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Health Care at the Crossroads: Personal Freedom or Government Control?

The Honorable John Shadegg and Mark McClellan, M.D., Ph.D.

ROBERT E. MOFFIT, Ph.D.: The most important domestic policy issue facing the United States is the future of the health care system.

American health care is at the crossroads. Right now, government spends almost 50 cents out of every health care dollar. Many of us believe that that is a serious problem, a dangerous concentration of political and economic power. Why? Because whoever controls the health care dollars will ultimately make the key health care decisions.

What Americans are debating today is whether we ought to continue the current policy of greater government control over health care decision-making, which is where we are drifting today, as is evident in the SCHIP debate, or whether we ought to reverse the current political dynamics toward greater government control and transfer the decision-making in our health care system back to individuals and families. That would be a sharp change in direction.

We have two outstanding speakers. First is Congressman John Shadegg, whom I first met many years ago when we were students together at the University of Arizona battling campus radicals. I suppose we're still fighting the old campus radicals, only now they're controlling the Congress, not just the student government.

Congressman Shadegg has represented Arizona's Third Congressional District since 1994. He has an outstanding reputation as a champion of the taxpayer, fighting for reduced government spending and greater tax relief for individuals and families. He achieved

Talking Points

- The most important domestic policy issue in America today is the future of our health care system. The long-term goal is to get the best quality care for every American at the most reasonable price.
- Government-funded health care programs, however, ration care. Socialized health care will not contain costs, will not give us quality, and will not serve the American people well.
- The key is more patient choice and control. Where states have given people with chronic illnesses more ability to choose coverage, they choose coverage that emphasizes prevention and care coordination and wellness, and that saves money.
- Recognizing that we're already paying for health care and redirecting that money and putting it behind a health tax credit could give all Americans the ability to buy a health plan that meets their needs.

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national notoriety when he ran for the House Majority Leadership, an exciting race that brought new ideas and a new direction to the Republican leadership debate.

Congressman Shadegg has been chairman of the House Republican Policy Committee and the House Republican Study Committee. He has also established himself as a leader in the field of health care policy. He introduced a number of bills to improve the health care system, most notably the Health Care Choice Act, which would allow interstate commerce in health insurance, thus giving individuals and families the freedom to buy the health insurance that they want wherever they want to buy it. He's also been working to reduce the red tape in the Medicare program and to restore the doctor–patient relationship. Restoring individual freedom has been the chief goal of Congressman Shadegg's efforts.

After Congressman Shadegg, we will have Dr. Mark McClellan of the AEI–Brookings Joint Center for Regulatory Studies, but without further ado, I give you the Congressman from Arizona.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

THE HONORABLE JOHN SHADEGG: Thank you very much. It is a privilege to address you.

As I listened to Bob's remarks, I recalled that I introduced my first health care reform proposal back in 1996 or early 1997. For me, this unresolved problem has been at the center of the debate on whether or not we expand government and government control of our lives versus whether we expand personal freedom and individual initiative in our lives. I once had a chief of staff who was not very interested in health care policy, and she asked me, "Why do you care so much about health care?" And my answer was, "Because in my view, health care is the issue where we as a nation are closest to embracing socialism."

Threat to Personal Freedom

That remains true today—more so today than when I said it back in 1996. Indeed, you need go no further than to listen to the campaign stump speeches of Hillary Clinton or Barack Obama or John Edwards, and they will tell you, in so many different words, that they want socialized medicine. Now, they may call it "universal coverage," but they are pretty unabashed in their acknowledgment that they believe in a government-controlled health care system for this country.

Not only is that not the answer, but the evidence shows us that it is exactly the wrong direction, because people have no real control. Whether you look at third-party payer insurance in the private sector, where an insurance company makes all the decisions, not the patient, or Medicare or Medicaid, where a government entity makes all the decisions, and not the patient, both illustrate what is wrong when you allow somebody other than the patient, the individual, in consultation with her doctor or his doctor, to make the key decisions about medical care. I see no reason why we cannot allow people to make the key decisions about health care and still accommodate the concern that no one go without care in America.

Bob said that this is the most important domestic issue. I would suggest that my party, the Republican Party, the party most committed to individual freedom, has taken a walk on the issues of health care and health care reform. They have not addressed the issue. They have chosen instead to say it's a Democrat issue. They have chosen to say, "Those are issues that are complicated and bureaucratic, and the government has to get involved, and we don't really as Republicans need to get involved in that issue." Or they have chosen to say, "There isn't a Republican or a free-market answer to this."

If you talk to the average Member of Congress, as I have for the past decade of my life, you have to drag them into a conversation on health care. Republicans don't want to talk about the issue.

Well, those days are over. We have to talk about this issue. We have to talk about it now, and there are very straightforward, free market–oriented answers to all of these questions. I am pleased that they are at least being discussed. I am pleased that the President has put some of those free-market solutions on the table. I am extremely pleased that my colleagues in the Senate—Senator Tom Coburn of Oklahoma, Senator Jim DeMint of South Carolina, Senator Rich-

ard Burr of North Carolina—are all putting innovative Republican solutions on the table.

