Health Care In America

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ROLL CALL

Q&A With Health and Human Services Secretary Mike Leavitt

Building a Health Market

HHS Secretary Mike Leavitt Is Ready for a Battle of Philosophies Over Health Care

File Photo

[Roll Call Q & A]

The challenges are clear: reducing the rolls of the uninsured, providing health care for all children, taking advantage of cutting-edge technologies. Health and Human Services Secretary Mike Leavitt believes many of the solutions can be generated by a robust marketplace. The former Utah governor and Environmental Protection Agency administrator says he's ready for a profound debate on the future of health care in the United States.

Roll Call Executive Editor Morton M. Kondracke sat down with Leavitt earlier this month to discuss the health care issues that lie ahead.

ROLL CALL EXECUTIVE EDITOR MORTON M. KONDRACKE: Before we begin to address contentious elements, it seems to me that there is a bipartisan agreement on a number of things on the health care front. One is that we ought to get maximum numbers of health records on digital, that we ought emphasize prevention in health care and pay for prevention, reward prevention and disease management. Now, how far along are we and can we get before the end of this administration in a bipartisan agreement that would at least get those things done to the maximum possible potential?

HEALTH AND HUMAN SERVICES SECRETARY MIKE LEAVITT: As you suggest, the wide land of agreement between the philosophies of how health care ought to be operated is that we need to have a health care system and right now we don't really have a system. All we have is a big, robust sector that is rapidly growing and without a great deal of organization to it. And at the heart of that is the electronic medical record. And then on top of that you need to have a way of measuring quality. And you have to also achieve a means of comparing price and there needs to be an incentive that motivates everyone to do the right thing and to increase quality and to reduce the cost. Those are essentially agreed-upon principles. The issue is how do you get from a sector to a system and accomplish that. In the past, people have said that there is just a lack of political will and yet my prescription is that it is likely the opposite of that. It is that there is an overabundance of political will and every time people try to legislatively get through the complexities of achieving those four things, they get bogged down in the political warfare that sort of breaks out based on proprietary interests. It is likely in my judgment that rather than a legislative solution that the market will begin to shape itself by market action. Without legislative action we've begun to see the largest payers in the country begin to say to their providers and to their vendors, "we need you go cooperate in the development of standards." Standards is what drives health records. ...

ROLL CALL: Health IT, information technology.

LEAVITT: That is health IT. Until you can come up with a standard. ... You may have heard me use this analogy before, so pardon me if you have, but I spent a fair amount of time studying the railroads of the 1850s and we were building railroads in the East and in the West and in the South. But they were different rail gauges. And we are going through the same debate right now: What is the size of the rail gauge? It is a highly oversimplified way of describing it ... and when you start trying to develop standards of interoperability for something as complex as health it is mind-numbing detail, but there is no other way to get there. So the thought that we are going to somehow legislatively create that mind-numbing detail is, well, it is just not likely.

ROLL CALL: So just how far are we from having interoperable health records digital?

LEAVITT: Well, we are making dramatic progress. The best way I can tell you is if interoperability was this big, we are about this far. And next year...

ROLL CALL: So we are about a third of the way?

LEAVITT: Well, I wouldn't say that. We are probably 15 or 20 percent, but rapidly moving. I think that within three to four years we will see interoperability of health records happening in a far more robust way. Now let me measure in a different way for you. We have created a means by which systems can be certified as interoperable or on a pathway to interoperable. And we now have more than 75 percent of the market certified that they are on that pathway. And we got there by having the federal government say we are going to adhere to these standards and if you are going to do business with us you need to adhere to these standards. Then we've got the largest other payers in the country — unions and large employers — to say the same thing. So the market followed and said, "Fine, if you are going to develop the standards and if you are going to adopt them then we will adopt them and we will migrate our systems to be compatible." So we now have about 75 percent of the market, not of the systems, but of the market have begun to adopt them.

ROLL CALL: So the one element that people say that there needs to be a federal subsidy [is] to get all these doctors' offices all around the country, which have all these paper records, digitized. That they simply cannot afford to do it on their own.

