You Might Be Right - Healthcare - Transcript

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Larry Van Horn: To me, US healthcare is like pulling in to a gas station, filling your car up with gas and not knowing until after the fact whether you pay 2.50 a gallon or $12 a gallon. That actually is the amount of price variation for services in a market for US healthcare.

Marianne Wanamaker: Welcome to "You Might Be Right," a place for civil conversations about tough topics brought to you by the Howard H. Baker Jr. Center for Public Policy at the University of Tennessee. In this episode, our hosts, former Tennessee Governors Bill Haslam and Phil Bredesen and their guests, check in on the healthcare system. How affordable is healthcare more than a decade after the Affordable Care Act became the law of the land? Do we need to do more to align incentives for providers and consumers or are there other ways to lower costs and improve outcomes?

Phil Bredesen: Well, it's great to be back here again, Bill, and I'm looking forward today's going to be an interesting topic, healthcare.

Bill Haslam: It's certainly a topic we've both had a lot of hands-on experience.

Phil Bredesen: And scars.

Bill Haslam: Yeah. One thing you learn really quick as governor is Medicaid and the cost of healthcare has to be reckoned with because it's such a big part of the budget. And as we start to talk today about the Affordable Care Act and its impact, both of us have lived in that world and with the consequences of the healthcare environment as it exists.

Phil Bredesen: No question. I look back on when I got elected, I mean, it was time care in the state and the problem is in Medicaid that got me elected, so I certainly felt an obligation to work with it, but people don't really recognize, I think, how expensive those systems are and how much resources they take. I think one of the examples I gave when I was trying to talk about it at the outset was that the top two drugs in our formulary in TennCare cost more than our contribution to the higher education system in the state. I mean, it's just these enormous numbers and they're difficult to get at because no one wants to lose anything. Like our next guest I really, really admire for the ability and the willingness to step into such a complicated subject.

Bill Haslam: You made a good point earlier that the cost, mind-boggling, and it's starting to squeeze out other costs. And now, states are in a little better shape. But 10 to 20 years ago when states were being squeezed by the rise of Medicaid costs, that's what made higher

education costs go up. Governors looked around the country, looked around and said, "Hey, the only place we have an outside payer is higher ed. We can get the students/parents to pay more. We can minimize our contribution to higher ed because something's got to give in this budget." So the effect of healthcare costs are felt way beyond just what your deductible might be. Specifically on the Affordable Care Act, we both were around for the politics of it. I was a candidate for governor in a Republican primary when Affordable Care Act was introduced and passed and it caused the Tea Party and a lot of other things later as governor when states were given the option of expanding Medicaid. I proposed to do that in a way that I actually thought had some Republican principles that put some accountability into the system and wasn't going to cost the state anything. But the politics around it were so great that it was probably our greatest legislative defeat. I say that only to say this topic engendered a lot of emotion then and still does.

Phil Bredesen: Well, it unfortunately got to be one of those issues that there's a catechism in both parties about what you're supposed to believe about that and there's not a lot of tolerance for outside of that. I mean, I had trouble in the Democratic party because I had some criticisms of the ACA based on my experience and it made some people furious that you weren't just raising your hand and say, "I'm there." If there's anything I believe, it's that the world's a lot more complicated than some ideology on either side of the isle ought to advise every decision you're making.

Bill Haslam: It's a particular pleasure for Phil and I to have our guest today on because Nancy-Ann DeParleis a native Tennesseean. She's gone on to great roles and great accomplishments, but at her heart, she's still a Tennessee person and we're thrilled to have her. She's the managing partner and co-founder of Consonance Capital Partners, a private equity firm that invests in the US healthcare industry. But as we said, she grew up in Tennessee, she went to the University of Tennessee, and she was a commissioner. You had to have been a child at this point at the Tennessee Department of Human Services, which is a huge department with a lot of responsibility. And then she went to Washington, I think first in the Clinton administration, and then the Obama administration. She was one of the primary architects of the Affordable Care Act in President Obama's administration and has had significant policy roles in the Obama administration as well. So should also note that maybe your most significant accomplishment is you were the first female president of the University of Tennessee.

