Conversations with Bill Kristol

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I. Healthcare and Innovation (0:15 – 30:27)

KRISTOL: Hi, I'm Bill Kristol, welcome to CONVERSATIONS. I'm pleased to be joined today by Jim Capretta, a Resident Fellow at the American Enterprise Institute. He served at senior levels of the Office of Management and Budget in the Bush administration, before that on the Hill, before that as a career civil servant, I think.

CAPRETTA: Yes.

KRISTOL: Which is the best part of the US government, I'll say that on my own ticket. I hope that's still true. It was true when I was in government.

CAPRETTA: I tend to agree.

KRISTOL: People who know a lot, who care a lot about having programs that work as opposed to having kind of an investment the way the people in the agencies have on it. But you supervised the health programs in the Bush administration, so you had a kind of comprehensive view of the US government's efforts in healthcare and you've written a ton on healthcare since. So let's talk about healthcare. Kind of a big topic, right?

CAPRETTA: Very big.

KRISTOL: So what about healthcare in the US? It's good, it's terrible, it costs too much, it's destroying, it's going to bankrupt us? At a 30,000 foot level, what's the basic, where do we begin? What's the truth?

CAPRETTA: What's the truth, yeah. Well, the US has a mixed public/private system. So it's a complicated system. But I would say that at the very highest level, we should be grateful that it is an open, adaptive system.

That is, it allows for change and introduction of new therapies, new ways of taking care of patients, new medical technology in a way that is resisted a little bit more around the world, especially in other high income countries. So the US, really, if you're someone who is in need of significant medical attention, there's no better place in the world to get healthcare than the United States.

Moreover, through a lot of change and adaptation, most Americans have pretty ready access to that amazing system. Through their employer-based health insurance, where the vast majority of working-age people get their coverage; through Medicare if they're 65 and older or disabled; and even through Medicaid which is a program focused on lower income Americans, but also allows for pretty ready access to this vast network of hospitals, physician groups, clinics, labs, all of the rest of it that comprises America's delivery system for care, which really is excellent in most cases.

KRISTOL: I mean, I'm surprised you say – well, on the surface I might be surprised that you say "open and adaptive." Because for an awful lot of people's interaction with the healthcare system, it seems awfully bureaucratic and I don't know, backward-looking almost, or not. It takes forever to get stuff adjudicated, or they have three year old standards for what should be done, or the insurance companies and so forth. So, explain a little bit more about that.

CAPRETTA: I mean mainly on the clinical side of the house, right? It's quite true that America has a bureaucratized system of insurance that is cumbersome, and a lot of people are frustrated with, including myself and we can talk more about that as we go.

But on the clinical side, that is, what the physicians are doing to patients as they're coming in, think of cancer, think of heart disease, think of things that a lot of Americans are afflicted with, diabetes care and so on, and it's really advanced. It gets better all the time.

And that's because there's a lot of people trying to make it better, through research and other efforts. And once something is found to be working better than previous standards of care, it gets introduced fairly readily in the United States.

So once it's proven scientifically in the journals that cover the specialties and so on, that a new way of doing something is going to be better than an old way of doing something, we move pretty quickly in the United States to doing it the new way. And the physician community is fairly well plugged into a pretty vast network of information about how to figure out what's going well and what's not going well.

And so, yes, it's far from perfect. I'm not trying to be Pollyanna-ish about it. But relative to what it could be, that is, if the government really tried to be more rigid about cost controls and controlling when things are introduced and so on, it's fairly open and adaptive that I think really accrues to the patient's benefit.

KRISTOL: And I suppose drug companies being able to make a lot of money off drugs helps?

CAPRETTA: Well, I mean that's a big issue and a big question. I think on drugs what we should think is that you want an incentive for these researchers to come up with the next big great thing, right? And what's the best way to incent that to happen? It's through money. I mean and so we have a pretty –

KRISTOL: Plus it costs a ton of money to produce and test these things.

CAPRETTA: It costs a ton of money to do it. And that's mainly, especially for products that would have widespread application, you have to do very large clinical trials which are really, really expensive. And so to get through that hurdle, you need a lot of investment capital. And the only way – where does that come from? It's going to come from investors. And of course investors invest in such a thing if they get a good return.

And so in the United States we have a pretty open and good system of investment money essentially fueling research on the next big great thing. And to my mind that's a good thing – it's not a bad thing. I mean that's the way the United States ends up dominating the development of new product developments that are going to occur.

KRISTOL: And does it? Because one could imagine, in some theoretical way, that you could have a very strong NIH sort of times 20 or 200, and government funding a huge amount of stuff, and get rid of that

profit, excess profits, and get rid of the bureaucracy of all these drug companies, or whatever, and certain kinds of competition which maybe aren't optimal because of whatever.

I don't know. But I guess – I mean do we have a sense of how much of the actual medical advances, leave aside the bureaucracy side of it – but the actual, as you say, clinical treatment to people. Would we – I guess we can't know for sure, but would we be getting more of it or less of it if we had a radically different system? Are there other countries that are as developed as we are, or I guess there are, that have different systems?

CAPRETTA: Yeah. Certainly there's a lot of a research and effort to go into countries like Japan and Germany and the UK and elsewhere, France and elsewhere. There are lots of researchers, very good researchers globally in high income countries that are working on all the same kind of questions as the US. And they do – I'm not saying that the US is exclusively the source of everything here.

But I would say you know lots of studies have looked at this and roughly about two-thirds of the product developments that really end up disseminating globally originate really in the United States. That's both on the device –

KRISTOL: Which is way beyond the pure, what you'd expect from just GDP. I mean Germany and Japan have huge economies. And smart scientists.

CAPRETTA: Yeah, from just the numbers of the population, right. Though we tend to dominate the biopharma space, and medical device space to the same degree.

And I think it's really relative to the adaptability and openness of our system to essentially paying for it, if these things do come online, and when they are successful.

Now, with respect to the question of could – let's say we got rid of this whole industry and just said let's have the government do the research and also then try to translate the research into product development, which is really the key. And I think it's that second step where a commercial sector just is far, far superior to a governmental sector.

How to take what's being learned about some basic scientific understanding of how the body works, and then translating it into a pill or something that you can administer to a patient. That's no small thing. It takes a lot of work to get from one to the other. And that's where our commercial base really excels and where sort of a strictly governmental approach I think would fall short.

I think you could ask the people that are working at NIH and you might get some people saying, "yeah, yeah, we could do it, we could do it." But I think a lot of them would say, "No, no thank you. That's not our skillset. We get it so far and then we need a commercial sector to take it the last mile really to a product that can actually be administered to a patient. "

KRISTOL: And to have failures too, I suppose.

CAPRETTA: They fail all the time.

KRISTOL: Which the private sector is good at kind of internalizing and expecting and the stock price goes down or whatever or up. As opposed to government where if you have a huge investment and then it doesn't work out, people have to be fired or there's a congressional hearing. You know what I mean?

CAPRETTA: Right.

KRISTOL: There's a way in which the private sector makes it easier – and if the field, as I kind of think it is from my limited knowledge – is one where there's a lot of experimentation and a lot of things don't turn out the way you expect. Drugs work for disease A, not for disease C, even though they were primarily

originally developed for disease C or maybe disease C+, you know. I mean, you do want a system that's more experimental and shielded a little bit, I suppose, from politics, right?

CAPRETTA: Absolutely, you want it shielded from politics. Because imagine if NIH was totally responsible for trying to take the next step on all of these things. I think the level, like you had indicated, the accountability ends up with funding cutoff, right?

And in the private sector, people lose money but that doesn't mean that the enterprise completely comes to a halt. They have ten projects going on, eight of them fail, but as long as two hit, then the company survives and carries on. So, I do think the commercial model in this particular respect is superior.

KRISTOL: Yeah, no, I'm glad you're sort of – I'm making this point just about the actual quality of care. So much of the discussion is about the cost, which is legitimate, and who pays for what, and access to it, and universal coverage and so forth.

But it is important to step back and realize that, I always think of it this way because I first came to Washington to work in the Education Department and education spending has gone up a lot over the last 30, 40 years. Probably not quite as much as healthcare spending, either in terms of GDP or government share, but a lot. There's not much evidence that *education* results are any better. Maybe that's the nature of the enterprise. You're teaching the next wave of six-year-olds reading. It doesn't – we don't get more efficient at it.

