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National Congress on the Un and Underinsured – Day 3 Presidential Candidates Health Advisors Roundtable December 12, 2007

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PETER GRANT: Just a couple of administrative announcements. Remember if you're going to seek continuing education credit you can get a certificate of attendance at the registration desk. Also the whole event is being filmed and CD ROMs which have actually the video of the general session with coordinated Power Points slides and all the audio of all the track sessions and all the presentations are for sale, there are forms out in the lobby. Also we would appreciate any comments that you have through the vehicle of the evaluation form that's in your binder.

I've gotten to know you over the last couple of days, my name is Peter Grant, because I worked on organizing this conference and would appreciate particularly your input on what we might do next year. I don't know how you're feeling, I'm feeling a little overpowered by all the information that has been imposed upon us on ten or eleven hour days thus far. I'm particularly looking forward this morning because while I feel I have a general sense of these reform proposals at the federal and state level and these people have told us before there's nothing new under the sun, everybody's rehashing old ideas and there seems to be a continuum. I don't know that I have my head around some of the technical issues like how guarantee issue fits into mandates and makes sense like that, and so hopefully we'll learn that today.

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But I've really been struck by Uwe Reinhardt's one graphic of the blue lower middle and middle middle class folks who have seen their benefit eaten away every year as healthcare inflation is above wages and who do so much for our society, the working and the fighting and the like. In his estimate that the transfer of income or wealth of 120 billion, let's double it 240 billion could cover that population and it just seems amazing to me that that's not something we could do. I do follow that if we do that then we have to bring the other uninsured: the wealthy, the young, the big to build a pool and it makes it even more difficult. But it just feels to me at least like it's something that could be done, is doable.

But then you begin to look at the realities and you become rather cynical. Look at a state like Massachusetts relatively wealthy, relatively few uninsured with some federal money warehoused, even that seems iffy if there's a downturn and you get Henry Aaron's saying we should have counter cyclical support from the feds or guarantees.

It just makes you cynical but I, the analogy in my life is before I became a healthcare person I was an international diplomatic historian and I lived in Europe for several years, I lived in Berlin in the '70s. And when the Berlin wall fell in 1989 it caught me absolutely unaware. It never occurred to me, my mind was so locked in that that structure of international relationships was like that when it happened. I've never

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really recovered and it was evidence to me at least that the transformational change can happen out of the blue in ways that nobody thinks it can.

So, I guess that gives me hope given my proclivities but what's really struck me is we looked at the scholarship applications in the attendance here is how many people are spending so much personal time at the community level dealing with these issues for people that they live with in their communities, whether it's the safety net, the public hospitals, the federally qualified health clinics, and the free clinics. And I think it's important for this event and what we want to do next year, as well as talk about national health reform hopefully in October before the Presidential election to work on that. To do technical assistance or tool kits and I've talked to a number of people that have ideas that are doing amazing things out in their own local markets. I'm not a big one on myself thinking that a thousand candles can light the whole society, but in the interim I would rather have in my town a place for people to go if they need help at any rate.

Chip Kahn is one of the major inside the beltway players in healthcare, has been for years. He's currently the President of the Federation of American Hospitals, this is a for-profit. He has done many things, before that he was the President of Health Insurance Association of America, before

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that he was senior staff director for the Health Staff Committee of the House Ways and Means Committee.

So I can think of nobody more able to tell us the realities of inside the beltway in health reform.

CHARLES (CHIP) KAHN, III, M.P.H.: Thank you Peter and good morning to all of you. I'm going to tell a story this morning and then sort of do a set up for the next panel, which will look at health reform from the standpoint of the Presidential campaigns.

Back in 2000, around the turn of the century, I was at the Health Insurance Association of America and the Association had begun to focus on healthcare coverage again and I started working with a friend of mine, Ron Pollack, at the Families USA on a bunch, a number of strange bedfellow projects. I guess Ron and I were the original strange bedfellows.

And one of the things that we did back in that period was write an article in HealthAffairs which argued for a health reform but argued for it incrementally with the concept that if you try to do too much you'll have the inevitable outcome of '93, '94 where you're going to alienate or become problematic for some or many groups and they will find a way to undermine reform because it is easier to stop something than to be successful with an initiative.

So Ron and I began a process over the years, and I guess in a sense we, and I thought it was interesting that

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Peter brought up the Berlin wall, we presumed there was a Berlin wall and that only incrementalism was possible in terms of reform. And that led over the years to the formation of something called the HCCCU which was a combine healthcare coalition for the uninsured of a number of groups ranging from AARP to the Chamber of Commerce to an assortment of health groups, our sister organization American Hospital Association and AMA and others.

And that group came up with sort of the ultimate incremental proposal, the attempt to combine tax credits with an expansion of SCHIP. And we worked very hard on that proposal for many years and it did become part of the process that began early this year with Congress considering an expansion of SCHIP. So, and this is where I guess the transformational change comes in. Not that I wouldn't want to see all Americans covered, but I didn't believe it was a political possibility and maybe it still isn't.

But in terms of the transformational stuff, I went to my members meeting, board meeting and committee meetings for the federation last October, or October a year ago, and at that meeting I went in to describe the great things we were doing with the HCCU and working hard on other kinds of efforts, the Robert Wood Johnson effort of getting people together to talk about the uninsured, and I was just bombarded. My members were just not interested in hearing more about one or two yard

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gains, at best, in the football game of health reform. They wanted to see universal coverage and they wanted to see it now. They were on the front lines, they had the emergency rooms that were seeing more and more uninsured patients, underinsured patients, and they felt something needed to be done and they gave me and the staff the directive to get going and come up with a universal coverage proposal.

So what I'm going to describe this morning, and I guess I have to move forward here, what I'm going to describe this morning is that proposal. What they came up with working with John Shields at Luen [misspelled?], who is sort of one of the gold standards of scoring and in the uninsured proposal area. I'm going to go through that proposal and describe to you how we came up with proposal that shows that you can reach at least in terms of the gold standard of John Shields scoring, you can reach in the context of our current system, universal coverage. But there's no free lunch and I'll talk about the economic or the fiscal effect and do that both by describing first how we came to the construct, what data we used to come to the construct of our proposal, what the proposal looks like, what the impact of the proposal is, and then finally as I said, I'll end up with just one chart where I'll set up the next panel in terms of describing the divide on healthcare reform between, at least as I see it, between Republicans and Democrats broadly, not that there aren't disagreements on the details within each

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camp, but I think there really is, at least in terms of the Presidential candidates, a big divide between the parties.

So let's proceed. So when we came back from our meeting in October a year ago, we put together a committee of our group and we collected a lot of data. And I'm sure over the last days you have seen all of this data and it's been described to you, there are 47 million uninsured. What we focused on was the fact that 48-percent of those, at least according to John, are under 200-percent of poverty and 80-percent are under 400-percent of poverty.

So in terms of affordability with the income they have, we determined that for those who are uninsured there is an issue about affordability of paying any healthcare premium. Second we noted that most of the uninsured are connected to employment, their either the employee or the dependant of an employee so that there are many working uninsured and that is one group that has some income and some access in the job market, sometimes being offered insurance and turning it down.

Then we noted that 20-percent of the uninsured are currently eligible for Medicaid or SCHIP. So we have a large number of people, obviously those who fall under the 200-percent, primarily under the 200-percent of poverty mark who are eligible but not being picked up by insurance.

And finally we noted that there is 82.4 billion dollars that is being spent on the uninsured in terms of healthcare

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right now. They don't necessarily get healthcare in the right place or at the right time, or necessarily the healthcare but there is a tremendous amount of free or partially free care that's being offered by hospitals, physicians, and these numbers are growing. Also it is noteworthy that there is a good deal of out of pocket expense on the part of the uninsured for the healthcare they receive, approximately 41-percent of it.

So those were the basic numbers that were most striking to my members when they looked at this issue of who to try to affect in terms of the health reform proposal. So they developed a number four tenants that would underlie our proposal. First, that we need to help those most in need. Now this is always a question, how do you define need? And they defined it as, as you'll see in a moment in terms of the proposal, as generally people under 400-percent of poverty but it needed to be something that was scaled because clearly there's so many working uninsured that can afford something, the question is could afford an entire premium. And I think the proof was in the pudding, they couldn't.

So that was the first tenant. The second was both for policy reasons and for political reasons, that we should try to preserve the existing coverage system as best we could and build upon it and around it to cover the uninsured. From a policy standpoint, one, they made the judgment that it was

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better to go with the devil we know than the devil we don't. That if we do adjustments to the current system, we can make fairly good judgments about what the effect might be. Whereas if we turn things on its head, undid the tax exclusion from employer paid health benefits and changed it radically, we don't know what the outcome would be. And the goal here was to work within the context also of a private health insurance market to try to the extent possible to maintain that market and not, and also not to change the status for most Americans who have coverage. That in a sense was a key both policy decision and political decision.

One of the key areas of debate, and I would argue the key areas that led to the undermining of the '93, '94 health reform effort was that those that had coverage felt uncomfortable about what the change would be for them. And so my members thought it was best to provide a change that kept most of them in the same or similar circumstances. At the same time, if we're going to cover more people, you're going to have to open up an individual market and make it more viable for those who need coverage because you're not going to be able to have employers pick up everyone. We have when we get into the details, a way to help those who are offered coverage to accept it, but you're still going to have to have some kind of market reform to assure that those, even those receiving subsidy

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dollars have access to something that's affordable. So you need market reform.

And finally, we felt strongly, they felt strongly that everyone had to be held responsible for themselves, all be it with assistance for those who could least afford it, but there had to be some kind of individual enforceable mandate.

So that led to the development of the proposal based on the data, based on those principles. The first point was to stick with employer paid coverage. The notion was that would be key to maintaining coverage for most, and also for those who were uninsured but either working and offered insurance and turning it down, or having dependents who they didn't cover, the subsidy structure should be designed to help them get into insurance they're already offered. And actually, in terms of a saver, that would reduce to some extent the cost of that insurance on the one hand because it would mean the groups would generally, the employer groups would generally be larger. Those who were turning insurance down and offered it, the working poor are generally fairly good risks.

So that led us to this construct. First, under 100-percent of poverty everyone should be eligible and states should be provided clear incentives to sign up those who could get on Medicaid or SCHIP between 101 and 150-percent of poverty we would give 100-percent subsidy for private coverage for those who are not covered and 100-percent subsidy for the

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employer paid insurance for the employee contribution for that insurance. Between 151 and 400-percent of poverty we'd have a scale, which I'll show you in a moment, a curve. And then finally over 400-percent of poverty we made the decision that for those who do not have employer coverage, and thus don't get the tax exclusion, that there ought to be tax equity and if their buying their own insurance with a mandate now, remember there's a mandate in place in our model, that they ought to have tax equity and get a full deduction for their premiums. This is the curve for sliding scale for families and it shows you that for that group between 100 and 150-percent, they're getting a total subsidy and we came up with a sliding scale for those up to 400-percent of poverty.

Now there was no magic, per se, with 100 to 150 or 150 to 400, I can make some arguments and we spent a lot of time talking to John Shields about his model and what would make most sense in terms of cut lines. You could but those in other places, you could make it up to 350-percent, and those kinds of changes would have an effect on the cost of the proposal. The notion is though that if we're not actively subsidizing below a certain level, the mandate, in a sense, will be sort of meaningless because you're not going to be able to sort of squeeze blood out of a turnip.

So how does the individual responsibility work? Well our assumption was, and we go into detail in the proposal

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itself, that all adults would be responsible for themselves, all parents would be responsible for their children, there would be an opportunity either in the public from public coverage or private coverage for everyone to be covered and we would use the tax system as a way to in a sense enforce coverage, when you filled out your tax form if you couldn't attest to having coverage then it would be provided for you and you would be charged for it. And hopefully we assume that by providing more incentives to the states for those who are below poverty, for those who are not filers, they would be signed up and also we would involved the social security system and social security offices as a way to help those who are not sure how to take advantage of what might be available to them so that they can be signed up. The whole notion is to try to have seamless access to coverage either through employer coverage, the private market, or through public coverage with states, private insurers and employers all working towards maximizing the number of people that could be covered in their areas.

So what would the impact of such a proposal be? Well first, if all, according to John Shields, if we do everything that's described and fully funded, we would cover 98-percent of Americans, 6.6-percent of Americans which would fall through the cracks, half of those would probably be illegal aliens, the others would be those who just either weren't filers or found a way around it, or were waiting to be penalized by the IRS.

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It's America and there's never 100-percent of anything here, whether it's mandated or voluntary. But we would cover almost all Americans, there would be a tremendous expansion of the non-group market but hopefully through reform and subsidy with the infusion of people in to that market, it could be made to work. And obviously employers would cover more people. And we would whittle down the very small number to 20-percent of those who were eligible for public coverage but not covered now.

As I said in my introduction, there is no free lunch, and obviously there would be an increase to public expenditures from our proposal. The total would be in the neighborhood of 115 billion dollars in the first year 2007 if the proposal was fully implemented in the current year that we are now. And in a sense the sees, this shows you how the money is spent. The auto enrollment for currently eligible but uninsured for Medicaid and SCHIP bringing those under 100-percent poverty primarily adults into Medicaid providing what we're calling our health coverage passport, the subsidy to those who are now eligible for employer plans but not signed up, getting that passport to those who are not eligible for employer coverage and would need to go into market and buy coverage, and then the tax deduction and then there are administrative costs included both at the federal level and in terms of encouraging states to find all those who need to be signed up.

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And at the end of the day the impact on the federal bottom line would be about 115, employer costs would go up marginally, a few billion dollars because even though their per unit cost may go down as their groups take in people who are otherwise well, probably a fairly good risk group, at the same time they would now be covering people they had not covered before but they had offered the insurance to. So there would be some cost to employers. States and households would save a considerable amount of money and if we look at the effect on the total spending, and I think this is always an important one to look at, in the year of our estimate it would be about 2.3 trillion dollars spent on healthcare and if you net out the savings that some have from the extra federal spending and employer spending, the net cost of our proposal would be about 68 billion dollars to the economy.

Now, I don't want to be glib about the importance of 68 billion dollars, but if any of you tune into the discussions in Congress right now about appropriations for next year for a whole set of activities, actually 68 or 70 billion dollars is not a tremendous investment to actually get almost all Americans covered. At the end of the day, I'm sure you're waiting for the next slide which says where the money will come from though to pay that 115 billion dollars on the federal bottom line and our attitude was we know about healthcare and healthcare delivery but it takes policy makers to decide how

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their going to ask for that redistribution that Peter talked about, where the money's going to come from to pay the tab here.

