

## **Briefing: Healthcare As a Campaign Issue: Ready to Rally?**

### **August 4, 2004**

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**ED HOWARD:** My name's Ed Howard. I'm with the Alliance for Health Reform. On behalf of Jay Rockefeller, our Chairman and Senator Bill Frist, our Vice Chairman, and the other members of our board, I want to thank you for joining us this afternoon to look at healthcare's potential role in the 2004 elections. Now, Senator Rockefeller and Senator Frist may not agree on their preferred outcome in November, but they do agree that healthcare is an important issue and ought to be prominently discussed in context with the campaign. I guess the only question is whether Senator Frist can induce his colleagues in New York in a couple of weeks to mention healthcare as much as the 161 times the Democrats mentioned it in their speeches in Boston. Our partner today in the program is the Robert Wood Johnson Foundation, the aggressively non-partisan Robert Wood Johnson Foundation, I might add. We're grateful for their support, though when I mentioned "election" and "Robert Wood Johnson" in the same sentence, it makes Stuart Schear very nervous. I assure you he keeps me honest in this regard. Stewart is here. He knows an awful lot about healthcare. He is the Foundation's point person on both Cover the Uninsured Week, Covering Kids, which is in the middle of a Back-to-School Campaign to try to sign up all those eligible kids for coverage, and I'm sure he would be happy to tell you more about any of that, or anything else that he can help you

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with in the way of stories. The same is true, with Bill Irwin, our Communications Director, whom many of you met, if you don't know him already, on the way in. But that's his job, and my job is to try to make your job easier.

In the last few days, there's been a veritable flood of healthcare news. The Center for Studying Health System Change found that about nine million fewer Americans had coverage through their jobs as a result of the shaky economy and higher healthcare costs over the period of 2001 to 2003. The Urban Institute told us that about half of uninsured kids don't get a medical checkup in the course of the previous year. The Kaiser Foundation in the state children's health insurance program, which had been growing constantly since its enactment back in 1997 had actually declined in the second half of 2003. So today's discussion couldn't be any more timely.

A couple of logistical items. In your packet you'll find a lot of background information including where we have the speakers' slides so you can follow along without having to write down everything you see on the screen. And including more biographical information than I'm going to be able to give about our speakers. And by the end of the day today you'll be able to see a webcast of this session on [kaisernetwork.org](http://kaisernetwork.org). As you can see, it's also being webcast live by C-SPAN, and in a few days you can see a transcript of the discussion if you need

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that for your story, and copies of the materials at both our website at [allhealth.org](http://allhealth.org), and [kaisernetwork.org](http://kaisernetwork.org).

Politics is a fluid business. I guess the airline business is a fluid business, as well, so our lineup is somewhat different. David Winston is on his way, so we're going to shift even from the lineup that you have on the newly revised agenda that's in your packets. The fact is, however, we have an excellent lineup of speakers to address this issue from a variety of perspectives. We'll here from all of them and then open to your questions, if that's okay. We're going to start with Daniel Gotoff, who's a Vice President of Lake, Snell, Perry and Associates. He's pinch-hitting for Celinda Lake, who's due to be hitting the tarmac at Reagan National right about now, having been stranded in Kansas City a little longer than she expected. Daniel's been with Lake, Snell, Perry for the last six or seven years, since 1996. He's handled survey and focus work on issues like campaign finance and healthcare reform, and he had been working with Celinda, in fact, for her presentation for today's program. So we're very glad to have as an expert pinch-hitter, Dan Gotoff. Dan?

**DAN GOTOFF:** Thank you. Thank you, Ed. And we also thank the Alliance for Health Reform and the Robert Wood Johnson Foundation for putting together this panel. I'm very excited to be here, and also say how much I enjoy speaking on this subject when I don't have my Republican Counterpart here

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to rebut, although I'm sure I'll get a chance later on. I thought what I would do is just run through an overview of the political landscape nationally, and where healthcare might fit into that landscape, and already is. And then turn it over to other folks. I know we're on a pretty aggressive schedule here, so I'll just jump right in.

The country's mood has grown negative over the last few months, and has actually stayed negative for a while. This is one of the most important indicators, as many of you know for an incumbent. When things are going well, people tend to want to reelect the incumbent; when things are not going well, they tend to look for a change. Now typically, an incumbent will get a little bit more than the right direction number, which in most recent polling was [inaudible] but this is a pretty serious warning for this president. In terms of the issue agenda, voters see jobs and the economy as the most important issue in the election, although when you combine Iraq and terrorism, it rivals that pretty well. Healthcare is further down the agenda as a second-tier issue, about 12 percent. However, when you ask people about their top economic concerns, healthcare rushes to the top of that agenda. So 54 percent of voters say that rising healthcare costs are a serious problem, 94 percent overall saying that it is a serious problem. If you see some of the other issues here, job losses, to try to [inaudible] important issue, but further down on the roster, as

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is unemployment. The other important indicator for a sitting incumbent is his job approval ratings. This president has pretty polarized ratings. They've been net negative, they've been net positive, but they have not broken 50 percent for some time now. Also a serious warning. This is just a couple head-to-heads, both with Nader, and without Nader. These are actually more recent numbers, post the convention, but the trend is pretty much the same with Kerry leading in most polls now, but both within the margin of error. It's a statistical dead heat at this point. Nader takes a few percent, although that doesn't look like it's cutting very deeply in to Kerry's margin.

Both candidates at this point have pretty polarized images, which is befitting this race. It is, as we have heard countless times, a very polarized race with partisans staunchly behind their party's candidates. George Bush 48 percent favorable, John Kerry 43 percent, and each have favorable ratings in the low 40's. Edwards is viewed a little bit more favorably, Cheney is net unfavorable at this point.

We asked voters specifically in terms of healthcare, what is their top concern, and by two to one, a pretty solid margin—sorry, I think I should skip this slide—Democrats also doing well coming out of the convention, posting a pretty solid lead over Republicans in terms of the Congressional balloting. So we're talking about voters' top concerns when it comes to

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healthcare specifically. Costs are by far the top concern; forty-three percent mention costs, two to one margin over any of the other issues mentioned, including seniors' issues, access, which is a pretty vague way of talking about the uninsured, medical conditions, procedures, insurance company concerns, but 43 percent immediately say costs. And it's something that we see in polling around the country, not just nationally, but in congressional districts and in battle ground states, as well as here in focus groups. And voters are extremely concerned about the ability to afford necessary healthcare. Healthcare issues are also important to voters in determining whom they're going to vote for. The cost of healthcare insurance, 82 percent say it's a very important issue, and it also leads in terms of intensity, being one of the most important issues.

The number of Americans without health insurance is a little lower, and I think that's why more than not we'll be hearing from the candidates about addressing the cost issue, more than addressing the millions and millions of Americans who are uninsured. On social issues, especially healthcare and prescription drugs, voters tend to favor Kerry. They tend to give him a 14 point margin. This is from a Fox News June poll. A 14-point margin on healthcare, a 15-point margin on prescription drugs. Those margins have increased over the past few days, not surprisingly. And following this trend, Democrats

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in Congress have an even wider margin over Republicans in Congress in terms of who would be best to deal with this issue.

Americans support differing policy solutions, so this is just a battery that we ran through and asked the voters what they favored. And all of these really have strong support. The one with the most moderate support is creating a single government plan, financed by taxpayers, which is probably one of the more unflattering ways to frame that. But 85 percent favor tax-deductions for employers, expanding government programs for low-income people, 74 percent requiring businesses to offer private health insurance. There's little agreement though, in terms of the top preferred option. You see a lot of these are mired in the mid-teens or the low-twenties. Interestingly, the one that gets the most intensity is creating a single plan that insures all Americans, but as we see in the last slide, that's an issue where there's more polarization.

We also thought it might be interesting to run through some public attitudes on the Medicare Prescription Drug Bill that was passed some months ago. A majority of Americans feel that they don't understand the new changes. Actually a majority of people don't know that Congress has passed a bill. Only 31 percent are aware that it was passed and signed into law, 16 percent believe it wasn't passed at all, and 54 percent don't know. Similarly, 54 percent don't feel they understand the new changes in prescription drug coverage well enough. Just a third

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say they do. One of the more startling numbers for a policy that was really directed at one age cohort of Americans, those who would benefit most directly from a Medicare prescription drug bill, seniors opposed the new drug benefit passed by Congress by a nine point margin. Younger voters tend to be more in favor of it, but seniors, the target group for this, are opposed.