But whatever you think about healthcare, we spend a lot of money on it, there's no question that healthcare is better than it was. An awful lot of people we know are living good lives and high quality lives who wouldn't have been able to do that 20, 40, 60 years ago. So in that respect, I think that some of the anger at healthcare or the impatience about healthcare is a little – I don't know, maybe not overdone, but it's not a failing part of the US economy or society, it doesn't seem to me.

CAPRETTA: No. And I think the actual – people expect a lot out of the healthcare system, some of which is unrealistic. But in terms of the basics, where elderly people are getting artificial joints, the knees and hips and other joints now as well, that's a big deal. I mean because there's so many more people, as they go into their older years now, who are mobile in a way they were not 30 and 40 and 50 years ago. And that mobility allows them for the rest of their body to function better over time. They don't fall into a pattern where they decay over time. And so the ability to allow people to stay functional and up and about and doing things and active, is a huge benefit that was developed over the last few decades and it's now very widespread and common.

Also heart disease was a huge problem and now many people with early stage heart disease are treated successfully and live long lives without any incident. And that's all because of better therapy and attention to what needs to be done to make sure that person can continue to function.

So those things are real big successes – and of course cancer. I mean, all the advances on the cancer side. and there the oncology treatment system is far superior to what it was three and four decades ago for most cancers, not all, and the survival rates are just way, way up.

And that's all due to essentially a lot of scientific effort and research into how do we do this? And then dissemination of that protocol, those protocols, through our system in a way that most people – I'm not saying it's guaranteed, but most people have pretty ready access to that system of care when they really need it.

KRISTOL: And sticking on the quality side just for one more minute – and then we'll talk of course about how to pay for it, and who provides the insurance, the insurance system and so forth. I mean are there any obvious reforms there that would sort of be helpful? Are we putting obstacles in the way to medical progress that you see? Or is that side of the equation reasonably well set up in the US?

CAPRETTA: I think it's reasonably well set up. I think most of the danger is public policy kind of worrying about the expense of it and intervening in ways that could impede real progress.

So, our knowledge base, and of course just the introduction now of – possibility, big data, and artificial intelligence intersecting with the scientific enterprise in a way that could improve human health. People are working on this feverishly and the promise of that is pretty stunning. If it pans out over the next 20 and 30 years, right, and in a way that could be very beneficial.

And so, the danger really is the government trying to get involved in that in a way that might impede real progress by trying to limit the expense or cut off the ability to make returns on it, and so on.

But as long as it's an open system that allows for investment money to sort of chase how to disseminate new therapies and new ways of taking care of patients, I think that side of the house is pretty good.

Now that doesn't mean American healthcare is high quality in all instances. It's a fragmented, somewhat chaotic and disorganized system for a lot of reasons and so people fall through the cracks. And there's an awful lot of burden, unfortunately, on the patient to navigate a complex care system. To know when they have to go here or there, connect this to that. And so I would say –

KRISTOL: And not all patients are in great shape to do that, because they're elderly or they have other problems.

CAPRETTA: Right. So things get misdiagnosed because of poor information flows, lack of communication, poor understanding. It's a fragmented, little bit chaotic system and that means that some people unfortunately do fall through the cracks on the quality side. They're just not getting the right kind of care they should have gotten, if people had really had properly understood what their problem was. And that happens all too often.

And also, honestly, there are just lapses on following good protocols in the care delivery system. There's a major report 20 years ago that documented that one of the most dangerous places to be if you're a patient is in a hospital, basically. Lots of things unrelated to your problem can occur in a hospital – infections, and other mishaps – quality problems.

And so there's been more attention to that over the last two decades because of that major report and some improvements have been made. But it's still lacking in terms of where it should be.

KRISTOL: So on the payments, on the provider side, so most working Americans, mostly get their health insurance through their employer which is sort of a historical accident, right?

CAPRETTA: Yes.

KRISTOL: Somewhat unusual, I guess, in the developed world?

CAPRETTA: Yeah, except for Germany, which pretty much built its system on a similar kind of anomaly that occurred there. They have basically an employer-based kind of approach to working age insurance.

The United States does stand out. Germany has evolved into a much more regulated government organized system, but the United States has retained a pretty privately-oriented voluntary – with an exception of how the Affordable Care Act treated it – voluntary employer-based system, that pretty much grew up because we didn't have a nationalized system in the kind of run up to World War II and then afterwards.

And employers sort of got in the business because at that point, really beginning in the '20s and '30s and the '40s, it was really during those years that medical care started to be beneficial.

KRISTOL: Right.

CAPRETTA: Right? Prior to that time, people wouldn't buy health insurance because there wasn't much the medical community was going to be able to do for you in a lot of circumstances. But once certain advances have been made, and those advances were expensive, you had to go into a hospital to be treated – then people say, yeah, I'd like to get health insurance because if that happens to me I want it taken care of.

Employers stepped in because there was no nationalized system and started offering it as a compensation provision to their benefit packages. And during World War II when there were wage controls on cash payments, they allowed that as a non-controlled fringe benefit.

So a lot of employers started jumping into it because they could attract employees by offering health care. It wasn't controlled by the government. And then the IRS stepped in and said it would be untaxed as well, and so therefore it became pretty popular to get an employer-based healthcare. The unions started pushing for it. So it spread really, really rapidly through the '50s and '60s and became the norm in the United States.

KRISTOL: And so we have this massive employer-based system, in which companies contract with insurance companies, I guess, really basically, right?

CAPRETTA: Yes.

KRISTOL: Under all kinds of federal regulations and state regulations and whatever.

CAPRETTA: Yes.

KRISTOL: So, talk about how does it work and talk about some of the proposals to reform it one way or the other.

CAPRETTA: Well, there are sort of two options if you're an employer. The big employers, for the most part, self-insure. That is, they take on the responsibility of owing the claims that people have for their medical benefits, under a law called ERISA that was enacted in the '70s.

That allows them to get out from under state regulation of what they're doing. But it's a federal law that allows them to do it. So it's federally-regulated sort of, through the Department of Labor. But it's pretty open. There are a lot of – they design it the way they like. But they contract with insurance companies.

KRISTOL: Because at the end of the day, some big – a publishing company is not going to have expertise in figuring out how to do healthcare insurance, so they hire or whatever.

CAPRETTA: Right, they hire a Blue Cross plan or maybe multiple plans, Kaiser-Permanente, United Healthcare. They hire one of these big insurance plans to organize the doctors and hospitals that their employees go to see in-network.

So that's sort of one option. You can do it yourself and hire an insurance company to sort of run it for you.

Or you can be an employer that just says, "I'm going to buy insurance from an insurance company. I don't organize it, I don't do anything, I don't self-insure. It's just a premium payment to an insurance plan." That is state-regulated and the states, for fully insured products like that, the states have historic jurisdiction for the regulation of insurance and retained it even under the Affordable Care Act, although with lots of rules now.

So, now those are your two basic options. Now, for reform, it's interesting. Remember in the run up to the Affordable Care Act in 2009 and '10, President Obama had said previous to that time that he was in favor

of single-payer healthcare as a candidate. But politically he looked at it and said it's really not possible to upend this sort of embedded arrangement.

KRISTOL: Single-payer, just to be clear, would be?

CAPRETTA: Single-payer means that the government takes over the insurance.

KRISTOL: We pay more taxes. The US Government pays when you go to Sibley Hospital and get whatever treatment you get.

CAPRETTA: Right, instead of paying premiums to an insurance plan, Americans would pay taxes to the federal government, presumably, or the state government. And the government, federal –

KRISTOL: They can still have co-pays I suppose and that kind of thing. That would be a question.

CAPRETTA: You could; most single-payer plans do not.

KRISTOL: Is that right?

CAPRETTA: On a principle of free at the point of service.

KRISTOL: So it's just, you just show up and they do what they have to do, and you leave the hospital and there's no bill and no paperwork.

CAPRETTA: Yes. You just show up and they take care of it. No paperwork.

KRISTOL: And people love that part of the system it seems like. Or they love the idea of that part of the system –

CAPRETTA: They do.

KRISTOL: – when they're dealing with the paperwork, after they've been home from the hospital for two weeks and this has been paid, and that one wasn't paid, and this one was sent to the wrong company, and so forth, right?

CAPRETTA: Right. And then you have to justify things and call back and get an 800 number, and nobody answers the phone.

KRISTOL: Right. And get your doctor to send a note saying this was necessary and your doctor has better things to do than send notes.

CAPRETTA: Than send notes to the insurance company, yeah. No, the whole business of dealing with private insurance is a source of frustration in the United States, and a source of joy that they don't have to do it in most other countries. The polling for single-payer is high.