I think it is vitally important that Republicans and all people concerned about individual freedom look at this issue and figure out the answers and where we should go. In doing that, it is vitally important that we look at the long-term goal: to get the best quality care for every American at the most reasonable price. The guaranteed way to *not* get the best quality care at the most reasonable price is to allow the government to play an even larger role in health care than it is playing today.

Let me ask you some questions. You are going to buy a new car. You want to pick out what car meets your needs, whether it's a Ford F-250 pickup or an SUV or a hybrid. Here are your three options. Which would you think would produce the best result and make you the most satisfied?

- *Option one:* Your employer will pick the car, pick its color, pick its size, hand it to you and say, "Here's your car."
- *Option two:* Your insurance company or the government will buy the car for you. They'll give some thought to what is in your interest; they might ask you a question, or they might not; they might look at demographics about you; and they will buy a car for you.
- *Option three:* You can pick the car for yourself.

How many of you think you would be most satisfied with a car picked by your employer? Nobody here thinks your employer can do a better job of picking your car than you can? All right, how many of you think your insurance company or the government can do a better job of picking your car than you can? Once again, nobody in this audience agrees with that.

Now, you're probably sitting here saying, "Come on, be realistic!" And yet that accurately describes where we are in health care today and where we will be with health care if you imagine the world shaped by Hillary Clinton, Barack Obama, and John Edwards. They want somebody other than you to pick your health care package. We all agree that you ought to have health care, but they want somebody other than you to pick it.

Where are we today in health care? Today, either your employer or the insurance plan they picked for you is choosing your health care benefits package. And since none of you thought they'd pick a better car for you, I'd like to ask you why anybody thinks that any of those entities—your employer, your insurer, or the government—can pick a health care plan for you better than you can.

The Source of the Problem

How did we get to this place? Americans must understand this: We got to this place when we decided, during World War II, to impose government price controls on the entire economy. Government price controls led to an inability of employers to attract and retain the best employees.

To deal with that problem, American employers went to the federal government and said, "Okay, we understand that you've got price controls imposed on us and we can't give our employees the raises we'd like to give them at the time that we'd like to give them to them, but what if we decided to give our employees health care benefits? Would you have any problem with that?" The government came back and said, "No, if you would like to give them health care benefits, you may do so."

Industry then came forward and said, "If we do decide to give them health care benefits, is that to be taxed, or is that going to be distributed pre-tax?" We all know the answer to that question; the government came back and said, "You can give them $100 worth of health care benefits, and we will deduct zero in taxes, so your employees get $100 in actual health care benefits. If you pay them $100 in cash, of course, they get somewhere in the neighborhood of $70; the government takes a third of that money."

Before I ran for Congress the first time, I went to see my doctor to get a physical and check myself out. He had been a young man with whom I had gone to school and who had been in my Boy Scout troop. I had known his family for a number of years; our families knew each other. His father was also a medical doctor.

We got into a conversation about health care in America, and he said, "John, you need to understand that health care in America has changed dra-

matically. When I was in the Boy Scout troop with you, my dad had a voluntary relationship with every single one of his patients. They had chosen him, and he had accepted them and knew them all. He'd take their calls late into the night or early in the morning or on a weekend because he knew that the code of ethics of the doctors required him to take care of them and view them as his patients and that he owed them a duty to do his best by them."

He said, "You need to understand, John, that world no longer exists. The world exists today such that on any given day, if I come in to work, I can walk in the door of my office and discover that I have lost a patient, a dozen patients, 100 patients that day, not as a result of my treatment of that patient, but because some employer has dropped some plan or because some plan has dropped my practice group in which I practice medicine."

The current system is very unlike the old system centered around the doctor–patient relationship. In the old system, the physician agreed to accept the patient; the patient selected the physician; the physician performed the service. The doctor owed 100 percent of his loyalty and duty to the patient. The patient got reimbursed from his insurance company for part or all of the service and paid the doctor, and there were no divided loyalties. It was a voluntary, free-market transaction. It worked well.

Health insurance in those days covered treatment of illnesses. It covered catastrophic injuries. It did not cover routine teeth cleaning, for example, or perhaps even a routine physical exam that someone my age might need once a year.

When we abandoned that older system and went to the newer employer-based third-party payment system where employers provided health care coverage to employees, we did some good things for this country. We got more people insured; but at the same time, there were some unintended consequences, as there always are when you change the system.

The largest unintended consequence is that we have divorced patients from their doctors and doctors from their patients. Because of the economic incentives today, whether we like it or not, the doctor has at least a partially divided loyalty. He's very interested in his patient and his patient's health, but the patient's not paying the bill. The insurance plan retained by the employer is paying the bill.

Skewed Incentives

The incentives are skewed in the wrong direction. Who's watching costs? We all know the answer to that. Since the employer is paying the tab, not the patient consuming the good, the employer is supposed to watch the costs. But we know that that didn't happen very effectively. We know that costs began to escalate radically. We know that we got to the point where almost a third of the cost of producing a Ford pickup truck was attributable to the company's health care costs. Was Ford Motor Company in a good position to evaluate the value of the services given to its employees? It was not.

Let's go back to my earlier example. If I as your employer bought you a car and handed it to you and you became unhappy with the car, what remedy would you have? You would have to come back to me, as the employer who bought the car, and I would have to take the car back to the car company and complain about it. You do not have a direct relationship, as the owner of that car provided by your employer or by your insurance company, as you would if you had bought it yourself.

