially close the gap in coverage. Pools are important also because of the leverage issue that I mentioned a few moments ago.

I do not believe that I, as an individual, will be able to negotiate with an insurance company around the kinds of procedures, the kinds of services that I ought to be entitled to. I need to have somebody who has more market power, more leverage. I have always worked for large employers so I have not personally had that problem.

But, I would be terrified being an individual in the health care marketplace where I did not have the protection that there was a larger buying group that was intervening between the health care industry and my interest because I do not think that individuals will fare well.

Now, I think there a number of things that I think it is easy to agree on. The current system, because of the kind of atomized way it was created, has a terrible information sharing and terrible access to the data that you need to make market

decisions and that you need to make good health care decisions. We have not invested, as a country, in the kinds of technology that would make it possible to go to a doctor in one city and then a doctor in another city and pull up your medical record so you do not have to do the whole workup all over again.

How many of us have been through the same screening procedures when we know the results because we just did it but they have no way of accessing the records. That is not good health policy, it is not good economic policy, but it is also not an easy problem to solve.

In a fragmented system where health care providers do not talk to each other and insurers do not talk to each other, one has to build a network that is expensive. I have had experience in a health care system that involved several hospitals, even in your own health care system, to make it possible to read x-rays across three different institutions that grew up with different IT platforms is really hard and it is really expensive and it is not going to happen without some public drive and support.

I think that we have the ability through Medicare to start to drive some that, even in anticipation of a broader health care debate but it is desperately needed because without that kind of information sharing, we will not be able to get the kinds of savings that are needed. In terms of the way we consume health care, I agree with part of the point that Al

made about third party payers, I think there is a certain insensitivity to price.

What I disagree about is comparing price sensitivity on elective procedures to price sensitivity on matters of life and death. If you are told that you are going to die unless you have a triple bypass operation, that is very different than if you are choosing whether or not to have Lasik surgery because you are tired of wearing glasses.

And I do not believe that individuals are particularly well-equipped to make the decision on their own to decide, do I need triple bypass surgery. We all go to the web and do research and we aggravate our doctors by coming in knowing more than individuals could know 10 years ago. But, fundamentally, we rely on expertise and we rely on a system that serves some people better than others.

The Institute of Medicine statistics show that there is an unbelievably large number of deaths each year because of bad medical care. So, it is not the case that everyone is getting the best medical care. I think the system is not set up right now so that providers and patients have easy access to best practice information.

If we had a system that had been centrally designed, you would have that. We do not. We have information residing in all kinds of different places. Look at the Medicare system. Payment rates on Medicare vary greatly from state to state. The

outcome differences do not vary anywhere near as widely as the spending.

So, there is obviously something that can be done there if we manage the system better to reduce expenses and I would argue, improve both outcomes and treatment. I would never choose to have an unnecessary procedure because best practices told me it was 90-percent likely that it was unnecessary. I do not think most people would. People take the advice of doctors and if they had access to a system that could tell them when that advice was good advice and when it was bad advice, they would make better decisions but I do not think that they can do so well as individuals.

If there were a pooled kind of coverage where those signals were sent by the system, where reimbursement patterns reflected the quality of outcomes, the system would naturally work to do that. I think that if you look at the question of coverage, the last thing I wanted to talk about was this critical question of the 37 million uninsured, I think you have to look— 47 million uninsured, excuse me, I am going back 10 years.

I think the problem is as much a problem that is central to controlling costs that it is to achieving equity and fairness. The system we have today is highly inefficient. If you are not insured and you cannot go to the doctor for preventive care without out-of-pocket expenses that you cannot

afford, you are going to ultimately present yourself with late stage diabetes, with advanced heart disease, with very expensive conditions that could be avoided if you were provided health care at an appropriate point and given the advice to change your habits, to take the proper therapeutic courses, to avoid both the very bad health outcomes and the very expensive treatments.