At the end of the day though, if we look at the amount of money that was spent on the Medicare Modernization Act, if we look at the amount of money that's being spent inefficiently now on this population of Americans regarding their healthcare that the effects of that on productivity in the workplace for so many of them who are connected to the workplace, or the social issues that tend to come from the kids who are not getting the right coverage, we think this is, this model provides at least one way that shows that it can be done and that it ought to be possible within the context of our current system. Big change but not radical change to reach the important goal.

So that's where the federation is on their proposal. Before I conclude, or as I conclude, let's talk about Republicans and Democrats a bit and set the stage for the next presentations from the Presidential campaigns. This chart to me argues that there is a gulf in the definition of the problems related to the healthcare system on the Republicans and Democrats side. That's not to say that both Republicans and Democrats aren't concerned about healthcare coverage and healthcare costs at the same time, or access to healthcare.

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But in terms of the way they deal with it or approach it, there's a completely different mindset.

I can remember a conversation I had about a year ago with Senator McCain and it was about the time that we had started to work on our healthcare proposal and I was talking to him about it. And he said, "You know, I really think that we should reach out and cover as many Americans as possible, but if we don't get our hands around the cost issue first and bring down healthcare costs, it really doesn't matter what we try to do on the other side. And if we look at the entitlements, they're going to crush us and you're talking about more Americans with federal dollars." And he saw that as problematic.

I think the other Republicans candidates would agree with him. From their standpoint there ought to be some kind of tax reform, sometimes it's HSAs, sometimes it's undoing the tax exclusion and re-filtering that money as President Bush proposed in his, into a deduction as he proposed in his budget earlier this year. There are a number of ways of looking at it, and they see the tax levers as useful, but they see it as useful in terms as much as changing incentives for the consumer as covering more people. Whether or not they would all block grant Medicaid, I guess Governor Romney would, some would do that, some would cut health insurance mandates, all of them for tort reform, they see transparency and helping the market along

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both with tax reform and with providing more information to consumers is key. And they generally, although some more than others, talk about entitlement reform. Clearly former Senator Thompson has put that at the top of his agenda.

That's quite different from the other side. And not that there aren't quibbles between Senator Clinton and Senator Obama, Senator Clinton's plan and Senator Edwards' plans are very similar, but there universal coverage is the primary theme, it's not that they don't talk about controlling costs, they would use a number of different means, whether it's disease management, comparative assessment of different technologies, health IT to try to come to grips with healthcare costs, but the priority is universal coverage. Some are for mandates, individual or employer, most are more some set of defined benefits rather than letting the market define benefits they think the government ought to define the benefits so that everyone can be assured of a minimal amount of coverage, they have market reform, they have Medicare, competing with the markets in their models and they have generous subsidies to assure even if their providing for some kind of individual mandate that every one gets subsidized to qualify for that mandate according to income.

Really Mars and Venus, I won't define which is which. But really quite different and striking in terms of a vision of where healthcare ought to go. On that note, I'll conclude and

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Peter, if there's time, I'll be happy to answer some questions, if there's not I'll welcome the next panel.

PETER GRANT: The number of Presidential advisors we have in the wings, we'll move directly to them, but thank you for your presentation. [Applause] And for your leadership in building coalitions on this issue.

I'd like to ask Ed Howard to come forward with his panel. Ed Howard is the Executive Vice President and Chief Executive Officer of the Alliance for Health Reform, a non partisan effort co-chaired by Jay Rockefeller of West Virginia and Senator Susan Collins of Maine. And since 1991 the Alliance has done organized informative briefings for key policy makers inside the beltway. One of the most valuable things you can do is get on the Alliance's email mailing list because it's just cutting issue after cutting issue with the right people. It really lets you stay up with what the policy people are thinking about.

Prior to that Mr. Collins was General Council to the US Bi-partisan Commission on Comprehensive Healthcare, or the PEPPER Commission, and he has quite an aggregation of people that we've tried to array in alphabetical order in all fairness, so if everybody would come up, we would really appreciate it. Thanks so much. Ed.

ED HOWARD, J.D.: Thank you Peter. I wonder if I could ask somebody to give me a little bit of water, I have a hunch

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that this is going to be a long session that might require lubrication.

Well good morning and welcome to this roundtable of health policy advisor to leading Presidential candidates. I want to thank Peter and conferences sponsors for arranging this discussion as part of the congress on the un and underinsured. In past years healthcare's been sort of the Rodney Dangerfield of political issues, didn't get no respect. Traditionally the exit polls would rank it fourth or fifth on the list of most important issues for voters and in 2006 the ultimate indignity, people putting together the exit polls didn't even put healthcare on the list of options from which to choose the most important issues to voters.

But I think that's been changing every day since. Just last month, for example, a bi-partisan poll found healthcare at the very top of the issues that voters in early primary and caucus states wanted candidates to discuss, eclipsing Iraq and Iran, the economy, terrorism, even illegal immigration, and it was true both among Democrats and Republicans who were likely caucus and primary voters.

Now, to look at how this issue ought to be handled, an issue that's so important to voters, we're very lucky to have with us today representatives of seven of the presidential candidates, four Democrats three Republicans, I know it looks like only six but we have a surprise for you. And I might add

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their all serious adults, I mean, they are living evidence that these candidates take the issue of healthcare very seriously and considering that we are on the cusp of the Des Moines registered debates, the very fact that we have this array of talent I think is quite impressive and a view of the commitment to the discussion, the thoughtful discussion of healthcare in this campaign.

We're under some very strict time constraints. You've heard an awful lot about these issues over the last three days anyway so let me just quickly review how we're going to proceed. First off, you'll hear from all seven of the representative, but very briefly. They've been asked to detail their candidates health plan and their entire scheme in four minutes. [Laughter] So we'll see who's faster afoot. And then I'll ask them to respond to a series of questions, and let me say to our panelists, you need not feel that you have to respond to every question, and let the folks in the audience know that you have been provided a list of the possible topics for those questions in advance, and then we'll try to reserve about 10 minutes at the end of the session for some brief questions from the floor.

So let's get started and let's meet our panel of advisors. I apologize to all of you for not giving you the kind of recognition you deserve and I refer you to the biographical information that you have in the materials that

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you have been given. Let me just go down the line. Barbara Markham Smith is the Policy Director for Senator Chris Dodd, Laurie Rubiner is the Advisor to the Hillary Clinton campaign, Don Moran is an Advisor to the Rudy Giuliani campaign, Doug Holtz-Eakin advises the John McCain campaign, Peter Harbage is an Advisor to the John Edwards campaign, Greg Block advises the Barrack Obama campaign, and I hope from conference call from Iowa we have Lanhee Chen, the Domestic Policy Advisor to the Mitt Romney campaign. Lanhee Chen, do we have you with us?

LANHEE CHEN: Yes I am, good morning from Des Moines.

ED HOWARD, J.D.: Good morning, you're loud and clear. [Laughter] Well, let's get started. I've asked our folks to adhere pretty closely to a four minute limit and arbitrarily we're going to start with the Democrats and arbitrarily we're going to go alphabetically by candidate which means Laurie, you're up first for Senator Clinton.

LAURIE RUBINER: Okay, thanks so much for having me here? Can you hear me? How's that? Better?

ED HOWARD, J.D.: Not much better.

LAURIE RUBINER: How's that?

ED HOWARD, J.D.: Better.

LAURIE RUBINER: Okay, good morning. Thank you very much for having me here. Senator Clinton's approach is one of essentially shared responsibility amongst four groups. First is individuals will be required to have health insurance and

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that is largely because if we want to have a universal health insurance system we have to have a requirement that all individuals have insurance, any healthcare economist will tell you that. So that's number one.

Number two, in order to make the individual mandate workable, you have to make it affordable and you have to make health insurance accessible to individuals. Anybody who's ever tried to purchase insurance in the individual market outside the context of an employer based system knows that it can be prohibitively expensive for a variety of reasons. And so her plan seeks to make changes in the system to make insurance affordable and accessible to all individuals.

She would make reforms to the insurance system so that insurers would be the second group that would have a responsibility to no longer discriminate against individuals based on their age, gender, health status, they would have to serve all people regardless of whether or not they've had a preexisting condition. We would impose those rules on all insurers so that insurance would be more accessible. The government has a role to make insurance affordable and this is a very critical piece of our plan, in order to make the individual mandate work it has to be affordable for individuals so what we say is that no individual or family will have to pay more than a set percentage of their income toward the cost of

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their health insurance, it's a version of a premium cap on families.

So that while we are going to require people to have healthcare we're also going to ensure that it doesn't break the bank. And we will create pools that emulate very much what we have in congress, we believe that people should have the same access to healthcare that the members of congress have and so we will create regional pools much like what we have in the federal employees health benefits plan where people will be able to go and choose from a range of plans just like we do.

It will also include one public plan that will look like Medicare but will be outside the context of the Medicare trust funds but will look like, will be structured like the Medicare plan.

Employers will be required to either continue offering insurance if their doing that now or to contribute a set amount towards the cost of their employees coverage. And that is the fourth pillar of the shared responsibility theme of Senator Clinton's plan.

We believe it's very important to bring all 47 million of the uninsured into the system, that's the only way to spread risk around evenly. We have to get everybody into the system, it's both a moral issue but it's also a financial issue. We have to stop the cost shifting that is occurring now with the uninsured, if we think we're not paying for the uninsured we're

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wrong. We are in very many ways so for all of those reasons we think it's critical that we bring all of those people into the system and that's what Senator Clinton's plan would do.

She hopes to achieve this in her first term. And that is her commitment, it's one of her highest priorities on the domestic agenda if not her highest priority. And I look forward to answering any questions that you may have.

ED HOWARD, J.D.: Thank you very much. Now let's go to Barbara Smith on behalf of Senator Dodd.

BARBARA MARKHAM SMITH: Good morning. It's really a pleasure to be here today. Senator Dodd's plan is based, obviously there are a lot of similarities between all of the Democratic plans, his plan is based on the concept of universal coverage through universal responsibility.

He is the only candidate to have originally included in his plan that was introduced in his plan on July 26th, an automatic or guaranteed enrollment provision so that he, so that a lot of the enrollment issues that have arisen over the last few weeks can be definitively addressed.

His plan relies on universal healthmart, which is a system similar to the employee, federal employees health benefit plan. Again, emphasizing that all Americans should have access of the same types of care that members of congress have. People can certainly keep their existing arrangements if they prefer. All of the mandates are based on not just getting

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affordability to the healthcare system, but allowing people to pay based on their ability to pay. So what you saw in the preceding presentation with Chip Kahn having the sliding scale subsidies, all of that is built into the system.

The other thing that is unique I think about Senator Dodd's plan is that he has committed to a specific timetable not just for bringing legislative action but for actually achieving implementation. This is absolutely a priority for him. He believes that universal coverage and universal responsibility are the only ways to achieve affordability in the healthcare system that we will not be able to get to cost containment without it.

The other thing that his plan does is call for an universal healthmart a complete realignment of how we take care and address chronic disease. So he has a lot of emphasis on reforming models of care to get better prevention and to get better management of chronic illness which accounts for about 75-percent of healthcare costs.

We know that 50-percent of healthcare costs for the uninsured are already in the system so we obviously intend to recapture those subsidies. I think it's important to emphasize that while people talk about the unaffordability of this, that the fact that 50-percent of the costs are in the system, the fact that universal coverage is a strong lever for cost containment, makes this imminently affordable.

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The final point of his plan, well he has many points, but the final point for the premises of discussion today is that he also, as medical underwriting, this is expected to yield tens of billions of dollars in administrative savings and assure that people can get the insurance they need seamlessly. And that complimenting his automatic enrollment features makes universal coverage completely attainable.

ED HOWARD, J.D.: Thanks very much Barbara. Let's move to Peter Harbage on behalf of Senator Edwards.

PETER HARBAGE: Good morning. I think Ed got it absolutely right. I mean, we are in the middle of a great debate now in healthcare in this country and it's long overdue and it's really happening for the first time in 15 year.

Even if you looked at the healthcare conversation four years ago, you didn't have one where you had people talking about the importance of universal coverage and getting everyone enrolled and bringing in all of the uninsured. In fact John Edwards talked a lot about a mandate for children four years ago as the basis and heart of his health plan, making sure all children receive health insurance and now he was very proud to be the first person to talk about universal coverage and bringing everyone in and having an individual mandate in terms of the presidential candidates for this cycle.

The plan is largely based on shared responsibility, again I'll be the third person to say it, but he was the first

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this year. And the principles there really are ones that have been well articulated already and so I don't want to spend a lot of time on that. What I'd really like to touch on in terms of what he wants to do is really some of the affordability provisions. I think his position on universal coverage has been well articulated and folks have been here all week talking about these issues.

So, in terms of affordability, it's really important that we develop a healthcare system where insurance companies are actually working for individuals. And so a week ago Senator Edwards put out a plan that talked about taking on the insurance companies. We have a very interesting dynamic where we say what we want everyone to have health insurance and then most of us in the next breath lament the state of private insurance and how the insurance are doing. And so he's talked about the importance of guarantee issue and making sure everyone can purchase insurance as a core principle. There've been a lot of stories coming out of California but you can find them anywhere in terms of the individual market and the decision policies where as soon as somebody starts to use the insurance the insurance company goes back, finds some defect, either real or perceived in the application and then excludes that person from their coverage retroactively and attempts to return their premiums to them.

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So we need guarantee issue, we need a national effort where there's a patient advocate so that there's a resource that everyone has access to, not just for managed care, which of course John Edwards was a leader on, but for all forms of insurance. We need to take a hard look at the monopoly system we have with private insurance. There's been tremendous consolidation over the past 10 years in the insurance industry and so we need to take a look at that and make sure there is fair and open competition in terms of insurance so that patients are not only getting the best deal possible but you also have providers who are able to work effectively with insurance companies.

This is just, it's simply not possible to talk about universal coverage which is of course the goal without talking about serious reform in terms of the insurance industry. And I think one of the most importance efforts John Edwards would have as part of his plan is to make public a public program available to everybody so if people wanted to choose to enter a Medicare type plan they can do that. And that option would be available to them, and I think that would be a significant check on the insurance companies.

Another check on the insurance companies is looking at lost ratios and making sure the dollars that are coming into the companies aren't going to advertising or executive compensation but that are in fact going back out in terms of

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patient care. There's an interesting story last week where the CEO of United Healthcare who was granted a billion dollars in stock options, that's billion with a B, that's one person, about a year a half ago has to give some of his money back because there were issues with the back dating of the options and that were mistakes and inconsistency on their part. I think that's great, I hope that's money that United can roll back into care, but the idea that somebody could have been granted a billion dollars to start with is fairly outrageous.