You say, "Well, that's all very good, Congressman, but we can't go back." I would suggest that's wrong. Americans interested in the best quality health care at the lowest possible cost need to think about this issue in simple terms, and those simple terms are best expressed in two words: patient choice. The reality: If you put patients in charge of health care and give them the ability to make the choices, they will select the best possible health plan, and they will demand the best quality, and they will demand the lowest price.

Years ago in Arizona, I was having this discussion with a member of our legislature who happened to be an emergency room physician. He said to me—this was about the time of the HMO crisis—"John, you would be stunned at the discounts that are available for cash in the health care market today. You have to just look at the bureaucracy we have created."

Is there a person in this room who hasn't heard from their doctor how many employees they have to have to fill out all the paperwork and to deal with all of the related bureaucratic struggles? Is there a person in this room who hasn't heard an employee complain about his employer's plan? How do you fix that?

There are some simple answers. The answer is to put people in charge. And how do you do that? You let them buy their own health care plan. There are a number of different mechanisms for doing that.

The first bill I introduced did not propose a radical reform; it proposed a modest reform. Under its terms, we would say to every employer in America, "You must calculate how much you are spending to insure any given employee, and you should do that calculation based on their age, their sex, and their geographical location." Once the employer calculated that number, the employer must go to that employee and say to them, "I am spending X dollars on your health insurance." For a younger employee, that's going to be a smaller number than for an older employee; for an employee in a rural location, it's probably going to be a higher number than for the same employee in an urban location; for a woman or a man, there will be a differential.

But once a year, the employer would say to the employee, "This is how much I am spending on your health care. You have the right in the next, say, four months to look for a health care plan that will better meet your needs. And if you choose to, you can tell me what plan you selected, and I will send them the money." That would give employees the freedom to find a plan that would meet their needs—that is, to let them, to go back to my original analogy, buy the automobile that met their own needs.

I would remind you, we allow people in America to buy their own automobile insurance, their own homeowner's insurance, their own life insurance, to buy their own commercial products. But somehow we have gotten to this point in America where we think we cannot allow individual people to buy their own health insurance. My answer: That is bunk.

Here's the upshot of instituting such a new policy. The employee might leave and find that they can find a policy that better meets their needs. It may not cover everything the company's plan covers, but maybe they don't care about that coverage. It may give them a doctor that they care about that they can't get from their employer's plan. In the Shadegg family, my wife's OBGYN drives our health care choice, because she wants a doctor that she's comfortable with, and I've always said yes to that. I would suggest that lots of Americans would do so for similar reasons. So the employee might be able to find a plan that covered a doctor they cared about.

What would be the worst-case scenario? The employee goes out and, lo and behold, the market that Shadegg thinks is out there for health care for individuals to buy on their own isn't quite as good as Shadegg thought; indeed, it's not good enough to beat the company plan. So the employee comes back to the employer and says, "I had no idea what a good deal you were giving me in health care. I'm keeping your plan, and I'm going to quit complaining about it."

Empowering Patients

My first bill was a modest attempt at reform. I next proposed the Patients' Health Care Choice Act. We proposed that you could allow, for example, the University of Arizona Alumni Association, of which Bob Moffit and I are members, to sponsor a health care plan; that you could allow Kiwanis International to sponsor a health care plan; you could allow any voluntary organization created for a legitimate purpose to sponsor a health insurance plan and give people the ability to get into other options beyond conventional health insurance.

Our friends who want to push us into government-run health care say, "But you're not going to take care of the least among us." We are engaged in a false discussion on that issue. Right now there is a debate going on, noted in yesterday's *Wall Street Journal*, about how we should cover the least among us. *The Wall Street Journal* posited that the best way is the way President Bush has proposed: a universal tax deduction. They criticized my Senate colleagues who say, "No, the right way to do that is a refundable tax credit." We can discuss a health care tax credit or health care deduction—I personally favor a tax credit—but let me make the point: *The Wall*

Street Journal editorial pretends that the cost of covering this group of uninsured people will be a new burden on American taxpayers.

The Wall Street Journal is dead wrong. This nation made a decision long ago, certainly with the passage of the Emergency Medical Training and Labor Act (EMTALA), that no one should be denied health care. Not a person in this room walked in here today seeing someone on the street with a broken leg who didn't know how to get it fixed. Not a person walked in here today and passed somebody coughing with tuberculosis because they had no place to go to get health care.

With the passage of EMTALA, we said, "No one can be turned down for health care in an emergency room in America because they don't have the money to pay for it." We made this decision. We're already paying for health care for every American. You can pick what avenue it is, and it's hard to quantify, but we're giving it out freely in hospital emergency rooms, which is making those rooms crowded, and they are not the most efficient place to get some of the care that is being dispensed. We are paying for it through transfer payments.

For every person in this room who has health insurance, that health insurance has two components: the cost of caring for you and the cost of caring for someone else in this society who doesn't have health care. And we pay in a myriad of other ways. We provide disproportionate share (DSH) payments to hospitals in areas where there are high concentrations of uninsured people.

So we *are* paying for people who are uninsured. What is wrong in this debate is that we are *already* providing health care to all Americans. But are we doing it in the right way? No, we are not.