Similarly, voters are split on whether or not the Medicaid Bill is actually going to help seniors pay for drugs. And a majority say it will either hurt seniors, not have an effect at all, or just don't have an opinion. Just 35 percent say that the new bill will help. This is in terms of focus group research on the legislation as well as some survey research. Seventy percent of the public doesn't know that the prescription drug discount cards will be available this year under the new law. What we've heard from voters is that they're generally dismissive of these new cards. They've seen them "implemented" in their states and haven't really recognized much of a benefit. When we asked voters whom they think is going to be most positively affected by this legislation, voters believe that pharmaceutical companies and the insurance companies are really making off and are the biggest beneficiaries under this new law. Forty-four percent say pharmaceutical companies, another 29 percent say insurance companies, and just 13 percent say seniors.

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And a couple of sticking points, I think. Two thirds of Americans, I think, want to be able to buy cheaper drugs from Canada, and that's something that this law does not allow. And Americans also want the law changed that the federal government can negotiate for lower prices the same way that the Defense Department and the VA can do. So, it's going to be tough as they try to raise the profile of this legislation to get voters that have a more favorable view of it with these pretty serious limitations. I'll stop there and turn it over to other folks.

**ED HOWARD:** Thank you very much, Dan. Next we're going to hear from Chris Jennings, who heads Jennings Policy Strategies. He's an unpaid but key advisor on healthcare issues to the Kerry Campaign. Sarah Bianchi is traveling with her candidate, so she can't be with use, but Chris worked with Sarah at the Clinton White House. Chris was there through eight wonderful years, working on healthcare issues. He can show you the scars if you ask him. When he worked at the Senate Aging Committee I was at the House Aging Committee, and I'd stop him in the hall of the Dirksen Building and learn more about what was going on than I could from reading every publication that was covering aging issues at the time. He is very welcome to pick up the banner of the Kerry campaign and talk about what Senator Kerry would do as President in healthcare. Chris?

**CHRIS JENNINGS:** Well good morning, and thanks Ed, RWJ as well. It didn't used to be the case that people were more

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disappointed to see me than Sarah Bianchi, but I have my has-been, used-to-be role. I find it quite liberating, actually. I don't have much time to convey all of the policy positions on healthcare that the Kerry/Edwards Campaign has, but I'm going to do it in ten slides or less, okay? And see how we do, and certainly turn it over to Megan and go beyond that.

I'd like to start out by saying that there isn't much that we'll agree on, in terms of policy, but I think we will agree on one thing, that there couldn't be a bigger contrast between domestic policy priorities than the issue of healthcare in this campaign. And I think it's a really interesting issue in terms of not just overall investment, but also policy structure, and the approach each side has taken to address an undeniable need.

So let's go to the first slide—and maybe it will be my only problem slide, okay—which is you've got to look at the last four years' record, because I think that tends to frame how people view where we are in the healthcare debate. It's indisputable that we have four million more Americans uninsured. That actually reverses a trend, and I think equally important, in the late 90's we were decreasing in the numbers of uninsured. Now we are increasing. But increasingly important, as those numbers increase, then more cost shifting occurs and more cost increases to those people who have healthcare. Not surprisingly, therefore, premiums consistently

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are increasing at double-digit rates, and family premiums increased almost 50 percent in the last four years.

Healthcare costs overall actually quadruple wage growth, which really helps explain why the polling data Dan was referencing really has an impact on the economic competition today, as businesses and labor, every time that they're negotiating contracts they find that healthcare is the big stumbling point. And not surprisingly, it is undermining business's ability to compete in a world marketplace. If you ask most big businesses in this country, they'll say their biggest challenge that they cannot seem to get a handle on in terms of their ability to compete internationally is the comparative difference of the costs they are investing in healthcare versus their competitors, both in terms of their current workforce and their retirees population. And lastly, despite this \$1.6 trillion investment, our outcomes in healthcare are poor or mediocre across the board and as Bill Macinterp [misspelled?] has found, consumer satisfaction with our healthcare system is at its lowest rate in twelve years. So it is, I think, by any definition time for a change, and we can talk about which candidate will be most able to address that.

The next slide gives you an overview of the Kerry/Edwards vision of healthcare reform. The first priority, and the priority that Senator Kerry referenced over and over again when he first unveiled the legislation, is that he wanted

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to make healthcare more affordable and predictable, not just for the people who don't have healthcare, but clearly for the people who do have health insurance in this country.

Secondly, he wanted to make it more reliable, and he wanted to make certain that we were using the programs that work. Group coverage works. It spreads risk, it's more predictable and you don't have to regulate it. It's already regulated by itself by pooling all the populations. So it builds on the private sector coverage that currently exists, primarily for the employer-based system, and through FEHBP, as well as to build on public programs that have been working quite well.

Thirdly, as we are investing more in healthcare and expanding coverage and addressing the affordability issue, it's important that we get a better return on our investment, both in terms of quality, outcomes, and to make us better negotiators for the healthcare services. And we'll talk a little about that. One of the best-kept secrets in Washington is that Senator John Kerry and Senator John Edwards have a very substantial medical malpractice reform initiative that I'll briefly go over with you. And lastly of course, he believes in passing legislation that has broad bipartisan support in the Senate, both in terms of public health as well as patient protections. And I'll get through that. Next slide.

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One of the issues that has received the most attention under the Kerry/Edwards plan has been the concept for providing federal support for the costs of catastrophic healthcare expenses, which after all is the primary driver of overall healthcare costs. And what the reinsurance policy that the Kerry/Edwards team advocates for is investing federal dollars to buy down the catastrophic costs, 75 percent of the catastrophic costs over a certain catastrophic threshold. And in this case, when implemented in 2013, it would be \$50,000. The whole design of that policy, and we can take questions about that, is designed to lower overall premiums by approximately ten percent. So the threshold is actually designed around that ten percent number. The \$50,000 in 2013, the \$30,000 in 2006, that policy is linked to the desired policy outcome of reducing premiums of qualifying plans by 10 percent. Next slide please.

Beyond reducing costs and making it more predictable, oh my gosh, you really—

**ED HOWARD:** Talk faster!

**CHRIS JENNINGS:** Okay. Well, okay. The private plans that he will be building on will be a new FEHBP buy-in, and strengthening employer-based coverage. The most important part about this is this whole plan option does avoid significant disruption, which was one of the criticisms, frankly, of the Health Security Act. And if you look at the two of the plans,

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between Kerry and Bush, the Bush plan would require and lead to more disruption in healthcare than Kerry/Edwards. By using FEHBP and allowing small businesses and people who don't have healthcare to buy in to FEHBP through tax credits you are providing a viable, reliable benefit package, and you're also providing additional tax credits for vulnerable populations in small business, 55 to 65 year-olds, and workers in-between jobs. Next slide.

In addition, by building on the private system, there will be other vulnerable populations that need help. As Ed mentioned, we're having problems in the CHIP plan now with disenrollment. We want to expand coverage in those areas for higher income children, to cover all children, parents and childless adults, and provide financial incentives for states to do that. And the way to do that is to buy out 100 percent of the Medicaid costs for children, also to provide additional financial incentives for states to participate and lastly, a one-time fiscal relief investment of \$25 billion. Next slide.

As you're expanding coverage, Senator Kerry and Senator Edwards believe you need to assure value and get a better return on investment. A major emphasis on disease management, information technology, which we can go into in greater detail later, but really being aggressive on this, requiring that all federal health plans go to paperless claims by 2008 will substantially reduce costs. Secondly, if we're going to be a

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better purchaser of healthcare, we have to do a better job of buying prescription drugs. As such, John Kerry and John Edwards believe that the Medicare Bill should be changed to repeal the explicit prohibition of direct negotiation by Medicare, and to authorize reimportation of FDA approved drugs, as well as a whole host of other initiatives that will reduce pharmaceutical products. Next slide.

