

The Arlin M. Adams Center  
FOR LAW AND SOCIETY

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Susquehanna University

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ARLIN M. ADAMS CENTER FOR LAW AND SOCIETY  
SYMPOSIUM  
CODE BLUE: CAN WE SAVE THE HEALTH CARE SYSTEM?

SUSQUEHANNA UNIVERSITY  
DEGENSTEIN THEATER  
SELINGROVE, PENNSYLVANIA  
MARCH 26, 2009  
7:00 P.M.

CONCLUDING DIALOGUE:  
SHOULD WE ADOPT UNIVERSAL HEALTH CARE COVERAGE IN AMERICA?

PARTICIPANTS:  
Claudia Fegan, M.D.  
Devon Herrick, Ph.D.  
Allan Sobel, Director  
Arlin M. Adams Center

Before: Sarah C. Thomas, RMR  
Reporter-Notary Public

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MR. SOBEL: Good evening and welcome to the concluding dialogue of our symposium on health care in America. During the past day we have had the benefit of a key note address from Jonathan Cohn, who wrote the book *Sick, The Untold Story of the American Health Care System*. We had a presentation first thing this morning from Dr. Dorothy Bazos, who is a member of the Citizen's Health Care Working Group, about what Americans would like to see in health care reform.

Then we had three panel discussions. The first was what role government, employers, and insurers have in the health care system. The second looked at the balance that is required when you have to consider both affordability and comprehensive coverage. And then the third panel this afternoon looked at barriers to reform, what you have to overcome to bring about health care reform to America.

This evening our concluding dialogue, I suspect, will involve a presentation that will make many of the points that the individual panel members made during the three panel discussions because, of course, all of these issues are involved when you ask the broad and difficult question of whether America should adopt a system of universal health care coverage. And we are very fortunate to have participating in this dialogue two of the nation's authorities on this topic. Dr. Claudia Fegan, who is a proponent of universal health care coverage, is a Board certified internist who served as the medical director at both Michael Reese Hospital in Chicago and the Fantus Health Care System, which is part of the Chicago public health system, and serves about 300,000 patients each year. Michael Reese Hospital, the hospital at which I was operated on a number of years ago, was probably one of the finest teaching hospitals in the United States and I understand that it's now closed, but it really was a great privilege to be a patient there. I am sure it was a great honor to be medical director there.

Dr. Fegan has -- by virtue of her daily activities, she's been and is in the trenches of health care in America. She's also served as president of Physicians for National Health Care Program, which is an organization of 15,000 physicians, medical students, and health professionals that advocates for a single payer universal health care system in this country.

Dr. Devon Herrick is a senior fellow of the National Center for Policy Analysis and he concentrates on health care issues. He received a Ph.D. in political economics and has a Master of public affairs from the University of Texas at Dallas, with a concentration in economic development. Dr. Herrick's dissertation examines patient empowerment through empirical analysis of the internet and disease advocacy.

Because of the fact that Dr. Fegan is the proponent of universal health care coverage, we have asked that she go first in this dialogue. Please help me welcome Dr. Claudia Fegan.

(The participants pointed out that Dr. Herrick is to go first).

DR. HERRICK: As Dr. Sobel said, I am the antichrist. Really, before you drag me out and beat me to a pulp, let me clarify. I am in favor of everyone having access to health care. I am in favor of a market that works well, where people can get high quality medicine at a price they can afford.

However, I am an analyst of the current health care debate and what is being discussed, many of the programs that are talked about. I think Dr. Fegan will also give you a -- give you her view, which may not be exactly what the administration is proposing, either. So in that regard we probably agree that we are a little bit hesitant to embrace the administration and their current view on health care.

What I'm going to do is, the current debate, I am opposed to the current view or the current definition of how they plan to achieve universal health care, but I promise you I am in favor of us all getting health care.

So let me start -- actually, before I get into the various proposals or the main dominant proposals, let me just get some context. If we talk about reform, what do we try and reform? Well, our problems in our health care system are numerous. We are all here today to say our health care system is in dire need of reform. I have not heard a single person here today say, I like the status quo. It is wonderful. There are stakeholders that are doing okay.

There are stakeholders that really do like the status quo, but virtually all policy holders agree our health care system is in dire need of reform.

So what is the problem? Access is problematic, quality is inconsistent, and cost is high.

For example -- I think this came from the Study for Health System Change -- they asked people what are some of the barriers to getting health care or physician care. About a third of the people said, "I can't get in to see my physician. I get sick after hours. I can't get my doctor on the phone or my doctor is too far away".

Now, this came from the California Health Care Foundation. As I recall, this was actually people that had insurance. "Why do you go to the emergency room?" Fifty percent said, "Oh, it's more convenient". I can't imagine the ER being more convenient than seeing your doctor. For some people the doctors are not open after hours or they can't get a timely appointment.

Now let's talk about quality. That's access. What about quality? I have more slides than I can really use. I have more material than I can talk about. If I jump over something, I'm trying to hit the high spots.

The Institute of Medicine says up to 98,000 people may die from medical errors every year. There are numerous drug errors. There are numerous possible hospital-acquired infections. We have wonderful health care in many hospitals. Some hospitals are no good at those. What is really annoying is that success is not high on the list. That's why I say quality is inconsistent.

It is expensive. U.S. firms are paying roughly eight percent of payroll on health care benefits. We are spending more than 50 percent more other than ODC countries. As an economist, what those words mean is that health care expenditure is rising at twice the national economy. It is rising at three times the rate of inflation.

This is a figure. You can see how we can compare to other countries.

You probably have the same graph, I bet.

This is an example of how our health care cost has risen in recent years. As you can see, health care expenditure is rising and the percentage of GDP has been rising in recent years from roughly five percent in 1960 to roughly 17 percent today. The national health expenditures, we will spend roughly 2.3 trillion dollars this year. Actually, last year. Health care inflation: what is the yellow line? That is inflation. That's the consumer's price index. That's all other goods. Medical care has gone up about three times the rate of other goods the last 60 years.