In the State Children's Health Insurance Program (SCHIP), we are providing low-income children with a government program with government benefits. Some people say, "Oh no, SCHIP is free-market because the government contracts with a private contractor." That is not the definition of a free-market health care plan, and by my first analogy, that is not going to provide the best possible health care. The government might be paying the contractor, but it's telling the participant in the program, "This is where you're going to get your health care," exactly as if we said, "Nowhere in America are we going to allow people to buy their own automobiles. We are going to tell them that either the government is going to buy their automobile, or an insurance company is going to buy their automobile, or their employer is going to buy their automobile and hand it to them."

That's where tax policy comes in, either through a deduction or, preferably, through a tax credit. Consider the savings we can achieve by recognizing that we're already paying for health care and by redirecting that money and putting it behind a health tax credit. We could give every single American the ability to buy a health plan that meets their needs.

I'll conclude by saying that the right tax and insurance policy will accomplish something that socialized medicine, run and controlled by the government, will never achieve: the best possible quality and the lowest possible cost. If we give the poor a refundable tax credit or allow those paying income taxes to take the tax credit and apply that to health insurance, they will make choices. Those choices will reflect two things that will not accurately be reflected in a government-run program: Those individuals will demand the best quality they can get for that amount of money, and they will demand the lowest possible price. It's a function of human nature and basic economics.

What would government-run health care do? With regard to quality, the government is going to decide what quality is. With regard to cost, we in Congress promised beneficiaries an array of benefits, and then, when we discovered the cost of those benefits is far in excess of what we're willing to pay for, we cut payments.

Ask any doctor. Ask any hospital in America. They'll tell you we're shorting the providers. That is, the providers say the cost to provide all the service promised by Medicare is X, and the government says, "We can't afford to pay you X. We told the citizens we'd pay you X; we told the citizens we'd give you the care; but we're going to pay you X minus 10 or X minus 20." The reality is this: The government doesn't want to own up to paying for the care it has promised.

So what do government-funded health care programs do? They ration care. Look at Britain, Canada, anywhere else. At least in several of those countries there are now loopholes outside of the government programs, so people go somewhere else, into the private market, to get the health care they need. The issue is not as complicated as many would like to make it. It is fundamentally about patient choice, and it is critically important because we are facing an onslaught of demand for socialized health care which will not contain costs, will not give us quality, and will not serve the American people well.

Questions & Answers

QUESTION: As I listened to the Republican presidential candidates' debate last night, I didn't hear anything from any of the candidates about how they felt about health care. Do you happen to know how any of the potential Republican candidates feel about health care?

REPRESENTATIVE SHADEGG: They all recognize that it's an important issue. Several of them have plans. Mr. Romney has a plan. Mr. Giuliani has a plan. Others do.

There is a temptation to get more complicated than need be; in too many instances, we are looking at too large a role for government. As a conservative Republican, I am a states' rights guy; but I do not believe this issue should be handed over to the states. I do not believe that if we give money and incentives to the states, those local politicians will create a system that is driven by individual choice.

Because of national repercussions, especially the costs of Medicare and Medicaid, we need to be looking for a national solution. The national solution can be two very different paths: the path being advocated by Dr. Coburn and Jim DeMint and Richard Burr and myself, where you give people choice, or the path toward government-controlled, top-down health care being advocated by Senators Hillary Clinton and Barack Obama and John Edwards. In the end, they will be telling you what care you get.

As you examine these plans, we ought to be focused on one thing. I like the word "freedom," but fundamentally, in the health care arena, it's patient choice. I would urge every American to examine any plan put forward by any candidate—Republican, Democrat, or other—and say, "Is that going to give me patient choice? Is it going to give me that kind of control?"

Because we can do it. We can, through either a tax deduction or preferably through a tax credit, hand somebody a tax credit and say, "Go buy yourself a health insurance plan, and go buy yourself the coverage that makes you the most satisfied and deals with your unique circumstances." Then they'll get the system that they want, and they'll pay attention to both quality and cost.

QUESTION: How do you feel about individual mandates? Would you implement individual mandates in your plan? If so, how would you make it work, and if not, what would you do about people who choose not to purchase their own insurance?

REPRESENTATIVE SHADEGG: I am not a fan of individual mandates. I don't believe government telling you what to do is the way to go.

I note that Senator John Edwards has now come out and said that preventive health care is productive, and, therefore, we should have individual mandates that you have to get an annual physical and other screenings that the government decides are important for you. Well, shouldn't we have a volunteer corps that comes by each block of houses each day, maybe on a regular basis, to see if I'm brushing my teeth? Because we all know that if I brush my teeth, they'll last longer. I think individual mandates take us down a slippery slope.

I think you can get universal coverage ensuring that every American has care through a system driven by patient choice. I would do that by giving every single American a tax credit—the wealthiest and the poorest. For the poorest, it would a refundable tax credit; they can only use that money to buy a health care plan.

If we had done that with SCHIP from the beginning of the debate—the money goes to the individual in the form of a tax credit, and they can only spend it on health care—then we wouldn't have the problem we have in SCHIP right now: Lots of people are qualified for SCHIP but choose not to sign up for it. The situation would have been different: "Here's my voucher, or here's my right to get a health

care plan to cover my kids." Then there would be an incentive for an insurance salesman to come by their door and say, "Wouldn't you like to have your kids covered?" And they would pick a plan.