In addition, another way to make healthcare more predictable and address a major issue is to have a meaningful but enactable medical malpractice reform initiative. AS I say, this is one of the best kept secrets in Washington, but I bet you most people in this room don't know that there is a policy, and secondly, that the policy is the following. First, to avoid the problems in the first place, there is a major emphasis on reducing medical errors and passing patient safety legislation. Secondly, all medical malpractice claims would have to be reviewed first by medical specialists to see if there was a viable case in the first case. Thirdly there would be new sanctions in place to punish lawyers who are bringing frivolous malpractice cases, including a new penalty that throws lawyers out of the ability to file such cases. Fourthly, there are a whole host of new alternative dispute resolution provisions that would be included, and lastly, there would be no punitive damages, except in the most egregious of cases, all of which really substantially address the problem and most importantly,

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be a policy that could be passed and enacted, and address a very serious issue.

Okay, the next chart goes to the issue of patient protection. I swear, it's like 45 seconds. As strong enforceable patient bill of rights, mental health parity provisions, a really focus on public health, really dealing with and not denying the existence of racial health disparities in this country, major commitment to AIDS, both domestically and internationally, and a new and long overdue authority on regulatory authority for FDA to regulate tobacco.

On the last page, very simply, there's a summation. I'm sure this is how Megan would draft it as well. But I think as a quick guide, you'll see that whether it's coverage, cost containment, reliability of coverage at the SBP public programs that worked, level investments that are paid for explicitly by a rollback of the tax cut to 200,000's, just to repeal that tax cut for those people over \$200,000 that would finance \$853 billion. That would more than cover the \$650 billion price tag.

You have an affordable, accountable and reliable reform package that will really address an issue that is long past due and clearly offers a meaningful alternative in contrast to the Bush/Cheney camp. Thank you.

Thank you, Chris. Now, as Paul Harvey would say, you'll here the rest of the story, and we'll see if Chris is correct in his assumption that there is agreement across the panel. Let

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me just reemphasize that there is a set of biographies for all speakers in your packets, and I apologize to them for not giving them the introductions they deserve. But we want to save the time for their speeches and your questions. We'll now hear from David Winston. He's the President and Founder of the Winston Group, where he advises a number of congressional Republican clients on a range of issues, including healthcare. He's worked for J.C. Watts when Senator Watts headed the Republican Conference in the House. He worked with the Republican National Committee under four different chairmen, and we're very pleased to have him here with us this afternoon. David?

**DAVID WINSTON:** In terms of healthcare, I'd like to start off with a bit of a broader overview, and get into some of the components that feed into this issue, before addressing the issue itself. I want to start off with something that's pretty obvious and basic. One of the things that's clearly incurred in terms of healthcare in this country is it's clearly gotten better, because we're living longer, and in fact, the life-expectancy since 1970's has increased about eight years. That's a pretty significant accomplishment and that's reflective of the quality of the system that we have. Having said that, that obviously is a huge problem as well. Suddenly, instead of all those people—again, since most people deal with the healthcare system when they're older, rather than when

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they're younger, that means there are more individuals to take care of. So while we're looking at this huge success, at the same time we're looking at this situation where the system is clearly going to deal with a level of stress, and then add onto that Baby Boomers, and you've got this bulge about to hit. You see the healthcare system being asked to do things that it just simply has not been asked to do before. And so one of the things we need to realize is that the healthcare system of the 70's and 80's—structurally, I'm not talking about the science—is going to have to deal with a completely different audience, and size than it has ever dealt with before.

So in terms of is this issue going to get bigger? Yeah, because there are just going to be more people dealing with the healthcare system, which gets to the second thing that I wanted to describe to you—I ended up doing a study on retirement, in terms of how people begin, and really this was more focused from an economic point of view, and initially when I took a look into it. And in the course of this I sort of discovered the three phases of how people look at retirement, and what you'll see is that this retirement ends up being much more healthcare dominated than financially dominated. Obviously, finances are a key part of this—and if I can I'll break these into these three segments. And yes this is a broad generalization but I think they'll get the drift. From about 45 to 54, when people start thinking retirement, it's really

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money. It's the first time they've thought about, "Gee, what am I going to do?" And so, the initial sort of panic is, "Do I have enough money?" and they start focusing on that and start putting funds away. That's their first engagement. The second stage is from 55 to 64, and that's when the focus really becomes on healthcare. Now actually that comes from one gender, and one gender only, because women have been dealing with the healthcare system pretty much since they were 18, once they sort of went off on their own. They've actually sort of focused on it. Men, around 55, things start to break for the first time and suddenly they've got to go to doctors, right? And there's this whole new system, a whole wide world that they've never dealt with before, and they suddenly engage, and so you see that from 55 to 64 concern about healthcare jumps. Sixty-five plus, there was an interesting transition, and that was, the focus is almost virtually on prescription drugs. And the reason is, it's like drinking water - that's how you stay alive. You can't get to the healthcare system if you can't physically get there. And prescription drugs have become such an integrated part of seniors' lives and I mean, I watch my mother and my grandmother consume these platefuls of pills every morning, and my guess is that's not uncommon in terms of most seniors. But before you can even get to a healthcare system, prescription drugs has become basically a staple in terms of the way people live. And I think it's an important context in terms of those

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three. Now, again, multiplying that problem, that you now have this huge extension, that you now have people who, fortunately are living longer, and you now have greater stress on the system.

There's one other key element to this evolving, and then I'll get into the politics of it, and this is a really important structural shift. And that is, the healthcare system is beginning to learn how to shift from dealing with being acute disease focused to being chronic disease focused, diabetes being perhaps the best example of that. That's a very different way for the entire healthcare infrastructure to have to deal with something. One of the things that was in the prescription drug bill that was recently passed, because it's so important to Americans was the fact that finally, insulin, one of the most basic living things for those people who are diabetics. Insulin would not be something that the government would fund. However you feel about other parts of the bill, that was an important structural change that is going to lead to some positive changes. But the whole concept of acute versus chronic means that also culturally, the healthcare system in this country is going to have to change, which is going to be very complicated. Doctors don't like having relationships with patients in terms of being friends and buddies, they just want to tell them what to do. Right? Here, take this and you're fixed.

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With that, let me talk about the size and scope of the issue. At this point, and I think this is pretty consistent with the cross-mode surveys, what you're seeing is, there are basically two lead issues in this country, economy and jobs are normally number one, Iraq war on terror coming in a close two, and then you have this grouping of three issues that tend to be pretty consistently around each other, and that's education, health care, Social Security/retirement. Generally, I've seen education leading the three, but they're all relatively close and they're all around seven to ten percent.

Specifically looking at which groups are impacted, no surprise, in terms of healthcare, women more so than men. At one level, because they pay attention more, and on average, women tend to live significantly longer than men. So one of the reasons when you're looking at 65 and older being, one, disproportionately concerned about healthcare, and also in terms of their attitudes, 65 and older, towards healthcare in terms of which party, I'm giving the gender differences. What you see is a significant focus in terms of that age group on it, also being driven by women.

One of the key groups in terms of looking at it is actually women 60-plus, and I'm going to give you an example of how focused they are and how solution oriented they are. This is not a Democrat/Republican dynamic for them, this is a solution/non-solution environment. I'll give you an example. In

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the year 2000 among women 60-plus, and what I did was look at DNS which does the exit polls, and I took a look at if they voted straight ticket. In that election, 46 percent of women 60-plus voted straight Democrat, 37 percent voted straight Republican, a margin of plus nine for Democrats. In 2002, those numbers flipped, 38 percent voting straight Dem, 41 percent straight Republican. What was the issue? The issue was prescriptions drugs. All right, the fact is the Senate didn't pass it, Republicans were effective in terms of saying the Democrats blocked it and people believed it. And what the Democrats tried to do, in terms of this particular issue, is they said, "Well, really people want \$800 billion, so we're not going to pass the \$400 billion one, we'll take the \$800 billion to the electorate," and the response from the electorate was, "Four hundred billion would have been fine. We may have agreed with you at the 800 billion. Get something done." And they basically punished Democrats. It's a 12-point swing. One of the other key things in terms of looking at the outcome of this particular prescription drug bill, is, do people perceive it as, "Okay, this is a solution and a step in the right direction," in which case you would see those numbers amongst that group stay the same, or do you see a sense of perhaps it wasn't and therefore you see behavior more like 2000. Obviously as a Republican you'd rather see the 2002 behavior as opposed to the 2000.