LEAVITT: Well, there are several parts to that. Let me unpack for you. If years ago we had said the Internet is the thing and everybody's got to have the Internet in order to do business in the future, and therefore the government will pay for it all, we'd still be back in 1995. But the market began to shape and the macroeconomics of business began to reshape, and it became clear that if you were going to do business you had to have the Internet, and people began to reorient their business systems. The same thing is happening in health care already. The government has said in the future you got to have electronic medical records. Not only are we going to require those we do business with to have them, but we are also going to pay you more if you begin to report information about quality. Over time those macroeconomics will change and health IT will become just like having a surgical table. It will be part of the overhead. And also the economics will produce real value. Right now, the value doesn't match up. Those who are being asked to make the investment aren't necessarily getting the benefit. But that is beginning to change and it is the reason we are seeing dramatic spikes up in the number of people who are adopting systems. And another thing that has happened is that when we were dealing with different standards and no one knew what the future was, people were reluctant to buy. Now that we are creating standards so that people know what to buy they are beginning to.

ROLL CALL: How far down the road are we toward a system that pays for prevention services, as opposed to treating diseases, and a reward-for-results kind of system?

LEAVITT: Well, again, if you look at the system that you have described it requires four things. You've got to have electronic medical records. You've got to have some way of measuring quality. You've got to have a means of being able to establish what a market basket of services costs by comparison; you've got to have a bucket of care that you can compare. And lastly, you've got to have incentives. All four of those have to be into place. And we are moving in parallel on all four and we continue to make progress. How far are we away from it? Well, we are already beginning to see in limited procedures and in limited areas those components coming together. I believe in two years you will see it as a regular feature of medicine. I think in five years you'll see value being a regular part of the medical lexicon. I think in 10 years it will be ubiquitous. So I think the system that you described will be with us 10 years from now, but it won't happen with a switch. It will happen incrementally and it will happen at different times and in different ways.

ROLL CALL: OK. Let us go to the contentious stuff. First, coverage.

LEAVITT: There is less contention there, but it is intensely technical and hard to talk about. And, frankly, very few people take the time to understand all of the complexities of it and hence it lacks attention.

ROLL CALL: Well, the Democratic candidates for president are seemingly all in favor of a national, universal coverage system of some sort or another. And some of the Republican candidates are, too. This administration has never proposed a national, universal health coverage system. Why not?

LEAVITT: I believe there is a widely held aspiration that has developed recently that every American have access to an affordable, basic insurance policy. That is an important development. I believe there are two divergent philosophies on how to get there. One would have the government owning the system: setting the prices, designing the benefits, taking the risk. The other vision would have ...

ROLL CALL: That is the Democratic vision.

LEAVITT: That is the Democratic vision. The alternative to that is to have a national strategy that says if you are elderly or poor or disabled, government needs to offer you coverage and pay for most of it. But everyone else deserves to live in a place where their state has organized a private market. I think we will see those two visions emerge, both leading to an outcome that would produce every American having access to an affordable, basic plan.

ROLL CALL: Well, we are going to have a presidential campaign presumably that pits those two against one another — based on what happened recently in the two debates, I think. Don't you?

LEAVITT: I think that it is very likely we will see health care emerge as the most significant domestic policy debate and I think we will see it emerge before that.

ROLL CALL: Now, when [Sen. Hillary Rodham] Clinton [D-N.Y.] and Sen. [Barack] Obama [D-Ill.] and [former Sen.] John Edwards [D-N.C.] talk about this, one of the first things they say is that the health insurance in-

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Leavitt: Drug Benefit Is a Model to Be Emulated

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dustry is making too much profits and spending too much on administration. They say that something like 30 percent of all health costs in the private sector go to insurance company administrative [costs] whereas Medicare can do it a lot cheaper, that administration overhead is 2 percent or something like that. What is your view on that subject?

LEAVITT: If one believes that the government ought to own the system and hence by price-setting and setting benefits and having taxpayers take the risk we can be the most efficient, it would be best to look back over the course of the last 40 years and see where Medicare — which is that system — got us. We are in a place where Medicare continues to encroach on every other aspect of our budget. The cost has gone through the roof. It threatens the sustainability of our system, and it is just not a system that can be sustained. That is what happens when government owns the system. It gets you longer lines and it gets you long waiting lines and that is what we have developing. It gets you government setting the prices, which means that the system pays way too much for certain things and underreimburses others. If you want an efficient system you have to have an efficient market. If the 21st century has proven anything, it is that an efficient market will create more productivity than government regulation. Again, I would come back to the fact that there are two emergent philosophies: Should the government own the system or should we organize the system? Government clearly has a role. This is a debate about the role of government in health care. If the government organizes it, we see what happened with Medicare Part D.