So, I think it is not just a matter of fairness and equity. It is, at the same time, a matter of fairness and equity. We spend twice what England and France do on health care and we still have 47 million uninsured. We have the highest per capita health care spending in the world and we have a gap that is just not acceptable. It is going to require some system of support to get some of those people in. The tax credit proposals are a very interesting idea.

I think if you look at the cost of health care, it is not likely that a \$5,000 tax credit is going to make it affordable for a family to buy a \$12,000 insurance policy if they are just barely getting by. So, there is something other than just putting people out in the marketplace that will have to be done. We spend a lot in this country subsidizing health insurance.

The biggest tax expenditure in the federal government is the exclusion of employer-provided health insurance. I am not sitting here today saying that that should be eliminated

but I am saying that we provide enormous support for people to get health insurance. It tends to go disproportionately to people who are at middle and upper income levels because that is who gets employer-provided insurance.

At the very bottom we have Medicaid. In the middle, there are a lot of hard working people. The 47 million people without health insurance, most have someone in the family who is working. It is not the case that most are unemployed. They just cannot afford it. And I do not think we are going to get to a place where the health care system can deal with costs in effective manner or have the kind of system that we would be proud of if we do not figure out how to address that problem.

**KAREN TUMULTY:** Well, thank you both very much. And I am just going to probably have time for a couple of questions before we turn it open to the audience. When I was looking at statistics about health care spending, I was really struck by one figure which is that almost half of health care spending is used to treat 5-percent of the population. I mean these are obviously our oldest people, our sickest people, people at the end of life.

Jack, you had said that if you were given accurate information and were to discover that there is only a 10-percent of a chance that a specific procedure would be effective in treating your condition, I think in these kinds of

circumstances, if it is my kid and there is a 10-percent chance, I am going to shoot for the 10-percent chance.

Getting a control of health care costs, is it not eventually going to have to involve some kind of, it not rationing, some kind of power of just telling people no?

**JACOB LEW:** I hope it does not come to that. I do not think it has to come to that. I think that the example you give, it is obviously the most painful kind of issue to think about, what decision do you make for a child. The more typical decisions, what kind of decision do you help a parent make. It is not free to make a decision to pursue the heroic means. It has a lot of implications for the quality of life at the end of life.

We have a system where people should be free to make those decisions and we also ought to have a health care system where people get information where it is not coming in the small slices that it comes now. If you have cancer and you see an oncologist, the oncologist gives you advice about how to kill the cancer cells. The oncologist does not often tell you that the result of the most aggressive treatment may leave you with a quality of life that you would not have chosen.

So, I am not saying that people should be told that they cannot pursue heroic means and I am not saying that I would not pursue heroic means if I thought the outcome were justified. But, I think there are a lot of cases where heroic

decisions were made where if people knew what they were choosing, they might not have made that choice. If it was spending whatever the rest of whatever remains of life on a respirator, some people would choose that, some people would not. And that is where your information comes in. That is not the kind of decisions that is easy for an individual to make and all of us have experienced, this is like education.

We all have real life experience with education. We all have real life experience with health care. I do not believe that there ought to be a system that flat says you cannot pursue the heroic strategies. I also do not think we are going to get away from a world where the predominant expenses come from those with serious illness. It does not cost that much to treat healthy people.

**KAREN TUMULTY:** Excuse me, is this an efficiency in the system? What if it is more mundane, that additional cat scan or that addition—

**Al HUBBARD:** Well, you raised a couple of issues which I think are interesting. One is, are we not eventually going to have to ration care? And by the way, I cannot remember what the procedure was but I was told recently about an 84-year-old gentleman in Switzerland which has government-provided health care and he was above the age they provided for the procedure that he needed. And so, he came to the U.S. to get that procedure.

Unfortunately, I think if we move to a government system, that will eventually happen because the budgetary requirements will force Congress to finally say if you are over a certain age, you cannot get a certain procedure and I think that would be a very sad situation. I happen to believe, and by the way, this is just me talking, I think the costs of health care are much, much higher than they would be if we had a market system working.

