Remarks as Delivered by
The Honorable Mike Leavitt
Secretary of Health and Human Services
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Chris [DeMuth, AEI president], thank you. I'm appreciative of having this distinguished forum and 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 about this to one of my friends, who explained to me why it is that there's such a close bound 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 Medicare Trust Funds to meet in our spring Trustee meeting, and I know you've had a report from Rick [Richard Foster, Chief Actuary, Center for Medicare and Medicaid Services] in some detail about that meeting. But as an American and as a grandfather, it was a sobering experience to me. It always is.

You would acknowledge, I am sure, that we measure this one government program that we call Medicare as a percentage of the gross domestic product. I think that fact in and of itself is telling. It became clear as I looked through the charts that we provided that, as the unfolding scenes of life take place, that when my grandson becomes 25 years old it will have grown from 3 percent of the gross domestic product to almost 7, and when he becomes my age, which I might add seems to happen very quickly, it will have grown to 10 percent. This is a very serious problem and one that we will 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 that at any point in time that you project forward that in a five-year period or two consecutive years that it will have exceeded 45 percent of the total support coming from the general revenues, we as Congress need to know it and the American people need to know it. What I believe is a very important warning yesterday, the trustees of the system issued that warning.

It's happened again last year, it's happened again this year. It's likely it will happen again next year as things unfold. The report doesn't tell it all. It's certainly accurate and actuarily sound, but I suspect that there are a couple of things that you may not 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 reimbursement rates. Some years ago Congress passed a law that required that the rates are adjusted downward whenever expenditures go up to a certain level, simply stated. The problem is, every time we reduce the rate, just magically

there are more procedures and the total amount just continues to go up. It's a vicious circle. 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" — how will we fill in the gap?

The way it's now set up, next year we will have to reduce doctors' rates under Medicare by ten percent, and then every successive year after that for the next nine years, we will have to reduce it by five percent, the cumulative effect of which will be about 41 percent reduction in physician rates. If you believe that Congress will do that, then you can assume that in fact we'll meet 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.

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's now eroding the capacity of the federal government to meet all of its other needs, because with every basis point it erodes it takes away our capacity to deal with national defense or any of the other things we call upon government to do.

Now 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 it 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. It's essentially two parts. The first is Part D. There was a lower than expected level of expenditure on Medicare Part D. The second was that hospitalization rates 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 that I have some hope and some optimism that there is 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 the desire on the part of the people of this country to have a prescription drug program for the reasons I just outlined. The plan had always been to say we'll have a one-size-fits-all government program like we do in Part A and Part B, but that was resisted. Republican Congress and the President indicated we're going to have prescription drugs but instead of using compulsion we're going to us markets, instead of having one-size-fits-all we'll have the market allow prices to be established and 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 were 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 can choose a plan that fits them. If they had one-size-fits-all, you can bet there'd 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 taxpayers money as well — over $2 billion.

I believe that this difference between the good news in the report and the bad news in the report frame up a very 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 Part 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 bare 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 the larger framework. Second, government sets and regulates the prices. Taxpayers bare the risk. Future generations bare the risk. And the system is very clearly on the road to insolvency. And we are sewing the seeds every day that will produce and 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 continued to. Government has 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, "How do I explain that the government sets prices on doctors and hospitals and medical devices but not prescription drugs?"

Well the answer? Government 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 Advantage and how 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 government acts as a proprietor, the same thing happens every time. Now 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 it 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 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 part of the day in the public system, and they most 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. If you've got the money, then you're very capable to go to a doctor and getting it there. Universal care is not always universal.

Let me just say, one of the things I worry about is 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 the 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 is 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 is a way in which societies can organize to share the word and to share the risk.

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 that don't have insurance for the most part need care. It may be ineffective, it may be unequal, it may be inconsistent, but they do need care. And we can do better than that. What's not widely understood is that while we don't have a calm 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 sums to hospitals to pay for those who don't have insurance.

One has to wonder that it doesn't make some sense at least to spend at least part of that money than perpetually paying the bills of people who don't have insurance that just help some of them get insurance. But … we are doing so today by giving care. So very quickly just 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 expand, like expand our business as a proprietor. Others believe that as we move forward we need to become an organizer. Clearly we have been headed in the direction of those who believe we ought to be a proprietor. We're headed for more government, at least that's the trend. Medicaid enrollment is up 50 percent 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.