In terms of other things we need to look at, affordability, John Edwards has talked a lot about nursing issues and increasing the number of nurses.

ED HOWARD, J.D.: Peter, you want to try to wrap it up in about 30 seconds.

PETER HARBAGE: And he's also talked about the importance and chronic care and I still think he's the only presidential candidate to be quoted talking about the importance of a medical home so that we can get effective primary care and chronic and preventative care out to folks. And I'll wrap up there.

ED HOWARD, J.D.: Terrific. Thanks very much. Now from on behalf of Senator Obama, Gregg Bloche.

GREGG BLOCHE: Thank you. I have just one quibble with what Laurie and Peter have to say, they left out their own role as leaders in the development of models of shared

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responsibility in health insurance in conjunction with the New America Foundation. And I think it's a fair point to say that all of the Democratic, the principle Democratic candidates health insurance plans are in that same family and there is as many observed, not a huge difference between them.

It's a privilege to be here now and to have a chance to speak to this congress on behalf of Barrack Obama. First some nuts and bolts practicality about this campaign and the uninsured. There really isn't a comparison as the speaker in the previous session pointed out between the Democrats and Republicans health plans when it comes to the uninsured. The major Democratic candidates plans all aspire towards universal coverage and come close to it by building on our existing system. The Republicans make no claim to come close to universal coverage nor do they.

The Democratic plans are quite similar, each expands Medicaid and SCHIP, each pools risk and guarantees issue via insurance exchanges, and each offers Americans a public plan as an option. Now single payer advocates including the next speaker and the next panel, have been quite disappointed by these plans but as Senator Edwards has pointed out, they leave open the possibility that by choosing the public plan Americans could move toward something resembling single payer by market means.

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There are some minor differences, Senator Obama's plan for federal reinsurance for patients catastrophic medical costs would lower the cost of coverage, especially for small employers enabling more of them to buy insurance for their workers. And Senator Obama's plan would also enable young adults up to age 25 to buy coverage cheaply by participating in their parent's plans.

As Robert Wright and others have noted, these design features make it likely that the Obama plan will cover some more Americans than the plan proposed by his leading rival. Much has been said by Senator Obama's leading rival on the question of mandates. And it's worth reminding folks that Senator Obama would require parents to buy coverage for their children and that Senator Obama is open to the possibility of an individual mandate down the line.

Senator Obama is not opposed to a mandate, what he said on the subject is that we should first focus on affordability. He's left open the possibility of an individual mandate in the future for people who can readily afford coverage but who take advantage of the system by not buying it. The healthy 20, excuse me, the health 29 year old who earns \$100,000 per year but who decides to go bare and to take his chances, acts irresponsibly. He counts on others, those who buy insurance and who thereby pay for others free care via hospitals cost shifting to pick up the tab if he's hit by a bus or bungee

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jumps or bungee jumps with failed results and can't afford to pay out of pocket for the expensive care he'll need.

But Barrack is also giving a lot of thought to the harshness of imposing an individual mandate upon people who must sacrifice their basic needs and their hopes and dreams for their kids in order to buy coverage on their own. What about the family of four that owes \$60,000 a year, three times the poverty line and who has to sacrifice childcare, skimp on quality education, or move to higher risk housing to pay for health insurance.

The Massachusetts experience adapts states decision to exempt 20-percent of the uninsured from it's mandate and the non-compliance of many others in Massachusetts thus far underscores the point that many have made about mandates. They're not a substitute for affordability. Mandates are a complicated issue and Senator Obama has taken a nuance position. I think that an unfortunate moment occurred in the campaign when the Senator's leading rival tried to make mandates into a wedge issue by characterizing his view as a sign of lack of commitment to universal coverage.

ED HOWARD, J.D.: Greg could you wrap up on 30 seconds.

GREGG BLOCHE: Okay. If we're going to move toward universal coverage we can't risk fraying the coalition for it by turning on each other, there's that famous line about health reform in the 1990s, everyone had different ideas about the

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best path to reform but all could agree on their second choice doing nothing. And it's incumbent that in the next four years we transcend that consensus about the second choice.

ED HOWARD, J.D.: Thanks very much Gregg. Now we turn to the Republican side of the aisle and we'll lead off with Don Moran on behalf of Mayor Giuliani.

DON MORAN: Thanks Ed and on behalf of Mayor Giuliani thank you for the opportunity to be with all of you this morning to discuss his ideas about where we're going.

I think it's important to understand that Mayor Giuliani's first impression on all of this is based on the understanding that the biggest single fiscal challenge we face in the United States today is figuring out how we're going to pay for the healthcare finance and commitments in the public sector that we've already made.

Everything that everyone can think of in the way of new financing sources to devote to healthcare have probably going to be needed to cover commitments that have been on the books since 1965. And in that regard as we think about the wider problem of those who are not covered by that current framework of program, the key thought is about how we generate affordable and attainable insurance in the private market and create a structure in which the private market can innovate cost reducing solutions. There just don't seem to be incurring in our public sector systems.

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Having said that Mayor Giuliani understands that the current private insurance market in the United States has problems and many of them are really the consequence of well meaning but ultimately misguided federal and state tax and regulatory policies that are currently on the books and Mayor Giuliani believes that the responsibility of the next president is frankly to fix those problems before concocting new ways of thinking about expanded public expenditures in healthcare.

To do that Mayor Giuliani sees a need to advance on two fronts, the first in the workplace to equalize the existing tax treatment that favors high cost group insurance making employment based and opens up the opportunity for those who are both employed and unemployed to seek alternative sources of more affordable insurance. At the same time it's going to be necessary to maximize the portability both from job to job and for those moving in and out of the labor market to make sure the continuity of coverage can be maintained.

What that means is that we need substantial attention in the non-group market to structural reforms that restore the viability of that as a mechanism to provide equitable insurance to people. The centerpiece of Mayor Giuliani's view of that is a series of incentives to states to restructure their own markets with wrap around federal reforms to make sure that the market is functional nationwide. And Mayor Giuliani also supports the offering of tax credits to low individuals who

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can't take advantage of the deduction that we talked about a moment ago.

In the key reality that Mayor Giuliani I believe understands is that at the end of the day only people pay healthcare costs and regardless of how we attempt to characterize where the money's coming from, the money's coming from the American people's pocket in one way or another in order to provide reform. And rather than sitting around and designing some notion of a designer insurance system that would be delightful for everyone to have and then superimposing the cost of that on everyone, Mayor Giuliani believes that we ought let the market seek its own level and stop perpetuating the mass illusion that the financing for all of this comes from Mars, it comes from all of us and we deserve the opportunity to have more affordable options. Thank you.

ED HOWARD, J.D.: Thank you Don. Turn now to Doug Holtz-Eakin on behalf of Senator McCain.

DOUGLAS HOLTZ-EAKIN: Well thank you on behalf of Senator McCain for the opportunity to be here and have this discussion. And for myself I want to thank Ed for welcoming me to the promised land of being a serious adult, it's a great moment. [Laughter] I also want to thank Chip Kahn for stealing my opening remarks. [Laughter]

This is an important issue. Everywhere Senator McCain goes people talk about healthcare, it is clearly the number one

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domestic policy issue facing us and he is committed to comprehensive reforms that give us durable solutions to these problems. And as Chip mentioned at the outset, a sensible approach to do that will be to focus on controlling the rising costs of healthcare spending in the United States. I think that it's now well known that spending per person has outstripped income per capita for decades in the United States and that that in and of itself is not troubling except that we have as a result outcomes that are not commensurate to the kind of money we're spending on our healthcare.

Senator McCain believes we need to address this. Rising healthcare costs are the primary threat to employer sponsored insurance, which is still the majority of insurance in the United States. It is the threat to Medicare, Medicaid and other public programs which are important aspects of the safety net in the United States and that if we are going to deal with this in a successful fashion we have to start with healthcare costs, the source of growth in healthcare costs, address that and not prematurely go to solutions like that tried in Massachusetts by Governor Romney where people have mandates that they cannot afford, leads to exemptions from those mandates and a system that really doesn't function over the long term.

I won't pretend to go through all the points in a form, it's a comprehensive approach that affects the provision of

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care in the United States, reforms to the health insurance market and changes in personal responsibility, which we quite, all quite realize are important. We have to teach our kids healthier lifestyles and address the rising incidence of chronic disease in the United States which is a huge source of cost growth. The plan is on johnmccain.com, the pieces I would flag to you are number one, he is committed to keeping Medicare from becoming too expensive for our seniors but changing the reimbursement systems within Medicare to reward the kinds of things that are not rewarded in the health system today. Payments for prevention, which are low cost approaches to dealing with chronic disease, payments for coordination of care, which would lead to high quality outcomes at lower costs, non-payment for errors and reward to quality.

He's committed to insurance reforms not just a tax credit that will be refundable and available to every American to help them, but also the kinds of reforms that will make the individual and other non-employer markets more palatable places to buy insurance. I don't think anyone on this panel would argue that the individual market in the United States is a robust and desirable place to getting health insurance at this moment.

The Senator is committed to reforming that and he is also committed to addressing the need for a better approach to chronic disease, the research necessary to deal with multiple

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comorbidities, and take advantage of the opportunities that we have to deliver high quality care at lower cost. I look forward to a thoughtful and illuminating discussion. Thank you.

ED HOWARD, J.D.: Thank you Doug. And I want to thank Lanhee Chen for being as patient as he has and we will now hear from him on behalf of Governor Romney.

LANHEE CHEN: Well thank you for this opportunity to join all of you and I apologize that I'm not able to be with you in person. On behalf of Governor Romney I just want to thank all of you for the opportunity to set his views on healthcare reform.

This is an issue that is critically important to Governor Romney and while I enjoyed hearing many of my colleagues there on stage talk about the reform that Governor Romney's put in to place in Massachusetts, the fact remains that Governor Romney is the only candidate in this election to have seriously considered, led and passed [inaudible] healthcare reform when he was the Governor of Massachusetts.

And it is en vogue these days I think to poke holes in the Governor's reform just a few months in and it upsets the ways in which these reforms have or have not succeed at goals which frankly are long term goals.

I don't want to talk too much about Massachusetts this morning, I want to talk more about Governor Romney's visions

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for healthcare reform going forward at the national level. And since I don't have that much time I'll just make a couple of brief remarks about where he thinks we can reform and improve the system to expand and increase access to affordable quality health insurance.

I think the first point to make is that Governor Romney is committed to a federalist view of healthcare reform. Which means he believes that healthcare reform begins with the state and that rather than relying on a one size fits all, government run, Washington dictated reform system. It's important to recognize the role that [inaudible] while the basic play in expanding access to health insurance but also bringing down healthcare costs.

Specifically Governor Romney has articulated four goals for his healthcare reform plan. And that first to make private health insurance more affordable, second to provide access to quality health insurance for every American, third to enhance the portability of private health insurance, and finally [inaudible] healthcare percentage.

And he's outlined a couple of specific action steps that would get us from where we are to where we want to be. Amongst those he talked about the importance of establishing federal incentives to deregulate and reform state health insurance market so that market forces truly work to bring down the cost of health insurance. He's talked about the importance

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of redirecting federal spending on free care to help the low income uninsured purchase private insurance. He's talked about making changes to the tax code to equalize the treatment between those that purchase insurance on their own and those who acquire insurance through their employer, the importance of instituting enhancements to see the growth of health savings accounts. The importance of promoting innovation in Medicaid to reign in entitlement spending, the importance of implementing medical liability reform, which is a driver of increased costs healthcare. And finally, bringing market dynamics and modern technology to healthcare to incentives to promote electronic medical records and the use of health IT.

So that's a very brief overview. I encourage all of you who have more questions to seek out the answers on Governor Romney's website, which is Romney.com and again thank you for allowing me to be with you this morning even if only by telephone.

ED HOWARD, J.D.: Thanks very much Lanhee and we will try to figure out a way when I ask people to raise their hands, for you to get into this discussion as we go forward.

And I want to thank everybody for being as concise as you were leaving us enough time to explore some of these questions in greater depth. And in many ways we've heard some of these questions in the statements that you've been making, but let's start with one that flows from not only Chip Kahn's

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presentation but the entire three days of this conference. A conference on the un and underinsured, not only is that the theme it's also the raise on death for the Alliance Health Reform coverage for everybody. But there are those who believe that there's care available now to anyone who really needs it.

So the question is, and if you think you've already addressed this you don't have to again, how important does your candidate think it is that we move toward covering everybody? And what about the other part of the title of this conference, the underinsured, is that really a problem and if it is how big of a problem?

Why don't we start with, since we started with the Democrats on our opening statements, why don't we give our Republican representatives a chance to respond to that first. I don't see a hand going up, which means Lanhee if you would like to go first you can do that.

LANHEE CHEN: Sure, I'm happy to. Governor Romney's talked about the importance of getting every American insured. He's talked about that on the campaign trail, that is a big goal of his plan. I think it's certainly true that whoever needs healthcare can get it, is it an optimal setting in which to get it? Absolutely not. I think Governor Romney recognizes that and is committed to expanding access to insurance. That was the goal with his plan in Massachusetts and it the goal of his vision for national healthcare plan.

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ED HOWARD, J.D.: Yes, Doug? On the half of Senator McCain.

DOUGLAS HOLTZ-EAKIN: Yes, Senator McCain has said many times that it would be wonderful if every American had health insurance, it would be wonderful if every young American went to college. We don't mandate that. It would be wonderful if every American family lived in a home, we don't mandate that. But we try to do is set the conditions so that people can pursue those goals, his reform is designed to bring the healthcare spending costs under control so that insurance stops disappearing at the employer level and the reforms in the insurance markets to provide more innovative insurance so that people who are currently underinsured because of the lack of options will have greater ability to meet their financial needs and their healthcare goals.

ED HOWARD, J.D.: Yes, Don Moran?

DON MORAN: Mayor Giuliani I think would share the view of the two gentlemen just expressed, that the key here is to offer every American access to an affordable health insurance plan for them. And then everyone will make and sort out their choices however they see fit, but access to affordable insurance is the entire goal of the policy.

ED HOWARD, J.D.: Laurie Rubiner, for Senator Clinton.