In other words, the citizens of countries that have it like it and don't really want to take on the responsibility of being someone who has to navigate a health system and think about financial aspects of it. They'd rather not deal with it, and have the government deal with it.

And as long as it – you know, think of it this way: In those countries – this is part of our later conversation – but in those countries, most people are relatively healthy. So unless you are someone who's really sick and need a very, very expensive care, high expertise care, maybe you don't miss the open aspect of the United States' system as much and you're fine with sort of more routine interactions with the health system. Someone can fix your broken leg, and your child has a fever. Those kinds of things are pretty routine, and a primary care system can take care of it.

It's really when you're really sick the question is, which system would be better for you? So those are the kinds of questions that come up when you start thinking about that kind of a model.

But back to our employer discussion, you can do it either through your own self-insured plan or through a state. But what I was going to get at is that it's very difficult to dislodge the system in the United States. That it's a big system, 160 million people, that is the workers and their families, are pretty much been in this system and that's an awful lot of people. And they're in Blue Cross plans, they're in Kaiser-Permanente, they're in United Healthcare. They're in these big insurance plans. And for the most part, frustrating as it sometimes can be, they know that that plan gives them, what I would say, the way to understand it is, ready access to very good care if they need it. So I think that's the thing that makes it very difficult to take it away.

They know that if you're in a Blue Cross plan and heaven forbid you end up with a diagnosis of cancer or you have a car accident and you need a lot of care, they know that that insurance plan is going to get them into the best hospital in town with the best surgeon, the best oncologists and the most ready access to that system that you can imagine.

And that's a source of great comfort to a lot of people and they are loathe to give that up to something where the government might start getting involved to say, you know, wait a second, how much is this costing?

So because of that, President Obama didn't take on the employer-based system and it will remain an issue, I think, in the 2020 campaign as something that might be problematic for those people trying to propose a single payer approach.

KRISTOL: "Medicare for all" is the tag, but that really is single payer, basically.

CAPRETTA: It unconsciously is single payer.

KRISTOL: And I suppose when you're a single payer, the government has to, do have, I guess in Medicare, for people 65 and over, in a sense, right?

CAPRETTA: Right. We have, in a sense, single payer for them, kind of.

KRISTOL: But it's sort of put on top of a non-single payer system, so it probably works differently than it would in a real single payer system.

CAPRETTA: Right. Our Medicare system is single payer with an asterisk in the sense that the government is the payer of claims to hospitals and doctors and it sets the payment terms for that relationship.

But I think one thing to keep in mind is there's another aspect of single payer that should be understood, which is that in some countries like the UK, the hospitals and physicians, in effect, work for the government. They are sort of the employees of the National Health Service, okay?

In Canada, also a single payer system, the government is the payer, but it's a private network of hospitals and physicians that accept the government payment when they take care of patients.

KRISTOL: But of course, that government payment has to be limited or set because otherwise the doctor shows up and says I'd like $10,000 dollars for this procedure. And the government and everyone else is saying it's $1,000 dollars. So you get, in effect, it's price setting. Not in a negotiation, which I suppose to avoid the situation, it's a negotiation, kind of, between the government and the hospitals or physicians.

CAPRETTA: Yeah, that's a really important point, which is that in our Medicare program and the government pretty much, through regulations, it has the ability to tell the hospitals in the country here's how much we will pay you for that particular service. And it's kind of a – it's a take it or leave it basis.

They do have under the law the authority to opt out of Medicare. Basically, no hospital does it and very, very few physicians do it because to do so is to cut yourself off from 30 percent of your patient population potentially and your revenue base. And it becomes a non-viable option for a lot of specialists, particularly because these are the patients that actually need your service. So they don't do that. And they end up with, the government's in a very powerful position to say here's how much we're going to pay.

I do think it's a little bit different than it is in the UK or Canada, here in Medicare in the sense that the government knows they can only go so far because at some point people do have options. And so the government can set their rates low, but not so low that – for instance, they don't want Medicare to become like Medicaid where a lot of physicians really do opt out. The payment rates on the Medicaid side, which are established at the state level, are quite a bit lower than Medicare in many instances. And, as a consequence, the physicians have dropped out of Medicaid.

KRISTOL: And I suppose Medicare, if I understand it correctly, I mean, it's kind of free riding on the – not free riding, but it's riding on the private system. And so it will set rates lower than you know, your actual insurance compensation for a working person, working age person is.

CAPRETTA: Yes.

KRISTOL: But it's 30 percent lower or whatever it is, but it's still lower than something that was set in a private negotiation. So it somewhat avoids the problem, I suppose, of the government simply saying, "I'm sorry, we're just paying for this. Or we're not going to pay for something at all." That's very rare, I think, in the US.

CAPRETTA: There are not very many instances of that. They have to have a pretty hard and fast case that it wasn't worthwhile clinically to be able to make that decision.

KRISTOL: Which one has the sense in some foreign countries they just say if you're over this age, this procedure is not available because I guess they have data claiming to show that it has a low, relatively low success rate. Or even if it succeeds, it only extends life for a few years or whatever.

CAPRETTA: Right, they have specific thresholds in the UK of when to introduce things that are measurable as beneficial to the patient's health and they try to measure that quantitatively.

I don't necessarily disagree with the thinking behind it, but it does result in the government saying from time to time we're not going to make that available under these conditions, if you're over a certain age or this. They do it a little bit informally to avoid major disruption in the populace, right, but they do introduce into their system a way of rationing care to keep costs under control.

KRISTOL: Whereas here the physicians seem to have more, and the hospitals, more leeway.

CAPRETTA: Absolutely.

KRISTOL: I mean, insurance companies can second guess them and I'm sure they fight all the time. But if a physician says well, this 68 year-old could benefit from this even though a lot of 63 year-olds even don't because she's healthier or just whatever reason. My sense is that that doesn't get automatically knocked out or – in fact, there is a certain deference to the, if it's a reputable hospital.

CAPRETTA: There's an interesting thing that goes on in medical care which is that there are still disagreements about what is the best clinical way to deal with certain things. And you know, I would say you kind of look at how things evolve over time.

You see that 95 percent of it, everybody kind of agrees on and it's pretty clear what the clinical answer should be for somebody under certain circumstances. But there's 5 or 10 percent out there that still rely on judgement and it's not hard and fast. And those are a little bit harder cases and physician judgment plays a big role in that.

And I think probably rightfully so. I think we all know of cases of people who were given certain advice about their treatment plan, maybe didn't follow it, followed a different course and ended up better off for not following the original advice.

And so I think that's an indication that while a lot of this can be reduced to pretty scientific clinical answers, not all of it can be. There's still a little bit of judgement involved because it's still murky sometimes.

II: Possibilities for Reform (30:27 – 1:21:21)

KRISTOL: But all of this costs a lot of money, and some of which the federal government pays and some of which we all pay through premiums – through insurance premiums, I suppose, or through direct payments.

CAPRETTA: Right. I mean, just to get into this a little bit, the Medicare and Medicaid programs are the number one source of fiscal distress for our government. And it's because costs for these, this type of system that we have is very, very high. We talked a lot about the good aspects of our system and I am obviously very much in favor of all of that.

But we have to admit to ourselves that our system lacks a certain discipline and that lack of discipline is problematic. It's making it so that Medicare and Medicaid in particular, financed through taxpayer money, are becoming heavy, heavy burdens on the national government, and will become really heavy burdens as the population ages.

KRISTOL: But even the non-Medicare Medicaid parts are more expensive than other countries.

CAPRETTA: Absolutely.

KRISTOL: We spend what percent of GDP, I don't know.

CAPRETTA: We're at 19 percent of GDP.

KRISTOL: On healthcare.

CAPRETTA: Yeah, and most countries are, even rich countries like Germany, they're down in 11, 12. I think France and Switzerland maybe a little closer to us, but lots of other countries are well below us. Certainly the UK and Canada are well below us – and even a country like Japan, tightly controls their expenditures.

So there's a big gap between us and our next high income countries. And some of that is justifiable, right? There is a pretty clear connection between the higher your income, the more you spend on health. Health is a preferred good.

So as you become richer, the demand for medical care goes up even more than your income went up. Because it's something that, the next extra dollar, if you've met all your basic human needs and now you've got another little increment of income coming in, what do you do with it? You say I'd really like to make sure my health stays well. And we do that as a collective society as well through our research efforts and other things.