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The interpretation of the prescription drug bill is extraordinarily important, but the other thing too, to realize in terms of evaluating the public's reaction, the public may not see every single thing that they wanted in it. That is a very different standard than whether they think progress was made and whether they have better access to prescription drugs than they had before. That's the dynamic, but what the Kerry campaign would clearly like to do is cherry-pick and find two or three things that are wrong with the bill and say, "This typifies the whole bill." What you're going to see from the Republican side is, "We know there are a lot more things that need to be done, but what we're managed to do is make significant progress, even if you take a look at those individuals under the poverty level getting \$600 just free in terms of drugs—using that and saying, "We've made progress. It's not perfect," moving forward.

In the overall scope, also of healthcare, one of the other elements that I think you're going to see as a part of this debate for a whole bunch of reasons—Edwards coming into this race is obviously going to put more focus—and that is the role of lawyers within the healthcare system. I did a question about eight months ago, where I did a question, does the increase in litigation make your healthcare better, worse, or has made no difference, and I specifically asked, has made no difference. Seventeen percent said "better", 70 percent said

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"worse", and the remainder said it made not difference. The point is, people see the legal system as being negative to their healthcare. That's an extraordinary result, and that's one of the reasons why you're seeing such pressures on senators to get litigation reform, particularly through the Senate. It's obviously gotten through the House. And that's why you see so much pressure in terms of OB-Gyn, etcetera.

There's also another dynamic that you just need to take a look at, and people believe this. I give you a simple example. Airline pilots have now created a dynamic that if they are involved in a close call when they get on the ground, they can go sit down with the FAA and work through what happened, how it occurred, to improve standard operating procedure. Can you imagine in this environment a doctor having a close call going to the administrator and saying, "Oops, maybe we could have done this better"? You can imagine the administrator saying, "Thank you for opening up those billions of dollars to lawsuit." People believe that litigation is in fact hurting their healthcare system.

In terms of looking to the future here, the question of access is really going to become the more dominant one. Fortunately in terms of when people lose their job, obviously after income, which is the most important thing, the next most important thing to them they lost is their health insurance. So this expansion that we're now seeing in terms of increase in

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the number of jobs, one of the dynamics that's beginning to deal with is, that means more people will be covered by health insurance. That will take care of some of the problem. There's obviously a lot more, but obviously one of the big issues that have to be addressed is access. Cost is a big component of that, which then feeds back to litigation as well. So I think you'll see litigation being an important component, and people at this point are negatively approaching the concept that costs can be held down without some sort of major litigation reform. Overall, historically, Democrats have had a clear lead on the issue of healthcare. When you ask who you have more confidence to handle the issue, Democrats have had a significant advantage. To some degree, this is sort of the chicken and the egg, because so many more women are interested in healthcare, then does the gender gap come into play, or is this one of the reasons for the gender gap? I'm not sure that I can give you that answer. Having said that, I will tell you that over the past five to eight years, I've seen where Republicans were losing that issue by about 25 points in issue-handling, we're now seeing it somewhere, anywhere between 15 to 17 points. And so it's improved. It's still obviously not—we would prefer for it to be neutral on the issue, as opposed to—actually we were ahead by one point in the 1994 election when HillaryCare sort of took a nosedive. For short period of time we were even on the issue, and then it sort of bounced back to where it had

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normally been. But in looking to the future, I think one of the dynamics everybody needs to really focus on is this issue, because there are going to be more people concerned, but it's also going to be more complicated, because the dynamic is going to change, acute versus chronic, and the fact that the healthcare system in this country is going to have to handle a larger amount of people than they've ever had to deal with. That puts both pressure on them because of the size of it, and obviously chronic is more complicated than acute. I'll stop.

**ED HOWARD:** Thank you, David. That's a good Republican context for us to now hear from Megan Hauck, Deputy Policy Director for Bush/Cheney for 2004, the official spokesman for the campaign, as she points out. She came to the campaign from the Health and Human Services Department where she was the Deputy Assistant Secretary for Human Services Legislation. Before that she helped to develop health policy for Senator Don Nickles for about eight years, including stints with the Senate Budget Committee and his work with the Senate Finance Committee as well. Is there an Oklahoma connection at work here with J.C. Watts and Don Nickles. In any event, we're very happy to have you here, Megan, and let's hear from you about the Bush/Cheney Healthcare Campaign.

**MEGAN HAUCK:** Thank you, very much, Ed, and thanks for having us here. We really appreciate you and the Robert Wood Johnson Foundation hosting us. Chris is right, we have very few

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agreements on his presentation and mine, although I will agree with the first point that he made, that this is one of the biggest differences between President Bush and John Kerry. I'll move quickly through my slides, because I know you guys are more interested in asking questions than you are listening to us rant a little bit more. I think it's interesting when you talk about the comparison of this issue between our two campaigns. I think that President Bush has looked at this issue and said, "Okay, what do we need to do? We need to get more people access to healthcare, we need to make healthcare more flexible to meet the needs of the people who have it, and we need to cut costs." And in looking at the same issue, the Kerry Campaign has said, "Okay, what's the problem here?" And they've come to the conclusion that there's not enough government intervention in healthcare.

I think that we would totally disagree with that analysis, so I would go through quickly and tell you what we've accomplished and what we hope to accomplish, and you won't like my last slide, but then we can go move on to your questions. If you want to go to the next one.

We talk a lot about healthcare costs rising, and to hear our opponents, this happened Inauguration Day 2001, when everyone lost their healthcare insurance and all the costs went up, when in fact, it's a 30-year trend. Rising healthcare costs have been increasing since the 70's. It's something that we

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continually work on in Washington, and obviously have more work to do. The number of uninsured is something that we would all like to see go down, but when you look at it in terms of percentage of the population, actually in 2002 it was 15.2 percent of the population according to the Census Bureau, but the highest it ever was was under the Clinton Administration. In 1998 it was at 16.3 percent of the population. This is something that fluctuates up and down, but when you look at it as a percentage of the population, we're not even at the highest levels that we have been with the uninsured. So we need to address this while we have the opportunity, to talk about costs, talk about slowing the rate of healthcare spending. You can move to the next slide.

This is just a comparison of those two. When you talk about coming into the 21<sup>st</sup> Century, the two biggest healthcare issues that we face, prescription drugs for seniors, and rising healthcare costs. The President worked with the bipartisan coalition to address adding prescription drugs to Medicare for the first time in the history of the program. Regardless of people's opinions of the bill now, I still think that there's no denying that this is the largest improvement to benefits for seniors since the program was created. It's a bipartisan law, which was supported by AARP, the Alzheimer's Association and all sorts of non-partisan groups. It's important to talk about this in terms of what the benefits are for seniors, and not

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what the benefits are for politicians. Seniors getting a prescription drug benefit in 2006 are going to see, those who pay all their prescription drug costs now are going to pay a \$35 premium, and save half of what they are currently spending. That's an incredible improvement in the benefits, plus they have the protection against catastrophic costs. But until that time, they have the drug discount card, and I would disagree that people aren't seeing a benefit from it. Four million seniors have signed up for the Prescription Drug Card, and they're signing up at a rate of 100,000 seniors per week. These are folks who are seeing a 30 to 60 percent savings on their drugs, depending on if they're using brand name or generic drugs, and that's not just CMS saying that. The Kaiser Foundation came out with a study on drugs, saying seniors are saving up to 61 percent. So in addition to the savings that they're seeing, low-income seniors are getting \$600 on their Drug Card. This is a tangible benefit for seniors to go out and see how this is cutting their drug costs. I think that David also touched on a couple things that are also in the Prescription Drug Bill, the improvements of the benefits that are there. There are options, choices, and preventive benefits being covered. We hear a lot of talk about that from the Kerry campaign. We love the fact that they're supportive of this, because this is something that we've implemented in the Medicare bill. Preventive benefits, chronic care disease

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management, as well as a rural package. For those of us who are from rural states, we know that one of the biggest problems that providers find in rural states is reimbursement rates. Folks in these small towns don't have the same access to doctors that you do in larger areas. We're trying to ensure that everybody gets access to care, so we have a 425 billion rural package, as well as speeding up the approval process for generic drugs. These are all things that are lowering costs and improving access. So, we're very proud of the Medicare Bill, and we're going to continue to talk about it. We see this as such a huge accomplishment. All right, I'm hurrying.