ROLL CALL: The prescription drug program.

LEAVITT: That is right. If you look at Part A and B and the results we've had over the last 40 years with costs going up, up, up, up, with dramatic disparities in how much is paid between different locations, with fraud and abuse and all the things that go with large socialized systems, and then compare that with what is happening with Part D where we have competition, we have choice and we have innovation, the results speak for themselves. On Part D, we are seeing costs come down. We are seeing people enrolling. We are seeing them feeling good about what they have. If they don't like what they have, they have a choice. We are seeing plans competing to find out what it is that consumers want. It is a stark and quite remarkable comparison.

ROLL CALL: What is the answer though to the assertion that private health insurance overhead is 30 percent and Medicare overhead is in single digits?

LEAVITT: Well, again, I don't think that you can draw that comparison because [of] what goes into Medicare overhead and what is paid for. I mean, there [are] a lot of things. ... People talk about the Veterans Administration. What is left out of that equation, as wonderful a system as it is, is that we have invested billions of dollars in their hospitals and in the campuses on which they sit. It is a much different set of economics and to measure them and compare them just isn't an apples to apples comparison.

ROLL CALL: Well, one comparison with the VA is that drug prices that they pay through negotiated or set prices by the VA are much lower than the average cost of the same drugs in the private sector under Part D, and Democrats are always saying that the government ought to be negotiating. What is your answer to that?

LEAVITT: Well, again, to try to compare the VA system with a private model is comparing apples and oranges. Again, the doctors are employees, the hospitals are owned and paid for, and the VA has a very restrictive formulary. In other words, if you go into the VA and you want to get certain drugs, if you want Lipitor, you can't get it because they buy a generic brand. If you go to a private-sector hospital you have choices. You can go to a Medicare Part D plan where they only offer generics and find that it is much cheaper than if you want to be able to have choice.

ROLL CALL: So the administration's answer to the fact that we have got 46 million to 47 million people uninsured in America is to go state by state and hope that the states will gradually cover these people?

LEAVITT: Well, what the president has said is that first of all we need to solve the problem of the blatant discrimination that occurs between people who get insurance through an employer and those who have to buy it on their own. He made a proposal. Others are now talking about other solutions to that same problem, but we are not going to be able to solve the problem until we deal with that dilemma. He has also said that there are lots of things happening in the states and we need to build on that. And it is not just a few states. It is almost every state. I believe that we could achieve every American having access to an affordable basic plan if we were to build on what is happening with the states and provide them with the tools that they need and it could happen within five years.

ROLL CALL: So what do you think about the Massachusetts plan and the proposed California plan, which are individual mandate ideas? Do you think that is a possible model for the country or not?

LEAVITT: Well, I signed a waiver that allowed the Massachusetts individual mandate experiment. I did it because I believe it is a very important development and we will all learn from it. But it is important to know what it is. It is a pooling mechanism. It is a way to make certain that people who are sick don't buy insurance just when they are sick. There are other ways to solve that problem and many states are looking at different ways of solving that pooling problem. An individual mandate is one. The most important development that happened, I believe, in Massachusetts was the so-called connector because it developed a means by which people who are individuals or small employers can buy insurance on the basis of larger group rates and, maybe just as importantly, it allows them also to streamline the way they pay for it and have different parties contribute to their payment. For example, if I need insurance and I go to a connector it may be that I can pay part; it may be that the employer is willing to pay part; it may be that the state is willing to pay part; and it may be that I can get some tax benefit that would pay part. Well, up until now there has been no way to bring all of those together to share in the payment of the premium. There now is. That is a very important development because it means that we can share ... everybody can do their share to make certain that they have access to an affordable policy.

ROLL CALL: Have you had any uptake from the Democratic Congress for the president's proposal of a tax credit to pay for health insurance?

LEAVITT: The president proposed what we refer to as the standard exclusion. ... Others have proposed to solve that problem in a different way. If you look at many of the proposals that the Democrats are putting forward they talk about refundable tax credits. There are Members of Congress on both the Republican and the Democratic side who are saying we need to solve this problem but we need to solve it with a refundable tax credit. The important thing is that the problem gets solved. Once it is solved and once we achieve that level of equality the problem becomes imminently more solvable.