So let's put this into context now. The reason why I'm going through the problems of the health care system is because when I discuss some of the current proposals I want you to be able to look at and be able to say, "do I really think the common proposals will solve those problems?"

And to be very fair, I mean, one of President Obama's advisors, Cass Sunstein from Harvard, he wrote a book a few years ago called *Your Money or Your Life*, he pointed out longevity has risen about nine years since 1950. We get quite a bit of benefits for the additional spending.

Also, why are we spending so much? Well, health care is paid for in a very inefficient way. I would argue that we overuse third-party paying for things we could afford to pay out of pocket. There is little cost control.

Why is there no cost control? Well, all other goods are rationed in some mechanism or other. We call it price rationing. You go to your local grocery store. You decide what to buy. Am I willing to pay for it? Is there another place I can get the same goods for less money? That's because they are competing on price because you are their consumer.

Well, in 1960, about half of all health care was paid out of pocket. Whenever you spoke to your doctor or went to your hospital, you were concerned about price. You were price sensitive. They would look you in the eye and they gave you the bill, one physician has told me.

Twenty years later we are paying for only about a quarter of health care directly out of pocket. We now pay about one-eighth of the health care consumed out of pocket or directly. The other seven-eighths are paid by someone else. That could be insurers. That could be government. That could be your health plan.

So what is the most common proposal out there? I mean, you can look at discussions in California from a couple years ago. Illinois has talked about it. There was a blue ribbon commission in Colorado. I think Pennsylvania has even discussed it. A lot of these proposals have a lot in common.

If you look back, for example, Hillary Clinton and her campaign had a very similar proposal and Barrack Obama has a very similar proposal. The route to universal health coverage in this country, the current debate centers on about five different concepts, the first of which is an individual mandate. What that means is you make a law, as they currently have in Massachusetts, that you must have health coverage.

I'll go through these and I'll go through examples of each. Another common refrain is employer mandate. What employer mandate is, if you work for someone, for a firm, they must provide you health coverage and subsidize a meaningful portion of that cost. And, of course, if you tell someone we can legally make you have health coverage, the common argument is, well, what about those that can't get coverage? Well, they say in that case we will mandate acceptance.

Community issued, community rating. We will force insurers to sell you coverage regardless of health status, regardless of if you have continuing process at a price that the sick pay very little more than the healthy. Oftentimes they also mandate benefits. You must cover this or you must cover that.

Of course, as we have already seen, expanding public programs. Last year and then again the first of this year, the big debate was, should we expand income eligibility for SCHIP, or the State Children's Health Insurance Program? Now that we have it, should that include a public plan to compete with private plans?

So let me explain why I think this road to universal coverage will not achieve its goals. What individual mandate? The argument that you must have coverage. We will make a law that you would have to have coverage.

Well, I think the problem with that is I'm not sure if it can be easily enforced. I think it can drive up the cost of coverage when you consider the fact that anything that's mandated, you create a magnet for special interests to depend on state capital and demand goods and services would be covered in a mandate. If you have a mandate, obviously some people will not be able to afford the coverage, so that this requires that -- really obligates taxpayers to have huge tax subsidies.

I think, like a minute ago, the special interest will depend on the state capitols and their particular origins or the federal government in Washington will demand that their particular service, whatever their service is, whatever their advocacy is, that will lead to costly regulations.

This is a graphic that I pulled -- now, this is not representative of every single state. I picked a sliding scale to throw out some examples of the various states.

It's argued about 47 states have a mandate you must have auto liability insurance, but yet in many states the portion of the uninsured drivers is very similar to the portion of those who lack health coverage. In fact, if you look at the middle, the very center, the average is more or less for both. Roughly 15 percent of the population lacks health coverage. Well, if you look at those that lack auto liability insurance, a national average is about 15 percent.

Now, there are some states that are not in this particular graph, that are higher or lower on one point or the other. Some are much higher in terms of portion of underinsured motorists versus those who lack health coverage and other states flip-flop. This is just a selection to show you what many of the states look like.

In New Mexico, nearly a quarter of the population lacks both health coverage and auto liability insurance. Massachusetts, which has one of the lowest rates of uninsured people in the country, also has the lowest rate of uninsured drivers.

Well, health insurance is far more costly than auto liability insurance. With auto liability insurance all you have to do is go in and get a new registration. Where you drive you have to get an inspection. But I'm not sure it will be easily enforced in terms of making people get coverage if they don't

want to have that coverage or if they don't want, in many cases, to pay for that coverage.

Employer mandate. It was mentioned this morning -- I think Mark Pauly was here this morning -- and it's really the idea that employers, you know, of course, stay off the coverage. They write the check. But that's really a form of compensation. Employers don't pay for health coverage. Employees do. It's passed on in lieu of wages.

So if you -- say you force employers to pay for coverage in cases where they otherwise would not, you, in fact, are forcing employers to pass that cost onto workers. And the employers that don't tend to offer employee benefits in terms of health insurance oftentimes don't offer it because their workers are unwilling to forego that amount of wages.

So from the standpoint if you decide to make employers pay for health care, you are, in fact, creating a tax on labor. Of course, taxes inhibit job creation.

And there is a recent study by TPREPFB Faye and Feldman that suggest it may even erode employer coverage from the standpoint of it's pay and play. If you don't offer that coverage, you must pay into a state fund, or federal fund in this case.

A lot of employers we say, "okay, we aren't going to offer health insurance. We are going to bail. We are just going to pay the wage. Let the federal government bear the cost, and we can go on about our business and not have to worry about it".

Of course, the biggest obstacle currently is that it violates federal law. Of course, federal law can be changed.

I mentioned mandate acceptance. The argument goes if you force workers to have coverage, then you should then force insurers to accept all that apply. These regulations are known as guaranteed issue and community rating.

I think approximately six states currently have this mandate, and the problem they have experienced is if you are charging younger people more so that older people can get a better deal, the younger people tend to want to opt out because, after all, why would you want to get insurance now if you can wait until later, when you really need it?