And so the higher the income, the more you're going to spend on health. So the fact that we are, we do have higher incomes than Canada and Europe and Japan means that we are going to spend more than them. So that's one explanation.

KRISTOL: Some of that expenditure pays for research and so forth, which advances care for everyone, ultimately.

CAPRETTA: It does. And as the president likes to point out, we're carrying a lot of weight for the whole world. So that's important to understand.

But a good portion of the gap is also waste. You know, our system is quite wasteful. It's overbuilt, there's lots of disconnects, it's fragmented.

People end up getting duplicative care. You end up seeing a specialist, they're not sure what to do, they send you to another specialist. You get the same set of tests run again. Happens still all the time. And that kind of stuff goes on in the United States in a way that probably doesn't go on in another country where they try to more tightly control those things, or pay much less for those diagnostic tests.

And that kind of stuff adds up. You do it over and over and over again throughout a big complex system and there's a fair amount of stuff going on that is really not benefitting the patients very much. And that's where the focus and energy needs to be to sort of say we need to get rid of that.

By the way, we also pay our clinicians well above what they're paid elsewhere. And you know, a lot of that would be justifiable. If it was a real market and we had orthopedic surgeons making three times what they were making in other countries, everybody I think would say okay, that's fine, that's just the market is saying that's how much it's valued.

The problem is our market signals are very weak and disconnected for a lot of reasons. And so therefore, the amounts that they're being paid, you're not quite sure they are reflective of the market signals or just we have excess payments going to certain –

KRISTOL: No, I was so struck when I had gone to the executive branch, when I came to Washington in the Education Department, I was cushioned away from all of it, not exposed to it. But then working in the White House, and we didn't do much with this stuff obviously, directly. I mean, you all at OMB and HHS dealt with it. I don't know, for whatever reason your people would come maybe from the Vice President's home state or whatever just to kind of meet. And you're suddenly being lobbied on the reimbursements for particular procedures. And it was like, "I don't have any idea what this should cost and whether it's fair or not for the government to do this, or to require that, or require that there be registered nurse there for this. Or, that a registered nurse can't do this because it has to be a physician."

And I don't know if there's any way to avoid that, really. There would have to be rules. Well perhaps not, but there will be rules, certainly, if there's federal money involved. And then once they are rules, they're going to be sort of arbitrary, I guess, and then everyone's going to lobby for changes in the rules.

That does seem like a little bit, maybe it's just a free country and that's how democracy works. There's something a little crazy about the degree of it, I would say, wouldn't you? I mean, when you worked on the Hill, it's unbelievable, right? Every single specialty is up there lobbying, every single subgroup of technicians and nurses and doctors.

CAPRETTA: Remember what they're lobbying on is, it's a massive system and so there's, you know, Congress is overwhelmed really with people pushing their particular issues on the health system. But the dominant issue there is Medicare's payments.

So this gets back to, again, what we're talking about which is that because Medicare is the payer, they know that lobbying Congress or going to HHS directly about the regulatory side, saying we need this or we need that – they can influence the payments that they get as practitioners. And so, it's a huge industry effort to kind of keep their payments high in the Medicare program, as high as they can get them.

So, the question is, if we move to a system that was dominated only with Medicare for All, would that go away or would it just intensify? I think it would intensify.

And the Medicare system, the one thing about it that is important to understand is that it can be somewhat rigid relative to the private system. In the sense that when the Medicare regulations are put out, you have to wait a whole year to change things, you have to go through the regulatory process to change things.

So let's say somebody is being overpaid and somebody brings it to HHS's attention, "Hey, this is being overpaid; let's cut it back." It's a heck of a fight to get that done. But if a private company was found to be overpaying eight or ten times, they could make the change if they want to and nobody has to approve it.

So I think those are the things that have to be thought through if people really think giving all control to the government would actually work out better.

KRISTOL: So there's sort of two ways the reformers seem to go. Those simple, over-simplified, the left wants more government, something approaching Medicare For All, or at least the single-payer option or public option I guess they call it.

The right has tended to want to introduce more competition and sometimes to disestablish the employer based system to have it more like car insurance or home insurance. That seems to work fine: there's a lot of competition, you go shop, you buy one. They seem to pay up okay.

CAPRETTA: Sometimes with some complaining.

KRISTOL: With some complaining, yes. But some state and federal regs – state regulations and supervision. And so that's sort of I guess the two sort of –

CAPRETTA: Sort of basic models.

KRISTOL: Two basic models. And so talk a little bit about –

CAPRETTA: What's going on there, yes.

KRISTOL: – the merits of each, and the politics of it, and where do you think we're actually going to go?

CAPRETTA: Yeah. Well, it's a good question, where are we going to go. I think the thing that people that are market proponents need to understand is that the other side has one pretty powerful argument, which is that our peer countries have all pretty much adopted the governmental model. They haven't really adopted a market model. There's a couple of minor exceptions.

But by and large if you look at Germany and France and the UK and Japan and Australia and Canada, I mean they long ago decided they wanted to publicly regulate their health systems to try to keep costs under control and to provide a relatively uniform system of accessing care so that people more or less got equal, at least from some measure, entry points into the system.

KRISTOL: Right. If it's a right or if it's a good that everyone deserves, it'd be like public education. There's better and worse, where you live, maybe depending on where you live and other things. But at the end of the day, everyone has the right to go to a public school, they don't pay anything, and presumably state regulations keep the quality somewhat comparable. So that would be the model, I suppose.

CAPRETTA: Yes. That's the model, that's the way it went and they long ago adopted that. And so for proponents and for people in the United States think they have a powerful argument. It says why did they do that? It's because, A, it's hard to do a market-driven approach – so we'll get to that in a second. And B, that no one's been able to prove that the market-driven approach couldn't overcome some of the equity concerns that people have with it, right? If everything's allocated based on price –

KRISTOL: Right.

CAPRETTA: So a market system by necessity has some price element in it. If things are allocated by price, then they say well doesn't that mean the people that can pay a higher price get better care? And of course there's an – like in all these arguments – there's an element of truth to that. That they then parlay into saying, "well we really should just regulate it totally and run it through the public system." So that's their pro.

Their con, "what's wrong with that approach," is that when the government takes things over as it has in these other countries, they do have a very strong tendency to under-capitalize high-end care. So they don't spend enough on their in-patient facilities and they decay over time. They are slow to adapt, so they don't bring in new innovation as rapidly as our open system. And they have a tendency because of price setting, toward queues as a way of allocating resources. So they say, "yeah, yeah, yeah, we're going to – we provide that service, but it's going to be six months from now," literally.

KRISTOL: Right.

CAPRETTA: And so, if you've got a real major health problem, six months is a long time to wait and even two months can be a long time to wait, if things aren't right for you physically.

And so there's a lot of patients who suffer in these high income countries because they've controlled the supply through price setting, and that drives out willing suppliers. And that means that there's still somebody who can provide that very high end necessary care, but it may be only one or two in the whole country, and people have to line up to get to them.

KRISTOL: And I guess some of these countries have two-tier systems where, like public schools, there can be private schools. And there people pay as much as they want and they get presumably –

CAPRETTA: Yeah, it's like a safety valve.

KRISTOL: – more value for their – so the wealthy kind of get out of the public system.

CAPRETTA: They do.

KRISTOL: But then the equity argument becomes – cuts the other way, it seems to me, which is there's more inequity probably, more inequality.

CAPRETTA: Right, depending on which country. Some countries that's more pronounced than others and the only time you can get to the best doctors and hospitals is by buying private insurance. A lot of countries, it's more the exception than the rule. So the people by and large use the public system and just grin and bear the waits they have to go through.

And so the UK and Canada in particular, I mean, they've been battling this issue of waiting lists and queues for decades. Successive governments of both, all the different political stripes, have all promised to fix the problem and sometimes they do fix it moderately for a while, but then it comes back. And it's a very difficult problem to stay ahead of. And so you end up with waiting lists and that's something I think in the United States would be very problematic. So that's the public side.

Now on the market side, if you don't want public regulation of costs, the only alternative is to discipline it through some kind of market mechanism where people on the margins have a choice, they can pay for it. But when they pay for it, if they pick something that's more expensive, even though it may not be higher quality, they have to pay for it out of their own pocket. So at some point in the US system we need to have more of that occurring if we want cost discipline. And we don't have nearly enough of it for –

KRISTOL: Then why aren't the companies enforcing –

CAPRETTA: That's a good –

KRISTOL: The American Enterprise Institute has a – which provides health insurance, I assume – has an incentive. And there's a lot of smart people there and they have an incentive to purchase the best insurance for the least, or not the best but the most cost-effective insurance for their staff and employees. So that presumably should put – take care of – that's what you want in a market system, right?