LAURIE RUBINER: I mean I just have to take issue with my Republican colleagues. I think every Democrat sitting here

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believes that healthcare is not only critical but is a right for all Americans. And I know certainly on behalf of Senator Clinton it is one of her top priorities. She believes that every American has the right to have health insurance and it's very important and it's one of her top priorities. And I think if people believe that it's a priority they would put forth a proposal that covers all the uninsured, which is what most of the Democratic candidates have done. So I think it's one thing to say that you believe that and it's another thing to actually put your proposal forward.

ED HOWARD, J.D.: Barbara Smith for Senator Dodd.

BARBARA MARKHAM SMITH: I just, I want to address specifically the issue of the uninsured, I agree with everything that Laurie has said so I'm not going to repeat that. But I want to address specifically the issue of the uninsured, we know that a significant portion of bankruptcies that are related to medical costs are by people who actually have insurance. We know that in an article recently published in the New England Journal that adults are getting approximately 55-percent of the care they need and children are getting 47-percent of the care they need. This is largely related to access problems again, inadequate in not totally lacking insurance.

The other issue related to chronic illness that I mentioned before is that, and one of the things that Senator

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Dodd has talked about is that it's not just nominal insurance, that it has to be insurance that has real value associated with it. Because we are not going to be able to sustain the coordination of care, the prevention that we need, the sustaining of therapies that people need, if they do not have benefits that enable them to sustain care.

This also means being able to sustain relationships with providers similar to the concept that Peter talked about in the medical home. Every time you have a disruption in care, every time you have a disruption in coverage, these things go down the drain.

Finally I would just say that one of the things that most of us have done is that we have put, created an opportunity for the uninsured to go into large pools that give them substantial leverages, pools have substantial leverage to bring down costs and to maintain affordability.

I wanted just to address the comment made quickly earlier about how it would be a burden on individuals to have to bare a mandate. It's only a burden if your subsidies are inadequate. All of the candidates up here who support universal coverage support subsidies that make this affordable and manageable and not burdensome. Chip Kahn in his presentation said that he coalition of business and consumer and public advocacy groups have talked about sliding scales up to 400-percent of poverty, so we're not looking at ownerist

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mandates and I think it's very important to put all of that into perspective.

ED HOWARD, J.D.: Yes. Anybody else? Peter.

PETER HARBAGE: In terms of the importance of the uninsured to Senator Edwards, I think I might have mentioned that our plan came out first, I'm not sure if I covered that. [Laughter] But it's critically important to Senator Edwards. There is, he was the first person to plan I think that certainly Governor Romney deserves respect for what happened in Massachusetts, I think it's important to keep in mind the critical role the Democratic legislature there who, for example, over-ruled the Governor's line item veto of the employer mandate, part of the Massachusetts plan and the contribution that the Democrats made in Massachusetts to helping that go forward.

And so, it's critical that everyone has insurance, I think the point that Barbara just made on burden it's a good one, Senator Edwards plan spends approximately, is scored at about 100 billion dollars, there is a lot of money there for subsidies to help make insurance affordable. My sort of question back to those who oppose the individual mandate is why is it exactly that health insurance isn't important enough that everyone should have it? Everyone has to have health insurance, the family that was making \$60,000 a year who got a policy and was misled to its provisions and is now being stuck

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with hundreds of thousands of dollars and loses their home, that's what we should be worried about and that's what we should be thinking about is to try to bring everyone in.

I'll comment briefly on the under insured, a little bit more, it's, when people buy a health insurance policy they need to know what they're getting, they need to know that what's paid for and what's not and what their responsibilities is exactly. We also need to make sure that we have a system where people are getting the full insurance that they need, one example of that would be Medicaid and Senator Edwards has talked about strengthening the benefits in the Medicaid program, strengthening what we do in the Medicare program so that people really are insured and are getting the coverage and the access that they need.

ED HOWARD, J.D.: Greg Bloche.

GREGG BLOCHE: This is a defining issue between the parties. Senator Obama believes that coverage for all is not just a matter of basic fairness, but a matter of equity of opportunity for everyone born in this country. Beyond the issue of basic fairness is the reality that less than virtually complete insurance means a large cost shift to those who are paying for insurance. A large cost shift to business. Approaching coverage for all is a pro-business position, it's a kind of always puzzled me that Republicans are reluctant to endorse an effort to move towards universal coverage since

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given that we know that 10 or 15-percent of what business pays in premiums goes to cover the cost shift, we're talking about a large opportunity to reduce the burden of American enterprise as it tries to compete in the world.

ED HOWARD, J.D.: We've heard an awful lot just in the response to this question about mandates, whether they're individual or employer mandates, let's talk a little about individual mandates since that's kind of the new kid on the block, at least as far as discussion is concerned. If you like a mandate in your plan, how do you enforce it given the substantial non-compliance with similar mandates in the auto insurance field and how do you deal with the affordability question as somebody mentioned there was 20-percent exemption from the mandate in Massachusetts because the monies to subsidize those premiums just weren't enough. If you don't like a mandate how do you deal with, assuming that the non-group market is going to be a major part of your health plan as many of the plans are, how do you deal with those high costs and risk adverse characteristics of the carriers in that market? Barbara Smith for Senator Dodd was first with her hand up. Sorry, Lanhee Chen.

BARBARA MARKHAM SMITH: I really want to address this issue of mandates head on. First of all, let me just say that auto insurance may not be the best analogy. I think we want to think about other places where we have mandates in this

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country that have been hugely embraced, warmly embraced, in fact you could not take them away from people. And those would be in the areas of Medicare, social security and education for children under 16.

In all of those areas we have mandates, we do not have the Medicare police running around rounding up Medicare beneficiaries who have failed to register for Medicare Part A. [Laughter] We do not have people lobbying the state legislatures to end compulsory education. Now, you can get education through the public schools, you can get education through the private schools, you can have home schooling, but all of those have to meet state accreditation standards.

The, and in fact you do not see people saying that we ought to be ending the public education system. In all of these systems the world and the American public wants to make these institutions stronger. With respect to auto insurance, I would just say that we don't have systems of automatic or guaranteed enrollment for automobile insurance. If you have to take out a car loan you do have to prove that you have it. If you can come buy a car or drive otherwise, you don't have a hurdle to jump through to get it.

And the final thing I would say about that is would you please raise your hand if you would like to terminate the mandate for automobile insurance? One person, okay, that's all.

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ED HOWARD, J.D.: He's from the Ron Paul campaign.

[Laughter] Yes, Laurie Rubiner for Senator Clinton.

LAURIE RUBINER: A couple of things, I mean, number one, this is not actually a new idea. My current boss had it in her '93 plan and my late boss is late Senator John Chaffey had it in his plan in '93. So this is not actually a new idea, it's been around for a while, it's just caught on more recently because I think people have started to realize that it's one of the two ways to get everybody into the system. Greg actually just made one of the best arguments for why we should have an individual mandate which is why I'm perplexed as to why Senator Obama didn't include it in his plan, but that's largely because if you don't have everybody in the systems spreading risk and people have the ability to sort of come in and out when they want, when they're sick, they can come into the system and then leave when they're well, you completely skew the risk pool. That's the purpose of having everybody in.

Imagine if we had a Medicare system where you could opt in and out when you're sick or not sick. So, I mean, thank you Greg for making that argument on our behalf. [Laughter] But, you know, and in terms of the affordability, the reason it didn't work in Massachusetts is that they didn't make it affordable. They didn't put the money forward to make it affordable for people so they had to exempt thousands of people from the mandate. Senator Clinton's plan says no family will

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have to spend more than a set percentage of their income toward the cost of health insurance and that is how we will make the mandate affordable and that's how we'll get everybody into the system which is the only way to get to universal coverage, you ask any credible healthcare economist and they'll tell you that.

ED HOWARD, J.D.: Okay, let's go to Don Moran for Mayor Giuliani and then Doug.

DON MORAN: Thank you and let me take on the aspect of your question where you asked about the individual market and how that intersects with this whole issue of mandate. I think the thing people have to understand about the individual market today, and it's varied somewhat by state but not a whole lot, is that it's a residual market that is basically is there and exists only to pick up the limited number of people who find themselves inadvertently outside of the group system and in an environment where they have differentially best access to the existing level of tax subsidies. And so the people who are actually buying this stuff are of a risk pool file that is substantially different than the average American. And it's, I guess, Mayor Giuliani believes that if we pay important attention to this structure both in terms of the boundary between the group market and the non-group market, the tax treatment on both sides of that boundary, we can create an environment where a substantially larger share of the American

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people, not a residual market, but a collection of people who's risk profile looks more like America will have access to a reform insurance system. And that kind of environment affordable insurance can be available under that kind of framework and at that point the argument about whether or not you're going to go further in the direction of mandates becomes a little bit more particular to how strongly you believe in public mandates as a matter of principle.

ED HOWARD, J.D.: Yes, Doug Holtz-Eakin for Senator McCain.

DOUGLAS HOLTZ-EAKIN: And this is clearly a very important issue and we have seen people on both sides of the aisle propose reforms that include or do not include an individual mandate, so I don't think this should be viewed as anything other than a policy decision that requires some thoughtful reflection and Senator McCain believes deeply that one does not intervene into the basic personal, political and economic freedoms that America is built on without a strong case that it's going to be successful and durable in moving national priorities forward.

The same would apply to overriding states and their prerogatives. And so if you look at the notion of do we want individuals to have insurance, of course. Do you want to mandate that as your top priority? No, because in the absence of the other pieces of the reforms, the ability to deliver

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healthcare with the same and higher quality at lower costs, those mandates will ultimately fail, the American public will once again be disappointed by the congress and the administration in dealing with national priorities and we will set back the efforts that are so crucial in this country.

So the first step is to undertake the kinds of healthcare reforms that deliver costs effective quality care. Those are available, they should be the top priority, not the illusory gains of mandating that people buy something that they either could not afford or didn't actually meet their needs right. It's important to recognize that not everyone who's uninsured is identical and the mandate treats them all the same. There is transitory uninsurance, there are people who are long-term uninsured, there are people who have high and low incomes who have uninsurance.

It's important to have a much more sophisticated and richer vision of the future than to simply say all of you have to have insurance. And he's committed to that richer vision, not all problems will be solved by insurance, there's still a role for public health clinics and other ways to access quality healthcare in America, he comes from Arizona, very rural in some places, while he's a big proponent of having a refundable tax credit that helps with insurance that's not going to solve all the health problems in a situation like that.

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So we need to move away from this one size fits all panacea, undertake a serious reform of all aspects of the system so that it revolves around American families and deals with their pressing needs.

ED HOWARD, J.D.: Greg Bloche, you've been accused of arguing for a mandate before you argued against it.

GREGG BLOCHE: I actually haven't yet but the New England Journal piece that came out a couple months ago indicated my personal preference for mandate as a matter of symbolism. The problem here, well first of all I should point out that Senator Obama does not oppose mandates. It is a wedge move, a smart move, by the Clinton campaign to present him as opposing mandates because he hasn't said that's first priority from the get go because he's focusing on affordability in the here and now. He's open to mandates. And he, let's get real as opposed to kabuki about these discussions, what will really happen if a Dem gets elected, is that there will be a process of negotiation and the issue of whether or not there are different kinds of mandates and when they get phased in is kind of a, it's within the range of the arrow flag so to speak of negotiation, this is all going to get worked out in the process of discussion.

So this conversation is a kind of kabuki thing for the purpose of making, can we make Iowa or New Hampshire voters worry enough about Senator Obama and there's no basis for that.

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Second, saying it so doesn't make it so with respect to mandates. I commend to all of you, Sheri Glees [misspelled?], wonderful article in the current issue of HealthAffairs. She drives home a really simple point, that when the costs of compliance with mandates are relatively up high, and the costs of non-compliance are relatively low, mandates don't work. And when the incentives are flipped, when the costs of compliance is low, and the cost of non-compliance is high, take signing up for Medicare for example, right? If the cost underneath the cost of non-compliance is that you don't have health insurance and you can face catastrophic financial lose, when the incentives are flipped that way then you could say mandates work. What's more realistic though to say is that it's a matter of the incentives.

So mandates as a matter of symbolism for shared responsibility, yes, I'd say yes. But mandates as a driver of the number of, major driver in themselves of the numbers of people who are insured or uninsured, no, it simply doesn't happen in that way as a matter basic economics.

I'm reminded of a TV show I watched when I was 11, I Dream of Genie, some of you may remember, or maybe I'm dating myself, I Dream of Genie, Genie would just, when she wanted to make something so go blink, like that. [Laughter] And it would be so. But in the case of the individual mandate it doesn't quite play out that way.

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ED HOWARD, J.D.: Let me, Lanhee Chen, did I see your hand raised wanting to answer this question?

LANHEE CHEN: Maybe you saw it virtually raised. I, just a couple of things on this, I mean, as a matter of policy I think Governor Romney has made it very clear that this is why he approaches healthcare reform from a federalist perspective. We don't have a single national market place for health insurance, so the notion of putting into place a single overarching national mandate, individual mandate, [inaudible] with being somewhat problematic. Now that does not mean that states on an individual level cannot make the decisions to enforce individual mandate.

The Massachusetts experiment is interesting, I really enjoyed hearing all of the sky is falling from people or various sources of criticism on a plan that the mandate of which is not even gone into effect yet. Will not go into effect until January 1st. The reality is that the first year of enforcement of this plan there has been some exemptions made with respect to affordability, but going forward it's Governor Romney's hope, and ultimately much of this is in the hands of the administration now in Massachusetts that has responsibility for administering the plan, but it's Governor Romney's hope that the market forces that were put in place by his reforms will help to bring down the cost of health insurance going

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forward and make the sorts of exemptions that we've seen this year less likely and unnecessary in the years going forward.

So that's just what I say briefly on that but I think with respect to a national plan, Governor Romney's made it very clear that he believes in a state by state method of reform.

ED HOWARD, J.D.: Thank you. And I guess I should point out that the state of Hawaii has had an employee mandate in effect for about 30 years now, along with an employer mandate. It's a limited one and we have seen neither the destruction of small business in Hawaii nor the elimination of the uninsured in Hawaii. So let us be cautious in our approach to these problems from both sides.

PETER HARBAGE: I'm sorry, if I can just jump in real quick on that.

ED HOWARD, J.D.: Yes, sure, Peter Harbage.

PETER HARBAGE: If I can just touch on the individual mandate for a second. I agree with Greg, I commend the folks that they read the Sheri Glees article as well on mandates because it really does show how and why mandates can work. The auto insurance example, that Ed mentioned, is frequently brought up including by Senator Obama's example of how mandates can't work. But auto insurance, if you think about it, is enforced more or less randomly when you go and register your car you have to show proof of insurance and then you cancel it

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the next day, not that I've never done that. I understand that it can be done. [Laughter] Maybe not in DC.