But we also have a whole agenda on the uninsured. If you want to go move the next slide we can kind of go through. The President talks about improving access to affordable healthcare for all Americans. One of the things that we did in the Bill was health savings accounts. And I think that these are such an amazing implementation that we've seen, just since January, that you're seeing that these consumer-driven healthcare plans lower costs. When people are in control of how their healthcare dollars are spent, that when they're more aware, they're more concerned about how much they're spending. We can go through the way they work but if you look at who's been selling them, eHealth Insurance and Assurance and others. They're finding that up 35 percent of the people who buy them were previously uninsured, and eHealth Insurance found that 56

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percent of the people who purchased the HSA's from were over 40. The idea that this is for the young and the healthy is totally incorrect. Aetna put out a release in June that talked about a comparison study they did between their traditional PPO's and their HSA's, and what they found was that their costs in their PPO's went up about 15.7 percent, but the cost in their HSA's only went up 1.5 percent. They went to look at the same thing that I'm sure that a lot of people in this room area thinking, which is, that's fine, those people didn't go to the doctor, and they didn't get treatment. But that's not actually what happened. They went to the doctor. They went to specialists. What they didn't do was go to the Emergency Room. What they did do was research their options and buy generic drugs instead of brand name drugs. They use consumer information to lower their own costs. And when you give people control of their own healthcare decisions, they make smarter decisions for themselves, and that lowers costs. The more people you have in these healthcare decisions between a doctor and a patient, Washington bureaucrats, insurance companies, etcetera, then you have less incentive for people to control their own costs. And the fact that they're portable. They're not tied to your employer. You can get them through your employer if he wants to offer them to you, and a lot of small businesses have started doing that while waiting for us to pass the Association Health Plan. You can also get them yourself,

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and that's something that you control, you take with you, if you lose your job or decide to go to a job that doesn't offer health insurance.

The next thing that I would just highlight is a couple of other things that we passed to strengthen the safety net. Community health centers are a great way to ensure that people get quality healthcare in the appropriate setting. A lot of high costs occur because people go to the Emergency Room instead of going to a doctor. One in four low-income kids get their healthcare through a community health center. So we have strengthened community health centers. Our goal in the next two years is we've covered initial three million people, and in the next two years to cover another three more.

On the S-CHIP issue, I read the study saying that a couple, I believe it was less than 100,000 was the lower of the enrollment. Obviously we don't want to see lower enrollment, but overall we've increased eligibility to 2.6 million people and increased benefits for eight million people under Medicaid and S-CHIP. That's 5.8 million kids who otherwise wouldn't have health coverage under this administration.

I'm going to speed through some of the last ones because I want to get to some of the last points. Association Health Plans, we hear a lot about what people can do for small business. Ask small business what they want to do, and they'll tell you that they want to be able to pool together like unions

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and large employers can. You can talk to any of these small businesses and what they will tell you they need is the same economies of scale and the same ability to negotiate their plan costs, just like these large corporations do. That's one thing that the President is going to look for them. We have a fundable tax credit that allows low-income people who don't have health insurance through their employer to purchase health insurance. You can use this in conjunction with the HSA and really leverage the tax credit to get as much health coverage as possible.

One of the going forward proposals, Ed suggested I use this forum to unveil the second-term agenda. I think I'll leave that to the President, but one of the proposals that they have already announced is allowing the premium for your high-deductible plan to be tax-deductible, 100 percent above the line tax deduction so that we can say to people—you know, for those of us who worked in the federal government, FEHBP allows you to pay for your health insurance premiums with pretax dollars, and you don't have the same right in the private market—that's what we're saying. If you buy these high deductible plans, you pay for them with pretax dollars.

And finally on the health technology issue, this is a huge issue for the President, and we're very excited about the initiatives that we've already implemented and the ones that we have moving forward. We had ones that provided for electronic

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prescribing in the Medicare Bill, and President Bush appointed Dr. David Brailer to be Head of our Health IT at HHS. He's been working with industries to try to develop common standards so that we can all move forward with Health IT. The President has a goal that the majority of Americans have electronic medical records over the next ten years. It's astonishing that you can get your credit card records for the past five years, no matter where you are, but if you break your leg in Florida and you live in Michigan, you have paper records that you have no access to. This is something that we really feel like we need to make an impact on.

Finally, I want to address the issue of costs. When you talk about costs, medical liability is the largest cost in the healthcare system. HHS came out with a study that said that we waste between 60 and 108 billion dollars because of frivolous lawsuits, that this is money going out of the system not to take care of patients, but to pay off personal injury lawyers. I think that the President has a proven, common-sense medical liability reform proposal that has worked in the states. WE see in the states that have instituted caps, the premiums are only increasing nine or ten percent. States without caps, medical premiums are increasing and average of 25 to 30 percent. So this is not only an issue of cost, but an issue of access. For the 18 to 19 crisis states that the AMA talks about, these are doctors who are leaving the profession, these are women who

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don't have access to their OB-Gyn's, these are emergency trauma centers that are closing down when people need them.

This is the slide that Chris wrote for me, this next one. There are just a couple points that I would make. When we talk about the cost of this plan, Dr. Forbes did an estimate of the Kerry Health Plan. It's an estimate for nine years, not a ten-year estimate. If you kind of extrapolate it a little bit, it's \$951 billion over nine years. I'm assuming it will cost at least 49 billion in that tenth year, and then you look at—Chris had mentioned the \$300 billion in savings, but I think that that's a fairly unrealistic estimate when you look at the fact that we did a lot of this stuff already, and we didn't see savings from them. The preventive benefits in chronic disease management that we put in the Medicare Bill is improving benefits for seniors, and this is a better way to deliver healthcare, but it's not necessarily cheaper. If you look at the CBO score of HR1, you'll see that we ended up paying about \$3 billion to have those benefits included, so I think it's kind of a stretch to think that we're going to save \$300 billion. We have a real big concern about the costs of the proposal and what you get for that, because I think what the President's vision is, to decrease costs in healthcare and give more people access and more control over their healthcare costs, and not increase the federal role in healthcare. With that we can just be done. We'll open it up for questions.

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**ED HOWARD:** Megan is exactly right. You've been very patient. Anyone have a question? Please identify yourself, if you would.

**MALE SPEAKER:** [Speaking from audience without mic. Inaudible.] rate settings along the lines of Medicare and other federal controls on how that money is spent. And I also would like some clarification of the chronic disease management idea. I believe Megan, that it's only demonstrations that are in the MMA, but they haven't settled on a model of how it would work. There are private sector examples of hands-on chronic disease management. So, if you could talk about both of those things, I'd appreciate it.

**ED HOWARD:** Chris, do you want to start?

**CHRIS JENNINGS:** Well, on the reinsurance policy, actually it is a two-pronged package, I think worth going over. One is, as I mentioned—it would be federal support for costs, catastrophics exceeding a certain catastrophic threshold, which would be 75 percent of \$50,000 projected in 2013. What that means is, the federal government would provide 75 percent subsidies or financial assistance directly to plans and employers who provide such care, and the only thing they have to do is provide coverage to their employees, and to have a disease management program, which is exactly what we want them to be doing. The biggest issue, the biggest driver of healthcare costs are catastrophic expenditures. In some

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populations we're seeing five percent of populations pushing 40 to 50 percent of the costs. Those are the costs you want to address. And the only way you would be eligible for that is if you have a qualifying disease management program, which is exactly what we think you should do. You should provide carrots and sticks to move the system, to modernize the system, to address the system. But there is no rate-setting or rate controls, or federal take-over. I always enjoy the Republicans who say, any time the federal government is involved to help the private sector, it's a federal take-over. I don't think you would say that would be the case for our retired health plans, would you Megan, through the Medicare Drug benefits, where you're providing financial assistance to employers which are providing retired healthcare

**MEGAN HAUCK:** I think what is the federal take-over is a federally run pool that's run on FEHB that isn't FEHB, that you open up and run through the federal government. I think that's essentially a federally run system, isn't it?