CAPRETTA: Absolutely.

KRISTOL: A purchaser who has an incentive to pay less, and suppliers who compete.

CAPRETTA: Right. So, a small employer with 250 or 300 employees, they go out to buy insurance and they want to get the best for their workers at the lowest premium, lowest price. Absolutely true.

One thing to keep in mind is though, they are offering this benefit as compensation to their workers. So they want their workers to be happy with what they offer them. So there's a real sensitivity on every employer, large and small, to say, well, it's true I want the lowest premium plan I can get, but I don't want all my employees saying, I got a lousy health plan at my office; I'd rather go to another employer to get a better health plan.

KRISTOL: Right.

CAPRETTA: Okay? So there's competition amongst the employers to offer decent health coverage because it attracts workers. So that's a hindrance against cost control.

The other really big, the really big problem is that even if you had an employer that wanted to be super aggressive and they were kind of small, 250, 500 employees, even 1,000 employees. That's just way too small to influence this vast medical delivery system that is really the source of the cost structure.

Insurance kind of – is sort of a layer that buys you into this thing, but the costs are in the hospital system, the medical clinics, the physicians, the labs, the way that patients are taken care of – big teaching hospitals. And if you're a 250 person employer, you're not going to get them to change their business practices for you.

KRISTOL: Right.

CAPRETTA: Okay? So to really influence the cost structure in the United States, you have to sort of reach into this superstructure of how care is delivered to patients and figure out how to discipline that. That's a much bigger deal than one little employer trying to pick what health plan they are going to have for their workers.

So it's a cumulative thing across a lot of employers. It also involves Medicare because it's the biggest purchaser, and it involves Medicaid. All of them would have to start pointing roughly in the same direction, which is, we're going to still buy into this very high end, high quality system, but on the margins we want our employees, the actual consumers of all this stuff, to have some incentive to say, I'd rather get – if someone's offering me just as high-end care, but they could do it for 10 percent less. And I got to save that money myself, put it in my own pocket. I'm interested in that.

That's a market system. You'd have to have that multiplied across tens of millions of Americans to start moderating this system more. And that's what's lacking. And it's hard to get because it's not politically – it's actually not that easy to do politically.

KRISTOL: And you could argue, the intelligent liberals would argue this, it's not that easy to do even practically. Because what am I going to do, go to Georgetown Hospital and the GW Hospital and make my own – one is 10 percent cheaper. How am I going to have a clue whether the actual care that's being offered for my problem that needs to be addressed is better or worse?

I could read, I guess, the way you could do for other things, *Consumer Reports* and Yelp and the equivalent and study – you know, read studies. I guess they would both advertise in a way that, you know, we have an 87 percent success rate. But I don't know, that seems a little – is that crazy, is that realistic? I don't know.

CAPRETTA: Yeah. It depends on the type of care, right? If you go in and someone says you need to – you get this terrible diagnosis of a cancer, and that you have to embark on some oncology treatment. At that point they don't really know what the care plan is going to be.

So you're just entering into it. They're going to have to do a lot of testing, a lot of diagnostics. They're going to have to start something and then come back to you after a few months and say here's where we are; now we need to go this direction or that direction. And so it's not something you can shop for.

KRISTOL: It's not like I go to a restaurant, I like this one which costs $40 bucks for dinner instead of this one which costs $55 bucks for dinner. I know the quality won't quite be as fancy, but –

CAPRETTA: Right. You're going to start down the process of being cared for, and they're going to have to order a bunch of things you're not even sure at the beginning of the process what they're going to be. So you can't really plan for it and buy for it in advance.

Now, having said that, we could have a system where a lot more care was price-competitive. Where you had a system where fairly routine things and common things are much more transparently priced in a way that consumers can digest and compare.

So think of a natural childbirth, right? You find out that a mother is expecting a baby at three months. That you could have a system in the United States where a natural childbirth from caring for the expectant mother through childbirth and then maybe the month afterwards, that every system in the country said, here's the price we're going to charge for an uncomplicated natural delivery.

That is something that could be price-competitive. It's fairly routine, obviously common. Happens all over. And the 5 percent of the cases that are kick-outs, that involve some complication that needs attention, they could be handled separately.

But you could have for the routine cases a pretty price-competitive system. It doesn't really exist today, but you could try to move in that direction through a number of things that would have to take place. But that's the kind of thing that would have to be replicated across a lot of dimensions – you know, common knee surgeries, hip replacement.

KRISTOL: Or just routine care, right? I mean, Doc in the Box.

CAPRETTA: Or routine primary and preventive care.

KRISTOL: Your kid has a fever and you just want to make sure everything's okay and get the medicine for the strep.

CAPRETTA: There's a monthly fee model that can be tried for pediatric care, instead of every time you go in you're paying $20 dollars or $30 dollars. A model that said, you have three children, $40 dollars a child on a monthly fee, you get unlimited pediatric care to make sure that they're well, and that encompasses all the stuff they need. Instead of sort of the piecemeal approach that occurs today, which is much more complicated for a consumer to try to price shop for.

KRISTOL: And it doesn't happen now because the individual consumer, the individual family, doesn't have either the incentive or even the ability really to shop in that way. You're steered by your insurance company into certain providers and that's that. And you don't go personally to say, can I get X? You don't personally save X by going to the cheaper provider. It's all you're part of a huge insurance pool, right?

CAPRETTA: That's pretty much it, yeah. I mean the whole system has been built up around an opaque insurance-led system where the insurer negotiates with the doctors and hospitals. They say, between them they decide what the payment is going to be.

The beneficiary, the patient, pays a copayment, but that copayment doesn't vary really based on where they go that much. Sometimes it does, but if they stay in-network so to speak, that is within the insurer's preferred system, they're going to pay the same no matter what they do. So they don't really care. They don't have any incentive to price shop.

So all of that would have to change if you wanted a more price-competitive system, and it's complicated to do, which is why it doesn't happen.

Although I will give the administration some credit. They're tip-toeing up to, through a couple of regulations, on price transparency, the hospital system. They're not there yet, but they're in the neighborhood sort of understanding where this needs to go to allow for simple, on routine things, simple apples to apples comparisons on price. Right now the whole system is built to not allow that to happen, but the administration is working hard to try to inch up to make that happen. The whole industry is against it. The insurers are against it, the hospitals are against it, the doctors are against it. That ought to be maybe a sign it's a good idea.

KRISTOL: Yeah, it's interesting. So many conservatives for years have used the car insurance model, that you bring your car in for a routine – upkeep and stuff. You know the garages, you like one, you trust one, you don't like another one. They'll do the Virginia inspection for $19.99 instead of $25.99, you go to that one.

But if you get in a serious accident and the whole thing has to be overhauled then your insurance kicks in, you wouldn't know how to really price the damage. What overhaul is really necessary to your engine and so forth. So that's really more of a bargain between the insurance company and various providers of the service.

CAPRETTA: Right. This brings me to something I wanted to get into a little bit, just to mention. Is that, on the, as you mentioned, there's sort of this choice. You can have public regulation of the system to discipline costs, or you can try to build in some more market incentives to discipline costs.

Within the market incentives side, you have the sort of two branches you can go down as well. You can have one where you try to rely a little bit on the consumer, the patient, to make some choices and navigate as an autonomous agent, kind of a consumer, picking where they want to do things. That's the HSA model, Health Savings Accounts, right?

KRISTOL: And that's assuming that you're going to have some catastrophic insurance for catastrophic care for the high end, because people aren't going to navigate that, and shouldn't really try.

CAPRETTA: Yes.

KRISTOL: But for the routine as you say –

CAPRETTA: You use your HSA and you shop around a little bit. You have an incentive to try to keep your account big and growing. You try not to spend money if you don't need to. So the hope has been that that would lead to that kind of a consumer approach.

The other model, which as you just indicated, they're not mutually exclusive; they can work a little bit in tandem. The other model is that the consumer hires someone to be their agent in navigating the system, and that's basically the insurance model.

Now, here is something very important, which is that people don't tend to – you know, sort of a distant commercial insurer, it's hard for people to hire them and say, please run my managed care for me, run

my HMO for me. Okay. That’s why the managed care push in the late ’90s foundered a little bit. These big companies got into it heavily and a lot of patients pushed back saying, I don’t want you telling me –

KRISTOL: That was really striking how much it foundered, right? Because it was really the new thing, HMOs and all this.