Nancy-Ann DeParle: I was the first woman student body president. Thank you. And you're reminding me, you said I was a child. I wasn't a child, but I was way too young to be a cabinet member, but it was an extraordinary experience. Governor McWherter – I drove to all 95 counties of Tennessee, which is something you have both done, but not that many other people have done it unless they were selling something. I guess, I was in a sense. But I went to all the Department of Human Services offices and it was just an incredible experience of learning my home state in a way that I never could have.

Phil Bredesen: Thanks for being here. I wanted to start out, as there's been so much said

about it and so much press and discussion, could you just talk a little bit at the outset about what the ACA, the Affordable Care Act, what it specifically was that you all were trying to accomplish with that, what its purpose was?

Nancy-Ann DeParle: I sure can. You have to think back to 2009 and where we were when that happened. Why would a president stake his presidency on something that presidents had tried for 100 years to try to solve? Why would you do that? And the reason was, as he explained it to me, why he had decided he was really going to try to do it is that at that point, there were around 51 million Americans who were uninsured and that number was going up every year as costs continued to spiral up. Tennessee had made an effort to try to do something about it, at least for the people who had preexisting conditions, but many states didn't have anything. Millions more lacked access to affordable care or quality care, so they might have a policy but it wasn't affordable to them or it wasn't high quality. Premiums had more than doubled over the past decade for the ones who were lucky enough to have health insurance.
It was bankrupting governments. You all know what that feels like looking at your state budget that you have to balance every year. And we spent about double what every other developed country spends on healthcare, but we had poor quality results compared to those other countries. Our insurance markets were, I would have to say, broken. If you were uninsured and sick, you could be unable to purchase insurance and that makes no sense. In some states, thankfully, not our state of Tennessee, but in some states women were charged as much as 27 times more than men in the so-called individual market to buy an insurance policy. And so, all of those are the reasons why President Obama decided to take it on. He decided that doing nothing was unsustainable and also unacceptable.

Bill Haslam: Nancy, all of us know that in politics, you have the goal that you're shooting for and then you have the practical, political realities of what you can get done. Are there things that got left on the cutting room floor, so to speak, or got changed in a way that you would've really liked to have seen worked out differently?

Nancy-Ann DeParle: It's funny because I tried to put more things on the cutting room floor.

Bill Haslam: Okay.

Nancy-Ann DeParle: That was a very long year and both of you understand the cadence of passing a bill. And not long into a president's term or a governor's term, the hearts and minds of the people in the legislature might have been with you at the beginning wanting to get something done start to turn away from your agenda and towards their reelection because we got into, past the fall, and we're actually in the most terrible time of 2009 for me was August sitting in my little office in the basement of the West Wing, sweating, swatting mosquitoes in there and watching MSNBC and CNN, and seeing the town hall meetings occurring around the country. So, it became harder and harder to think we were going to get anything done. I spent that August going through the bill and paring it down to about 100 pages, the bill that the house had passed.

The Senate had added even more to it and I, at some point, presented this to former leader Reid, who was a wonderful leader and was so important to getting this done. And he looked at me and he said, "Nancy, that's the stupidest thing I've ever heard" when I present him with this slim version of his bill that I thought accomplished the main things we were trying to get done, which were getting everyone in through the requirement that everyone have insurance and if you didn't have it, the government would help subsidize it, bringing down the rate of healthcare cost growth through all the Medicare reforms and delivery system reforms we were doing, reforming the insurance markets, those were the really important things and it accomplished those things without a lot of the other stuff, which was fine. For example, requiring that menus be labeled to show the caloric content, that may end up doing as much as anything to help with health by helping people to maybe make choices that are better. But when you're trying to pass a bill and you're looking for something that has 218 votes in the house and 60 votes in the Senate, you're looking to not antagonize anyone or any interest. So I thought it made more sense to have a slimmer bill.

Phil Bredesen: If you were back there again, I mean, what are the next steps that it would take to move it further into a mainstream solution for a lot of Americans?

Nancy-Ann DeParle: I guess I think it is a mainstream solution now, so I'll say that. I think it can be improved. My biggest regret about the law isn't the policy, it's that it was not bipartisan in the end. I could go through page by page and show you ideas that were contributed by Senator Grassley. In fact, one that's happening right now, there are new requirements for hospitals across the country and for insurance plans to be transparent about their prices, and that's something that Senator Chuck Grassley argued for. And to the name of your program, "You Might Be Right," I sat there and I thought, you know think that's right. He's got a good idea. Went back to the president and he said, "Chuck's right, we should do that. We should put that in there." So there are 100s of Republican ideas in there. In the end, we had one Republican in the House and one Republican in the Senate who voted for it, on the House floor in the case of Representative Joe Gallen, in the Senate Finance Committee in the case of Olympia Snowe. And then, we didn't have a single Republican vote.