**CHRIS JENNINGS:** Actually, the Federal Employee Health Benefit plan, which is the benefit that is offered to members of Congress, excuse me, is a privately run system. Isn't it an all-private plan, the FEHB plan. Are there public plans, or are there private plans?

**MEGAN HAUCK:** This plan isn't FEHB, though. From what I've seen it said, we won't open FEHB, we'll model-

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**CHRIS JENNINGS:** You can represent the Bush plan, but I'll represent the Kerry plan. The Kerry plan is the FEHB model.

**MEGAN HAUCK:** It opens up at the FEHB so that people can join the same plan, but they can't.

**CHRIS JENNINGS:** Yeah, it would be that you are accessing an FEHB-type plan. FEHB is OBM administered private plans. Yes. That is a separate pool for those people.

**ED HOWARD:** Megan, why don't you talk about the chronic care demonstrations or plans?

**MEGAN HAUCK:** The post-regulations came out in July, and you're right, they're working through a process of how they're going to do it. There are two ways to proceed with the chronic disease management. For people who are in the traditional fee-for-services as well as people who are in the Medicare Advantage, and the idea is to model it on something that's had success in the private sector, but to coordinate the benefits that they're getting and make sure that all their diseases—there are a lot of people with multiple chronic diseases. People with diseases that impact, like diabetes and other issues so that they can coordinate all the care. The structure is being worked through with HHS. They have a proposed rule out there, but I don't think the final rules come out until the end of October, early November.

**ED HOWARD:** Yes, behind the table. That lady's been trying to get our attention.

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**CECE CONNELLY:** I'm CeCe Connelly from the Washington Post. I was wondering Megan. You gave us a critique of Chris's final chart, that he calls the final policy comparison.

**MEGAN HAUCK:** I don't have Chris's final chart.

**CECE CONNELLY:** Okay, you've seen it probably a dozen times. It's been kicking around for a few months. It's the Ken Thorpe analysis.

**MEGAN HAUCK:** Oh, yes. I have it memorized.

**CECE CONNELLY:** My question is, you sort of run down the Kerry/Edwards side and where you would disagree. Can you speak though, to the Bush/Cheney side, whether that's accurate in your view, or what corrections you would make and why? Another factual question on the Medicare Drug Discount Card. Four million are enrolled, but how many of those were automatic enrollment?

**MEGAN HAUCK:** I think it was 2.8 or 2.9 were enrolled through their Medicare Advantage Plan.

**CECE CONNELLY:** Thanks.

**MEGAN HAUCK:** Sure, I'd be happy to go through this. I anticipate disagreeing with most of the points on here. The first one, two million previously uninsured is incorrect. We have estimated that our proposals cover between six and ten million additionally uninsured, when you take the HSA's, the tax credits, as well as our Medicaid and S-CHIP expansions. I think that when Thorpe did his analysis of the Bush plan, he didn't include AHP, and he included

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only the tax credit if I remember correctly, but I'd have to go back and look at it.

Provides no relief for catastrophic costs, we would disagree with that since the whole point of health savings accounts is for people to save for catastrophic costs you have to have an account that you save tax-free and you earn tax-free, and you spend money tax-free that continues to rollover from year to year, so that the years that you have fewer healthcare costs, you save more money. The years that you have more healthcare costs, there's a cushion for you there. The opposition to negotiation and re-importation, I would agree with that because the Congressional Budget Office has said that both don't save any money.

The direct negotiation is one that has been introduced in every Medicare bill, Democrat and Republican. Democrats and Republicans alike have voted for it, and the Congressional Budget Office has said that direct negotiation isn't going to save money. The PBM's, the pharmacy managers have more of an incentive to keep their costs as low as possible to get more patients than to provide a deeper discount. And I think that if you look at an example from just this past week, that if you wrote about, was the oncology drug, and the few places that the administration is actually negotiating prices, we found that we were negotiating so well, that we were overpaying by \$16 billion over ten years. So, I don't think that we would think that drug negotiations would save money. We would agree with the Congressional Budget Office.

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Re-importation we do not support because the Secretary of HHS can't ensure the safety. Neither could the previous administration, and I think we have a real concern that we just open this up to something that once again the congressional Budget Office says that re-importation from Canada would have negligible savings, and then we have the potential to really damage the integrity of the drugs in this country.

Costs shifting from uninsured. I don't even really know what that means. Plan only covers two million of four million. I think I addressed that already. Unreliable expensive discriminatory individual market. I think that there are a couple things, that in the Trade Bill we provided seed money for high-risk pools, and we have continued to try to address the issues in the individual market. I don't disagree that we probably all could do a little bit more work there. But HSA's have shown that that's not a discriminatory unfair market, that people are seeing—just the excitement of these plans since January 1 when they went into effect, and that you're seeing up to 30 percent of these people being previously uninsured, 56 percent being over the age of 40, this isn't a discriminatory market. And then, \$90 billion offset by non-specified Medicare and Medicaid costs. Well, we're not cutting Medicare or Medicaid. It's not 90 billion. This latest budget submission was 69 billion over ten through the tax credit, and I'd have to go back to look at what the deductibility for the HSA is. All that stuff is contained within our

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budget. It has a blueprint for how we will cut the deficit in half in five years, so.

**CECE CONNELLY:** [From audience. Inaudible.]

**MEGAN HAUCK:** Well, this 90 only represents the tax credit, because that's the only thing that Thorpe analyzed. I'm just saying that the tax credit is 69 billion. That's what the budget submission was. The AHP's over ten years cost about two billion dollars. The HSA's have already been implemented. HSA deductibility, I think is about 24 billion over ten, but I don't know. I'm not positive about those numbers. I may need to go back and look at it. So I'm just saying that he took an old number on the tax credits. That's not a compilation of all of our work.

**FEMALE SPEAKER:** I know you don't want to announce things for the President for a second term, but just to follow up on her question, so basically, this is the scale of the package that you're going to run on for healthcare?

**MEGAN HAUCK:** I think that the President will probably talk more about health insurance at the convention.

**FEMALE SPEAKER:** [Inaudible from audience.]

**MEGAN HAUCK:** I think he'll talk about it at the convention.

**ED HOWARD:** Yes, sorry.

**MARCIA CLEMENT:** Marcia Clement, Medicine Health. Chris, you said something about in your view the Bush plan would disrupt the current system more than yours, and I was wondering if you could

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expand on that, and Megan if you could explain what the system would sort of look like, or evolve into, if anything different, under your-

**CHRIS JENNINGS:** As you know, two thirds of the working force now gets their health insurance through employer-based coverage. If you want to shift everyone into HSA's or into the individual market through individual tax credits, you're talking about a lot of transition from the current marketplaces where more people are used to getting their coverage, to a new system. You know, as a point of personal privilege, since I was first and not last, there are a few statistics that I have to say that Megan is going to have to get some sites for. The Health Savings Accounts Policy, the latest number that was done by MIT was actually that the President's proposal on tax-deductibility that was cited in Megan's presentation would actually lose coverage of 350,000. Megan cited Kaiser as a source for a number of different things. She cited that the waiver programs under the Bush Administration had expanded coverage for over two million people, yet the only number that I see from Kaiser it 200,000 through waivers, in fact at a time that we have clearly documented 4 million and more uninsured. This whole issue on lawsuits and liability, CBO, the Congressional Budget Office says that that will reduce premiums less than one percent. I don't know, when people are seeing premiums go up by 12 percent for their insurance I don't see that one percent really makes a big difference. We really have to address, and get real numbers, independent analysis. I have never heard the sox to ten million number ever mentioned under the Bush

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record for their policies. I don't know if any independent person has done a projection of that many people.