The idea, what we need is people in the insurance exchange the whole time. If you are the young 22-year-old and immortal and you are told you need to pay two or three times the expected cost so those that are older can get a much lower bill, they tend to balk. So we don't want people waiting until they need care to apply for coverage.

And this is an example of the annual cost of medical care by age. This is intuitive. We already know when you are younger health care needs tend to be very low. In fact, what's interesting is the costs don't even tend to rise very much until you get to your 50s and, of course, in your 60s and 70s it goes up at a much, much higher rate.

So the rates that -- the guaranteed issue and community rated states, what they want to do is they want to have people at the far end of the graph pay more than their medical costs.

Well, my argument is this is very similar to the life cycle theory of investing for retirement funds. When you are young you are paying into a fund that you don't control, where only a portion of my money goes for high level health coverage, but about half of my premium goes into an account I don't control, so in time instead of paying into a general fund, I am actually putting money aside when I'm young. Although I'm claiming I'm still young. That's debatable. So when I reach this age I can draw down some of those funds. Very similar to an IRA or 403(b).

And the reason why I think this is a better model than just paying into a state pool, where a third party controls your money, is because I am a better steward of my money. If I can benefit financially by taking that \$4 drug from Wal-Mart. If I can benefit financially by seeing that retail-based clinic, there are things we can do as consumers, which I think we have little incentive to do if someone else is paying the bill.

The states have used this model of guaranteed issued and community rating. The annual cost of family premiums, according to the American Health Insurance Program, is in some cases double from the other states.

Something else that worries me is, as I said a minute ago, or a few minutes ago, any time that you have a law that says you must have this product, there is a whole, you know, category of people, lobbyists, advocates who want to be able to decide what is good enough. It's not enough just to say, "You must have insurance". A body, an organization, a board must have the authority, the ability to decide at that point whether you met the mandate.

Of course, the communications will be advocacy to be only comprehensive plans count. Under those conditions my plan will not be good enough. I have a self-pay account. There are those that don't like that concept. What if the board decides that doesn't work?

I believe that we run a big risk of having a lot of special interests trying to mandate a package. If you look at nationwide, counting all 50 states, you can add a total across all states of roughly 2,000 mandated benefits and providers. And various studies have shown that maybe up to a quarter of uninsured may have been priced out of the market.

A recent study by Stephen Parente at University of Minnesota suggested if we have had a national market, meaning if you could buy insurance across state lines, where somebody in a high-cost state may bypass regulations and go to a less expensive state, you may increase the individual and group market by roughly 12 million people.

Of course, the states where the small group and the individual market would climb the most are those states that have the highest cost due to regulation. For example, New Jersey would increase their market by roughly 49 percent, according to Stephen Parente.

I am almost out of time. In fact, I have about two minutes, maybe.

Finally, one of the other examples -- we have already seen this occur -- is that the road to universal coverage always includes expanding public programs. And we already had a debate the first of this year about expanding income eligibility for the State Children's Health Insurance Program.

Of course, this requires massive subsidies, but what worries me more than that, because it's not particularly expensive to insure a child -- we all want kids to have health care -- but what worries me is if you increase eligibility you give a lot of kids who already have coverage and their parents suddenly find, hey, we are paying for something that's now available for free.

Jonathan Gruber from MIT did research on crowd-out ratings from the Medicaid expansion program. They also did research on crowd-out from the SCHIP program. And they are other studies out there. I think CBO did a lit. review and they found a range of 20 to 50 percent crowd-out. Jonathan Gruber, who is by no means a conservative -- in fact, he likes the SCHIP program -- he found a range of crowd-out from every ten kids enrolled may have been five to seven people who dropped private coverage. SCHIP, the average is around six in ten.

The devil is in the detail. If you increase the public program by increasing eligibility, you will have people who drop their private coverage to take advantage of the new public program.

And the arguments or the debate in Congress a year ago, the House wanted to increase eligibility for children in families earning up to 200 and 300 percent of the federal poverty level, which is roughly the law that went into effect this year. Among those kids, 77 percent already had private coverage.

The Senate was interested in expanding coverage from to people from 300 up to 400 percent. Of those families, nearly 90 percent already had private coverage. So the more people in the newly eligible program who already had private coverage, the more people you find suddenly dropping what they are paying for privately to get what is now free publicly.

In Massachusetts -- I think this is coming from New England Journal of Medicine or JAMA, actually, about a year and a half ago -- what they found -- they have a mandate where everyone is supposed to have health coverage. Of course, most of those taking advantage of this are finding the newly insured or, in fact, people who are getting into the public programs, they are having a harder time getting those people who have to pay their own way to actually go out and get coverage.

This is my last graph and I'm out of time, so I'll make this very quick. What I advocate, I think consumer-driven health care is where you control more of your own plan. You have a higher deductible plan. You don't give a third party insurer control of an account that you control. Why do I think this would

work? I think 300 million consumers can do more to rein in high costs than federal bureaucrats or state bureaucrats or HMOs, or so on.

This is research I did a couple years ago on cosmetic surgery. You say, Why cosmetic surgery? It's the one area in the U.S. where you pay entirely out of pocket.

So what does this mean? This is actually surgeon fees. This is an index of surgeon fees, weighed by how popular certain procedures are and increases in prices over time.

Basically look across the red line. That is the consumer price index component for medical services. Over the last roughly 13, 14 years the price - - consumer price in Texas, the increase in price for surgeon fees rose about 77 percent.

The yellow line, that's inflation. That went up about 39 percent. In other words, the general fees for medical care services rose double the rate of inflation.

The green line is cosmetic surgery. That's the cost of cosmetic surgeon fees people paid out of pocket where they had to price compare. They had to find the surgeon or even a package deal, someone competing for their business. That actually rose at a rate less than inflation.

So, in fact, that is what we would like to do with the health care system, get consumers involved. And I don't really see that happening unless consumers control more of their own funds, more of their own health care dollars.

We are paying for it indirectly. We are paying for it in taxes, foregone wages, in some cases out-of-pocket payment.