MALE SPEAKER: [Inaudible] in DC and put you in big trouble.

PETER HARBAGE: Well, and that leads into my point which is there are states where they are doing computer tracking. Georgia for example has 2-percent uninsured rate for its auto insurance because the insurance companies track who has insurance and when you don't have insurance they contact the state. And applied to healthcare you could have a system where if somebody loses insurance the state could reach out and say has your income dropped, have you lost your job, can we help you with state assistance, can we look at what's going on? In the context of the Edwards' plan it would be we have subsidies available to make insurance more affordable let's keep you on insurance and let's make sure insurance keeps going.

We're really having this conversation and I think it's just important to understand the fundamentals is because we don't have, we lack a culture of coverage in the United States. Jonathan Cohen who spoke earlier this week has a wonderful book, "Sick" that talks very well about the development of health insurance and it really was developed in such a way that it was a reward for work, frankly it was a reward for workers and frankly it was because there was a sense in which workers

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are going to be more healthy and probably aren't going to be sick and they're just a good risk to bring in.

And what we've done over time is we keep adding in separate groups, whether they're low income, whether they're seniors and what we need to do now is finally bring everyone into the system and finally develop a culture of coverage. No one would find it acceptable if they didn't send their children to school, what we need to do with health insurance is find a way to make it affordable, make it automatic, make it available so that people feel the responsibility and take on the responsibility of actually having insurance and paying into a health system that they, that everyone will surely use at some point in the future.

ED HOWARD, J.D.: Quick comment from Barbara Smith and then I'd like to move on if I can.

GREGG BLOCHE: Can I just respond briefly to that?

ED HOWARD, J.D.: Yes, sure.

GREGG BLOCHE: The basic economic problem here is if you look at the way that coverage is supported in all the major Dem's plans, you've got a phasing out of the tax cuts for folks earning 200 to 250 thousand a year. That doesn't provide enough in subsidies. That plus the savings estimated by the different plans don't, that doesn't provide enough in subsidies to cover the folks all the way up the line to the point where coverage is readily affordable. Senator Clinton's plan for

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instance says exactly what Laurie mentioned but there are no numbers in there. And the campaign was smart from a political perspective not put numbers in there because they simply wouldn't add up in terms of being able to insulate folks and make it readily affordable. We have certain expenses in this society, healthcare is one of them, college education at least at elite private colleges is another, there are basically unavoidable absent subsidies for all but folks who are really quite well off. Harvard University, just announced it's going to provide financial aid to kids in families making up to \$180,000, an amazing figure.

The society has to wrestle with the challenge of how we're going to take on the task of paying for these kinds of expenses and we're not there yet with the levels of subsidies that are being proposed by any of the plans that are now on the table.

ED HOWARD, J.D.: Barbara Smith for a very quick comment.

BARBARA MARKHAM SMITH: Yes, I just wanted to quickly reiterate the point about how you get if you do not have mandated universal coverage and I want to address this to my Republican colleagues as well, the risk selection in the pool makes it very much more expensive, it makes the subsidies much more expensive, and more importantly it prevents you from being able to eliminate medical underwriting which is a substantial

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impediment to coverage and to affordability. So if you use the universal coverage pools to leverage cost containment, which is your, which makes the pools the largest and the most robust, and you eliminate medical underwriting, then you have the best chances of succeeding in affordability.

I would just remind people that Jimmy Carter tried very hard to get through to universal coverage through cost containment first, he never got there.

ED HOWARD, J.D.: We have about five minutes left according to my watch. And if we can get some questions from the audience, if you can keep it brief and address it to a particular person who will give you a brief answer, we'll try to get you involved here. I don't know if there are microphones to be handed out, yes. If you would wait for the microphone, this lady right here I think had her hand up first. And you want to identify yourself please.

KRISTEN HANNAH: Hi, Kristen Hannah, I'm from Healthcare for All Colorado. And my question is for Barbara Markham Smith, you said that mandates were more comparable to universal education, social security or Medicare, but those things don't force private citizens to subsidize private industry where the first responsibility is to their stockholders. And you can also opt out of auto, well, okay, there you go.

ED HOWARD, J.D.: Alright, good. Barbara?

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BARBARA MARKHAM SMITH: So basically I think the point you're making is that if you went to a Medicare for all system of some sort of single payer system that that would be more equitable and reliable.

I think that the issue is how do you achieve transparency and accountability. Senator Dodd believes that if you can, if you pool people together in large enough pools, if you have enough leverage that you can achieve the transparency and accountability that you can require because you have a large market and the insurers have to provide that kind of accountability in order to participate in your market. It's not a perfect system but we feel that, Senator Dodd believes strongly that it is a system that is most compatible for Americans. The other thing that he wants to assure is that there is a robust level of diversity and choice underneath a system of accountability and financing. And so he thinks that the American people require that level of choice and that's why he made the decision he did.

ED HOWARD, J.D.: Yes, Peter for a quick comment.

PETER HARBAGE: If I can just jump in, I would say it's a good question and it's one of the key reasons why Senator Edwards suggested that there be a public plan option as part of his plan for folks who don't want to buy into private insurance they don't have to.

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ED HOWARD, J.D.: Yes, there was a, oh, yes, go right ahead.

GEORGANN CHAPIN: Yes, I'd like to point out that the equivalent-

ED HOWARD, J.D.: Can you identify yourself please?

GEORGANN CHAPIN: The equivalent of mandatory public education is publically available healthcare, not purchasing of insurance, get education get healthcare. I have a question about the percentage of income that Laurie you've put out there, it costs real dollars to live, it doesn't cost percentage of income when you go to the grocery store you can't say I only have 6-percent of my income to spend on groceries, so as healthcare costs rise even if you were able to make a guarantee that only a percentage of your income would be spent, first, how would you do that because healthcare costs are going to rise which means huge public increase in subsidies. And the second is you're still going to have people at the lower income levels who are not going to have enough money to live on what's left.

LAURIE RUBINER: Well first of all, we're getting rid of the Medicaid system, so you would still have the Medicaid program as the safety net for lower income individuals who have no money to spend on healthcare. And one thing we would do is get rid of some of the restrictions on Medicaid right now that restrict people from being a part of the program based on

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family status as opposed to income, so single adults and so forth as sort of vestiges of the old welfare program would be done away with so we'd have sort of a single Medicaid program that would serve as a safety net for all low income individuals.

Then you would have a subsidized program where you would have a percentage of your income above which you would be subsidized and it would be indexed to medical inflation. So it would track how much increases there are so that you wouldn't, if healthcare costs went up then so too would the percentage of your income that you would have to contribute towards the cost of your health insurance. So we would make sure that it stayed consistent.

But I think the other thing to remember is that she has, her plan over time would bring down costs for everybody because we have a number of very important cost containment provisions in our plan. Senator Clinton actually started off with a speech on cost and a seven point plan on cost putting aside the coverage piece because she realizes that the cost issue is so important, her first major healthcare proposal was a cost containment proposal that she announced in June of this year. And I encourage you to go to her website at the campaign and look at the seven point plan that she has to reduce costs, but that's another way in which we'll be bringing down

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healthcare costs. Subsidizing peoples costs to make sure that they can afford the insurance.

ED HOWARD, J.D.: We have time for one more question, I believe we have a-

JAMES REARSE: Hi, my name is James Rearse and I'm from the free clinic in Kalamazoo and the free clinics of Michigan and there are probably a dozen or so of us in the audience that have been actually face to face on a daily basis for many years talking to the uninsured. And I think there's a few things you all need to get a sense of from us. Number one that mental health issues amongst the uninsured is a huge, huge issue, there's been a little mention about management of their care, they need access to their medications and if you're having trouble, if the government can't find enough funding for this maybe they could go to the homeland security pot because I really do think our shopping malls, our churches [applause], really, we have homeland security issues because we have so many people who need medication and management of chronic mental illnesses. And these are manageable diseases so I would urge you all to think about this and start talking about it. [Applause]

GREGG BLOCHE: I'm a psychiatrist in a past life and I've had lots of clinical experience with exactly the patients who you're talking about. And that's one feature of Senator Obama's plans, it's also in the other plans is that there's

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full parity for coverage for mental illness, mental illness has truly made it into the mainstream in all the Democratic plans. And I think making life outside of institutions work requires exactly the kind of access to not just monthly medication but the assisted living life supporting structures that are really going to be crucial to make it work for folks.

I just wanted to briefly respond to something Laurie said before, Laurie I think said subsidies would be in depths to medical inflation. In the long haul that is budget busting beyond belief. The recent congressional budget office report that Peter Orzack, my former bookings colleague released, looking just at Medicare and what happens. The astonishing percentage of GDP and an even more astonishing percentage of the federal budget that medical costs will take up unless we really get a lid on cost inflation. And what's accurate about all the Democratic plans is they build a foundation for long term cost control by investing in comparative efficacy research. I'd make the claim that Senator Obama's plan does that more than the others, they've all got foundation but they, the rest of the work of cost containment, a lot of the work of long term cost containment still needs to be done. We still haven't come up with the magic bullet in terms of putting a lid, yes, on these scary long term projections that the CDO has developed.

LAURIE RUBINER: Which is why the-

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ED HOWARD, J.D.: Quick response from Laurie Rubiner, then Barbara Smith, and then Doug Holtz-Eakin gets the last word.

LAURIE RUBINER: Which is why I followed it Greg with saying that she started out her plan with a seven point cost containment cost proposal that is the most aggressive of any of the Democratic plans to bring down costs in the healthcare system, so, thank you.

ED HOWARD, J.D.: Barbara?

BARBARA MARKHAM SMITH: I wanted to address the issue of public health and access to care and safety net. Because obviously I thin we all recognize that having an insurance card does not guarantee you access to care. So one of Senator Dodd's priorities has been to direct money into enlarging the public health foot print through not just, through delivery, enrichment of delivery of services on the ground and education on the ground and the public health side, and to try and improve and enhance the safety net upon which we rely for so many things including actual physical access to care. We're not going to get cost containment throughout the system if we have a safety net that's falling apart, so he clearly recognizes and has stated explicitly the role of public health clinics, community health centers and of course this supports mental health parody.

ED HOWARD, J.D.: Doug Holtz-Eakin for Senator McCain.

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DOUG EAKIN: Yes, let me just connect the dots between the Medicare projections and the issue about mental health coverage. These Medicare health projections which have been known for a long time are absolutely terrifying. Now, allow my cynical side to appear, what do we have in Medicare? We have Part A, so the hospitals get their money, we have Part B so the doctors get their money, well Part C's so the insurance companies get their money and Part D so the drug companies get their money, but there's nothing in there that guarantees the beneficiary gets quality care. It's a system that's oriented around fee for service, shoveling money out to providers regardless of the quality of the outcome. The Senator is committed to paying for quality outcomes and if appropriate care, at least a high quality outcome is mental health, or physical therapy, those should be treated on a level playing field we need to deal with the costs projections and it's the way medicine is practiced in America not mandates. Thank you.

ED HOWARD, J.D.: Well, you heard hints of a very sophisticated and difficult debate about costs, the implications for quality, not to mention all of the questions that have been raised about coverage and access to coverage. We didn't quite settle every issue this morning, [laughter] but I did, I did see I think a little light being shed on some of the major issues. I encourage you to watch the debates from Des Moines when you're finished with the conference. Be part

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of the debates from now on, continue to ask the tough questions and I ask you to join me in thanking our panel for what I think was a very thoughtful discussion this morning. [Applause]
Thank you very much.

PETER GRANT: Yes, thanks to the panel. I know they need to go gather votes in Iowa or New Hampshire or something like that. But really thanks not only for their participation today but for the obvious sophistication they're bringing to this debate. They're really moving forward and frankly I don't think they would have probably been here if they hadn't been so generous to be here and to put his name on both early on in the enterprise, but give single payer a chance.

David Himmelstein is Associate Professor of Medicine at the Harvard Medical School. He practices private care internal medicine and serves as Chief at the Division of Social and Community Medicine at Cambridge Hospital in Cambridge, Massachusetts. He was a founder of Physicians for a National Health Program. He serves as co-director of the Center for National Health Programs that is at Cambridge Hospital in the Harvard Medical School. Dr. Himmelstein thanks very much for joining us. [Applause]

DAVID HIMMELSTEIN, M.D.: Thanks for having me, I always worry a little bit about introductions, what they're going to say about me. I have teenage children and I don't know if you know Eleanor Roosevelt years ago was talking in

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Maine and the woman who was supposed to introduce her said how do you want to be introduces and she said I hate those long introductions, please make it brief, and the woman said this is Eleanor Roosevelt and the less said about her the better.

[Laughter]

Well I guess I'm supposed to represent Dennis Kucinich I think. [Laughter] Actually not but he's the only candidate in my view who's saying what needs to be said in this campaign. I'm going to say a lot that's conventional, a little bit that's unconventional. The conventional part is that our healthcare system is in deep trouble. I stole this slide years ago from Uwe Reinhardt, and Uwe told me that you can use it to illustrate any point in health economics that you want.

[Laughter] And in the 20 years since I stole it from him it's never gone out of date. [Laughter] And if you flip it upside down it's the Democratic congress is standing in the polls and the President Bush is standing in the polls, and this of course is health spending which is continuing to rise at unsustainable rates, I think we're all familiar with that. On the other side of the crisis in our healthcare system is the rising number of uninsured.

I practice at a public hospital where I've been for 25 years now, and I'll talk a little bit about why I think it is fact the Massachusetts miracle is largely a Massachusetts fraud from the perspective of someone who actually cares for the

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uninsured. And to make the point that the uninsured are the mainstream of America, our administration honors veterans and yet dishonors them when they come home. There's some data we published last month on 12.1-percent of America's veterans are both uninsured and lacking access to the VA. And I guess Ms. Smith quoted the data we developed on medical bankruptcy and quoted it accurately, three quarters of the medically bankrupt in this country had insurance and what she failed to say is that most of them had the kind of coverage that Mr. Dodd, Mr. Edwards, Mr. Obama, Mrs. Clinton would actually suggest is adequate coverage.

Sixty-three percent had private policies and most of those people had policies quite comparable to what the Democratic front runners would mandate as coverage that should be adequate. And yet, medical bankruptcy is extraordinarily common. American women are more likely to file for bankruptcy than to graduate from college and half of those bankruptcies are caused by healthcare costs or medical catastrophe. And as you see 60-percent had private coverage. Well our healthcare system rations medical care, gross numbers uninsured and underinsured and I think all of you familiar with that.