Bill Haslam: Just following up real quick on that, are there things that at hindsight could have happened to make it more bipartisan or was it just the times just made it impossible?

Nancy-Ann DeParle: As both of you know, I served in the Clinton administration.

Bill Haslam: Right.

Nancy-Ann DeParle: The entire administration, so until 2000, and ran the agency formally known as HCFA, now known as the Centers for Medicare and Medicaid Services, for that period. And Republicans controlled the House and Senate during the period that I did that. And I would say I worked very well with the Republican members and leadership in the House and Senate. Many of the ones in the house went over to the Senate, so when I went up to work with

President Obama, I was worried about getting the votes to pass his healthcare bill, but it never occurred to me that I wouldn't be able to get a single Republican vote because we had such good relationships and had always been able to talk about these things and it felt, I'm going to make us all sound like geezers here, it felt like a different universe. It felt so much more partisan.

And I had people tell me, "Look, I think this is interesting, but I can't be with you on the other side." I spent dozens of hours with, well, 100s of hours probably with Republican staffers and dozens of hours with Republican senators. Not so much on the House side, but definitely on the Senate side. And the President did too. And there was no intention to have a fully Democratic bill. We always intended to have a bipartisan bill. In fact, the President told me that was one of the reasons he wanted me to come. I said, "I have never passed a bill before." He said, "No, but you've worked with Republicans well." And you all know, this is Tennessee, that's what you do. So to your question, Governor Haslam, is there anything we could have done?

President talks about this in his book, so I'll let his words without revealing other conversations I might have had. He said with one senator who was a leader and who spent a lot of time working on healthcare and really wanted to do healthcare reform, the contours of our bill again were developed during that period between the failure of the Clinton healthcare plan and 2009. And that was bipartisan, bipartisan people worked together on it. And this particular senator, the president said, "Okay, if we make all of these changes that you want, can you be with us? Can you vote for the bill?" And he said, "No, I can't. Not unless there's at least a dozen other people who can come with me and I don't think I can get them."

And by that point, we had seen Senator Bennett in Utah get a primary opponent, conservative Republican from Utah, longtime member of the Senate, was primaried, quote-unquote, on his right. And that's what we were starting to see. So I think people who might have worked with us started to pull away. I've racked my brain and my heart for was there anything we could have done to prevent that. I'm not sure there is. I mean, the Tea Party movement, which was part of what fueled this was bubbling up or boiling over, whatever the right metaphor, is in Tennessee. Governor Bredesen, you were there right during this time. So then, you had to make a decision, and this is a place you've both been. Okay, does this go far enough to lay a foundation, to move forward that we should do it and go for broke realizing that it's going to cost us some seats, it's going to cost us some votes on other things. And the President decided, yes, it did.

Phil Bredesen: There certainly are things in the bill that attempt to address costs, but the kind of overarching things, even like drug cost pricing and that kind of stuff were not really in it. Was that a conscious decision or it just wasn't possible to do? I mean, how did that play out and do you agree with me?

Nancy-Ann DeParle: Well, with respect to drug costs, you're correct that we decided to let the market work there. When more people had coverage in the individual market, we trusted that the insurance plans would work to negotiate with the drug pharmaceutical makers and hold

costs down, same for Medicare, same for Medicaid. You as governors did that. I know you did it, Governor Bredesen, the formularies and other ways of trying to control costs. And I would say, I don't think we could have passed the bill if we'd taken that on. But in other areas, I think I would disagree with you. I mean, I could start to list all the different policies that we enacted, not paying hospitals when people go back to the hospital after they've been cared for, the penalties on readmissions. We did a whole slew of things. Pretty much everything, every expert, MedPAC, et cetera had recommended to control cost. And when you're controlling Medicare, it's the 900 pound gorilla. You're not just affecting a change in behavior that a hospital would have with respect to Medicare, you're changing their whole behavior for everything. So that's why healthcare cost growth was its lowest in recorded history during the time period, at least the first five or six years after the Affordable Care Act. It's still lower than it might have been.