ROLL CALL: Well, the initial reaction of the House Democrats at least to the president's proposal was no. There seems to be some interest on the Senate side in the deduction or exclusion. What do you think the prognosis is for this Congress?

LEAVITT: Let me foreshadow what I think is going to happen over the next six months. The vehicle to force this debate onto the floor of Congress is [the State Children's Health Insurance Program]. SCHIP was passed 10 years ago and now insures several million children. It has been a successful program to insure low-income children. Everyone believes it needs to be reauthorized, but again there are two competing visions. Those who would have the federal government own the insurance system and insure everyone say "let's just add 9 million more people to the rolls of those the federal government insures." I will tell you that about half of those currently have private insurance.

ROLL CALL: That is a disputed study, is it not?

LEAVITT: There is not much dispute about it.

ROLL CALL: There are 9 million uninsured in the country, aren't there?

LEAVITT: That is the disputed statement. What we do know is that when you add people to public-funded insurance that people drop off of private plans and end up on federally paid-for plans. Is it an exact causal relationship? No one knows with certainty, but there is a clear pattern that whenever you add people to federally paid for coverage that people leave private plans. Now let me go on in terms of where I think this happens. The Democrats are proposing that we add millions to the rolls of those who are covered by SCHIP. They propose a plan that would cost about $75 billion, or $50 billion more than what it currently costs over the next five years. I believe there will be alternative plans that emerge from the Congress that will essentially say it is good to reauthorize SCHIP, but we ought to go further. We ought to be helping not just children, but adults. And we ought to not just be going after just children and adults, we ought to be going after every American and providing them with a means by which they can provide insurance. So therefore let's reauthorize SCHIP, but let's also take on these other issues and look at ways of solving the problem.

ROLL CALL: This is your proposal?

LEAVITT: No, this is what I see emerging from Congress

ROLL CALL: OK. But where is that going to come from?

LEAVITT: Well, there are four or five pockets of Members that are currently organizing and I think you will see a proposal begin to come forward in the next few weeks that will essentially juxtaposition ...

ROLL CALL: And this will somehow embody either the president's standard deduction or a tax credit?

LEAVITT: Mmm hmm.

ROLL CALL: And this will be kind of a private market solution?

LEAVITT: It will be a solution that includes the states meeting to organize their marketplace so that every person has a choice of basic insurance plans. The vision will be that every American will have access to an affordable basic policy. That there will be a marketplace that will create choice and that consumers will have the ability to acquire insurances and receive equal treatment under the provisions of our tax code to help them afford it.

ROLL CALL: On SCHIP, the administration is recommending only $5 billion over five years additional to extend the program. The critics say that in order to cover all kids currently eligible you would have to have $13.4 billion at a minimum. In other words, there are kids who are now covered who are going to lose coverage under your plan. What do you say about that?

LEAVITT: We commissioned the Urban Institute to do a study on how many children who are currently eligible don't have coverage, and it is 690,000. If you multiply that by the cost of an SCHIP benefit you'll see that our proposal is well within range of being able to cover all of the eligible children. If you start to add all of their parents and if you begin to run the number of who is eligible up to 400 percent you can get to a number that is ...

ROLL CALL: You are talking about all kids under 200 percent of poverty, that that is what it would cost? You could cover all kids under 200 percent of poverty for $5 billion?

LEAVITT: Yes.

ROLL CALL: OK. Now, the critics say that in these states — 14 of them, I believe, where adults are covered or up to 350 percent of poverty in some cases — they are doing this because you signed a waiver to let them do it. And now you want to underfund them and you will kick some of those people off of coverage that they already have.

LEAVITT: Let me reveal a truth to you that is lost in this. This is not a question of whether or not those people are eligible to get insurance. This is a dispute between the states and the federal government on who is going to pay and how much because every adult that is eligible for this plan would be eligible for Medicaid. The reason the states want to put their adult people on SCHIP is because they get a much higher match than if they had them on Medicaid. This is about the money. This is about whether states pay 25 percent or whether they pay 50 percent. And given a choice they would rather pay 25 percent. Our proposal makes very clear: We want everyone who is currently on SCHIP to be eligible. We are not kicking anybody off, but we are only prepared to pay the enhanced match for low-income children. If you are putting adults on SCHIP just to get more money we think that is wrong. Either take the Medicaid match and leave them on SCHIP or take them off SCHIP and put them on Medicaid.