If you ever look at a hospital bill and see what they charge for different things like Aspirin, things that we know they cost or even for a room, what they are charging and what doctor's charge, I think there is a price umbrella there and it is because we have had this third party pay system. By the way, I happen to disagree with Jack; I think insurance companies do not have the leverage. I think the leverage is with the providers and insurance companies are intermediaries.

They take about 17-percent for profit in administration and all they are doing is trying to keep both sides happy. The best way to drive down costs, if Laski surgery had been insured, provided by your insurance company, I guarantee you the cost would have increased from \$2,500. We would probably be paying 4 or \$5,000 for it.

But, because we have millions of consumers out there, that are driving the price down, the price has dropped. By the way, we are never going to have a perfect system in health care

because you have the catastrophic and we are never going to be afford heart transplant or quadruple bypass surgery or these more expensive so the market is never going to be, get it totally away from a third party payer, you are going to have to have insurance for catastrophic events.

But, the idea that we have insurance for the anticipated event like a routine dental visit or a checkup or to go buy glasses, all that means is that it is being, and it is because of our tax system that we do this, but the result is we do not shop for it and so we are not driving down price. I happen to believe that and I do not think we will be successful but if we could ever harness the marketplace, the cost of our health care would drop I think in half. I literally think that the average cost of an individual procedure would drop in half if there were true competition out there.

Just to respond to Jack about the, if you need bypass surgery or whatever, there is no question. With emergency care, you are not going to shop. But, if it is not an emergency, there is no reason why you should not shop and cannot shop and that is what we want to encourage. The health care industry should be subject to the same market forces that the rest of our society is. And what is amazing is, the rest of society, and you pick out whether it is services or products, we drive down the cost and it that is what raises our standard of living.

But, in health care, which unfortunately represents now one-sixth of the economy, we do not do that. The costs keep going up year after year after year. And there are two ways of dealing with it. Either we use price, the government sets prices, or we have got to harness the marketplace.

**KAREN TUMULTY:** The other question I wanted to ask is one thing that I do not think either of you really touched on, was that an inordinately big driver of health care cost in general is the cost of prescription drugs which is going up faster even than health care costs are. Our companies, they lead the world in research. We are grateful. Probably there is nobody in this room who has not had access to some drug that was not around 20 years ago but made a big difference in their lives.

But, a lot of that money goes to things like marketing as well. Does something need to be done with prescription drug prices and how can you harness those forces in that arena?

**AL HUBBARD:** That is a tough question. Because the problem is, a successful new drug is just— we have new drugs that are phenomenal. When I was growing up and you had a stomach ulcer, you had your stomach removed. Today, you take a drug. You think about the savings in cost and aggravation and deaths etcetera from operations and we have statins, the cholesterol drugs have dramatically reduced heart disease.

So, the last thing in the world we want to do is take away the incentive for creating new drugs and at the same time, I would agree with you that there is a big problem, that new prescription drugs are, in many cases, not affordable. And, to be perfectly honest, I do not know what the answer is.

One problem is that the drug companies can set the price of a brand new drug and assume it is going to be reimbursed. So, as opposed to assuming that people are going to look at that price and say but there is this other one that is almost as good or maybe as good and it costs less. Again, because there is the third party pay, people say, well I want the latest and the greatest where, with other things in society, we do not say we want the latest and greatest.

The other things that we have learned, by the way, and this feeds into your whole marketing point, is that often the drug that has been around is every bit as effective as the brand new drug. We do not have good information about the effectiveness. It is a very difficult— the worst thing we could do though is kill the drug industry where they do not have the incentive to innovate and come up with new drugs.

Hopefully, as they come up with new drugs, that is going to eliminate the need for the operations, it is going to deal with the cancer problems that we have. And the opportunities are just enormous. I wish I could give you a better answer. Jack, what is the answer?