Years ago when I showed this slide my boss then said you're misusing the term rationing, the dictionary defines rationing as egalitarian distribution of a scarce resource. And we don't distribute this resource in an egalitarian manner

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and it's not scarce, the RAN corporation tells us that 16-percent of hysterectomies are clearly unnecessary, 25-percent questionable and for virtually every kind of procedure that's been done large numbers of unnecessary and questionable things for CT scans, we're headed towards causing 2-percent of all cancers in this country from CT scans that we do, and probably a third of those aren't necessary.

If effect our health policy has focused on rationing the surplus of resources. To many high tech machines, to many unnecessary procedures and then we establish a health policy system to ration that surplus, which to my mind is an oxymoronic phrase if you think about it a minute, it's a little bit like political leadership I guess. [Laughter] And this is of course what it takes to ration a surplus, the yellow is the number of physicians in the United States and the blue is the number of bureaucrats in our healthcare system.

It takes a great deal of effort to keep sick patients away from idol doctors and empty hospital beds but in fact bureaucracy is the fastest growing element in our healthcare system by far and what's been proposed on this platform is more blue. The other thing that's proposed besides more insurance company bureaucracy essentially is competition and Rick Cronin [misspelled?] drew this map, Rick was one of the original theorists of managed competition in the United States. And he's colored in black the parts of the United States that have

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sufficient population density to conceivably support medical competition. A town's only hospital will not compete with itself no matter what your fantasy. [Laughter] The only neurologist in a region, the only neurosurgeon will not compete with herself, and half of Americans live in regions of the country without sufficient population density to make any conceivable competition in healthcare possible. The theory doesn't hold for half of our nation at first blush.

And we've had over the last 25 years increasing for profit domination of our healthcare system and I want to just turn to what that means for a minute as we've gone to, as we went to managed care, you see the yellow piece of the ball which is non-profit managed care shrinking, we've gone to for-profit managed care that now dominates our system. Why is that of concern? Some data we published in the JAMA a number of years back now showing for every measure ever collected on quality, for profits do worse than not for profits. I apologize that we don't have more recent data, the for profits refuse to allow release of their quality data for researchers after we published this article.

But the market driving towards lower quality care and we see largely Medicare enrollment in HMOs has been for profit variety. It took a dip in the early 2000s because HMOs couldn't affectively compete with Medicare without a huge subsidy that the congress subsequently voted for them. And if

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you think the transparency of private insurers paid by a public program is adequate to avert fraud, I commend you the Medicare HMO program. HMO is very quickly realized this important piece of health policy news and that is as you go to the right you're going to sicker groups of patients, the sickest 20-percent of our population accounts for 78-percent of total healthcare costs. And of course if you avoid them as an HMO you effectively are guaranteed making money and how do you do that? You put your sign up office is on the third floor of a walk up building or more subtly you hold your sign up dinners in a rural area only approachable by automobile late at night when sick people aren't still up and not driving around.

There's a whole science to how do you sign up selectively healthy patients and the HMOs spend billions on that and of course that's financially worthwhile to their stockholders. And we know that they've succeeded because of research like this so in the months before joining a Medicare HMO, the middle bar there, those patients cost 66-percent as much as the average Medicare patient and after they left the HMO, the right hand bar, they cost 180-percent as much for Medicare as the average Medicare patients. Patients were leaving the HMO when they needed their elective hip surgery, their elective prostate surgery, the expensive stuff and in fact we know that there's been a huge subsidy for Medicare HMOs under our Medicare program where we now pay 12-percent more for

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a patient signed up for an HMO under Medicare than it would have cost to care for that patient in the public Medicare program.

Market theory says we also need informed consumers in order to make rational market choices. The AARP surveyed its members and found that 11-percent of seniors have adequate knowledge for selecting among insurance choices, market theory doesn't work if you don't have informed consumers and I invite you to comparison shop our emergency department next time you're having your chest pain. [Laughter]

Medicare costs have gone up far more slowly than private insurance costs over the last 39 years, in fact the most effective cost containment program in the nation has been the public Medicare program, not the private insurance industry. We know that private insurers have failed over the 33 year period for which we have clear data. Medicare has gone up 1700-percent, that's a problem, but private insurers for comparable benefits rising 2500-percent, far bigger problem. We know that the public is better in quality of care, the best quality care now delivered in the nation on average is our VA system so this is a comparison of quality measures collected by the headiest group. Comparing the VA average with the best HMO score in the country and for each of the quality measures the VA's now outscoring the best HMO in the United States, good evidence public works.

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Now there are of course folks who've done very well in managed care, [laughter] Bill Maguire I guess I should have redone this stock, he made 1.776 billion dollars from his HMO United Healthcare in the course of his 10 year residency, but he had to give back 600 million this week so he's only got 1.1 billion. My personal favorite on this list is Jack Row, he made 446 million at Aetna, now that comes out to 225 thousand dollars per day during his entire time at Aetna. Now Jack's previous job was as Chief of Geriatrics at Harvard. And I happen to know from Harvard's pay scale that he was not making 225 thousand dollars a day as a geriatrician colleague of mine. And of course that comes out of our patients pockets so Jack's salary comes out of his enrollees pockets. Twenty percent of every dollar we pay into Aetna stays with the company and the question is can we actually afford that kind of drain on our healthcare system. Medicare charges 3-percent overhead, the Canadian National Health Insurance Program runs for 1.2-percent overhead, can we actually afford the extra 16 to 18-percent that it costs us to run private insurance plans as opposed to running a public universal health insurance plan?

Now Melda Freedman [misspelled?] told us years ago what to expect from allowing for profit firms into the midst of our social programs. He said few trends could so thoroughly undermine the foundations of our free society as the acceptance of corporate officials of a social responsibility other than to

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make as much money for their shareholders as possible. And the question is is that what we want in the middle of our healthcare system?

We looked at who owned tobacco stock and the biggest insurance companies are the biggest owners of tobacco stock. It's sort of the combined veterinarian and taxidermist approach. [Laughter] Either way you do get your dog back. [Laughter]

This is a complicated slide that presents the data from a meticulous systematic analysis of every study ever published comparing for profit hospitals quality with not for profit hospitals quality. And the bottom line there is that for profit hospitals have 2-percent higher death rates than not for profit hospitals caring for comparable patients. We kill 2500 people each year by allowing Senator Frisk and his colleagues to run their hospitals. Now, are they more efficient, a meticulous meta-analysis looking at every study ever published, on average for profit hospitals raise costs by 19-percent. We waste 25 billion dollars a year by allowing Senator Frisk and his colleagues to run hospitals.

We pay for inferior care at inflated prices by allowing for profit into our healthcare system. It's not only the hospital systems, this is more recent data by the way since that meta-analysis was published, even more striking showing that for all of the quality measure for acute myocardial

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infarction, congestive heart failure, pneumonia, VA is head and shoulders above both not for profit and for profit private hospitals, though the for profits are by far the worst.

Tenant, the second largest hospital system, far too much in the way of their fraudulent behavior on this slide to go over in detail, I'll just hit a few of the highlights. Back in the late '80s they were literally kidnapping patients and labeling them as psychiatrically ill and holding them against their will in their psychiatric hospitals until the day their insurance ran out. That's not my charge, they plead guilty to it and paid 250 million dollars in, 200 million dollars in settlements, 379 million dollars in fines, said they'd never do anything like that again. Well in the late '90s they were doing open heart surgery on patients with no detectable heart disease. Which is profitable, those patients have very short lengths of stay and are very profitable under the Medicare DRG program and you have good quality measures, those patients do very well since they weren't sick to begin with. [Laughter] They paid a fine and have continued to run their hospitals.

And for profit dialysis clinics that now dominate the market have 9-percent higher death rates, again a systematic analysis of every study ever published. We kill 1500 people by allowing for profit firms to run our dialysis clinics in the country. Well, just to complete the tour, our drug firms one could say they should be allowed to make a profit, should they

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be allowed to make a profit three times the average of the fortune 500? And of course most of that profit comes, I'm sorry, that profit is far bigger than their research and development and their costs of marketing far outweigh their RND costs. And here are some of the recent frauds in the drug and other industry.

Well, I want to turn to some alternative models that we know work. I've show in yellow here the amount of per person spending in the US that comes from government sources. And the point I make with this slide is that we spend more in government money than other nations spend on their entire healthcare systems. We fund national health insurance in this country but we don't get it. So we spend more per person in government money than Canada spends on its entire healthcare system, public and private together.

Now, the image that Americans are voracious consumers because we're so well insured, which many of the Republicans portray is sort of a bizarre image, we already pay the highest out of pocket healthcare costs and yet we continue to have by far the highest health spending. Our life expectancy trails other nations to which we compare ourselves, our infant mortality rate which used to be among the best in the world is not far down the ranks. Our maternal mortality rate virtually off the charts, it's not that we're expensive because we have so many elderly people, it's not that we're expensive because

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our patients get so much care in hospitals, it's not that they come to visit doctors so often, it's not that we do extraordinary amounts of high tech care. Years ago when Paul Songis was running for President he said he wouldn't have supported national health insurance ala Canada because he was convinced he wouldn't have gotten a bone marrow transplant that he thought lengthened his life under that kind of system, which was a surprise to the doctors in Toronto who developed that procedure. And who do it in larger numbers for capita than we do in Boston. And yet the image persists that other people don't get much care, we don't produce extraordinary amounts of research on a per capita basis.

I want to turn to Canada's program for a moment, a simple program where the feds offer the provinces block grant funds for coverage that, for a program meeting four criteria. It has to cover everybody with no co-payments, no deductibles. Second is portability of benefits, if you're from Ontario and get sick in Quebec, you must be covered. Third is coverage for all medically necessary services, which the feds haven't defined but everybody in Canada has better insurance than anybody in this room. And fourth, publically administered through a non-profit program, which came because they found that it costs four times as much when they tried to subcontract administration to a for profit firm when they started the program and they said no, we can't afford that.

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If you ask Americans and Canadians do you have an unmet health need and the statistical agencies in the two countries have now done this, Canadians look like insured Americans. Not perfect by any means but remember they're only spending half as much per person as we do on healthcare. A med-analysis that we and colleague from Canada published recently looking at every study comparing quality of care for Canadians with insured Americans, and the somewhat complex slide here shows that the predominant study suggests that Canadians get somewhat better care than the average insured American gets.

Infant mortality that was higher in Canada before their national health insurance program fell below ours and has stayed there. The poorest 20-percent of Canadians, the right hand blue bar there, have lower infant mortality rate than the average in the United States. They have disparities, they are much smaller than ours and even poor Canadians do better than average Americans. And of course, national health insurance has been extraordinarily affective cost containment in Canada, one might argue too effective at cost containment. My view is that we ought to spend substantially more than Canada does, we ought to have Canada deluxe. [Laughter]

If you look at where the differences in spending are, we're spending about \$1262 per person per year on useless bureaucracy, 350 billion dollars a year in this country goes to the bureaucracy needed to keep the private health insurance

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industry in place. That's not just the million people employed in health insurance firms doing useless jobs, it's also the hospital billing and administration personnel, so years ago visiting Toronto General Hospital, 900 bed tertiary care referral center, three people in its billing office who's main job was to send bills to Americans who wandered across the boarder [laughter] because Toronto General gets paid like a fire department gets paid in this country, one check every month to cover its operating expenses. They don't have to fight hand to hand over every aspirin and band-aid tab like Massachusetts General does.

When we got to Boston we went by Mass General, 352 people in its billing department. Not because they're inefficient, but because that's what you have to do as a hospital to collect your bills. And doctors face a similar kind of nightmare of collecting our bills. The private insurance industry in this country costs us 350 billion dollars a year, not only in their overhead but in the paperwork they inflict on the rest of us. That's more than enough to cover all of the uninsured and to upgrade coverage for all of the rest of us as well. To eliminate every co-payment, every deductible, to expand long term care and home care, to give every American free medical care without any increase in our health spending. But you've got to throw the private health insurance industry out to get that money.

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Now, their insurance overhead is only a piece of this but it's a significant piece. Americans are spending about 300 dollars per person per year on health insurance company bureaucracy that we don't need.

I'm going to skip in the interest of time to looking at some of the other proposals on the table. I think this is the best characterization of the Republicans proposals. Steven Colbears [misspelled?] it's so simple, most people who can't afford health insurance are also too poor to owe taxes but if you give them a deduction from the taxes they don't owe they can use the money their not getting back to buy the healthcare they can't afford. [Laughter]

Now, even if you say tax credits as some of the Republicans do, the tax credits their talking about are maybe 20-percent of what a real health insurance policy costs. Let's get real they're not actually seriously talking about coverage. An existing tax credit program for workers displaced by overseas competition, 34-percent of the total spending in that program has gone to administrative costs for the tax credit. This is an administrative enormously complex thing to administer, a real time tax credit program. In the interest of time I won't go into it in detail.

Consumer directed healthcare they propose that people should be more cost sensitive than basically saying we need things like \$5000 deductibles and the fantasy that the

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employers going to put money into a medical savings account, that's the blue piece at the bottom. And most employers of course aren't putting anything into a medical savings accounts, so the red piece extends down to the bottom, that's the out of pocket costs that are \$5000 or more because if you get some uncovered service that doesn't count towards your deductible, like physical therapy that is needed for more than 60 days.

We know from the RAND experiment years ago what this means. In the free care group in the RAND experiment the only randomized control trial of health insurance arrangements ever done, the free care group 5-percent of toddlers didn't see a doctor in the course of a year, that's bad care, that's on your left. In the high co-payment group that's like medical savings accounts, 18-percent didn't see a doctor in the course of a year, 13-percent difference in the number of toddlers not seeing a doctor in a year. It means if you're a diabetic on medications your average costs are \$5700 a year, you're a sure loser under this plan.

I'm going to go on to another group who are sure losers, that's women. The average woman spends \$1000 more on medical care in the course of the year than men. And if you say that we're going to have high out of pocket costs before insurance kicks in, you're saying to women you're taking a \$1000 pay cut as compared to your male colleague.

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And in the interest of time let me skip to the Democrats. Why do I put Richard Nixon's picture up in talking about the Democrats? That's because actually what Obama, Edwards, Clinton, Dodd are proposing was first proposed by Richard Nixon in 1971. On the eve of Senator Kennedy's introduction of his single payer bill, Richard Nixon expressly to try and block national health insurance introduced his alternative a mandate model for reform. And he said government should use it's coercive power not to collect taxes and to provide coverage but to make people buy defective private policies. He didn't say defective, he just said private policies. And the mandate model he said should expand a Medicaid like public program for the poor, he said it should cover everybody up to 23 thousand dollars in income, in today's dollars, with partial subsidies for those above that who want to buy in on their own, that's virtually what's identical to what's proposed by today's Democrats. An employer mandate, employers should have to pay 75-percent of the costs of coverage for their workers. And managed care in order to hold down the costs of chronic disease.