Bill Haslam: Now, I want to ask you a bigger healthcare question, one that you started out with, with what are the reasons for ACA that we spend almost double what other nations spend with not measurably better and arguably worse outcomes. I'm curious, talk from an ACA impact on that or not, just in general, help explain to our listeners why that's true. What's happening to make that be true in America?

Nancy-Ann DeParle: I think it's the prices. There's a famous article, "It's The Prices, Stupid" about healthcare. Look, for good and bad reasons, we pay higher prices, in part because we do a lot of research and development of new products and drugs and innovations here. We pay doctors more here and other healthcare workers more in our country than they are paid in other countries. One can argue about whether that's good or bad. I happen to think it's probably good. I'm glad that young people are attracted to the medical profession here, but that's a big part of the reason why we spend so much more. Our quality has been less because we haven't really demanded much of it. And I think we're starting to do that.

One of the things we did in the Affordable Care Act was we started star ratings for Medicare plans and providers so that a consumer could look and see, well, wait a minute, why am I paying this much for this plan, it only has two stars, when I could get a five star plan? It's a bit of a trade off. How much can you control the cost while maintaining a market system? And honestly, that's why some of my friends in the Democratic party, more progressives have moved towards saying they want Medicare for all because they think that's a way of administering prices and controlling the cost. Again, I think there's some real trade offs there, but if you really want to look at that, that's probably what you would be looking at is something more like a single payer system, which some of those other countries that we're compared with have.

Phil Bredesen: It's always struck me that we depend or we want to depend on market forces to control the prices when the healthcare market just doesn't have a lot of the characteristics of what you think of as a market. I mean, consumers themselves have relatively little to say about the prices. I mean, if I go into get some particular procedure, because of insurance, I don't really care what it costs. In fact, I probably think where it's most expensive, that's probably the best one. And so, I should – you don't have that market tension in there.

Nancy-Ann DeParle: You'd never go into a store in Nashville and buy that shirt and have them tell you, well, we'll let you know later how much it's going to cost. Some of it may not be covered and we'll let you know later, you would not do that. But that's a little bit the way we expect the healthcare market to work. The transparency's got to improve a lot and the accountability.

Bill Haslam: Wrapping up type question, since your government service, you now have served on several boards of some of the larger healthcare companies in the country. I'm curious, what are the things that – have you gained perspective from those roles that if you were looking back in the roles of being, whether it's commission or human service or a policy director in the White House, that you think, boy, I wish I'd known then what I'd know now? Are there perspectives that you've gained from what you do now?

Nancy-Ann DeParle: I actually think I was very fortunate in my career to have the experiences that I had in the order that I had them.

Bill Haslam: Okay.

Nancy-Ann DeParle: Working so early right after I started practicing law, really in state government, just taught me so much about working on a team, how to get things done, how to talk to people, how to communicate, going and sitting down with people. I'm not going to lie, I wasn't all that thrilled about driving to all 95 counties.

Bill Haslam: Nancy, thanks so much for joining us. It's been really a good and helpful conversation. Both of us appreciate you taking the time.

Phil Bredesen: Thank you.

Nancy-Ann DeParle: Thank you.

Bill Haslam: So Phil, you were governor during the implementation of the Affordable Care Act, I was running in a Republican primary where it certainly got a lot of attention and then lived with the implementation of it. I'm curious if you have observations after listening to Nancy-Ann who was one of the primary architects.

Phil Bredesen: In listening to her, we've been friends a long time and have differed on some issues, and she obviously is a very bright person. I guess to me, it really underlines sometimes, the fixes to these problems have this huge political component. It's not just the technical side of what it is you have to do. My disappointment with the Act was that I thought it didn't go far enough in some ways to really transform the system. But listening to her, I mean, you come to understand that that's a nice hope, but that may not have been within the realm of possibility. And I certainly faced a bunch of things like that in my own time. I ended up with a lot of respect for the way she approached it, the way she handled it.

Bill Haslam: Yeah, my concern at the time, and it's still lingers, and like I said, the point would be we still spend, and this is certainly in the Affordable Care Act's fault, but we still spend way more than anyone else with not noticeably and arguably, not as good results. And there's a whole lot of things behind that. And I guess my hope, and again, you have to filter that through the political realities, is at this point in time when we were saying to the healthcare industry, "we're going to take care of paying for all these folks that you've been covering under indigent care, but in exchange, we need these things from you," I've just always felt like, and again, maybe it's a politically naive view, but that we left an opportunity on the table.