**JACOB LEW:** Well, look, I think we again agree that you do not want to undermine the research and the drug industry that is producing the breakthroughs which will make the problem you described worse. Now, drugs are at 10-percent of the health care bill. It is going to grow as a percentage. Drugs and technology are growing faster than everything else. So, it is a very real cost issue.

I guess I think a few things. First of all, I think the advertising issue you make is one that it makes for good political fodder but it is also a real issue. They spend more money on advertising than they do on research. So, we would do nothing in terms of the pure research if we did not do the advertising. Obviously, without the advertising, you would not have as much profit in a lot of these drugs.

So, I do not think you will ever see the advertising dial down to zero. I think some reasonable bounds on the advertising need to be achieved. As a matter of health policy, I do not think it is a good thing for people to go to their doctor and say I want that drug that had the rainbow and the sunshine on TV. That is not the way we ought to be making health care decisions and that is a lot of what the advertising money is going to, is the TV advertising at consumers, not the informational advertising at doctors.

So, I think there is actually a health care policy issue. Most doctors have a hard time saying no to a patient

who says I saw it on TV. It is going to help me. That is just not a good way to practice medicine. I would not want a heavy hand saying no advertising because I think a lot of doctors and providers learn a lot from the advertising. It is just so much information out there that if you were to eliminate all advertising, that would be a bad thing. There is a mid-point where there is substantial resources that could be saved.

I think there is also policies and practices. As mentioned the statins and they are similar but they are not identical. There ought to be a better way of knowing which drug is best for an individual. It ought not to be that it is always the most expensive one. It ought to be the one, given your biochemical characteristics, which is the best drug? I think you might eliminate a lot of the latest and greatest use if you had a system where people could really rely on the fact that the one that is a dollar is more effective for you than the one that is \$10.

I think there is also practices where you read in the paper, I am not an expert on this, I am out of touch of the current policy debate, but you start by reading the newspaper that companies with drugs whose patents are about to expire are getting very aggressive about trying to keep generics out of the marketplace. I worry a lot about that because we have patent term protection that is long; it gives a drug maker every incentive in the world to have a breakthrough. We ought

not to be allowing that to be extended by kinds of predatory or collusive practices which I think there is some of out there.

You boil it all down, it is a really hard problem because there will be new drugs. They will address health conditions where we will want the drug to be used and at least in its early life, those drugs will be expensive. I think all the things that we are talking about will help but it is not going to change the direction. Drugs are going to be a growing share of the health care dollar.

If it works well, it will reduce other expenses. It will reduce hospitalizations, it will reduce some of those end of life long expensive treatments. But, it is something that good minds are going to have to look at in a non-ideological way to address.

**KAREN TUMULTY:** Well, I think this is maybe a good moment to open things up to questions. We have a microphone and if, I guess, identify yourself and let us go right to the front row.

**CAROLYN POPLYN:** Hi, I am Carolyn Poplyn, [misspelled?] I work here, I am a physician. This is a question for Dr. Hubbard, how do you account for the fact that in European countries and in Canada, where there is third party payer, the third party is the government or some government sponsored institution, they get health outcomes that are as good or better than ours at one-third to a half the cost?

**AL HUBBARD:** That is a very good question. The reason the cost is— by the way, let me just step back. We have 47 million who are uninsured but they do have access to health care. By the way, that is one reason the people— one-third of the people earn more than, 15 or 16 million earn more than \$50 thousand a year and could afford insurance but they choose not to when they think they are bullet-proof. And secondly, they know in a worst case, they can go to the emergency room and get taken care of.

In Canada and England and France where the cost is about half what it is here, Germany, they set the prices. They ration care and that is why it costs significantly less than it does here. I think again, if we could introduce more free market forces, we would have a drop in the cost because I think what physicians and hospitals and drug companies and oxygen equipment providers charge would drop dramatically if they were subject to competitive forces.