What I would like to see is patients control more of their money rather than conceding that control to employers, insurers, or government.

With that I will -- well, hand that to you.

DR. FEGAN: Thank you. I'm glad to be here. So my name is Claudia Fegan. Physicians for National Health Program is an organization of 50,000 physicians and we are committed to a single payer universal health care.

I think we have heard some good discussion today and the question is, where do you go from here? What's next? And this is my trouble ready project, that President Obama was left with a lot to clean up. You get the idea.

This is Cook County Hospital. Anybody see The Fugitive? Okay. This is our hospital and they're actually tearing it down now. We have a brand new hospital. But I feel like a lot of people walk past this building in disrepair and wince.

It's emblematic of where I think our health care system is today. There is a lot of work that needs to be done.

We built a new hospital. It's a beautiful hospital. It's a state-of-the-art hospital. It's too small because we built it -- first got the approval for it was in the '90s. At that time we thought everything was going to ambulatory care and that we wouldn't need as large a hospital. But no one foresaw the concurrent downturn and increase in the number of uninsured, and so we have a tremendous capacity problem now with an occupancy rate at the new hospital of over 100 percent.

Seventy percent of the patients I see on a daily basis are uninsured. We have a million outpatient visits a year within the county system. We have a network of three hospitals, one of the largest jail facilities/health facilities in the country, and a network of clinics. And we are struggling, but I think that our struggle is really more of a symptom of this country and where we are with health care today.

One of the things that people are confused about or forget is that the majority of the uninsured in this country today are working people and their families. The majority of the 70 percent that we see that are uninsured are folks that get up every day and go to work, and they have jobs that increasingly health care is not provided as a benefit because the employer can't afford to provide that benefit. The cost has become too high.

And the public study of health affairs in February of 2005, showed that over half of all personal bankruptcies in this country today were as a result of a medical illness or medical debt. It's interesting because the majority of the people who were in that study were insured at the time of the precipitating illness. Most people had spent \$11,000 out of pocket with their insurance for

their health care before declaring bankruptcy. If they have diagnoses of cancer, they had spent on the average of over \$30,000 out of pocket before bankruptcy with insurance.

And increasingly the people who are uninsured in this country -- you see the diverging line; the uninsured being the yellow or over line and the people in poverty being the red line -- increasingly people who are uninsured are people who are not in property.

I used to operate the Fantus Clinic, part of the county system, Cook County system. We have a walk-in clinic at the first floor. We used to see between 250 and 450 walk-in patients a day who came in because they didn't have insurance. That was the way to access the system. Because of the cutbacks in 2007, we are down to about an average of 300 patients a day we see there.

And the most common refrain we hear from people -- we and take people on a first come, first serve basis and we open at 7:00. The common refrain I hear from people in that line is, "I never thought I would be here." I will tell you that in that line I find accountants, school teachers. Yeah, I find taxi drivers and burger flippers and people who sell shoes, as well. But these are folks who woke up today and today they had to see a physician. It's not an emergency, but it's been going on and they finally have to see someone, so it's our reality.

Now, if you ask yourself, how is it that one of the richest, most powerful countries in the world does not guarantee access to health care? If you look around the world at all the other industrialized nations, there are about three basic ways that the rest of the world got to providing health care -- I tried to simplify them -- a single payer, a national health service, or a multi payer health insurance system.

So single payer is a publicly administered health insurance. Most of the physicians are in private practice, although some can be employed. There is variations. This would be common in countries like Canada, Denmark, Norway, Australia, Sweden, and Taiwan most recently.

An example would be if everybody woke up tomorrow and they were covered by Medicare. That would be a single payer system.

The question I get, well, isn't that socialized medicine? And if you look at health care delivery and you divide it into funding and delivery, in a single payer system we are talking about taking public dollars and paying for delivery, which can be either public or private delivery. And in our neighbor to the north, Canada, most people have their care privately delivered. But in a single payer system they will pay privately delivered, not-for-profit care, but not for-profit care, not investor-only care.

So the reality, yes, this is a socialized funding scheme, much as we make a decision to fund education or fire or police protection. It's a societal good and society is going to provide it.

In national health service, our salaried physicians predominate. The hospitals are publicly owned and operated.

An example of this would be Great Britain and Spain. And what would be comparable in this country is if we woke up tomorrow and everybody was covered under Veterans' Affairs. That would be U.S. national health service as applied to this country.

Now, the third way is the multi payer health insurance systems. People say, Oh, that seems most like us. We should go to that. That's what people know in this country. That's what they would be most comfortable with.

But it's a highly regulated and universal. They have not-for-profit funds or social insurance funds. There is no cherry picking. There are no exclusions. Physicians and hospitals are paid for at a rate ten percent annually.

Examples of this would be France and Germany. And there is no U.S. example because if you were in this system and you have a fund, you have a sickness fund that's subject to adverse selection, so you have in one fund a lot of people have gotten very sick and cost a lot money, and the fund is losing money. And then over here you have a fund that is doing quite well, very profitable, subject to not adverse selection. They had all young people, just college graduates. The fund that is doing well would then have to take money and give it to the fund that's doing poorly so they have a level playing field.

And if you said that to CIGNA or United, they would say, You have lost your mind. These funds compete on the basis of service and compete by increasing their enrollment; not by cherry picking or selecting who they are going to get.

The physicians' proposal, which was published in JAMA in August of 2003, says that we think there are four basic principles, that access to comprehensive health care is a human right. It's a responsibility for society through government to insure this right, that the right to choose and change one's physicians is fundamental to patient autonomy.

Something I have learned in my 25 years of practice is that every physician is not for every patient. Every patient cannot relate. Patients need a physician who hears their concerns, answers their questions, and responds to their needs. Pursuit of corporate profit and corporate fortune have no place in care giving. There are lots easier ways to earn a buck and being a physician should not be all about how much profit can we squeeze out of this dollar.

In a democracy the public should set health policies and budgets, but personal medical decisions must be made by patients with their health givers; not by corporate or government bureaucrats. Those are the principles of the physicians' proposal.