So my answer is, give every single American the funds to purchase a health care plan, either a credit against the taxes they would pay or, for poorer people, a refundable tax credit. That is what Senators Tom Coburn and Jim DeMint and Richard Burr think is the way we ought to go.

Then, if there is a person who doesn't choose to sign up, you put that earmarked money into a fund. If that individual shows up at an emergency room—or, for that matter, at a doctor's office or a federal clinic—and needs health care for a broken ankle, we can check him out and discover he or she didn't sign up for a health care plan. They are going to be financed, at least in part, from the earmarked funding pool.

So every American has a choice, and the people who don't exercise that choice to pick a plan of their choosing are essentially all in a single pool that pays for their care. We get universal care without taking from the vast majority of Americans the freedom to pick their health plan.

QUESTION: Generally, we've seen that women's health has been very important to the federal government. We've seen commissions for women; we've seen research funding going toward women's health; but men's health has not been seen as important as a policy priority, whether it's prostate cancer or research funding or men's health in general. Where are we going here?

REPRESENTATIVE SHADEGG: I'm not an expert and not probably the best person to comment on that question other than to say that we are not creating the best incentives for the kind of advanced care or screening for the kinds of problems you cited. If you implemented, alternatively, a patient-driven system and an education program, you could incentivize people to pay more attention to those issues.

QUESTION: You said that the tax credit would be for everyone, even the most wealthy. What is the rationale for that?

REPRESENTATIVE SHADEGG: Quite frankly, I don't have a strong bias that it needs to be for everyone. Right now, we have a tax break for people who pay taxes. Whether you left that deduction in place or not, it is vitally important that we end the discrimination in the tax code. It is an outrage. It is a moral outrage. It has personally offended me since I got to the United States Congress.

We say to all Americans, "We want you to have health insurance. We do not want you to be a burden on society and go into an emergency room for your care at government expense." And then, if they're unfortunate enough not to work for an employer that provides them health care, we slap them in the face with a tax penalty and say, "Here's how we are going to reward you. You are going to have to pay a third more for your health insurance than your neighbor who gets it from his employer."

It is simply wrong. We are saying to the least among us, who work for an employer that doesn't give them health insurance coverage, "You owe it to society to buy health insurance, so much so that we're even thinking about mandating your employer to get it. But we're going to make you pay a third more because you've got to buy it with after-tax dollars, whereas your next-door neighbor gets that same health insurance plan tax-free, and the employer can deduct the cost." That unequal treatment has to be eliminated.

The biggest issue is not the health care of those who can afford it; the biggest issue is health care for those who can't afford it. Right now, the mechanism we're using to provide them with that care is federal mandates on hospitals, coupled with federal subsidies and federal health clinics and a myriad of other programs, including SCHIP.

My answer: End all of that and give them a refundable tax credit so that they actually have the ability to get the health care coverage they need. Americans aren't too concerned about whether or not Bill Gates has health insurance. They are concerned and should be concerned about the least among us. Give them a refundable tax credit, and quit thinking that that's a new expenditure, because they're getting that health care now. They're getting it at an emergency room; they're getting it through

DSH payments at the hospital; they're getting it in a myriad of different ways. They're getting it at federal heath care clinics. They're getting care, but we're paying for it in an extremely inefficient way.

On the argument of equity, you can say that if we're going to give a tax credit to the least, we should also give that tax credit to others, and then we can cap the tax credit, and if they choose to spend more than that, that's their financial burden and their tax burden. If you left the current system alone for the people who already have health insurance and determined that we're not going to give the wealthiest or those who pay taxes a tax credit, but instead we're going to continue to let them use a deduction, that would be fine. It would have taken care of those that now have to use after-tax dollars for health insurance.

I'd even go beyond that. I'd go back to my original bill. It specified that if you're employed, we're going to allow your employer to keep the deduction he's using but make your employer set you free. Your employer once a year would tell you, "You can buy your own plan, and if it costs less than I'm spending, you keep it, or if it costs more and you choose to pay it, you pay it."

But at least the tax deduction caps it. If you have an unlimited tax deduction, then the wealthiest can buy a platinum-plated policy where they can charter a Lear jet to get to their health care clinic.

I don't care how you deal with those who are already affording their health care. They are already getting favorable tax treatment. It's OK with me if you leave that as a deduction, OK with me if you make it a tax credit. It's exactly equal; there's no issue of equity between the two. Remember, equity is one of the issues: what's fair. But you need to deal with the uninsured—that's the issue that faces the country—and deal with them in a manner that preserves patient choice for them and for everybody else.

DR. MOFFIT: Our next speaker is Mark McClellan. Dr. McClellan is a senior fellow at the AEI–Brookings Joint Center for Regulatory Studies. Mark is also a former administrator of the Center for Medicare and Medicaid Services (CMS), a former head of the Food and Drug Administration (FDA), and a White House health policy adviser.

He's also had an outstanding academic career. He was an associate editor of the *Journal of Health Economics* and is a graduate of the University of Texas at Austin. Mark got his master's from Harvard University's Kennedy School of Government and his doctorate in medicine from the Harvard MIT Division of Health Sciences and Technology. Doubly dangerous, he's a *real* doctor and an economist. Mark also got his Ph.D. in economics from MIT.