The interesting thing, I will tell you a little story. I was speaking to a group from Canada when I was in the White House and they would ask about the President's proposals and I sort of made the same pitch that I did to you all, that if we went to a government-provided health care system, we would ration care and I often talked about that it took a year, year and a half to get elective hip replacement surgery in Canada.

And I hesitated and I thought, oh my goodness, it is going to turn the audience against me but I took a chance and I went ahead and said it and someone spoke up and said, "If you are lucky." So, the point is, there is significant rationing of care in these other systems and Americans do not want that and I hope we will not tolerate that.

**CAROLYN POPLYN:** But they are not overrun by people seeking free care.

**AL HUBBARD:** They are not overrun—

**CAROLYN POPLYN:** In other words, people do not demand a lot of care simply because the price is lower negligible.

**AL HUBBARD:** Well, they have to wait in line so that discourages people from using the system. The other thing about our— this is a very complicated factor, a complicated subject and I am no expert at all but I think we have a much more heterogeneous population in lots of respects and that is one reason why our health outcomes are the way they are. But, there is no question they do it for half the cost, they have better outcomes and it is because they set the price and they ration care.

**VIRGINIA RICHARDSON:** I am Virginia Richardson and I Co-Chair of the Montgomery Health Care Action. This is a question for you Mr. Hubbard. Since you feel that the private free market system is going to be the answer to our problems, I

wonder what you have to say about the profit motive in the free market system.

**AL HUBBARD:** I think the profit motive is a beautiful thing. That is what has made our economy the strongest in the world. It has made our standard of living the highest in the world, take away the countries that basically of small populations that produce a lot of oil because the profit motive encourages competition. That is why our cell phone service so much cheaper than it was ten years ago or our HDTV's are now affordable and coming down in price every year. It is a question of do you believe in the free market system and capitalism and I happen to be a huge believer and I think the American economy is an example of why it works.

We had a great example of East Germany and West Germany. East Germany, there was no profit motive and West Germany, there was a profit motive. They both started off with the same population, started off at 1945 and then when the Wall came down in, when was it? '89 or '90, when was it? Somewhere, Bush '41. Then you could see that the standard of living in West Germany where there was a profit motive was about three times higher than the standard of living in East Germany where there was no profit motive.

**VIRGINIA RICHARDSON:** I was really inferring to the healthcare system, the profit [inaudible] within the insurance

industry and the healthcare industry. I am not talking about [inaudible].

**AL HUBBARD:** Well, again, I think you get the same benefits from people competing with one another. The health care system will work just like— the only difference between the health care system and other systems is you have a catastrophic event where you are going to have to have a third party pay. But, for non-catastrophic events where people can afford it, you have the same dynamic. Yes, Jack?

**JACOB LEW:** As much as I do not believe a free market system alone will work, I think we need to have a hybrid system which has heavy market components to it. But, you look at the distribution of physicians in the country, we now have physicians choosing what area to practice in based on compensation rates as opposed to where health needs are. Individuals act on the basis of what is in their best interest and we need to compensate physicians and providers to do what we need done.

I would argue, kind of in response to the prior question, that the closest we have in this country to a single payer system is Medicare. Medicare expenses are rising and roughly the cost of the overall health economy. We do not have a problem that it is exploding faster than everything else. I do not think it is a forgone conclusion that if we had more of a single payer system, the only solution would be rationing.

I do not think the political climate is right for a debate on single payer. I think in some ways it is unfortunate because it would be the cleanest choice between a totally free market and a government program. We have a history in this country of segmented health care that single payer goes up against which is even more overwhelming than the principal of market versus non-market. People like to get care from the kinds of places they get care and there is a fear that if you had a single payer system that would change.