CAPRETTA: The new thing, yeah. It ran into some problems and the problem basically was distrust between the patient and the insurer. The patient saying – I’m not picking on one national insurer in particular but pick your favorite villain national insurer – “I don’t want them deciding which hospital I go to or which doctor I go to, especially.”

KRISTOL: Right, which doctor.

CAPRETTA: So having said that though, lots of patients in the United States are now enrolled in kind of what I would call provider-driven managed care. That is, actual hospitals and physician groups, in a sense becoming their own managed care plans. Many of them have their own insurance attached to their system, so they are selling insurance to their patients and acting as an HMO on their behalf. And they become the agent to kind of navigate the system.

Now lots of people are a little worried about this kind of approach, too. They say gosh it’s an HMO and there’s a bureaucracy there, do they really know what’s best for all these patients too and so on? I would say I’m much more optimistic that if we invested and went down that road, it might pay pretty big dividends.

I mean, the way to think about is that not all care, but a lot of patient care, can be examined pretty scientifically. And you could say okay, somebody comes into a system, they’re sick. We collect all the diagnostics on them. Then we do a bunch of stuff to them and then we spit them out. And then we track them. If you’re a managed care system, you should track them and say did they get better, okay? And then they collect the data and then they run it through their kind of care protocols.

If they do that repeatedly for patient after patient after patient, you could start figuring out what works and what doesn’t. And honestly, that’s sort of the good version of managed care. So lots of people are in Kaiser and there are problems with Kaiser and people are happy, a lot of people are happy with it; some people not happy with it.

But that kind of model done right lends itself to a pretty data-heavy approach to taking care of patients. When someone comes in that looks like this, we know the cheapest, best way to take care of them. And we push them down that system and 99 percent of the patients will get better. The 1 percent that we need to do more for, we’ll kick out and take care of.

So that’s the good version of managed care, okay? Think of Intermountain Healthcare in Utah. This is a big integrated health system where the doctors and hospitals are all kind of part of an organized system. It’s not fragmented and open like a lot of American healthcare.

And it’s those kind of systems that where they’re coupled with insurance, you could be a patient out there in Utah and say I’m just going to hire Intermountain Healthcare. I don't have to deal with anything else. I pay them a premium. They tell me, and I trust them to, when I get cancer, here’s the best way to take care of me.

KRISTOL: Now you pay them, but what about the employer?

CAPRETTA: And employers buy it too, of course. So it would be their way of –

KRISTOL: But if your employer doesn’t buy it?

CAPRETTA: Then they could buy a Blue Cross/Blue Shield or United Healthcare.

KRISTOL: But if you personally want the Intermountain, you're out of luck.

So then you come back to the employer-based character of the system is checking some of the obvious ways you might get more cost sensitivity or even accountability, right? I mean, in a funny way it's a barrier to that because everyone's in the same pool. Because you can't let individuals just leave because then you have the obvious insurance problems of, what's called, what is it, self-selection –

CAPRETTA: Yeah, risk selection, adverse selection.

KRISTOL: Yeah, adverse selection and all that. But then you don't personally have a choice. I mean, I was thinking about that. When you go to buy a house, you don't – or an apartment or something – you don't necessarily know how to evaluate the worth, how well each of these buildings is built or whatever, or these neighbors and stuff.

That there are many people who get, many agents who buy and sell houses and hopefully have an interest in making the deal happen and therefore have an interest in responding to what your concerns are and then finding you a good, what looks like a good deal, at least.

It's funny that that doesn't happen in the healthcare system. I guess it doesn't because it's employer-based. But you'd think there would be like a huge number of people who would be your guide to the healthcare system. People would pay quite a lot, right?

CAPRETTA: Yeah, they do, yeah. There's a broker system out there for people in the individual market for that very reason. So it was a pretty developed, sophisticated broker market that people basically – When someone had to navigate on their own and buy insurance, you could go to a broker, pay them a fee. They then would say, "here are your options in our community and here's what this one has." And they know the system pretty well. And that system does work. It's a pretty market-driven system.

I'd say that, back to the point about the employer being a barrier here, I agree with that. That if you had free agent consumers out there, having to buy something to get their insurance, we'd have a dynamic that would be more beneficial towards the kind of discipline I'm looking for. And choice would drive towards lower cost, higher value options.

KRISTOL: And I suppose what cuts the other way, correct me if I'm wrong, is if you *really* had that system, you would lose the advantages of the employer pooling, 300 AEI scholars or 1,000 people elsewhere.

CAPRETTA: Yes.

KRISTOL: Which then, then you get into all the obvious pre-existing conditions problems. Because if you individually have to go buy insurance, the insurance says, "I got to charge you much more than the person here, you have a high likelihood, unfortunately, of this disease coming back." And then we say "no, you can't do that." Well, then suddenly you're in a regulated – isn't that –

CAPRETTA: Totally. I mean, I think the –

KRISTOL: So you do, you can dislike the employer-based system. When you think about it, you have to have some way of grouping people, if it's insurance.

CAPRETTA: We didn't even get into that before. You're making a very important point, which is another reason why the employer system grew up was, it was a natural non-health way of buying group coverage. In other words, although people are working and that is a certain self-selection involved in that itself, right?

KRISTOL: Right.

CAPRETTA: If you're disabled, it's hard to work. But if you're not disabled and you're basically healthy, you go to work. Then the normal risk factors, genetic and otherwise that apply are generally uniform throughout a big employer. And so you have a good way of spreading the risk. Okay?

If you don't have that, what you need in the individual market, you're going to end up with some regulation. I'm not one of these people that thinks you're going to have an unregulated individual market.

KRISTOL: No. I mean the way the individual market car insurance handles that, if you have eight accidents you pay a lot more than if you have one. And if you're 18, 19 year old male you pay a lot more than if you're a 52 year old person who's never had an accident.

But we don't really want to go down that road I don't think, in health. You don't want to say that someone has the bad luck of having this or having had a disease or whatever. Or been in an accident which then leaves him or her vulnerable to things, has to pay more. So once you say you can't pay more, though, then you're into sort of back into price setting basically, or community rating of –

CAPRETTA: Some way of protecting people. I mean, you could – the inverse of what they did in the Affordable Care Act is said that if you stayed insured, you were going to be treated like everybody else. If you tried to game the system, and you went out and said I don't want to buy insurance because I'm healthy now, and I'm not going to buy insurance. And then I could try to get back in later after I've got a condition, then you got penalized.

KRISTOL: Yeah, the famous mandate.

CAPRETTA: Yeah, right, exactly. So, the Affordable Care Act tried to do it differently by mandating everybody to participate. You could have done it the other way and just said hey, if you jump out and then try to get back in, you're going to have to pay a penalty.

KRISTOL: Right.

CAPRETTA: Either way, the same concept applies which is, hey, you know, we kind of want people when they're in the system not to be penalized based on their health status because it is a little bit hard to justify. Right? I mean, unlike the car accident analogy, most things that people end up with are misfortune and not strictly related to their own personal behavior. There are things that are – obviously smoking and things that can –

KRISTOL: Even then you don't want – you're not going to not provide care to people even if it is due to their personal behavior.

CAPRETTA: Of course.

KRISTOL: So you're sort of, at the end of the day, there you are.

CAPRETTA: Yeah, there you are, right.

KRISTOL: Providing care.

CAPRETTA: Yeah, yeah.

KRISTOL: So where does this – I was going to ask where this all goes, to conclude. But maybe – have we missed anything really fundamental in terms of the –

CAPRETTA: Well, it's a big –

KRISTOL: How much of the system is paid for now by the government?

CAPRETTA: It's about half of the dollars are federally financed.

KRISTOL: Since it's 19 percent of GDP, and 9 or 10 percent or whatever of that federal budget – federal or state – is and state budgets.

CAPRETTA: Yeah, federal and state.

KRISTOL: And that's why Medicare and Medicaid are such big chunks of the federal budget.

CAPRETTA: Big chunks of the budget, yeah, really big chunks.

KRISTOL: And then the other half is private sector of one kind or another.

CAPRETTA: Private, yes, exactly.

KRISTOL: And is that continuing to grow as fast as it once was? Or has it sort of topped off, and have we hit some kind of natural limit of what you can – ?