Now the Democrats today are completely reversing managed care, they call it care management. [Laughter] What's new since Nixon, well the individual mandate is new, promised cost savings through computerization is new. I spent 20 years as a Director of Clinical Computing at our hospital and I'm a

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big computer enthusiast but I have to tell you there is not an iota of evidence that computerization saves money, a fact recently confirmed by the director of the Congressional Budget Office who said this is fantasy.

And government brokering private coverage is new. So not only would government have this public program that it offers but it should serve as a broker for the private coverage, an FEHBP like program. I'm going to skip through to the Massachusetts reform which is sort of this model working today and I think you're mostly familiar with it, Medicaid HMO for the poor, partial subsidies for those in the near poor category, and buy your own for the above 300-percent of poverty. Just to make the point, Massachusetts was the optimal place to try this, we had a huge free care pool which could be diverted from safety net institutions to this coverage. We had a federal contribution of a one time lump sum of added money that runs out in two years by the way, and we have a very low uninsurance rate.

For someone like me, what that mandate means is if you have an income of 30 thousand dollars you're expected to pay \$4000 for coverage that has a \$2000 deductible. So you're \$6000 out of pocket before you get a sent paid and 20-percent co-payments after that. And here is some crimes and punishments in Massachusetts. An employer mandate piece is the employers have to pony up \$295, individuals of my ilk will have

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to pony up \$2000, which is a bigger fine by the way than for drunk driving or for beating your wife in our state. And here's how it's worked as of November 1st, the free care group on your left has 86-percent of those people have signed up. So if you think that people will sign up for free coverage you're right. The middle group is the partial subsidy group, 12-percent of that group have actually signed up, and the right hand pie there is people over 300-percent of poverty, 4-percent had signed up for that coverage by November 1st. That's how it's working. I can tell you that it is shredding the safety net in our state. Our hospital is going under water because the funds that are being diverted from free care to pay for this program are going from our public hospitals and clinics but our patients are not actually getting covered.

Our governor said every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of care will be reduced, and the Times said the bill does what health experts say no other state has been able to do, provide a mechanism for all citizens to obtain health insurance. Now we've heard that before in our state, Governor Dukakis on the eve of his presidential run passed a bill, said I am very proud of the fact that Massachusetts will be the first state in the country to enact universal health insurance, and the Times said Massachusetts last week ventured where no

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state has gone before, guaranteed health insurance for every resident.

Employer mandate and a mandate that the self employed buy coverage, so an individual mandate as well. Here's what happened with the Dukakis bill, this is the curve of the uninsured in our state. We have never had as few uninsured as the day the Dukakis bill was passed. Cost run, sustainable, eventually the mandate was repealed and the subsidy for the low income was repealed. We're already 147 million dollars over budget for those subsidies in our state this year.

Now, Oregon passed a similar program in 1992 and the governor said today our dreams of providing effective and affordable health care to all Oregonians has come true, and the Post said the most far reaching health reform in the nation, here's what happened in Oregon. In Tennessee the governor said we've passed the most radical healthcare plan in America, Tennessee will cover at least 95-percent of its citizens with health insurance, by the end of 1994. There's what happened in Tennessee. In Vermont, the governor running for president said this is an incredibly exciting moment that should make all Vermonters proud, and the Times said Governor Howard being the only governor how is a doctor, signed a law here today that sets in motion a plan to give Vermont universal healthcare by 1995. There's what happened in Vermont. In Washington state, employer mandate and individual mandate on the self employed.

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The Times said Washington's new state passed one of the most aggressive healthcare experiments in the nation, a program that would extend medical benefits to all 5.1 million residents of this state. There's what happened in Washington. I'm sorry I'm getting dull. [Laughter] In Maine, the governor said it's bold and comprehensive, it's the law and the Washington Post said Maine has just become the first state in the union to approve a plan to provide universal access to affordable health insurance, how quickly they forget. And here's what's happened in Maine.

Well, let me just end with a very brief thing saying I'm not completely out of my mind. This is a Boston skyline as seen from our Cambridge side, those are our two tallest buildings, that's our John Hancock on your left and Prudential on your right [laughter] and the money we need for national health insurance comes out of the pockets of folks like this, and that's the political problem. But if you ask Americans what they want 64-percent of us say we want national health insurance.

Now if you ask Canadians, by the way the symmetrical question, would they like a US style system, 3-percent would prefer it, which is their illiteracy rate. [Laughter] And just to end, here's how we've been making policy in this country, instead of building the fence that keeps people from falling in when they park their cars on this dock next to the

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water here, we send tow trucks to haul them out [laughter], instead of doing it right the first time but that can get you into trouble. [Laughter] But the American approach, there's always a bigger tow truck but [laughter] even that can get you in trouble.

If you keep getting the same thing over and over again and you expect different results, that's either insanity or fraud. And I guess the question is from the Democrats, are we getting insanity or are we getting fraud. We know what their proposing doesn't work, I think the Republicans self consciously know what their proposing doesn't work. And the issue before us is are we actually going to do something that can fix our healthcare system or will we persist in non-solutions. I thank you very much. [Applause]

PETER GRANT: And he was funny too. [Laughter] I'm going to do something radical because we have time issues and we've had people from states coming through snow and trying to get here for this panel on the states, so I'm going to invite you if you need to go to the bathroom, you need to get a cup of coffee, run out and get one, we're continuing. Is Diane Rowland here? I hope. In the audience. Yes, Diane, if you wouldn't mind coming forward and making your presentation.

Diane is Executive Vice President of the [inaudible] J. Kaiser Family Foundation. An Executive Director of the Kaiser Commission on Medicaid in the uninsured. She also was staff on

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the step committee on health and the environment of the committee of energy at the House of Representatives, and a senior policy official at HHS, that is HIPFA, the predecessor to CMS.

So, she is going to start our discussion of various state alternatives and options. Diane, I'm sorry I had you follow David Himmelstein, he's a very funny guy but, thanks for agreeing to speak.

DIANE ROWLAND, SC.D.: Oh God, I certainly hope that no tow trucks get a following off the presentation while I'm doing this talk. They promised me a break but instead we'll proceed and I guess this is the slide remote so I hope I can work it.

Well I'm very pleased to join you and to talk about the role public programs currently have in some of the health reform efforts. I think David's given you quite a overview of where the state efforts are so I will try to not repeat some of what he said, but I think it's important to go back to the beginning and look at where we start from in our healthcare system. And my task assigned to me was to look at the role Medicare and Medicaid may play in health reform efforts.

And I know you've been through a very long conference already and you've probably heard everything five times over so that's one of the disadvantages of speaking at the end. But let me just start by pointing out that Medicare still is the basic social insurance program for elderly and disabled people.

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And if we look at the distribution of our population about 14-percent of all Americans count on Medicare for their health insurance.

Medicaid and SCHIP together with other public programs provide coverage to our low income populations and represent about 12-percent of the coverage for the American population. But that leaves us with the declining employer based coverage with about 16-percent of our population uninsured, 47 million people. And as I'm sure you've heard throughout this conference, many who have coverage are increasingly finding that coverage inadequate to meet their healthcare needs, or as David just showed you, some may have deductibles so large that they're in affect uninsured for the most basic healthcare services they need.

When we look at the challenge of trying to provide health insurance coverage we see that while it's a national problem it differs substantially among the states and many states have a much harder road to hoe if they're trying to get above coverage to their universal coverage level for their population. And I think you can see clearly that the states that have been out there leading the way, if you can call Maine and Massachusetts and other efforts at least making an attempt to get to universal coverage, are the states where the uninsured is the lowest. Whereas some of the states with the

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most daunting challenges like California have been struggling to try and put together a proposal.

If we think about the uninsured and we think about who we are, I think there are three components of the uninsured population that give a reason to look at public programs as part of the building block for reform. First, working families are the mainstay of our uninsured population. They work at jobs that are too low wage or don't offer health insurance coverage for their workers so that these families, 82-percent of Americans families who are uninsured come from a family with a full or part time worker. So we really need to think about how the workplace interacts with health insurance coverage.

But second and probably most important is that the lack of insurance is an issue of affordability. Two-thirds of our uninsured population come from low income families earning less than \$40,000 a year when the cost of a family health insurance plan is \$12,000 a year, it's not rocket science to understand why these families remain uninsured.

And finally we talk a lot about coverage of children and they have been a main priority in trying to get broader coverage. They make up 20-percent of the uninsured population but our real problem in uninsurance is that public programs don't do very well by adults, they tend to favor children and leave adults behind and the bulk of our uninsured population

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tend to be adults under the age of 65 because they aren't yet eligible for Medicare.

If we look at it a slightly different way, in terms of where could public programs play a better role, I think that it becomes quite clear that if you look at the combination of low income and family characteristic, you see that in the current system our Medicaid program and our SCHIP programs could help provide coverage to about 14-percent of the uninsured that are below 200-percent of poverty and children. Yet lags substantially behind in being able to help the parents of those children or the low income adults without children who are currently ineligible for Medicaid coverage and matching funds unless the state has obtained a federal waiver.

So that we look at the share, the pink and then the yellow as possible areas where broadened coverage for the low income population through public programs could become a major building block in helping to close the gap in insurance coverage for the population.

Now Medicare could clearly come in and cover everyone if we did as David might have liked us to do and just expanded Medicare to be a universal coverage for all Americans, a so called single payer approach. But what we seem to be as a nation as stumbling through our uninsured problems, we tend to do it in an incremental way and building on the public programs for the low income has become our major way for trying to build

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the foundation for health coverage. But I'd like to make sure you know that Medicaid alone does not just do health insurance coverage, it does cover 29 million children and 15 million adults and low income families and provides coverage to some other elderly individuals to help fill their gaps as well as persons with disabilities. But it's also a main source of coverage to Medicare beneficiaries, Medicare alone cannot provide adequate coverage for the lowest income population. Medicaid fills in those gaps and it's obviously the only program in the nation that really provides for long term care assistance. You will note the absence in all of the health reform proposals about any discussion of broadening coverage beyond medical care in health insurance to the long term care issues that our nation continues to face.

But I think the piece that let's Medicaid be a major building block is it provides substantial support today to public hospitals, to clinics in the healthcare safety net and is also the major source of revenue from the federal government to the states so it is majorly financing much of state reform activities. So when we talk about what the states are doing, we need to remember that they're doing it building upon federal dollars that match their state dollars through the Medicaid and SCHIP programs.

If we look at Medicaid as well, and this is kind of the commissions favorite slide, it's important to remember that it

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doesn't cost Medicaid a lot to do its role as the health insurer. Children account for 50-percent of its enrollees but only 17-percent of the costs because the major costs of Medicaid go for the elderly and disabled for its role in long-term care and its role in helping people with disabilities. So that if we look at Medicaid as an expansion program for covering people with health insurance, we're not looking at extending the program in its most costly directions.

And finally, I would say that it's important to think about how we get to broader coverage for the low income population. And here you see that while children have a much more likely if they are poor, near poor, relationship with the Medicaid program, there are still many children who remain uninsured. When we look at this issue, its really to look at the issue of eligible but not enrolled. How do we do outreach? How do we find these children and how do we get them covered? But when we look at adults, when we look especially at parents, we see that for them much of the issue is that they're not even eligible for the program, as I'll show you in a moment, and when we look at adults without children we look at a federal law, Medicaid, that was based on the Elizabethan poor laws that said if you're an adult with dependent children you're eligible for coverage but if you're a single adult no matter how poor, unless you're disabled your ineligible for Medicaid coverage

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and for federal funds to the state to match any expenditures the states may make on your behalf.

As a result over time, Medicaid has really grown to be predominantly a program covering America's children. Today one in four American children get their health insurance coverage through Medicaid or SCHIP. There's been a lot of debate and discussion recently about reauthorization of the SCHIP program and in many of those discussions it's appeared that SCHIP is really the dominant source of coverage for kids. We like to show this slide to show you that it's really Medicaid that's picking up the bulk of our low income children and SCHIP is supplementing that but certainly we are not seeing SCHIP as the vehicle that provides universal coverage to children and right now, of course, the debate is over whether it can even be extended and how much it will be extended.

And I think that if you look at the progress we've made though that we can see that when we expand public programs, when we give low income people broader access to coverage, especially for their children, they do take it up and it does make a difference. And I like to show this slide to show you that there's been virtually no progress in reducing the number of children who are uninsured over 200-percent of poverty or over about \$40,000 for a family of four, compared to the notable progress that the expansion of Medicaid and the

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implementation of SCHIP have made in reducing the uninsured numbers among low income children.

And this largely because with the SCHIP enactment states really did go broadly to try and improve the income eligibility for children mounted substantial outreach campaigns and really began to embrace this as part of at least a strategy to provide universal coverage and near states to children. But coverage of parents lags substantially behind as you saw some 11 states had covered children above 200-percent of poverty, here you see that only 16 states cover parents at poverty or above. So we have very low income eligibility levels for parents and lack of eligibility for most childless adults.

We also have within the public programs an issue of course with children about finding an enrolling children. We know that when you cover their parents you are more likely to pick up the children as well. So some of the strategies and building blocks that can be used on the Medicaid side are to actually extend broader coverage to parents so that their eligibility matches that of their children. And here you see that of the eight million children today uninsured we estimate that about three quarters are actually eligible already for public coverage but are not being enrolled, not being signed up for that coverage. And so one of the goals of much of the reform effort is to do broader outreach and better enrollment of those children.

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But you see on the flip side that when you look at parents, and other adults, most of them are actually not eligible no matter how low income for public program assistance. So there the real challenge is to change the eligibility levels and to help match them to children and then to help do outreach and broader coverage. And that becomes then the building block for most of the state reform efforts.

So what we see today is that most states have returned to a relatively better economy than they faced before, although the economic news coming out is now we may be headed for another downturn, which could really thwart the efforts of many states to broaden coverage. But in our most recent survey of state efforts to look at Medicaid and SCHIP coverage for the low income population, 42 states reported to us that they have plans to both expand healthcare coverage basically using Medicaid to improve outreach and enrollment, improving SCHIP coverage as well for children, and even moving beyond that broaden coverage for parents. And in terms of that I think it becomes the building block then that could be there for national reform.