But to go to your question, disruption, health savings accounts doesn't address the issue of coverage or of cost containment in any significant way. There are no numbers to suggest that. To some extent, to the extent that it creates incentives for healthier populations to go on those plans, you'll segment sicker from healthier populations, and you'll see premiums go up. When premiums go up for people who want to maintain their health coverage, I would maintain that's disruption. When you rely on something called association health plans, the only policy that I've seen in the history of mankind that uniquely brings together governors, insurers, insurance commissioners, providers and consumers against the policy because of a fear of segmenting population and increasing costs. Again, the Congressional Budget Office says that association health plans will increase premiums for the rest of the healthcare system. So again, that is another disruptive force. And then I think lastly I would say, under the Bush Administration, when you are suggesting that you want to block grant the Medicaid program and cut the program, you're talking about going backwards, not going forwards. To me, that is disruption in the healthcare system. I could go forward, but I'll just stop there.

**ED HOWARD:** Megan?

**MEGAN HAUCK:** You'll be surprised to find out we disagree.

A couple of things. We can go back and forth about numbers and

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things. The expansion under S-CHIP and Medicaid comes from PMF, so they're telling us how many more people they're providing care for, so I'm fairly certain I know the answer to that. As far as disrupting the market, the tax credits that we have are for individuals who don't have employee-sponsored healthcare. These are people who aren't currently getting healthcare coverage. We're not shifting them from anywhere, but the rolls of the uninsured. Health savings accounts can be offered by your employer and a lot of employers have chosen to give their employees that option. This isn't something that you can't have as well as an employer sponsored plan. Forty-nine percent of the working uninsured are at work for small businesses. That association health plans allow small businesses to put together, just like unions and just like large corporations do, to offer healthcare to their employees, so this isn't a shifting away from the employer-sponsored market, it's looking at where the employer-sponsored market is failing and what can we do to fill in those gaps. We're trying to target our approach at those populations. I hear this we're blocking Medicaid thing a lot. It's not. It isn't, actually, and I can just explain the proposal. The proposal is to build off of waivers that the states are currently using that are actually effective, that have allowed them to cover more people. The mandatory populations are not affected by the proposal under the President's budget. It allows two thirds of the spending in the Medicaid program is on the mandatory benefits or mandatory populations. But the states have two options, either put them on Medicaid, or don't. What we're saying is, for the

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non-mandatory populations, that they should have more flexibility to leverage that money to do what works for them. Some states have used some of their Medicaid or S-CHIP money to purchase an employer-sponsored plan that this family couldn't have afforded otherwise, that they can't pay their parts of the premium. There are a lot of creative solutions out there that the governors are implementing, and we're trying to reward that. It's not a block grant of the Medicaid program. The mandatory population is protected under this proposal. It's flexibility for the states building on what works.

**ED HOWARD:** I would just say, by the way, that there's a lot more information, and a bunch of good sources and phone numbers about HSA's. Based on a briefing we did just a few weeks ago, actually with the sponsorship of the Robert Wood Johnson Foundation, at our website, [allhealth.org](http://allhealth.org). Yes, sir?

**MALE SPEAKER:** Megan, you said that President Bush is opposed to the re-importation of prescription drugs, right? What I said was, the Medicare Bill allows for the re-importation of prescription drugs if the Secretary can certify them to be safe, which he cannot, so we have not been able to certify them as safe, and until we can, we will not support the proposal.

**MALE SPEAKER:** Didn't the Food and Drug Administration signal to Senator Gregg that his re-importation bill was acceptable, and is the Food and Drug Administration freelancing, or do they speak for the Administration?

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**MEGAN HAUCK:** I work on the campaign, not in the White House, so I can't speak to the interactions of the Administration and the Hill.

**AL MILLIKEN:** I'm Al Milliken, affiliated with Washington independent writers. Would the one trillion dollar costs estimated for the Kerry Health Plan give every American access to the same healthcare plan as the members of Congress, and what they have, and at this cost, what would Americans get from John Kerry that Congress gets that they would not get from President Bush.

**CHRIS JENNINGS:** First of all the cost of the Kerry Plan is \$650 billion as projected by independent analysis, and it's completely paid for, to the extent to which the FEHBP is utilized as an option. It would be an option. They could stay in employer based FEHBP. What they would not get in the Bush world, they would not have access to a meaningful, reliable group benefit policy like FEHBP, which members of Congress get. It's a BlueCross/BlueShield standard. It covers doctor's visits, maintenance therapy, preventive care, 80-20 coverage all the way up for hospital and physician services, unlike health savings accounts, unlike individual marketplace. And it would not discriminate against populations. It wouldn't have to have a regulatory authority because it already exists. So in many, many ways, as I pointed out, it is a reliable group, non-regulatory system that already exists that it seems to John Kerry, if members of Congress have access to it, so too should Americans.

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**ED HOWARD:** On the odd chance there might be one or two C-Span viewers who don't know what FEHBP or FEHB stands for, would somebody tell us?

**CHRIS JENNINGS:** Federal Employees Health Benefit Plan. It is the health insurance plan that members of Congress have access to, and the White House Staff, and all administrative folks have access to. It provides millions of federal employees meaningful affordable health insurance plan, and it is an option that should be available for all workers.

**MALE SPEAKER:** [From audience, off mic. Inaudible.]

**ED HOWARD:** He said that the plan is completely paid for, to use your words, but doesn't this flow from the assumption that you get the tax roll-back on those earning over \$200,000, and that's not a sure thing? So how can you say it's completely paid for?

**CHRIS JENNINGS:** You know, every presidential election is about priorities. To govern is to choose. He has a plan. It's paid for. It rolls back. The good thing about John Kerry is a long-standing record of working on a bi-partisan basis to get things done. He's worked with Senator Frist on Global AIDS, he's worked with Republicans on a balanced budget. He's worked on welfare reform. He feels very strongly that we have to move away from the polarization that we have in Washington today and move more towards a bipartisanship. In that end of the day, what we've learned from the Medicare Bill is, if you don't have a truly bipartisan agreement on healthcare, and movement forward on a consensus, then you don't have

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a sustainable health policy. And he well recognizes that, and he will be the first to reach out to Republicans when he is inaugurated into office in January.

Well, it's like saying—you know, the irony of your question is, of course, if he doesn't have the financing source, he doesn't have the financing source. The difference between John Kerry is he's committed to paying for his initiatives, and not having non-paid for initiatives, which in many ways, the Bush Administration has quite a track record on.

**ANDREW HOLTZ:** Andrew Holtz at Holtz Report. I wanted to get back to the sort of the politics of this, or the electoral issue on this. We've had a lot of dueling, a blizzard of statistics, and yet, the background is, on both sides you're saying, when you ask people who they think can better handle this, there's a general trend towards Democrats; there may be some gender issues, and subgroups. Are there particular issues that for those folks who are employed, this swing voters that might tip it one way or another, is there one area where voters can actually think they have an idea about what's going on? Or are they totally confused and just throwing up their hands, and falling back on those predispositions, which lean Democratic.

**DAVID WINSTON:** I'm going to give you a really satisfying answer: Both. Let me start off with one thing, just as you all were just having this discussion here, and I remember this very vividly, and this sounded very much like that. Do you remember the wonderful

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discussion of OMB versus the CBO numbers? Right? If that's what you're going to write, the American people are going to hear, and you're right, it's just a blizzard of nothingness to them.

Interestingly enough, there have been two fundamental elections recently that have centered around healthcare. It's a treat because Republicans have won, and I want you to listen to the simplicity of the question that was being posed. Let's go back to 1994. There was HillaryCare. And what was the question that the couple put forward? Are you going to be able to choose your own doctor? And we won that. Very basic, very straightforward question. In 2002, when you had this debate over \$400 versus \$800 billion, what seniors basically wanted to know was, after they cast that vote in September or October, "Gee, am I going to be able to go and get more prescription drugs than I could before?" And the answer was, "No, I can't. Why couldn't I? Because the Democrats wouldn't let me." In looking at this debate, and I know it's very hard today. I worked at the Heritage Foundation for a while, actually doing policy stuff, dealing with healthcare, and it is a blizzard of numbers and it's really complicated. But ultimately, it comes down to this question that both campaigns have to prove. One of the components of this particular bill that has just passed, the Prescription Drug Bill, why it's such an important debate right now, is because it's not resolved in people's minds. They're just beginning to form an opinion—is this simple, basic question. "Will this improve the quality of my healthcare—not the healthcare system—my healthcare or not?" And one of the things that I've seen

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very clearly in polling results is when people have participated in the program, they perceive that their healthcare is better. Those that haven't don't know enough and tend to be negative. But ultimately, to get to your point, the difficulty with both of these campaigns is—and I'd like to say that our side is trying to do this better than the other side is, for obvious reasons, I'm saying that—structuring it in such a way that people can hear these policy differences and policy options, and say, "My healthcare will be better."