Now -- and our feeling is that this is where we need to go. Now, why do we believe a single payer is the way to get there? We should be able to discuss if you have another way to get to those four basic principles.

Massachusetts has been touted as a way we can get to universal health care. They have succeeded in decreasing the number of uninsured dramatically. They took over 360,000 people who were not insured who are now insured in Massachusetts. People who make less than 100 percent of the poverty level are enrolled in Medicaid HMOs.

These programs are not available to many immigrants living in the state, who make up a large population. People who make between 150 and 300 percent of poverty have a partial premium subsidy. They have a copay. It's not affordable for many. I am going to show you what the statistics say.

People make more than 300 percent of poverty, \$31,000 for a single adult, they have to enroll in a private plan that's required. They pay \$390 a month premium with a \$2,000 deductible. Once they hit their \$2,000 deductible they are responsible for 20 percent of their costs. So if you are 56 years old you might pay a premium of \$4,000, a \$2,000 deductible, and 20 percent afterwards. So people who are in these plans say there are problems with it.

Everyone agrees -- insureds, employers, and government -- that this plan is financially not sustainable. They are currently at \$1.3 billion, which is more than \$150 million over budget. The question is, how do we continue?

They have made -- the argument this morning was, okay, so we have gotten to covering people. How do we sustain that? What they are looking at in Massachusetts, can we find different ways to compensate instead of paying fee for service?

We talk about fees mandate. We talk about some other ways to provide funding or reimbursement for providers who are within this system. We think that the problem here is that it allows the insurance industry to remain in charge in directing the costs.

The public option is a plan I think we had a little bit of explanation from Jonathan Cohn last night. This is a big piece of the Obama plan, is that we will have individual mandates. We will have employer mandates. We will offer a public option for those who wouldn't fall under the other rubric.

The problem with the public option is the concept that government insurance will be good enough and that it competes with the private insurance. If enough people enroll in that we might actually get the single payer through the back door.

The problem with public option is that it leaves too much saving. It leaves too many dollars on the table. The hospitals are already using computerized billing. Everyone who is familiar with hospital billing knows what UVA-2 is. So global budgeting will save us \$90 billion annually. We have no savings for nursing homes or home care. We could save another \$24 billion there. There is no savings for physicians' offices. We still have to bill

multiple different payers, so we lose another \$85 billion just for uniformity we achieved with a single payer.

And although the public option does reduce insurance overhead by \$38 billion, we are passing up another \$131 billion that we would have saved as a single payer. A billion dollars here, a billion dollars there, there is no way you are talking about real money.

So what I wanted to show you here, if you look at the cost savings -- the other slide is on the right. If you look at the cost savings, this big is a hospital administration. You look at the difference between the public or what we were doing currently. You look at what the public option plan would do versus single payer.

I think the real difference is the numbers here in terms of what you could save in terms of overhead. This piece, this little bar here that doesn't even exist in the single payer, that's the employers' benefit management.

So if the intelligent people can disagree about how we get where we need to be, I think that after the discussions last night and today, there is no question where we are now. It's not where we want to be.

The whole issue of national health insurance is a civil rights issue for the 21st century. Someday we will look back the same way we ask ourselves about slavery and women's rights and say, How could we have done that to 46 million Americans? How could we have the anxiety, the pain, the suffering that occurs with not being insured in this country? Because in this country if you don't have health insurance you don't really have access to health care.

So my question is on what can we agree. I gave you the basic principles of the physicians' proposal.

I had the opportunity to attend one of President Obama's health forums last week in Dearborn, Michigan and discussed this issue with Melody Barnes, who is his chief of domestic affairs. I said, Okay. We had already debated this issue of single payer. I knew that she doesn't agree with single payer. Since she is directing Obama's health policy discussion, there is a reticence to even allow single payer to be in the room.

So my question to Director Barnes and to the governors and to the state representatives there is that, Okay. If we can't talk about single payer or we can't agree to single payer, if you had certain values that you could make a part of any plan that you were going to accept, one that removes the financial barriers to care -- we have done the studies.

We know the RAND experiment that was done in the 1970s, and showed that a copayment, no matter how small, deterred people from necessary care just as often as unnecessary care and that people make bad decisions when there is an economic question about whether they should get care today. I see that on a daily basis.

So removing the financial barriers to care has to be part of any plan that we would have in this country.

Two, it's to stop the insurance industry from determining who can get what care. We require physicians or any practitioner in this country to have a lot of training before we allow them to practice medicine. And the notion that we allow the insurance industry to dictate who can get care and where they can get care, what care is available is problematic at best.

And three is that we need to remove financial harm from people to get the care they need and that no one who gets the care they need should have to lose their home, lose their job or lose their dignity. Because what we do to people who don't have health insurance in this country is humiliating. The idea that people come out at 4:00 o'clock in the morning to line up for a chance to see a doctor at County is something that no one should ever have to go through in their life time.

Now, many of you may not have heard of Paul Krugman, who was awarded the Nobel Prize in 2008. And he said, "The cost of health care is exploding. The number of uninsured is growing and corporations that still provide employee coverage are growing under strain, so I would argue that good economics is good politics. Reformers will do best with a straightforward single payer plan which offers maximum savings and, unlike the Clinton plan, can be easily explained. We need to get this one right."

Last night Jonathan Cohn said that politics is about doing what you can. And he said single payer is great. I would love to get there. But there is one big obstacle, the U.S. Senate.

I would say to you that that's the argument of the unfeasible and that we, as a country, cannot allow political feasibility to stop us from arguing for what is right. Women's suffrage wasn't politically feasible. Civil rights was not politically feasibility. The war in Vietnam, coming back was not politically feasible.

At some point we have to look at what our options are and decide, what kind of society do we want to be, what kind of society are we, and then make our decisions about what we should be doing, about the 45 million people who are uninsured in this country and another 50 to 100 who are underinsured, and everyone today who worries about losing their job and losing their health insurance. Thank you.