Phil Bredesen: I do believe that. And that's again, without the perspective of having sat in her office when she was working through those kinds of things. There's some fundamental problems.

Bill Haslam: Just to prove that, I really did read your book 12 years ago and I actually remember pieces of it. You have a great analogy of it. It's like if you go – I think this, I'm pretty sure it was – you go to the grocery store, you get your cart and you go around, and the manager helps you and says, "you should get one of those, you should get one of these." And then you get to the checkout counter and they say, "have a nice day." And that's just never going to be a market-driven system.

Phil Bredesen: Right.

Bill Haslam: One of the concerns I had with Medicaid is how do we figure out a way to incentivize healthy behavior in a world where you can't turn down service for any reason? I don't know the answer to that one.

Phil Bredesen: And I think also that this incentivizing healthy behavior, particularly in a poor population like Medicaid, where you can't just refuse the service, it's pretty tough because the question is, "what's healthy behavior?" I mean, we all know you're not supposed to smoke, so I make some problem for you if you smoke and you come back and say, well, that's nice, but you have roast beef seven nights a week and butter on your baked potato, and my friend over here goes skydiving, and why are you singling out smoking?

Bill Haslam: The issues are hard to me. I almost feel like we need to reboot the whole system. I have no idea in today's political world how you get that done, but it feels like that what's needed is a reboot, and all the different acts in the world are going to be just tweaking a system that all of us recognize doesn't work.

Phil Bredesen: Yeah. Well Bill, our next guest has got a little different view about healthcare. It's Larry Van Horn. Larry is an associate professor at Vanderbilt in both economics and management. He's Director of Health Affairs at the Owen Graduate School of Management, frequent author of academic papers in a number of very well-respected journals. His focus has

been on consumer-driven healthcare markets, how you measure outcomes and productivity in the field, taking a business approach to the operation of healthcare. I've known Larry a long time and have enormous respect for him and Larry, it's great to have you with us here today.

Larry Van Horn: It's a pleasure to be back with you, Governor Bredesen.

Bill Haslam: Let me jump right in. The ACA now is more than a decade old, 12 or 13 years. At the time, I think you had some questions about just the economics of the Affordable Care Act. In hindsight now, any different observations for us?

Larry Van Horn: I was not terribly enthused at the time it was being advanced. Nothing's changed in 10 years. To the extent, predictions made by economists are correct, I think my predictions have generally born out. One of the things that's most frustrating is we have very limited opportunities to engage in the policy conversation around healthcare, period. And I view what happened with the ACA as a lost opportunity to address the healthcare needs of the United States from a policy perspective. It was very much focused on the coverage and insurance coverage as the primary driver for a set of individuals. And my high level is: prior to the ACA, we had about 45 million uninsured. After the ACA, we had around 30 million uninsured. So, we picked up the insurance for about 15 million people net net. There's transfers around employer versus Medicaid versus subsidized market, but 15 million people got more insurance coverage. But we've got 330 million Americans in the United States and it did very little to address the fiscal realities facing Americans around healthcare.

Bill Haslam: Larry, one of the things the ACA worked toward doing was paying more based on outcomes rather than fee-for-service. Has any progress been made there? And is that the right thing to push for?

Larry Van Horn: That's a very challenging thing to do, in my opinion. This fee-for-service payment arrangement in America, which is the way most of healthcare is still purchased, is somehow vilified. And we need to move to value over volume. The problem is contracting and paying for value is really hard. You have to be able to measure what the outcomes are, what the quality is, and then denominate that by some measure of the cost to purchase it. Measuring outcomes and value in healthcare is exceedingly difficult, almost to the point that I don't know that it's actually contractable and possible. There are so many things that determine quality and healthcare that are outside the provider's control. The primary determinant of whether you and I are healthy on any given day is our individual behavior. The outcomes of medical care are frequently driven by, did the patient listen to me and do what I told them to do? It's very hard to contract and pay somebody for value. It's very difficult to measure, as well as perspectives on what value is are highly subjective and differ across individuals.