MARK McCLELLAN, M.D., Ph.D.: It's a real pleasure to be here with all of you, and it's always a privilege to work with Congressman Shadegg. I've had the opportunity to work with him over the years through his efforts on the Republican Policy Committee on health care and many other issues to get to better results for Americans.

One of my favorite top staff members at CMS was a direct product of the "Shadegg shop": Doug Stoss, who is still at CMS, is having the same kind of impact there that he did with the Policy Committee—another tribute to Representative Shadegg's leadership. I also want to thank Heritage and Bob Moffit for putting this very timely event together.

Health care is front and center on the policy agenda. We continue to have some very hard-fought debates about it, but it's through sessions like this that we can find the best way forward.

Key Tax Policy

The tax reforms that Representative Shadegg raised here today must be a key element of health care reform for achieving affordable, sustainable, high-quality health care and health care coverage in this country. It may not happen this year. We're getting late in the legislative session, and there's a lot of contentiousness even around SCHIP, but there's no question in my mind that tax reform along the lines that Representative Shadegg has talked about is a part of the solution to our problems of the uninsured and of health care costs.

First, the tax reforms the Congressman outlined, from the standpoint of incentives, would promote efficient, high-quality care by involving patients in

choices. As you heard in some of the questions and answers, they are also pretty good in a distributional way. We're spending a lot of money on the employer tax break today, well over $200 billion a year and growing rapidly; it is by far the largest tax expenditure in the federal tax code. The second-largest, the home mortgage deduction, which many people think of first when they think of the federal tax code, is about a third as large as the health insurance tax expenditure, and that mortgage deduction is capped as well.

This is a very big source of funding. Much of it goes to higher-income Americans; as much of those tax breaks goes to families with incomes over $100,000 as goes to all the families with incomes under $50,000 combined. So we're talking about a lot of money, and we're not really getting much bang for the buck from it in terms of affordable coverage for people who really need help.

Second, when people are looking ahead to find ways to expand health insurance coverage in this country, there really isn't going to be any other easy source of funds for expanded coverage. As you saw from President Bush's proposal, if there's a way to get millions more people covered without adding to the federal budget deficit by redirecting the money in this tax expenditure, a tax credit as opposed to a tax deduction—a refundable credit—would do even more to get millions more covered for the same amount of money that we're channeling right now through the tax code. As our health care costs continue to rise, it's going to be harder and harder to pass up that kind of opportunity to get more bang for the buck.

If you look at some of the presidential campaign proposals, particularly on the Democratic side, they talk about some alternative sources of funds; namely, rolling back tax cuts on the very wealthy. But as the Congressional Budget Office can tell you, under our PAYGO rules, since those tax reductions for high-income individuals are already scheduled to expire, that's not a new source of funding for a major expansion of health insurance coverage. It would have to be a double whammy: not just letting the tax cuts expire, but adding an increase onto that, and that's something that would have a lot of difficulty getting political support compared to approaches like the tax reform approach that get more people covered for the same money that we're spending now.

Third, one of the things that you will see in all the presidential campaign proposals this year is an emphasis on making our health care system work more efficiently to enable more people to get coverage, and that's very understandable. I hear that from Representative Shadegg as well. We're spending a lot of money for care that is not very well coordinated, that is not focused on prevention, that has a lot of duplication, a lot of paperwork, a lot of steps that result in higher expenditures and worse health outcomes.

We ought to be able to achieve much more in the United States with the tremendous potential of our health care system. So you'll see from the candidates a lot of discussion about emphasizing prevention, or emphasizing better treatment of chronic care, or using health information technology to get better coordinated care, or preventing medical errors.

The challenge: How do you actually make that happen? Despite years and years of trying, we haven't been able to come up with a regulation or a government-directed approach that gets the right care to the right patient at the right time. The best way to do that is through a patient and their physician working together with a health care system that supports them. That is the kind of system that supports the best personalized, individualized care for their needs. The kind of reforms that promote patient choice and patient control in health care delivery can really help make that happen.

So it's not enough to talk about that being the goal. You need concrete steps that help promote the goal of getting better-quality care at a lower cost and getting the financial incentives right: putting money behind efforts to get better coordinated care, more personalized care, more prevention-oriented care. These tax reforms would do that, and they are absolutely essential.

Medicare Experience

I agree with Representative Shadegg that personal control is so important in these efforts. My agreement is based on the experience that I had in the last few years with the Medicare and Medicaid pro-

grams, in particular implementing the Medicare Part D prescription drug regulations. That was a very controversial piece of legislation, and when I took over my job at CMS in early 2004, it was not at all clear if this was going to work.

The program was unpopular, very contentious, very politically sensitive, and in that environment we started looking closely at what we could do to make sure that this program succeeded. In implementation, what was important time after time was giving seniors the opportunity to choose how to get their coverage. The result of that was some very dramatic impacts on the way that that coverage is working.

There are some recent surveys showing that the number of uninsured seniors—seniors that don't have drug coverage—has gone way down. Well over 90 percent have coverage, which is a huge improvement. Also, the costs of the coverage have turned out to be much, much lower than expected; they're running about 40 percent lower than the projections in place at the time when we started implementing the law in 2004. I think a very important reason for that is patient choice.