MR. SOBEL: Before we open this up to allow the audience to ask questions, I'm wondering if either of you would like to make any comments about what the other person in this dialogue had to say. Dr. Herrick?

DR. HERRICK: I had one question. President Obama had a health care summit in Washington a couple weeks ago and he did not include initially anyone from your organization or your line of thinking. Of course, I think it was a threatened boycott or something. Threatened protest.

DR. FEGAN: It was 50,000 phone calls to the White House on Monday afternoon.

DR. HERRICK: I guess, why do you think there is this reluctance?

DR. FEGAN: It's that political feasibility argument. Everybody says single payer is the best program. Obama said that during his campaign. There is no question. Single payer -- if you were starting from scratch, single payer would be the way to go and -- but we are not starting from scratch and that people like the insurance they have.

And I would say to you that people only like the health insurance they have maybe because they haven't used it. I mean, the numbers that we talked about is that 20 percent of the population spends 80 percent of the health care dollars. It's only when people have a catastrophic event and have to use their insurance policies that they find out where the deficits or problems are.

But the whole -- the main argument against single payer is that people say it's not politically feasible. You can't simply vote a health insurance company out of business.

And it's true. There are three health industry lobbyists for every member of Congress. That's a very powerful disincentive to look at what we need to do.

What I have a problem with, like I said, if everyone agrees that that's the best way to go. I mean, a year ago we wouldn't have talked about nationalizing the banks. What the heck are we doing right now?

So I don't see what the politically feasible argument is about.

MR. SOBEL: Dr. Fegan, do you have any comments or any questions you would like to ask Dr. Herrick?

DR. FEGAN: My only question, I understand people want to have financial control of their health care, but for many people that's not an option. For many people who are uninsured in this country there aren't any dollars that they have that they can put aside for their health care.

And the notion of putting a financial barrier is a disincentive for preventative measures. People with health savings accounts are less likely to get Pap smears, mammograms, colonoscopies, all of which we know allow us to prevent or treat disease or, in the case of colonoscopies, prevent cancer or treat disease when it's earlier and less expensive. If we wait until people have symptoms or wait for the untrained person to make a suggestion about some of these, oftentimes we lose the opportunity to save someone's life.

MR. SOBEL: Well, ladies and gentlemen, it's now time for people in the audience to ask questions that they might like to pose to the people in the dialogue. We have an aisle mic on both sides of the auditorium. If you would like to ask questions, please step up to one of the aisle mics and pose it when it becomes your turn.

QUESTION: Dr. Herrick, I've got a little bit of a list here, a couple things that bothered me about your presentation. I agree that guaranteed issue and community rating does raise insurance premiums when you don't have an individual mandate. If you did these two things together, you don't get the cost spiral that you do when you do them singly, so I would --

DR. HERRICK: That's the theory, yes. I assume it probably would be the case.

QUESTION: Thank you. We agree on that. So you are absolutely true, the cost of health care goes up as you age. Most plans put in age rate bans so the younger people even in community rating -- they are still allowed to rate on age -- so that the younger people still pay less and the older people still pay more. You can still have that in a community rated system and encourage the young people to pay.

You talked about mandated benefits and all those lobbyists descending on the state capitol floor. Well, it's true that mandated benefits add some to the premium, but it doesn't add a whole lot, economists will say, over what people would buy, anyway. People want maternity coverage and they want most of the mandated benefits. If you talk to -- other health economists will say that will add a couple percentage points to the premium. Not a whole lot of money.

Another way to frame mandated benefits is consumer protection. So I would have you respond to that. The other thing -- and I will let you -- I only have one or two more things and you can respond. I would say that the crowd-out literature, a fair reading of that is a little bit more complicated. The literature on Medicaid crowding out private insurance is more mixed and you can't really say what the causality is. Employers were dropping coverage. Private insurance was going down. At the same time SCHIP was coming online. Adult uninsurance went up. Children stayed even.

So we don't know what caused it. It could be that the public program caught those kids who would have become uninsured, anyway, which does look -- if you look at the temporal trends in adults, would happen.

And last, the health savings account, people controlling more of their money and making decisions about what they pay because of price sensitivity. I'm glad you brought up the RAND study. People don't make good decisions on that because they don't know. They don't have enough information.

But I would also say health savings accounts show a one-time decrease in expenditures of about eight percent of the care that they need is a given. But it's a one-time drop and then the increase in expenditures continues.

So it's not the panacea that saving our health care system would cost much more than that.

DR. HERRICK: I wouldn't say that anyone would say HSAs all by themselves are the saviour of our entire system. What we are saying is increased consumerism is a good thing in health care.

As you have pointed out, in a lot of studies we cite the same studies with different interpretations of those studies. For example, the RAND study found that when exposed to cost sharing, people reduce their consumption of medical expenditures by about 30 percent. By and large, the difference in health status was very similar except for the low income population. So, there again, does that mean that you have no cost sharing, which means you do not allow anyone to control any of those dollars? I personally like the system I have because I really feel that if I control more of those dollars, innovative physicians or innovative providers will create services that aren't currently available.

For example, I wrote about a service called Tell A Doc. I had a graphic up here that showed people complaining they can't get their doctor on the phone. How come? Every other business out there has a phone. Even the doctor has a phone. He just can't talk to you on the phone.

Why not? That's because the third parties -- whether it's Medicare, Medicaid, and many insurance -- although they are coming around -- they don't want to reimburse for that.

Yet with my system I can get a consultation easily and quickly for a nominal fee of around \$35. This started out with the third party payment system and now third party insurers are beginning to say, you know, that kind of makes sense.

I don't want to get away from controlling the money because I think there are innovative ideas out there that are only available if providers compete for my dollars.

I know you had a laundry list of comments. I can't recall all of them.

QUESTION: I can read them off to you.

I think we agreed on the guaranteed issue and individual mandate. Age rate ban?

DR. HERRICK: Well, you make an important point. That's why during the campaign Hillary Clinton wanted to have individual mandate and employer mandate, whereas Barrack Obama says, Well, I think all kids should have coverage. If the idea is if we don't make people buy it, we are going to pay a lot more than they otherwise would, they would be unwilling to. I'm afraid even if you try to make them, you will be unable to.