CAPRETTA: Things have moderated a little bit over the last 15 or 20 years, particularly actually in the public programs, relative to the private. And there's lots of disputes about why that's occurred. It's probably a combination of factors, one being that we have higher deductibles. So there is some evidence that people are foregoing some care. They're not price shopping. But they just don't get some things because they think to themselves, "I don't want to spend $200 dollars on this, I'm not going to get it."

So when you have a high deductible plan, even with an HSA, the evidence indicates that people use a little bit less care. And because the high deductibles are now fairly wide-spread in the commercial sector, that is happening more and more.

The second factor is, improvements in certain diseases. So, heart disease especially is being cared for a lot better than it used to be. And so you just have fewer heart attacks and that's a big deal.

KRISTOL: And drugs are cheaper than –

CAPRETTA: Drugs are cheaper, yeah.

KRISTOL: – than hospital stays.

CAPRETTA: Exactly.

KRISTOL: Mostly.

CAPRETTA: Yeah, exactly. And so that's another big deal.

And the third one, we had a financial crash. And use of health care is directly related to our income, and so when we have less income, people use less services. So that's another factor that's global, not just in the United States.

I do want to mention one thing before we get to our conclusion, which is that when we compare the United States to other countries in terms of their overall health systems, one thing I forgot to mention which is also important which is, things spill into the United States system that don't spill into other countries' systems.

What do I mean by that? Is that basically on a couple of dimensions, things that – the number of people that end up in trauma in our emergency rooms is way, way above what it is in our peer countries for a couple of reasons.

KRISTOL: Gunshots.

CAPRETTA: We have some social –

KRISTOL: Drugs. Right.

CAPRETTA: – societal things that go on in the United States that do not go on in other countries. And some of that ends up spilling into how much we spend on healthcare.

KRISTOL: Yeah, no, I mean it's kind of a liberal gun control talking point but nonetheless true, that if you have 100,000 people showing up in emergency rooms – I'm making up that number, but it's got to be –

CAPRETTA: It's a big number.

KRISTOL: – something like that. It's a big number. We've got 30,000 people who get killed –

CAPRETTA: With knife wounds and –

KRISTOL: Yeah, sure, and emergency rooms with gunshot wounds and knife wounds. And in some other country it's 10 percent of that. That's going to affect your medical costs.

CAPRETTA: It does. And the other one being accidents, car accidents on more open highways and so on. And so, those are big ones. And between the two of them, they add a non-trivial increment to how much the U.S. spends on medical care relative to – lots of studies have compared it to Canada in particular, right across the border. Very similar cultures in a lot of ways. But those two dimensions are different in Canada than in the United States and they end up spending less as a result.

KRISTOL: Yeah, that's interesting. So what do you think over the next year or two, next five or ten years, in terms of the public policy? I mean which way is the debate likely to go, or could it go or what will be the big flashpoints do you think?

CAPRETTA: I think that the Democratic Party, as they get into 2020, I think there's lots of talk inside their own party about what they're going to do. A lot depends on the candidate they pick. But I think almost irrespective – unless it's Biden or Warren, if it's any of the others – that's a big if. But then I think they're going to migrate to something like a public option. Something that appeals to the party, it doesn't threaten the employer-based system, and allows them to say we're introducing more public insurance –

KRISTOL: How does the public option work? So if you are at AEI, you can say to AEI, no thanks, I'm going to take the public option, which is in effect a Medicare type situation?

CAPRETTA: Yes. It depends on how they introduce it. They probably would introduce it first just inside the Affordable Care Act exchanges, which is the individual insurance part of it.

KRISTOL: For the individual market, right.

CAPRETTA: So they say okay, we've got these competing insurance plans out there that's working not so great. Let's introduce an actual public option into that, which President Obama favored in '09 and '10, couldn't get through the Senate, so that's why it dropped out.

It's particularly Biden, obviously, but I think a couple of other candidates, if they were to break through. It's the clear answer for the Democratic Party in 2020. A popular position that's much safer for them politically than Medicare for All.

KRISTOL: And fixing Obamacare.

CAPRETTA: And building on it.

KRISTOL: Building on it, as they say.

CAPRETTA: So I think that's the smart play for them. For President Trump –

KRISTOL: Wouldn't have an actual radical effect on the real world, or just cost a little more money.

CAPRETTA: It would be consequential. It would be a 5 or 10-year play. It would take a while for it to kind of mature. But one could imagine in five or ten years a public option having, would be like another increment to Medicare and Medicaid. Another 30 million people are in the public option.

KRISTOL: That's a big –

CAPRETTA: Yeah, it's a big, but it's not 200 million people.

KRISTOL: And it's not taking away individual employer-provided health insurance.

CAPRETTA: And so I think the vast majority of employers would continue on as they're doing because people would prefer that, their workers would prefer that. But some number would end up in the public option because it would be a rate regulated system.

Now a key aspect of it, one thing that is very complicated but important is how do they get the doctors to participate in a public option? The formulation now in Congress, Senator Bennet's idea, called Medicare X, is to make them. To tell them essentially hey, if you take Medicare, regular Medicare, you also have to take the public option.

That would be a big controversial thing in the physician community and tough to pass. So if they sever that and make it totally voluntary for the physicians, then it won't get so big and it won't get so dominant. And I think that may be actually where it ends up over time.

KRISTOL: So that would be the sort of moderate Democratic alternative.

CAPRETTA: Yes.

KRISTOL: Do you think there's some reasonable chance they go for some real Medicare for All kind of, single payer?

CAPRETTA: I think if Sanders were to win the presidency, there's no doubt he'd try. And if Senator Warren were to win, I think she would try also. I think it would be a five, ten, twenty year transition, right?

But they would try to get something through. I don't think it would pass. I think the politics are way too complicated. We have a vast major health system in the United States. It's very big and it's a super tanker.

And even the Affordable Care Act, we had this raucous, ten years ago I had this raucous debate. And the super tanker I would say is still sailing more or less in the same direction that it was prior to the enactment.

KRISTOL: I feel like we've published a million things in *The Weekly Standard* about it and you wrote many –

CAPRETTA: Yeah, I wrote many of them.

KRISTOL: And it was important and all that, but it's not, it does feel like a little bit "gee, what was that debate about, exactly?" It was about the individual market, which is –

CAPRETTA: Pre-existing conditions and individual markets, and a pretty big expansion of Medicaid. Its most important provision really was the expansion of Medicaid.

KRISTOL: But at the end of the day yeah, the big system doesn't look that wildly different. Pre-existing conditions was already happening sort of, right? In the '90s there had been legislation.

CAPRETTA: 90 percent of the problem had been taken care of. They took care of the last 10 percent. They made a big deal of it. It was a big deal for that 10 percent, but most people were already protected for their pre-existing conditions.

KRISTOL: So then the conservative alternative – But I want to ask one question which I forgot earlier, which is how much is it true that, we must have data on this, one of the criticisms of the employer-based health insurance system we have is it has all kinds of other side effects that are not good. I mean, that it slows down people's willingness to leave one job and go to another so it slows down the job mobility, geographical mobility. It sort of makes the general economic situation, economic mobility in a way more sclerotic and so forth. Do you buy that, or is that like overdone?

CAPRETTA: I think it's slightly overdone. There's a little bit of truth to it. And I'd like to see our system be a little bit more adaptable to make it easier for people to get insurance on their own when they want to.

And I think actually the Affordable Care Act, I had lots of problems with it, but did point in that direction, right? You can now, if you want to start your own company, you can buy insurance on the Affordable Care Act for two years while you get it started and it's pretty guaranteed you can get something. So that wasn't always the case in every situation.

KRISTOL: And COBRA, I guess, where you leave a job, you can get –

CAPRETTA: Yeah, that doesn't work that great, but yeah, that did help a little bit for a time.

But here's the big argument for the employer-based system, which is that – and it's a political argument. Which is that if we didn't have it, if it was more broken up, wouldn't it be easier for proponents of a government run system just to swoop away the whole system and move it into the government? I think the employer system is the major bulwark against the government taking over all of healthcare. And so in some ways, I have some problems with it, but for that reason alone, I see its value.

KRISTOL: And I guess if you want to put it in political science terms, these are 40-year-old political science terms when I tell you this, but I mean kind of "interest group pluralism," big interest groups have their problems in terms of producing good policy, and in terms of the accountability and citizen choice because of these massive institutions. But on the other hand, they do, one thing they do tend to block is government takeover of everything. Because there are these big interest groups that can't just be pushed around at the whim of some president who comes in.

CAPRETTA: Right, exactly, because there's a lot of workers behind it and they like it and they don't want it to go away.