I'll go back to one other number then I'll stop. The whole concept of litigation and how it impacts the healthcare system. I asked the question that way because I didn't want them to think it was making the healthcare system worse. I wanted to know their perception of how it impacted their healthcare. Seventy-seven percent said that that was making their healthcare personally worse. So I would encourage you, as you write about this, through this blizzard of OMB and CBO stuff, people have no idea what you're saying, and truth be told, that's not what they're reading for.

**ED HOWARD:** Daniel?

**DAN GOTOFF:** Sir. I would agree with David that any voter, undecided voter or not, were to sit in here for an hour, they probably would be confused about this issue. For better or for worse, the policy debate rarely reaches this level of depth. But I think on this issue, voters aren't clear necessarily on exactly the solution that they want to see, but they're aware of the general direction

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they want things to go. As I listen to Megan doing a great job, I'm reminded of the fundamental obstacle that the Bush/Cheney campaign has in talking to voters about this issue is that they have to try to convince them that what they're seeing around them is not the case. Costs are not actually going up, they're going down, and that's not what they are experiencing. The number of uninsured is not going up, that it's a problem that's being dealt with, and they're not seeing it. And that insurance industry and the pharmaceutical industry aren't making out like bandits, and voters are concluding that this is the case, particularly from this Prescription Drug Bill. And I think a lot of issues came to play in Republican victories in 2002. This is probably one of them, and the Republicans used it well. But again, I think you have to be careful what you wish for. Now that the law has been passed, voters tend not to favor it. The voters that are targeted most by this legislation are the most strongly opposed to it. They have real concerns about who's benefiting, and that it's not seniors, that it's basically Republican Party contributors.

**ED HOWARD:** We've come to the end of the scheduled time, but we've got a lot of folks who want to ask questions. If our panelists are willing to stick around for a few more minutes. We'll try to take as many as we can. If you have to leave, we'll understand. The gentleman back there was first with his hand up, I believe.

**JOEL FINKELSTEIN:** My name is Joel Finkelstein with American Medical News. This is a question for Mr. Jennings. IN terms

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of the issue of liability reform that's going to be I think an Achilles' heel for Kerry/Edwards, because of Edwards' history, and I'm wondering how they can convince voters that this is an issue that they can address if they were to be elected.

**CHRIS JENNINGS:** Well, you know, part of that is up to you. They have to know that there's a policy. When you look at penalties on lawyers who file frivolous cases, or no punitive damages except in the most egregious cases, or alternative dispute resolution approaches and options in all plans, or a requirement that all grievances go through a review process, I think that what you will find is that people will say that's a pretty meaningful package. That's something worth contemplating, and it's something that illustrates that John Kerry and John Edwards do have a policy well worth pursuing and promoting, and enacting to law. I find that if anyone is under the illusion that healthcare costs are driven solely and primarily by liability costs, there is absolutely no data to illustrate that. Yes, it's an issue. Yes, it should be addressed, but that's not going to be the issue that addresses the fact that employers can't compete internationally, because they have their healthcare costs going up at double-digit rates. I think in your asking the question, what is it that drives voters, and we're talking about, I think, the voters in the middle, it is going to be the issue of affordability, the issue of which campaign has a vision that credibly will reduce my costs more accountable and reliable, and I think if we could just focus on the general themes of that fair and

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objective analysis about which campaign has the most thoughtful proposals in there, it will be a no-brainer, and I think John Kerry and John Edwards will win.

**DAVID WINSTON:** I'm going to really object to this point in terms of the medical liability, and it hasn't been proven. I'd suggest that you go interview those women who have wondered around trying to find OB-Gyn's to deliver their babies because their doctors decided that it's too expensive to have the insurance to deliver babies. That has been a significant issue that has been covered, and to suggest that there's no proof, read the newspapers.

**CHRIS JENNINGS:** That doesn't mean that that addresses affordability and coverage.

**DAVID WINSTON:** When you can't deliver a baby, that's sort of a basic service that you need.

**CHRIS JENNINGS:** To make the whole debate around that issue and ignore the fact that there are policies to address those issues, I think is irresponsible.

**ED HOWARD:** We have time for just a couple more questions. In the back, Howard?

**HOWARD GLECKMAN:** Howard Gleckman with Business Week. Megan, just to follow up your six to ten million dollar number, can you tell us where that comes from, and is that a gross number, or a net number.

**MEGAN HAUCK:** I can get you—the analysis is that there are 4.5 million covered with the tax credit, and you're looking at an

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additional between two and four for the HSA's, and then, I think it's about 1.4 million in HSA deductibility, about a million for AHP's. It's a calculation based on a bunch of different numbers from Treasury, CBO, and other places, but we'll work to get an official estimate out.

**HOWARD GLECKMAN:** [From audience, off mic. Inaudible.]

**MEGAN HAUCK:** That could be soon, sure.

**HOWARD GLECKMAN:** [From audience, off mic. Inaudible.]

**MEGAN HAUCK:** Previously uninsured, yeah.

**ED HOWARD:** Yes, you had your hand up. This will be a very good question, I believe, because it's the last one.

**MARY AGNES CAREY:** Oh, great. I'm Mary Agnes Carey with CQ. I had a question about the drug card numbers. If it's four million signed up, and almost three million were automatically enrolled, and I believe the estimates from the Administration were seven million seniors would take this card-

**MEGAN HAUCK:** Seven point two.

**MARY AGNES CAREY:** Seven point two. Okay. We have really one million of that group that have chosen to sign up for the card, that were automatically enrolled, doesn't that speak to problems, the seniors understanding the Drug Card, and also problems for the party, to sell the Drug Card and the drug benefit as a plus to voters this Fall?

**MEGAN HAUCK:** I don't think so. Obviously, this is a complicated program to explain to people. And even if you read that

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Kaiser study that came out that did the analysis on what the drug care was saving, they make the point in there that HHS is doing a better job of improving. It was probably a bumpier start than we would have liked. It's a complicated explanation for people to see. There are a lot of seniors who have access to the Internet; there are some who don't. We have really worked through HHS to improve the number of operators, the Language of Medicare number, the website. The website now has started listing what are the top three to five cards that take the most money so that seniors don't have to go through a list of 72 cards and figure out what is going to be the most beneficial for them. I think it's kind of a work in progress and we're hoping to improve the number of people signing up, but we think four million is a good start.

**CHRIS JENNINGS:** Can I make an unpartisan positive remark in that regard?

**ED HOWARD:** Please.

**CHRIS JENNINGS:** I think that regardless of your views about the Medicare Reform Legislation, that it needs to be fixed is something that all people should hopefully agree on. As it relates to the drug discount card program, one area that really cries out for administrative action, and I believe they have the authority to do this, is to do automatic enrollment for the low-income Medicare beneficiaries, the qualified Medicare beneficiaries that so-called Climby, Slimby populations. That would enhance the likelihood that they would be enrolled. They would have access to \$600. As a

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constructive suggestion, I would suggest to Mark and his folks and others that they do everything that they can to see if that can be pursued effectively. And secondarily, I would just make a pitch for the Bush Administration to seriously contemplate reversing their position on the re-importation language and have FDA approve. That policy would make a big difference and would address the discount issue in a way that Medicare beneficiaries see as a very high priority. So, in the spirit of hopefully getting things done, I'll conclude with those constructive suggestions.

**ED HOWARD:** On a note of bipartisanship that may not be fully shared with both those points, I do want to thank all of our panelists for taking the time to be with us and try to respond to your questions. A couple of them have to leave, and a couple of them are going to be around to respond to your questions individually. Thanks to the Robert Wood Johnson Foundation, and thanks to you for coming. Let's stay tuned and watch healthcare in the coming election.  
[END RECORDING]

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