QUESTION: Mandated benefits.

DR. HERRICK: Mandated benefits, I did some research on that recently. Arguments oftentimes made by the other side, you might say this is patient protection. They also say in many cases, especially for rare diseases, somebody might not otherwise buy coverage or this is a way to spread the cost of those rare diseases to more people.

I don't necessarily agree that every mandate that comes down the pike is a good mandate and that we should cover everything regardless of the cost. Some mandates cost more than others to cover. Some are rather cheap. In fact, most of them only add less than one percent to the cost, maybe only a fraction of one percent.

My complaint is they all add up. I spoke in depth to the -- someone from the Department of Health in the State of Texas a while back on the very issue, saying, How much does it really cost? We have what is known as mandate-like policies that are available in our state. A lot of businesses don't buy them because they don't really want to deprive their workers of a given. It's a mandate or stuff wouldn't involve mental health parity and the like. They want their workers at work.

But yet the Department of Health said, you know, We agree that -- our members agree, members of our legislature agree that we need to be very careful with mandated benefits because we don't want to -- each member does not want to find out that the mandate they proposed was the one mandate that cause people to begin dropping coverage. And we know that if you increase the price of something more and more, people will say, I can't really afford that.

So, you know, some people like a Cadillac plan. Others would rather get a much less expensive plan. I think people just have the choice. I'm not in favor of special interest groups, provider groups, and all the stakeholders and advocates telling me and telling the whole country what they have to have and what's good enough.

DR. FEGAN: I think there are certain public health issues here, though. There are certain things that we know that are preventative or, for example, something as basic as a Pap smear or you don't want pregnant women to not have maternity benefits. And yes, that may increase the cost, but let me tell you, the cost of a low birth weight baby or premature infant is much greater to society and it's a lifetime.

So there are certain things that are societal goods that we really need to provide. People forget that 35,000 people a year die from influenza. You want people to get flu shots. They should have access to them. So they need to be offered and available to them and should be cost efficient. It shouldn't be a cost decision for them.

There is just too much suffering. There is no reason for a woman to die from cervical cancer in 2009, and yet we still have that happen. It's not a coverage benefit for these people and that shouldn't be the case.

QUESTION: I know we are talking a lot about policy today. Of course, I've always considered that costs are effect policy.

Dr. Fegan, I would like to have a comment from you about, as a practicing physician, also as your group, how do you look upon the legal aspects of practicing medicine and the cost it adds, no matter what policy we adopt?

DR. FEGAN: You are talking about the risk of litigation?

QUESTION: Absolutely.

DR. FEGAN: Well, you know, we know that there is a lot added to the cost of health care because of defending medical practices. Actually, some of the studies show it is not as bad as situation as you would expect.

But one of the things that -- the way we talk about single payers, one of the things that we have not done very well in this country are practice guidelines. And there is tremendous opportunity, if we had single payer, to look at what we do in a much more definitive way. And practice guidelines actually offer some protection from litigation, practicing within certain standards.

For example, when I was in private practice I remember getting a health report card from Aetna on congestive heart failure. Congestive heart failure, most of the patients over 65 are admitted to the hospital. I got a score of 98.9 percent. The problem with that report card, which suggested I was doing very well, in that particular year, when I had over 2,000 patients, I only had four from Aetna with congestive heart failure. So I looked really good and they weren't able to see the whole breath of what I was doing in my work.

I think that when you have a single payer you can do some great things and focus on quality and that one of the problems or challenges we have in health care in the United States today is we don't pay a whole lot of attention to what individual practitioners do.

The majority of malpractice cases in the United States today don't have anything to do with negligence or bad practice. They have to do with poor communications. I think less than 17 percent of malpractice cases involve any type of negligence at all and the majority of negligence cases actually never come to litigation.

So this whole notion of practicing within a framework, I think that changing the way in which we fund health care also allows us to change the way in which we look at the quality of health care. We change the discussion, move it to a different place. And I think that's a great opportunity there to deal with the concerns about litigation in our society.

QUESTION: That's one of the best explanations I've heard. Thanks.

MR. SOBEL: Do we have any other audience members who would like to ask a question before we close? Well, I want to thank --

QUESTION: Excuse me. I'm sorry about that. I was all the way in the back. I don't think I was visible. Just a few comments about a few things. Dr. Fegan, I agree with much of what you say. I think it's wonderful. I would love to see a single payer system.

However, along the lines of medical malpractice reform, I have a real problem with that slogan that's up there, "Health care is a human right." I have found -- I have only been in the area for a little while, so I'm speaking from my experience in New York City. I have found that that slogan gets into patients' heads and they show up with this incredible sense of entitlement. I need to be seen right now. You have to take care of me. Basically that slogan winds up enslaving the doctor.

I'll give you a great example. Food is a basic human necessity, but can you walk into a supermarket and demand a piece of ham or anything else in that aisle? No, you cannot.

I think it's wonderful as a society we should decide to provide health care. I think that's something we should do as a conscientious society. I don't agree with calling it a right. I was not existing even for a few hundred years ago. It enslaves the practitioner.

I have come across so many people in patients in New York City, Oh, I'm going to be noncompliant. I'm going to show up to a doctor whenever I want. They are going to have to see me because my health care is a right. If something goes wrong, let's take it to court and see how it goes.

That's kind of my commentary about health care being a human right. I think we have to let people know that health care is a privilege, but a privilege that, as a conscientious society, we want to provide to everybody. I certainly agree with you that leaving people -- leaving it up to them when they want to spend money, when they want to go to a doctor is possibly catastrophic.

I've seen so many patients that, because they can't afford health care, because they can't get in early, they treat an emergency room as their primary care physician. Going to an emergency room is a huge cost compared to if they had access in the first place to a primary care physician.

So I agree with what much of what you say. I commend you for it. But I just don't like the slogan. I see how wrong it can go. That's it. Any comment on that?