Phil Bredesen: You're known for pushing in the direction of a more consumer-centric healthcare, I think in some ways, more driven by a study of the economics of healthcare. If you don't like what the ACA and I guess by extension, what a Medicaid and Medicare does, what's

the substitute for that and how does it work?

Larry Van Horn: We have very fundamental issues in US healthcare. One is we have too much money going to the US healthcare industry, period. And we need to have less money going to the US healthcare industry. And how does that happen? It all starts individual because all of the money starts either through taxes or through premiums for employer-sponsored health insurance. The amount of money that goes out the door has got to be less. We've got to return the control of those dollars to the individual. Historically, the individuala has had very little control over the dollars that end up going into the US healthcare system. And once the dollars are out the door, the industry will find a way to spend them. There is no boundary function on the ability of the US healthcare industry to figure out a way to spend money to try to improve my health. So to me, we need to return the locus of control of the dollar back to the individual and then empower them to make decisions about that.

Bill Haslam: I fundamentally agree with what you're saying, but how do we do that? How do you turn it back to the individual?

Larry Van Horn: We've seen this starting, Governor Haslam, in 2006 with the rise of high deductible health plans. What that does is it puts the dollars in the control of the indivudal by putting money in a health savings account, which is triple tax preferred that an individual can accumulate over time. And if I was a 30 year old, all I would want is a catastrophic health insurance plan that's very inexpensive, and then I would want a triple tax preferred HSA that is growing over time such that I am individually insured based off of my accumulated assets in my health savings account.

Phil Bredesen: I mean, you're arguing for price transparency, I think, and people understanding in a mechanism. The expenditures on healthcare of an individual vary so dramatically, depending on circumstances. I mean during my 35th year, I probably spent zero on healthcare and somebody else got cancer or a bad auto accident and spent hundreds of thousands of dollars. A significant part of the cost of healthcare are in those very high expense, extreme kinds of things. How does an HSA or something like that addressing it?

Larry Van Horn: Fair point. In terms of thinking about this, I would decompose the US healthcare spend. Right now, any healthcare that we consume is run through insurance. Insurance is a very inefficient and costly way to pay for anything. You would never say, I'm going to finance anything and I'm going to use insurance to do it. So the examples you were throwing out, Governor Bredesen, high consequence, low probability events, those are all things that should be covered by a catastrophic insurance program. And I personally think that should be a nationwide government program to take those catastrophic events off the table. But if you look at somebody under the age of, say, 55, the majority of their blocking and tackling day in, day out of healthcare consumption satisfy the definition of insurance. It's going to a doctor, it's getting a lab test, it's having x-rays.

All of these activities that prior to the growth of HMOs was covered by major medical and 40% of all medical care was paid out of individual's wallet with prices that were easy to pay and affordable. And because we've built up this insurance apparatus to pay for anything in healthcare, we've made it incredibly expensive to consume any medical care. An example is back in the days of major medical, having a baby delivery cost about 4% of a household's income. You could go out and you could buy a baby delivery. Today, it's 18% of a household income, median household income to have a baby to produce the next generation of Americans. To me, a most clear indictment that we've failed our citizenry, the way to address access is by making prices affordable. And the price mechanism in US healthcare has been all wrong for the last 25 or 30 years.

Phil Bredesen: I mean, a 30 year old is very different from a 70 year old just in terms of the stuff that's needed. Would you change Medicare in that way? Because it seems to me that what you're proposing is to say to people just at the time when their income starts to be minimized because they've retired, the ordinary healthcare costs for drugs and doctors' business stuff start escalating. That seems like a difficult problem for an elderly person. I mean, would you change Medicare in that way as well?

Larry Van Horn: Medicare is predicated on having young working people contribute tax revenue to pay for old people. And so for that to work, it's got to be the case that the relative number of working people to old people, it's got to be time-invariant, and that isn't an economically rational and stable way for the long haul to deal with this. You made the very fair point that the healthcare utilization is predictable and it increases with age. I'm much more sympathetic to a Singaporean approach as embodied in what we could do with HSAs or in prior administration's monster HSAs, where we have individuals who save over the course of their life and accumulate the funds that are necessary for when those more likely healthcare needs are going to take place. So bringing it back to Medicare, to me, we might sit there and say, if you are currently under the age of 40, here is an opportunity, you have the monster HSA opportunity. Your Medicare payroll deductions will go into your HSA. You have the ability to, your employer to contribute to HSA in tax preferred way. Medicare is not going to be part of your future. I believe that they would be better off in the long run. And our Medicare program would be more economically sound if we had a world where it was generational savings as opposed to intergenerational wealth transfers.