At this point, in Part D, do you know how many people are enrolled in the standard drug plan design? Congress came up with a standard plan design based on traditional insurance principles, with a co-insurance and catastrophic protection. There was a "doughnut hole" in the middle, a gap in coverage because of the projected budget shortfalls, and that was part of the standard design.

Do you know how many people in Part D are on that standard benefit now? Almost none. Virtually everyone has chosen a different kind of plan design, one that gives them an opportunity to save more money when they get the drugs they need at a lower cost. If they find that a generic version of a drug is available for their condition, they get a lot of savings from switching to that. If they look at several drugs in a class and find that one works better than or as well as the others but has a bigger discount negotiated by the drug plan, they get most of the savings for that.

The result has been high levels of beneficiary satisfaction and, again, much lower costs than expected.

The Very Sick

The other thing we learned from Part D, though, is that there are some very real concerns that need to be addressed regarding people who have predictably high health expenditures. A lot of people thought that Part D coverage wouldn't even work because of the problem of so-called adverse selection—that no plans would want to take care of people with chronic diseases like AIDS or cancer or other conditions where they would have very high expected costs because they very predictably are going to need to take a number of very expensive and important prescription drugs.

That hasn't really materialized as a problem. Why? Because of some additional steps designed to address the problem of adverse selection. That includes things like "risk adjustment" where, if a plan is able to get someone to enroll who's 65 and healthy, that's nice, but they don't get a very big subsidy from the government. In contrast, if they're able to attract and keep someone who's 85 with multiple chronic conditions or who has HIV/AIDS and has, therefore, a higher expected cost, they get a bigger flat subsidy amount from the government.

We've developed a system that's focused plan competition not on plans selecting just the healthiest patients in this very competitive system. The result is that we've driven costs down substantially while incentivizing plans for providing coverage that's best for individual patient needs. Often, people with chronic conditions are in the best position to know what works well for them; they're the people who can benefit the most from choice and control. But without steps to address adverse selection, it can be a problem for them getting the coverage that they need.

Representative Shadegg has proposed some other related steps to try to address this challenge, like high-risk pools. The important thing to note, though, as Medicare Part D showed, even for medical expenses that are very predictable, is that there are ways to address it and help patients who have chronic care needs. We have some of the most important tools toward getting the most efficient health care delivery.

Finally, I just want to agree with Representative Shadegg's comments about the *Wall Street Journal* editorial yesterday. He's absolutely right that this isn't a choice in the abstract between a deduction, modifying a deduction, and creating a refundable credit. It's a choice as to how we provide coverage for people who don't have the means to afford it on their own.

The alternative to a tax deduction isn't just the tax credit; it's an expansion of government programs that would give people *less* control and *less* of an ability to get the kind of care that really reflects their personal needs. Instead, we need a system that keeps up with the developments in modern medicine and that does all the innovative things that are so important to get to a better health care system.

It's been a privilege to join you today. Help us move forward and gain some momentum for needed health care reforms. I'm sure that all of you are going to continue to pay close attention about the right way to get to affordable, sustainable health care that's high-quality and innovative for all Americans.

Questions & Answers

QUESTION: I'm a doctor. I don't think the Medicare reimbursement has gone up 20 percent since 1992, but everything else has gone up. You see a patient—I want to know what you would do, and I'll tell you what I have done.

A senior comes in with GI bleeding, and the proper care is to do sigmoidoscopy right then and there, to look and find the source of the bleeding. Medicare will no longer pay for both the visit and doing the sigmoidoscopy. Your choice is, as a physician, to eat half of the fee or to send the patient home and bring them back the next day. What would you do, and what do you want to tell my colleagues? Should they pick money, or should they pick proper care?

DR. McCLELLAN: I think what I would do is what most physicians would do, and what I expect you did, which is the right thing for the sake of the patient. The problem is that our traditional fee-for-service Medicare system imposes tight limits on the fees. There is no way, as medicine gets more and more complicated, that you can come up with payment rules and a regulatory schedule that is going to accurately reflect all the circumstances that your patients might face.

Instead, what we need is what we've been talking about today, which is more of an ability for physicians and patients to make their own decisions based on the bottom-line focus that we should have in our health care system, which is how do we get the best outcomes for our patients at the lowest overall cost? And to do that you need reforms that move away from that kind of bureaucratic structure.

QUESTION: You are only talking about changing the system for about half of our national health care expenditures. Is it possible for this kind of a reform to obviate the necessity of having Medicare and Medicaid?

DR. McCLELLAN: I don't think anybody's talking about getting rid of Medicare and Medicaid. What I think is possible, and what you've seen in some of the reforms that have been implemented in Medicare in the last few years, is that there's a different way to do this. There are other ways to provide coverage for seniors that don't depend on these very detailed regulations of prices and services the way the traditional Medicare program has worked.

In the last few years, a broad range of other kinds of health care options have become available for seniors, very much more like what I was talking about with Part D earlier. The government provides an amount of subsidy on your behalf. It can go toward the cost of your health insurance, and you pick the health insurance that you want. Today, in Medicare, for the first time ever, not only does just about every Medicare beneficiary have access to a range of private health plans that are alternatives to traditional Medicare—HMOs, PPOs, private fee-for-service—but the vast majority even have access to medical savings accounts, and soon HSA-type plans as well.