DR. FEGAN: Well, I think that that's an extreme. Even with something as a right, you are talking about an entitlement to access to your physicians any time of day or night versus the right to be taken care of, and there is a difference. The patients that I take care of don't have the option. I was in private practice for 15 years and I had people who were very noncompliant and then I had people who did everything I asked of them, and some folks will never get it.

But a lot of it is about communication. As a physician I tell my patients, I will never take care of you, but I will teach you how to take care of yourself, so it's all about how to go about doing what we do.

You know, unless we decide it's a human right we don't get to the next step, which is to figure out how we are going to provide for everyone.

QUESTION: I have a comment for -- I'm sorry. I forgot your name, Doctor.

DR. HERRICK: Herrick.

QUESTION: Okay. Great. It's about your final slide. I'm afraid it might be misleading. You show cosmetic surgeons, the inflation in there is low and other medical services, the inflation rate is huge. Well, I want to know, with cosmetic surgery the money is going directly from patient to doctor; correct?

DR. HERRICK: Yes.

QUESTION: Wonderful. Who is getting all that money in that other line? Because I know it's not the doctor. Cataract surgery in the '80s, used to pay a heck of a lot more than it does today. I don't know why the eyes suddenly defatted.

DR. HERRICK: That was not expenditure. That was price. In other words -- and despite the fact there has been a huge increase in volume. And the reason is because your surgeon doesn't have all the overhead. They know that you are price sensitive. They know, therefore, they have to compete on price and quality and they quote a package deal.

If you went into a cosmetic surgeon and said, I'm interested in a various procedure. What will that cost, if that surgeon said, I don't know. I'll have to do it and bill you, you wouldn't go there. You would go elsewhere.

In some cases the same doctors that treat other services that are covered by third parties, covered by possibly Medicare and Medicaid, but yet because they don't have the overhead and because they are competing for your business and because they act more competitive. That's really what we want to engage in our health care system, more competition from hospitals and more selective consumerism from patients.

QUESTION: Well, I know we definitely have competition. We try to get patients to come to us versus another doctor. I guess my concern is that I see all that increase in prices, I don't think that's going to the doctor. I think that's going to go third party payers. That's our increase in volume. That was the problem with the HMOs. Oh, we will pay you less and you will have more volume.

Well, it turns out that's why a lot of people going to a doctor's office feel like cattle. Doctors are trying to make up for the loss.

It seems that all the money is going to all these third party companies that I would love to see go away.

DR. HERRICK: Obviously it is going somewhere. It's not necessarily going in their pocket. It may be going for overhead or malpractice liability insurance or a manner of things.

QUESTION: A CEO of a health care company, how much do you think they make?

DR. HERRICK: It's not my area of research. I can't tell you.

QUESTION: Okay. Just food for thought. I really would like to say Dr. Fegan's ideas implemented and I would like to see medical malpractice reform. I think that would go a long way towards helping things. Thank you.

MR. SOBEL: Anyone else out there that would like to ask a question?

DR. HERRICK: Can I just make one comment? We just mentioned whether health care should be a right. I want to raise a different aspect of that. Roughly a rule of thumb is maybe 60 percent to two-thirds of disease is related directly or indirectly to lifestyle choices.

In other words, in fact, I don't jog as much as I should. In fact, I don't watch my weight or my diet as I should. Whenever I go to speak -- and typically it's with other health policy conferences -- everyone quietly among themselves agrees that we need to take -- be more responsible or held responsible for some of our own conditions, even if they don't agree to control the dollar. What can we do to encourage good behavior?

It was mentioned earlier today that preventative medical screening and tests won't necessarily reduce costs or improve health, but things that do reduce costs and improve health are almost free. Let's say that jogging on a regular basis, watching what you eat, eating your vegetables, these aren't preventative medical services. These are lifestyle choices.

If we make health care, you know, a right, how do we delineate what the responsibilities are? Because it's very difficult to tell one person, You made 30 years of bad choices, so you don't get the heart bypass.

Really, I am an economist; not a philosopher.

DR. FEGAN: Well, actually, we do do that, decide who gets transplants or not. If you are divorced and living alone and don't take good care of yourself, you are less likely to get a transplant.

But I want to be very careful with this discussion because you are right on the edge of blaming the victim here. And for some of us, I belong to a health club. I live not far from a lake and I exercise regularly, although being overweight and have been all my life.

That is not the same option as my patients. You can't blame someone who lives in a neighborhood where there are shootings in the middle of the daytime and it's not safe to go out and exercise. There is no safe place for them to work out. I write a prescription for everyone of my patients who live in such a neighborhood for gym membership without cost so they can have access to it.

There are areas on the west side of Chicago where you go for more than a mile without finding a single grocery store or store that sells fresh fruits and vegetables. I had this argument with our city health commissioner. Before we start chastising people for their lifestyle choices we have to do something about providing options that are real options.

When you live in a neighborhood where it's not safe to be out of the house other than in broad daylight and we don't have good public transportation and we don't provide access to fresh fruit and vegetables, then we can't fault people for making choices, for buying the cheap can of beans or not taking the bus. That's a public health issue and very easy to blame.

MR. SOBEL: Well, I would very much like to thank you, Dr. Fegan, and you, Dr. Herrick, for your contribution to this symposium. This has been a very enlightening discussion. I think it's clear that in the weeks and months ahead and probably years ahead we will be hearing much public discussion and debate about what to do about our health care system, and it's my hope that those of you who attended this evening's dialogue and those who attended other parts of the symposium will have gained some knowledge that will enable them to better analyze the debates that they hear and better think about choices that the American public has as it looks at possible ways of reforming the health care system.

I invite all of you who are here to join us outside. We have some refreshments. And if you have other questions for Dr. Fegan or Dr. Herrick, I'm sure, if they are available, they would be happy to talk with you. And we have some other members of the symposium and faculty who are also here and they will be out joining us for refreshments.

Thank you again for coming.

(Whereupon, the symposium concluded at 8:15 p.m.)