Phil Bredesen: You have a more, I guess, a happier view of human nature than I do here. Unfortunately, I think the reality is for most people, they don't make those savings. I mean social security is for a huge number of people in the United States. I don't know what the most recent numbers are, but certainly, it can be north of 50%. It's the only source of income that they have as an elderly person. And I think part of the reasons it's valuable is that it does force people to save in a way that they would not if they were left to their own. So I guess the question is what you're talking about is it makes an awful lot of sense for somebody who's really thoughtful about this and is very careful about saving in the future and frankly, is in a position to be able to do that. But what about the other 250 million people in the US?

Larry Van Horn: I guess, Governor, I would maybe push back a little bit or maybe I wasn't clear in terms of the thought process. And that is, if when you start working at age 22 and your employer is taking, let's say, 2.9% of your compensation every month and it's being directed into your specific health retirement account, health savings account, a healthcare need account, and you accumulate that over 40 years, and everybody is participating in that, it's not voluntary, it's compulsory.

Phil Bredesen: Okay, got you.

Larry Van Horn: And you can choose to increase that number from, that's a policy decision from what it is, 2.9% today to make it 5%. What happens in Singapore is that once an individual has accumulated enough in their account, then the government says, wait a minute, you basically have created a sufficient bank account for yourself, you don't need to contribute anymore. But those are policy levers that we could use. What I'm suggesting is let's get rid of the intergenerational wealth transfer to fund healthcare. Let's make it intragenerational planning for the long haul. And I think that is a good economic foundation for securing sustainable medical care access and delivery for the long haul. The other byproduct of it is it puts the money back in the individual's control. And I think that is very useful in terms of rationalizing the market and having people make better decisions.

Bill Haslam: You focused a lot of your time on price transparency, which is obviously an issue in healthcare. And I spent my first 25 years in business in the retail gasoline business where you put your price out there on the street big every day, and I can promise you, demand is elastic. And for a penny a gallon, people will go across the street. So, I get the premise. I guess my question is around the reality of it, if I come in after an accident, I'm not going to check the price, et cetera. So, I get the fundamental idea around transparency. How does it work in reality given the way we buy healthcare?

Larry Van Horn: Your example of car accident, catastrophic thing happening like that emergent, nobody's going to shop prices there. But the reality is that 80% plus of medical care that's consumed in the United States is planned and there is a shopping and a consideration process, so set aside emergent activity. What Americans don't appreciate, and this is part of the work I did with the prior administration to raise this, is the amount of price variation that exists in US healthcare. Most Americans believe because I have insurance, I don't need to shop, the insurers solve the problem. One, this is some research I've done and some surveys of Americans, most Americans think that because I have insurance, I don't need to shop because the price, they've solved that. Two is that Americans don't understand the variability in price. So taking it back to your example, governor Haslam, to me, US healthcare is like pulling in to a gas station, filling your car up with gas and not knowing until after the fact whether you pay 2.50 a gallon or $12 a gallon. That actually is the amount of price variation for services in a market for US healthcare.

Bill Haslam: Explain to our listeners why that much variability exists.

Larry Van Horn: It's a number of factors. One is that, and let's just use the gas industry, people filling up their cars, people shop, right? And people will go across the street for lower prices because those prices are transparent. In US healthcare, there are no transparent prices, so there is no marketplace of many willing buyers and many willing sellers coming up with a market price. The way the price is determined is you have a big health system sit across the table from a big insurer and they play whackamole. And they beat each other over the head to negotiate contracted rates based on who has market power. That determines the prices, and that mechanism has led to tremendous consolidation amongst healthcare providers and consolidation amongst health insurers because the entire price determination mechanism is one of banging each other on the head, oligopolies, monopsonies all trying to beat each other to get the best price. So, that price mechanism is fundamentally the problem. And if you pull back the veil and you let everybody see the prices and people can make informed decisions ex-ante, I think you're going to get to a much more competitive market equilibrium with much more rational prices where people are making purchase decisions for services that they value.