And what you see, although the efforts wan with the economy going down, but you do see now that 12 states have proposed universal coverage and have task forces or other initiatives that are working toward universal coverage, three states including Massachusetts, Maine and Vermont are the three

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states up there near the Canadian border so maybe it's the Canadian influence that's come down, have actually enacted proposals for universal coverage for their population.

And what you see in these proposals is that all of them led Medicare in tact and count on Medicare to provide coverage to the elderly and disabled and then use Medicaid to provide expanded eligibility and increased outreach. They use it as a financing vehicle Medicaid has disproportionate share hospital funds that have helped support the safety net, the pool that Himmelstein just talked about, that can be reallocated to help provide broadened health insurance coverage and some can be left to help maintain a safety net.

And finally they use federal funds and draw down more generously federal funds by doing things like raising provider payment rates under Medicaid so that they're bringing in more federal funds to help support their efforts. And this was a key issue and a key element in the Massachusetts health reform plan. We like to think about it and we hear about it as the state did this big initiative, well the state couldn't have done what it did without a substantial infusion in federal funds. And it has a lot of elements going to it but the underbelly of this program is the public program expansions and the coverage to the lowest income population under 300-percent of poverty through expansions of Medicaid, through using Medicaid funds to subsidize the insurance coverage for people

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under 300-percent of poverty, and then trying to build upon that to then do the mandate for people above 300-percent of poverty.

And if we look at this slide, we just see how you put these pieces together and how state efforts are really built upon the base of these public programs. Those who get coverage through the Medicaid expansion are show in the yellow square in the proposal but all of those getting the subsidized coverage are dependant largely on Medicaid funds to help finance the subsidy that will enable them to sign up for health insurance coverage. And you see that very broadly in this one where you see that out of all of the funds that Massachusetts was counting on to finance its reform plan, over half of those funds came from increased federal dollars coming either from the reallocation of their Medicaid disproportionate hospital share funds or from broadening Medicaid payments for providers so that they could draw down more federal funds or through Medicaid expansions.

So when you hear about state reform efforts, always look to see where the dollars are because follow the money is a really good story of how you look at and see what the structure is if any financing reform. Whether those monies will continue and whether they will be adequate is of course the real challenge that faces any state, especially when they're building on a one time only reallocation of the

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disproportionate share funds which only last two or three years. Well Massachusetts state had said be able to step up to the plate and continue to finance coverage for its lowest income population.

And I think that we've seen and he gave you a better update than I will on the progress, but there are people enrolling in the public program expansion, there's been tremendous outreach there and substantial uptake enrollment. The commonwealth care which has the subsidies is also seeing some increased enrollment but we don't really know yet how many people have taken up the commonwealth choice plan, it's a small share right now but many may have instead opted to get their coverage through their employer who had previously declined employer coverage. Now Massachusetts is clearly a work in progress and everyone is watching it and looking at it and trying to determine if it's going to be the model for the next wave of reform. And as I'll show you in a minute it has become the real building block that all of the Democratic candidates have used in putting together their reform efforts except for Dennis Kucinich who opts of course for single payer approach.

And we see this because as the Presidential '08 election heats up, national interest in health reform is growing. And I think one of the telltale signs here is that it's not just growing among Democrats and Independents, but it's also been on the rise among Republicans so that as we

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listen to some of the debates, if we've seen some of the candidates go forward they've begun to talk much more aggressively about healthcare than anyone would have predicted in this election.

In much of the polling work that we do healthcare has now become the top domestic priority in the '08 election and follows very closely behind Iraq as the top overall priority for the American public. And so as a result we see the candidates beginning to mount major proposals and trying to take an approach but I think that the takeaway message from the candidates is one side favors building on the existing system, leaving things pretty much as they are for most who have coverage and then broadening coverage for others, utilizing a Massachusetts type model as its main focus. And the other side sees following the proposals that President Bush has put forward to really radically restructure how we get and use our health insurance through reforms to the tax code that would change where we get our coverage from, a shift away from employer based coverage to more utilization of the individual market.

So Democrats are generally favoring the concept of universal coverage, getting to 100-percent or 90-percent or somewhere toward universal coverage. Strengthening the private employer based system, so keeping more people in employer based coverage, broadening employer based coverage, expanding the

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role of existing public programs, so really using public programs as we've seen in the state efforts for the building block, and then using purchasing pools and insurance market reforms to try and make availability of coverage more accessible to people and more affordable to people by having group pooling instead of reliance on the individual market. And putting in mandates on both individual and employers to try and close the gap in who has coverage in moving toward universal coverage by requiring everyone have it. And they're all talking about various ways of cost saving in their proposals but the predominate way they're financing much of this is by rolling back the tax breaks that have been enacted for the wealthiest Americans.

On the flip side, the Republicans have generally been favoring tax incentives for the purchase of health insurance, expanding the individual insurance market, limiting the role of public programs, giving more state flexibility, perhaps even, some have proposed block granting the Medicaid program to give states more options of how to use Medicaid funds, going to more consumer directed plans with high deductibles, some with savings account proposals, some with just moving toward more skin in the game per consumers, and more deregulation of the insurance market.

So as you can see from just a simple comparison we've done of some of the major candidates, there's not a lot of

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overlap in the way their proposals are being advanced. And as we've also seen from the SCHIP debate that's gone on over reauthorization, we are increasingly seeing an ideologic divide between how to approach broader coverage for the American population and even now are debating at what level should the poor be defined so that they can't get coverage from public programs above that, how can we use more tax incentives to put people into a position where they are making their own choices about healthcare coverage rather than government regulation and government purchasing power.

And you see in the candidates really this divide between individual mandates and employer mandates. No one on the Republican side is proposing that, you see public program expansions as a building block. On the Democratic side you see more flexibility to states and more use of tax incentives and high deductible plans on the Republicans side. And even a divide over how well the insurance market should be regulated.

So I think what we're going to see as the election plays out is a real debate over how we want to move forward on healthcare reform in this country. It's a debate that's defined over to the right of where your previous speaker was because on this forum you hear almost no one except for [inaudible] a candidate talking about moving the broader single payer approach. Though I would note that both Edwards and Clinton have put into their plans a provision where among the

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choices you would have you could go with a public plan instead of a private insurance plan. Edwards argues that at some point let people vote with their feet and if they all choose to be in a more public Medicare type sponsor plan that would ultimately move us down the road towards single payer.

But what we're really seeing is that you have incrementalism on the Democratic side and kind of radical reform on the Republican side but its reform toward the market and reform toward use of the tax code and less about building on existing programs.

Now the one program I didn't mention yet in this whole health reform thing is Medicare. Virtually all of the candidates at this point in the election process leave Medicare untouched. If you've got Medicare you stay on Medicare, you have Medicare as your source of coverage. Many of the Democrats talk a little bit about broadening the option for people in the 55 to 64 year old category who may not have employer based coverage to be able to buy into Medicare for their retiree coverage, and so that's one approach of building on Medicare. But most of the debate is really about what you do for the under 65 population and most of the debate is over what the role of public programs is versus private health insurance. I think however that as this debate unfold Medicare as a social insurance program is being also pushed towards more deregulation, more private insurance approaches, we saw that

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with the implementation of Part D. So I don't think that you can say that as these reform proposals unroll that you will not be seeing more and more discussion at some level about changes in Medicare.

However I do believe that Medicare is a third rail in politics and so in '08 most of the candidates are not going to be talking about anything that would be perceived by elderly voters to be a dismantling of the Medicare program, yet I think it will ultimately be a part of the discussion about how you put together broader health reform proposals.

So in conclusion, I would just say that if you look at what's going on in the health reform debate between those of the Republican and Democratic side, you really see a very big difference in how Medicaid and Medicare may fair after the '08 election, as in '09, the beginning of putting together a real health reform proposal takes place. But in all of the efforts I think Medicaid provides such a broad base now of coverage, especially for children, that it will obviously be a building block depending on how the debate goes, though it may be a building block that is changed dramatically or a building block that is strengthened.

The SCHIP reauthorization debate has indeed raised questions about the role of public programs and what we should do in terms of what level of income is the right level to provide public program assistance, what the scope of coverage

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of public assistance should be and how public assistance should be used versus tax credits for coverage. And I think in the coming months you're going to see a lot of debate about these issues, especially as the candidates get down to going beyond the issue of rather Hilary Clinton or Barrack Obama is going to get to universal coverage, it will be broader than the choices that we're going to make between candidates. But in all of this the role of public programs is undoubtedly going to be critical because that's where much of the financing for health reform is today. Thank you very much. [Applause]

PETER GRANT: Yes.

JENNIFER GUTRIER: Hi, Ms. Rowland, my name is Jennifer Gutrier and I work for Parkland Health and Hospital System in Dallas. I want to thank the Kaiser commission for your website, health08.org. It's been incredibly helpful, we've been distributing that information throughout the hospital, I also teach at a university and I've, that was part of the requirements of my course this semester was to keep up with the candidates. I was wondering, are you getting many hits on that website and are you getting a lot of feedback because it's really incredible if you folks haven't looked at it. Absolutely great comparison of all the candidates, their positions and it also has candidate debates and, pardon me? Oh, health08.org, is that it? Yes.

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DIANE ROWLAND, SC.D.: Yes, you can reach it through health08.org or through the kff.org website or Kaisernetwork.org website because we obviously have them all cross there. What we've tried to do there is to cover the candidates so that you can get clips as you said, of their speeches, if they've done a speech on healthcare or made a general comment. But we also put together, I abbreviated it very highly here, but we have put together a side by side comparison of the candidates and you can go onto the website and you can pick, there's a lot of candidates beyond the one's I've summarized here and you can pick the four you want to compare and then get a side by side comparison of those four and print that out or do whatever. And we did do those comparisons, it's kind of hard, these plans are pretty sketchy and I think if you listen to the presidential candidates there's a lot of, the devil's always in the details and there's not a lot of details on the plans. But what details there were or what statements were made we tried to put into this side by side and then we did send that to all of the campaigns so that they could review their individual statements to try and see if we captured it. And we've had a very good response to the website and we're getting a lot of hits on it and I assume as we go down the road we'll continue to get more. And I hope if any of you have comments about it can be more helpful, you'll let us know.

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DARCY DANASEVER: I'm Darcy Danasever, I'm with a consortium of community clinics and community health centers in Minnesota. The prior speaker referred to how in his opinion the Massachusetts program was "shredding" the safety net there. I wonder if you also see that happening and if so that, will it might happen more broadly as more states undertake reform efforts like that one.

DIANE ROWLAND, SC.D.: I think his point is very well taken. Part of how the safety net gets its support is through Medicaid individuals like clinics who come in and get reimbursed by Medicaid. That part of the safety net is not going away and has continued but where the safety net was dependant on hospital disproportionate share payments and the upper payment limit money, much of that is being used by this administration in their granting of waivers to be reprogrammed from dollars that help subsidize care for the uninsured at safety net facilities into private health insurance products instead. And so if the patients continue to come and the money's been gone off to a private health insurance plan then you're not necessarily getting the coverage there that those dollars used to provide.

And I think where it really played out most dramatically as a battle between the administration and the state was in Louisiana over what would happen to their disproportionate share hospital funds that had gone to support

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the Charity Hospital system when Charity had to close in New Orleans and the administration wanted all of that money to be reprogrammed into private Blue Cross Blue Shield insurance products and the state was arguing that they wanted to do a Medicaid expansion and cover people at a higher income level under Medicaid and then use some of those other funds to continue to support the safety net.

So I think if you look at Medicaid waivers, you begin to see the danger of taking the monies that have currently supported the uninsured and using them for private insurance products that may or may not provide any patient revenues to the safety net facilities. And so I think that's what David was referring to.

MICHAEL JACOB: Good morning, my name is Michael Jacob from Wisconsin. I wanted to echo your points about capturing adults through Medicaid. In Wisconsin we have in our SCHIP program, Badger Care, two-thirds of the enrollees are adults and so while you capture the children by going to the adults in some ways you can use the child program to find the adults you'll capture them. So that has worked very well in our state, also-

DIANE ROWLAND, SC.D.: And we're very glad that you did that because we constantly refer to Wisconsin as an example of why covering parents helps you bring in the children.

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MICHAEL JACOB: And if you look at our uninsurance rate, 9-percent, it's working very well. So thank you for those references. We have also just extended Badger Care to Badger Care Plus and for those folks who are sitting in a political situation like we have, a Republican controlled Assembly, a Democratic controlled Senate, we had a moderate Democrat in the Governor's office; it's set up a situation where SCHIP would be the middle ground but the Governor sees the opportunity to move that center toward expansion so when the Democrats fought very hard for universal coverage and the Republicans fought hard for health savings accounts, instead of winding up Badger Care we expanded Badger Care Plus to make it some premium assistance to buy into the program instead of ending at status quo we ended with a very helpful expansion.

My question is in Wisconsin we see not so much awareness of the program or eligibility of the program as the main hurdles, but the verification and the paperwork and the processing that goes in and the anger and the hatred and the fear that comes out of working with undocumented immigrants effectively keeping out their citizen children from enrolling in our programs. And so I wonder if you have any advice for states on easing the documentation, the verification burdens for people who are eligible to actually get enrolled.

DIANE ROWLAND, SC.D.: Well we certainly think that the implementation of the citizen documentation requirements has

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been a real set back for the efforts at the state level to simplify enrollment, to provide more incentives for families to come in. But I think one of the things that we, and so we hope that and hope that in the SCHIP reauthorization they might have been changed to be simplified or at least eased somewhat, I think that the prospects for that happening in this current session of congress are now pretty slim given that the legislation seems to be totally stalled, although I'm told the House may move another bill this afternoon, so we'll see.

What I think the real challenge is, is that as I watch the '08 election heat up, immigrants have become sort of one of those red kneed issues that no one wants to touch and that really is a, it's building up a sentiment, I can only equate it to years ago the same way in which abortion played in the debates and in the discussion of where we were going on healthcare and were we covering abortions or not covering abortions. And it's that kind of, if you cover immigrants, you've made a morally bad choice. And I thought it was very interesting in our, we did a number of forums that were sponsored by Families USA and the American Federation of Hospitals with the Presidential candidates in our building where four reporters would be interviewing them and asking them questions, and literally none of them wanted to talk about covering immigrants in their health reform proposals because

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they said this needs to be dealt with in immigration policy not in health policy.

So I think the documentation requirements may unfortunately be with us for a while to come and probably not very simplified. But I think it has been proven clearly by the states to be very counterproductive to their efforts to try and reach the eligible but not enrolled population.

Thank you. Thank you very much. [Applause]

[END RECORDING]