So, I think you work with the world as you find it. But, we ought to preserve market elements where they work effectively and there is the role for government is where markets do not work perfectly and we have a lot of areas of the economy where there is a role for regulation, there is a role for policy to correct for the signals that do not get sent correctly in the market and the inefficiencies of the market. That is why we need to end up with a hybrid system.

**AL HUBBARD:** Let me just reinforce that. I would agree we need a hybrid system. But, just to show you how market forces can work successfully in a hybrid system is the Part D Medicare program, a drug program for seniors where the senior pays 25-percent of the cost to the insurance. This is a shock and I think we were all shocked. But, the cost of the program ended up about 30 or 35-percent less than anticipated because what happened was the government thought CMS, the Center for

Medicare, whatever it is, thought that the average senior would spend \$37 for the insurance per month.

Well, the seniors shopped around, the insurance companies competed with one another to get the business because they were profit motivated and the result was that the average cost was about \$25. So, as opposed to \$37, it was \$25 and by the way, the government paid three times that because the government paid 75-percent of the cost and the individual paid 25-percent. But the government paid a third less than was originally anticipated and it was because it was a hybrid but we allowed market forces and we allowed people or we made it where the system was that people had an incentive to be a wise consumer.

That is what we so desperately need in health care, is for people to be a wise consumer where you have transparency, Jack alluded to that, where we know about price or we know about quality or we know what statin is good for this or that or whether if I have got a cholesterol of 230 do I need the best in the \$10 variety of statin or is the dollar variety of statin okay for me. And then we can be wise consumers. But, right now, we are consumers without the knowledge and without the incentive to be a wise consumer.

**KAREN TUMULTY:** How about this gentleman back here?

**COREY DUCKSON:** My name is Corey Duckson [misspelled?] for Representative Nancy Boyda. Mr. Hubbard, you talked about—

Representative Nancy Boyda. You talked about the price transparency and how that would drop cost. I am sympathetic to that in a normal competitive situation where you have a normal standard kind of needs for competitive markets to work but I am rather skeptic about whether health care is exactly the arena where that would work in the first place.

Because you just mentioned that what you know about price but you do not know about price because you do not know how much something is meant to cost and when you do find it, it is not useful in the future because it is a one shot game. You do not have the same procedure twice often. And then you also kind of talked about well, if we respond to the incentives of price and this will drop the cost.

But, in 2000 when I think it was in New York, they published quality rankings of loads of different hospitals. You would expect on your kind of model, people to therefore gravitate to the best physicians etcetera. They did not, there was very little change. Because it does not seem that people respond to information in health care in the same way as they do kind of in traditional markets.

So, it seems that your whole model does not exactly indicate the way people make a rational decisions that are on the basis of the lower small numbers because somebody referred them to them and said he is quite good, just go to him. So, I am wonder whether you genuinely think that this is a real

competitive situation and do we need to, instead of just applying kind of a traditional economic model that context-specific situation in a more detailed approach than just letter price transparency and let the market sort itself out.

**KAREN TUMULTY:** Actually, if you do not mind though just— are there not some things in health care that have become almost commodities? I mean you go in for a physical and it is the same— you go over and over again and it is the same set of blood tests and EKG's and I think that is why places like Wal-Mart are suddenly offering stuff like that, doc-in-a-box in the store.

**AL HUBBARD:** But, the sad thing is, and MRI's are generally, for example, a commodity. They have been around for 20 years now. But, the variation in price, from \$2,500 to \$500 for an MRI and by the way, there was a recent study that I read about and the \$2500 one did not have the highest quality, it was the \$800 one that had the highest quality. So, the point is, people do not— when is the last time you got an MRI and asked what the price was going to be?

You just do not do it. And by the way, if you ask, probably the person you are talking to, does not even know him or herself. But, to get back to the Part D drug exercise that occurred in the last three years, it shows that when there is— by the way, CMS did a great job of providing the information or making the insurance companies provide the insurance

information so people could understand what they were paying for and what they were going to get.