Bill Haslam: Larry, this has been fantastic and you make some really compelling arguments. Let me wrap up with this question we ask all our guests, the podcast is based on Senator Howard Baker's famous statement of, "Always remember, the other fellow might be right." Can you think of a time, particularly as it relates to this topic, when you realized the other side, the other person might be right?

Larry Van Horn: I had the good fortune 10, 14 years ago of having a lot of conversation with Governor Bredesen over at Vanderbilt where he'd swing by and we'd roll ideas around. I was very influenced in my thought process by the holistic approach that Governor Bredesen had in our conversations to thinking about how we balance the social contract and what society we want to live in and the fact that everybody has a different draw from the deck. And some are advantaged and some are disadvantaged. I think listening to Governor Bredesen and Governor Bredesen, I would be probably on different sides of the aisle, was very impactful for me in terms of thinking about what are policy solutions that balance my innately hardcore market-based approach with a balance to what generates social cohesion, honors the social contract in America, and puts forth a solution that we all would be proud of at the end of the day. So, that was my response and I was very impacted by those conversations.

Phil Bredesen: Thank you very much. And it worked the other way as well.

Bill Haslam: Thanks for letting the rest of us listen in on what's been a, it sounds like a 12 or 15-year conversation between two of you, but recognizing I think what we'd say the reality, we're spending way too much on healthcare for not good enough outcomes. There is within that, as Governor Bredesen says, a social contract or what I'd call the common good that we want to think about while we're incentivizing people to make the right choices. And we know that usually that happens when people are making decisions of self-interest. So, thank you all. It's been fun

to be a part of this conversation. Larry, thanks so much for joining us.

Larry Van Horn: Thank you Governor Haslam and thank you Governor Bredesen.

Phil Bredesen: Larry, again, my thanks as well.

Bill Haslam: Let me let you go first. You and Larry obviously have a long history. You and Nancy-Ann knew each other well. I'm curious your initial response to both conversation.

Phil Bredesen: Well, I thought the two of them both represented very well and thoughtfully, just two really competing visions on how you provide a service like healthcare. And Nancy-Ann really believes it to be a social function of government and that's the best way to make it happen and has persuasive arguments. And Larry, obviously, different from that. We've talked in other contacts, Bill, about one of the reasons for the power of Howard Baker's observation or thought is that most problems benefit from picking and choosing a little bit from different ideologies. And I think both of us have had the experience of doing that. So, I looked at both of these not in terms of one is the right answer and one is the wrong answer but what can we glean from each of them, which can be useful in solving the problem.

Bill Haslam: I do think Larry's point about the cost of healthcare increasing incrementally because fundamentally, very few people are paying for it, personally, to me rings true.

Phil Bredesen: Right. No, I think that's absolutely right. I mean, you don't even know what it is.

Bill Haslam: Yeah. So here's my concern, politically, we're at a place where nobody really has the guts to make hard decisions politically anymore because there's no political reward. I mean, as you know, the easiest thing to do at all in government is keep doing things the way you have. If you're wasting a bajillion dollars nobody knows or seemingly... Well, they care, but they just don't know.

Phil Bredesen: Well, and your bajillion dollar waste is somebody else's income.

Bill Haslam: Right. But my point is that there's... That's actually very well-said, somebody is doing very well off of that. And so, the easiest thing in the world is to leave it the same. The hardest thing is to make a change and to change the healthcare path in this country is going to be a consequential decision that is very tough with some long-term losers that are doing very well now.

Phil Bredesen: There's no question. What I've been thinking about as I've listened to both of our guests today is what does it look like to be able to take the system we have that a lot of people are bought into and a lot of people... I mean, Medicare is a very popular program and so on. And how do you change it in a way that you're not taking away from a lot of people, something that they really value but moves it on a more sustainable path? I mean, that to me is

the problem. It's not what's the right system or the wrong system, it's saying how do you make small changes and get us going in the right direction.

Bill Haslam: I think you're right. My hope is more in technology being able to move us there than it is on political decisions because currently, I don't see much the courage it takes to make those kind of decisions.

Phil Bredesen: This has been a stimulating session. Looking forward to our next time.

Bill Haslam: Me too.

Marianne Wanamaker: Thanks for listening to "You Might Be Right." Be sure to follow on Apple Podcasts, Spotify, or wherever you listen to your favorite shows and please help spread the word by sharing, rating, and reviewing the show.

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