This is very different from the situation we were talking about earlier. Here, government gives you an amount of money that you can spend as you choose on one of these different types of health plan choices that are available. It's much greater patient control, and it has led to a lot of innovation in the kinds of benefits that are available to seniors, as well

as a lot of very new and promising programs that help people with chronic diseases to manage their conditions, wellness programs or programs to help keep people out of the hospital, to help them keep their costs down.

There's a big debate going on now about whether these steps toward making a broader range of health plan choices available should be rolled back or lessened, and my hope is that in that debate, we're not going to lose the real advantages we've seen from genuine choice in Medicare in helping to update the way that the Medicare program provides benefits.

QUESTION: We are pressing, in the Coalition for Affordable Health Care Coverage, for health care tax credits to reduce the uninsured. Whether I'm up with the Senate Finance Committee talking about the reauthorization of the TAA Health Care Tax Credit or how to help small businesses, I keep hearing the same thing from certain members, and that is, we don't trust the individual market.

The concept that the Congressman has put forward runs into the same thing. What would be your suggestions? You had an interesting concept with paying more for higher-cost cases. Whether it's a voucher or a health care tax credit, how do you protect those individuals?

DR. McCLELLAN: That is a very good question. If you're clearly identifiable as someone who is going to have much higher costs, then an insurance company is rightly going to want more money to provide the same types of benefits for you.

There are a lot of ways to address that. We talked about high-risk pools as being one; another is what Medicare has relied on, which is risk adjustment. Medicare has an extremely heterogeneous population, most of whom are not employed and all of whom are making their own individual decisions about which plan they go to, and the choice system is working there in conjunction with this risk adjustment of payments. So, again, if someone's predictably high-cost, that's taken into account in the subsidies that the government gives them.

There have been other approaches that focus on helping to foster and create pools. Some states, like Massachusetts, are working toward implementing health insurance exchanges by putting people in a statewide group, and I would add too, in Massachusetts, officials are taking some steps to directly address adverse selection through risk adjustment of payments. Things like that would help limit problems of adverse selection.

They can be addressed, and we hopefully can achieve both of the goals that we're talking about. On one hand, I don't think there's much argument that choosing their own coverage is going to get individuals into plans that are much better and get them into health care that's much more likely to reflect what they want. On the adverse selection problem, on the other hand, there are a lot of good ideas out there. I see potential for a bipartisan path forward if we have both patient choice and serious effort to look at the problem of adverse selection.

DR. MOFFIT: My colleague here at Heritage, Ed Haislmaier, at the request of a number of state officials, is designing a statewide risk transfer pool. Basically, all the insurers in the state join a pool. The pool is not run by the government; it's run by the insurers, and when they enroll somebody in their plan who is high-risk, they cede that high-risk person to the statewide pool and pay an appropriate premium for that person. At the end of the year, if a health insurance plan ends up, say, with a disproportionate number of high-cost diabetics, they are made whole by the pool itself.

The key element of this, however, is that the government doesn't give a dime to the pool. It's redistributed completely within the private sector, and the entire governance of the pool is done within the private sector. That's just one option. Interestingly enough, the very first government that has initially shown a great deal of interest in this solution is that of the District of Columbia.

QUESTION: Even if we move to individual choice, how do you think that would affect the delivery system? Health care is expensive; we know that. But we also know that our delivery system is pretty inefficient, and the insurers as they currently exist in most places, even where they have significant market power, seem to be unable, so long as they're not vertically integrated staffer-model HMOs, to affect the delivery system.

DR. McCLELLAN: When doctors or nurse practitioners or health care groups take steps together to find better ways to treat a patient with diabetes, to reduce the duplicative tests, to use phone calls and education to help improve compliance and keep them out of the hospital and maybe out of the doctor's office, the consequence of that, not only in traditional fee-for-service Medicare, but in many other health plans as well, is you get paid less.

So it's very hard to take those kinds of steps, even if you know they are the right thing to do as a health professional, and still make ends meet in your practice. What I've continued to be impressed with, as I go around the country and talk to people in a lot of these health care systems, is how much they are trying to do the right things despite the fact that they are facing a very strong financial tide pushing them in the other way.

But, again, there are more things that we can do. More patient choice and control is going to help. That has certainly been the case in Medicare, and also Medicaid. Where states have given people with chronic illnesses more ability to choose coverage, they choose coverage that has an emphasis on prevention and care coordination and wellness, and that saves money.

There also are more steps we can take to help provide better information on what's working and what kinds of health care delivery systems are delivering better care at a lower cost. Many of these systems are trying to do things like Professor Michael Porter of Harvard University talks about in his book, *Redefining Health Care*. But we need to take more steps to make available better information on quality and cost. That's something we're working on now at my Center through a collaboration with a large number of health plans and with help from Medicare as well.

Finally, no single private health plan can do it if the rest of the health care system is acting in a way that doesn't promote prevention and efficiency and personalization in care. That's why it is so important to keep taking steps forward with Medicare and Medicaid—the public insurance programs that now account for about half of health care spending—to make sure they support the kinds of reforms that we're talking about. The Senate Finance Committee is trying to work on some bipartisan ideas to do that in the Medicare program, and it's also very important to see those move forward.