And they chose less expensive and the insurance companies offered less expensive because the marketplace was driving them to offer less expensive because people were having to buy it, pay 25-percent of the cost on their own, is a great example of how it works. Lasik surgery, again, is another great example of how it works.

So, it does work but you have got to have the information and you have got to have people to have incentive. By the way, if people have incentive, they will insist on getting the information. But today, they do not have the incentive in most situations.

**KAREN TUMULTY:** Right here?

**WENDY SHUFORD:** Wendy Shuford, [misspelled?] retired nurse after 40 years. One of the things that I think has a big impact on cost and I just want you to speak to the— is the gatekeepers of insurance companies that are not educated, they do not know what you are talking about. They ask legitimate questions and the nurse answers and they do not understand the answer. So, we are paying their salaries and then the huge horrendous cost of malpractice fees, I think is obscene.

**KAREN TUMULTY:** How much is malpractice driving—

**AL HUBBARD:** How much are you guys driving up malpractice fees?

**JACOB LEW:** Malpractice is what, 2-percent or so of the total health budget. It is not zero but it is often exaggerated what the impact of malpractice is. There is no doubt that the fear of litigation affects the style of medical treatment, the amount of medical treatment. I actually think the biggest problem is not the cost, but it is the over-testing and the defensive medicine.

I think you have to look at what the flipside of having no malpractice opportunities. You have a health system where the individual has very little leverage. They do not have information, they do not have knowledge. If they get treated badly as consumers, the only last resort they have is litigation. I am not a big fan of litigation but I do not think it would be a good thing for the health system if the fear of litigation were gone completely.

To say that we are at the right balance now, it is not my area of greatest expertise, I am a lawyer, but I am not entirely sympathetic to some of the arguments made by my colleagues. I think there are questions as to what the right balance is but I think it would be a terrible thing if we ended up with limits that were so tight that it essentially gave amnesty to any health provider no matter how negligent they were. I would not want to be treated in a health care system that did not have some element of that.

I think the issue has to be kind of collaborated and understood. It is not— you could eliminate malpractice as an issue and we would be having the same conversation about health care costs. So, it is not driving it fundamentally.

**KAREN TUMULTY:** The other part of your question, I remember all the way through the health care debate in '94, people were screaming we cannot have Hilary Clinton's care because we do not want bureaucrats taking over our health care. Have you dealt with an insurance company bureaucrat lately? So, how do you deal with that problem?

**AL HUBBARD:** It drives me crazy. If you know you have a hurt knee, but you have to go to your general practitioner in order to get referred to the orthopedic, it is the craziest thing in the world. The system is so user-unfriendly today. It takes you— again, I have been complaining about the government-provided health care systems with Canada and France and England and Germany, which is much worse than our system but our system is very user unfriendly. It is difficult to get the appointments you want, you have to wait in line. I always take reading with me when you are seeing a doctor because you know you are going to have to wait a while.

So, I am not defending the current system and I think again, if the system were more subject to— I will give you another example of markets. Again, it is going to have to be a hybrid, I agree with Jack. But, the more we can subject to

hybrids, the more user-friendly it is going to become. I will tell you something we do. It is difficult to get appointments to see specialists. Doctors limit the supply of specialists.

Specialists, ophthalmologist or neurosurgeons or whatever, they are like opaque, they decide how many new doctors are going to be trained in a given year. And they make certain that there is not an oversupply because that would affect how much they could charge and the demand for their services. That is un-American. That is, as far as I am concerned, a violation of the antitrust laws. Why we should limit the supply and why we should allow physicians to decide what the supply should be makes absolutely no sense whatsoever.

**KAREN TUMULTY:** Well, I am getting the high sign here from Jeanne. So, I am grateful that we have had these two specialists here this morning at least and had a chance to take some of your time. So, thank you very much.

**AL HUBBARD:** Thank you.

**JACOB LEW:** Thank you. [Applause]

[END RECORDING]