KRISTOL: And doctors.

CAPRETTA: And doctors.

KRISTOL: Employees. If it's 19 percent of GDP, it must be some percentage that is comparable of the workforce.

CAPRETTA: It's a huge portion of it. I'm not sure I could quantify it, but yeah, you're right.

KRISTOL: And cities have boomed because they've been medical centers and suddenly their congressman doesn't want to –

CAPRETTA: Right. We have – look, I mean, we complain a lot about our higher education system and complain a lot about our medical system. But if you're somewhere globally and you want to go to the best universities in the world, you go to the UK or here. And if you have a big problem medically, you want to come to the United States.

KRISTOL: So what would the conservative agenda be then, sort of as opposed to the, let's leave Trump aside almost and just say there's a stomach, once again, for getting back onto the more conservative healthcare reform side of things. Which may be happening a little beneath the surface in the Trump administration, but nothing legislatively since the fiasco of the Repeal and Replace.

CAPRETTA: Repeal and Replace, right. Well, I mean, the president, we don't need to dwell on his role in all of this, but they are signaling that he might give a speech in the next couple months. Now we all know that that's necessarily a reliable indicator of whether he *will* give a speech.

KRISTOL: Right.

CAPRETTA: But they've talked about it enough that it might happen. So there could be a foray into this at the presidential level in the next few months, who knows.

I think the problem for conservatives is they need to take the next step. You know, they talk the talk; they need to walk the walk on a market-driven system. Right? If you don't want – what is driving people to want Medicare for All? Of course, there's some aspect, I'd like to make sure everybody has insurance, there's a little bit of an ideological, historical aspect to it. But there is an element also of "this thing is such a hassle. It costs a lot of money and it's hard to navigate. And in these other countries, they seem to have simplified it by the government taking it over and they don't pay anything."

And I think this cost side really is a big deal. And the system needs to be more responsive in terms of keeping costs under control, and helping the patient, making it easy for them to navigate.

How does that happen? Well, I mean, it's like anything else. A market could deliver those benefits to patients, lower costs and easier to navigate approach, but it has to have an incentive to do that. And only – if you want a market system, somewhere along the way, I keep emphasizing, someone has to *choose* lower cost and higher value. Someone has to say I'd rather pay less, get more and I'm told that if I go this direction, I'm going to be able to get that. And I'll save $100 dollars a month out of my own pocket if I make that choice.

And the way you do that is instead of open-ended subsidization that occurs in a lot of different ways now, you close it off. You say for Medicare, you're going to get $10,000 dollars; you're not going to get $10,500. So here's $10,000 dollars, buy the best plan you can. If you buy a $12,000 dollar plan, you pay $2,000 dollars. If you buy an $11,000 dollar plan, you only pay $1,000.

KRISTOL: And the sellers can't discriminate against you, though, if you have a preexisting condition.

CAPRETTA: No, it's all regulated.

KRISTOL: So it's even –

CAPRETTA: It's regulated and it's fair competition in terms of the same benefits. It's really, the question becomes, like I was trying to say, you're hiring an agent through that choice to keep the costs under control. So, the truth is, if you put up that kind of choice in Medicare, a lot more people would end up in more tightly-run HMOs. Good HMOs, I believe, that would weed out some of the nonsense that's costing the system a lot of money.

KRISTOL: And this was basically Paul Ryan's plan.

CAPRETTA: Yes, basically.

KRISTOL: This is basically *the* conservative, the Republican way to reduce the rate of growth –

CAPRETTA: In healthcare.

KRISTOL: – in healthcare, and especially in Medicare, and Medicaid I suppose.

CAPRETTA: Yes. You replicate that in Medicare. You do something similar in the employer system by changing how we work the tax preference. And those two are the biggest players. Medicare and the employer system are the biggest players in American healthcare.

You point both of those in the direction where the participants in it have an incentive to go low-cost, high-value. You'll start to get a dynamic where the delivery system – that is all the hospitals and doctors – have to be responsive to it. And cut their costs and get into systems that will be less expensive. So you need – you know if we don't want eventually public regulation of pricing, that's really the road we've got to go down.

KRISTOL: And I should think the transparency part of that would be important.

CAPRETTA: It is.

KRISTOL: And the sort of result, you know, making results public and explaining them and so forth. Because if it were to cause us to abandon, I don't know, some procedure, number five, because they're now competing in price, if they can say "look we are abandoning this procedure which we've done for 20 years, but here are the studies and show that this procedure number five gives us no additional –

CAPRETTA: It doesn't really help the patient.

KRISTOL: – outcome. It doesn't really help the patient. Or in the instance where – this is where if we think it would, we would add it, but you know it's never – we're not going to routinely provide it." And someone can say that, and people would say, "Fine, if that's a legitimate – "

So that's where I think the whole opaqueness of it is a problem now. You have no idea what is really necessary. And you don't want to start second-guessing your physician. But even other non-physicians at hospitals and so forth.

And there is I suppose a lot of preventive medicine, for legal reasons and stuff. I don't know –

CAPRETTA: It's critically important in that kind of a system that there's – we have a lot of oversight, attempted oversight of our medical system. And that would have to even get better if you had a market-driven approach where the quality was measured carefully, and there was a system that said, here is basically the standard of care. And if you're not getting it, then they're mistreating you in that system. And they shouldn't be doing that.

So it's a lot of, you know, medical care is really important on this really fundamental thing which is sort of false positives and negatives. Right? So a lot of people end up getting back surgery in the United States, and a lot of people say you know what? We do too much of it. That we end up not really helping a lot of patients because they're getting their backs operated on when physical therapy and other steps really could have taken care of their problem first. Back surgery is obviously very, very expensive and the recuperation is difficult.

On the other hand, there are some patients who need back surgery and they're not going to benefit, they're not going to get better without it. And you don't want them suffering for three, four, five, ten years,

because people are saying no, no, we can help you this other way, when actually what they need is back surgery. Right?

So the system has to be refined and delicate. It has to know when to steer people which way, right? And that's not easy to do. So there are no hard and fast rules here. You need it to be adaptable and open and monitored and constantly reviewed.

KRISTOL: But with *some* market incentives, is what you're saying.

CAPRETTA: With some market incentives.

KRISTOL: You really can't do it without that. From the –

CAPRETTA: Cost side, for sure.

KRISTOL: The cost side from the conservative. You can do it with price controls, but then you have your own other set of issues.

CAPRETTA: Problems. Price controls almost always descend into supply problems.

KRISTOL: Yeah. That's queueing and that's –

CAPRETTA: Queueing and also good people leaving the professions, and not drawing the highest talent.

KRISTOL: And then getting the quality question.

CAPRETTA: And the quality question erodes slowly over time. It's one of these things, though. If we went down the road, people wouldn't notice that the quality was worse until three decades later, right? And obviously then it's too late.

KRISTOL: Yeah. No, that's a very – I think the quality – coming back. I'm glad we ended up coming back to the quality thing because it is so important. And it seems to be taken for granted, and people go on and on about the 19 percent of GDP and stuff like that. You know what? If we're getting a lot better medical care and it costs 19 percent of – 19 cents on every dollar in the country. I don't know, is that the worst thing in the world?

What else are we spending the money on? We spend 5 cents of GDP on defense and related national security expenditures, which I am for, and maybe that should be a little higher. And we spend other things on education and infrastructure. That's all fine, but it's not crazy – People talk about it sort of as if it's obviously nuts to spend close to 20 cents on the dollar on healthcare. I don't know, it's kind of an important good for people, you know?

CAPRETTA: Very important. I think it's the sort of like it's the first thing, right? You need to be educated and you need to have good health. And so, without those two things, lots of other things suffer. So, yeah. It's a starting point for what people will value in life.

KRISTOL: Well, Jim, thanks very much.

CAPRETTA: Sure.

KRISTOL: This has been – I've learned a lot, and I think it think it stimulates further thinking about things. And at least allows, I hope, for our viewers and listeners to begin to at least to evaluate these debates. They are conducted so often in such a shorthand way. And it's sort of in a demagogic way, too, right?

CAPRETTA: Yeah, right.

KRISTOL: With, here's one anecdote, you know, and then we're supposed to reform the whole system because this one person got –really did get bad care or something like that, or got good care in some other country or something. So, anyway. Thank you, Jim.

CAPRETTA: You're welcome.

KRISTOL: Thank you, Jim Capretta for being with us today.

And thank you for joining us on CONVERSATIONS.

[END]