Now the next few months we will see a debate ensue in Congress about the future of SCHIP, the state children's health insurance plan. SCHIP was meant to be for low income children who were not eligible for Medicaid, those that are earning less than twice of the federal poverty level. There are some that 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. There are those that would expand it to cover adults. In fact, there are already three states who 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 formally 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."

We need to re-authorize institutions, we're clear about that. It's a very important thing. But we need to stick with what it's 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 is not to incrementally put one more car on the train of government funded, government-run health care. The solution is for every American to have access to basic affordable insurance, including children.

Those of us who understand the flaws of government-run care need to step forward. We need to step forward with genuine plans to accomplish that task. The old saying in politics is, "You can't beat a candidate with no candidate." The corollary to that is, you can't be a bad plan with no plan. Plans need to be based a very simple core philosophy. It will surprise nobody here that I believe that philosophy needs to be government as an organizer. It needs to be a uniquely American plan. A plan needs to have a core strategy.

Let me give you an example: 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 are everyone else, you deserve to live in a state where your government has organized the private marketplace, where through your employer or on your own or

through a mechanism organized [by the state] you have access to a choice of basic plans that are affordable.

Now in the State of Union, the President made clear that 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 am 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 probably working directly with almost two dozen states, who 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 at a level that’s supportable.

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 some of those problems are and the process that each state that must go through. 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 risk to ensure that the hard to insure and chronically ill can be covered as well?

And lastly, how do we solve the problem of affordability to those who can’t afford it on their own.

Let’s talk for a few minutes about the basic plan. Let me suggest that I believe every state needs to answer a question for themselves. That question is, “Is there more virtue in having a thousand people with a basic plan of insurance or having 500 with a comprehensive plan and 500 without?” I believe that across the country states are acknowledging the virtue in having a basic plan available to all their citizens.

One barrier to that in many states is the actions over time for reasons that were noble and understandable, the accumulation of a large series of mandated coverages. Most coverages have in total created an atmosphere where some people are simply priced out ofthe market. They simply can’t afford it.

Each state then needs to deal with that question. States approach it differently. When I went to Vermont, unsurprisingly I found a highly comprehensive plan. Frankly the state was willing to step up and tax their citizens to accomplish it. Now 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 has defined a very simple plan, very basic. It has a relatively low limit of liability, but it's $100 a month, and the deal is, $50 from the insured, $50 from the employer, $50 from 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 and capacities of Tennessee.

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 was able to be worked out so people could afford it.

Missouri: Missouri has been completely reorienting theirs under Governor Blount. There is a lot of action going on right now. I think we're working with almost two dozen states.

Some say, well, Congress ought to establish a basic benefit package. Congress will have the capacity to restrain 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 ensure 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 been discussed in California, it's being discussed in Illinois. It's not being discussed in a lot of other places who are solving the pooling problem a different way. Some are choosing to use their Medicare 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 function and then allow tax dollars to focus on those who need subsidies in that area. Others are looking at 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.

One thing I believe, we will look at Massachusetts over time as having piloted or at least tried the idea of a connector. It's not just important to just pool risk; it's also a very important tool in being able to aggregate the different contributions to a premium to make it affordable.

Let's talk about affordability. What does 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 question that will 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, who works at 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 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 the Union to make a uniform standard deduction for those that have health insurance. Now there are others who have made proposals. The bottom line is that it needs to be solved if we're going to achieve an affordability plan in these states who 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 a basic plan? The President has proposed the idea of some Affordable Choice grants where under certain conditions the federal government could partner in the development of those plans.

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 of the tax problems solved - a partner in affordability - they could 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 in a political time like this — may I just tell you that this whole atmosphere is reminiscent to me of 1995-1996 and welfare reform. At the time, I was chairman of one of the governors' associations, I was deeply involved in this. The government was divided: White House in one party, Congress in another. There were different opinions 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, 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 it, 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."

Now ten years in retrospect, it's pretty clear now it worked. The atmosphere is eerily reminiscent of that. I'm aware that governors are in fact working right now to develop a list of tools.

Let me just say that in summary, 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 a 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, the disabled need to be able to turn to Medicare and Medicaid and SCHIP as they have in the past. Every other American deserves to have a 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 at a lower cost for all Americans. Thank you.