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Former Governor Mitt Romney (R-Mass.) Outlines Health Care Plan Florida Medical Association August 24, 2007

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[START RECORDING]

[Applause]

FORMER GOV. MITT ROMNEY (R-MASS.): Thank you. Thank you. Thank you, Dr. Rubenstein. I appreciated that generous introduction. It is an honor also to have President Cecil Wilson here, the President of the AMA; to have Pat Hutton here, who has a striking resemblance to Teddy Roosevelt, your current President; to Karl Altenburger, who will be assuming the responsibility of the Presidency of the FMA this coming year; Rick Lentz also, who is the individual in my campaign here in Florida who manages my effort, particularly with regards to the health care community. So I hope you all get to know Dr. Lanz. And finally, I would like to have a special person stand up, the young lady I fell in love with 40 some odd years ago — have been married 38 of those years — my wife, Ann. Ann?

[Applause]

Thank you. Now, there was a bit of irony in the fact that I am addressing you. Here I have a room full of doctors and health care professionals, and I'm talking to you about health care. And I am used to somewhat this unusual setting, where I am placed in a position where my skill is overwhelmingly overshadowed by the people whom I'm addressing or I'm responsible for.

When I went out to run the Olympics, as Dr. Rubenstein indicated that, you have to understand that my boys felt there

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was a certain degree of irony in that and that was I was not a fabulous athlete. And so when my five sons heard that I was going to run the premiere sporting event in the world they acknowledged the irony, but when they saw it in the paper my oldest son called and he said, "Dad, we saw the paper this morning. The five brothers and I have talked. We want you to know there is not a circumstance we could have conceived of that would put you on the front page of the Sports section." [Laughter]

So there are unusual circumstances to put me before you today, but I have a pretty significant agenda I want to talk to you about because I think there are changes needed in our health insurance world that will make a world of difference for the people of our country. There are a number of things I would like to see have happened. One is I would like to make health insurance more affordable. There are a lot of families in this country that are finding it harder and harder to afford health insurance. I was in Massachusetts and met a woman named Linda DeWolfe [misspelled?]. She runs an auto repair shop there with her husband. She said they were having a very difficult time buying insurance for themselves and their employees. It was simply getting too expensive. We need to find a way to reign in the extraordinary growth in the rate of health insurance cost. Secondly, I would like to provide access to quality health insurance for every American. I would

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like to see every American have insurance that is affordable, every American.

[Applause]

And let me just note something. The 45 million that don't have insurance in this country represent a small section of those people who are worried about losing insurance, because if there are 45 million without insurance, there are a lot of others who think, well, gosh, I could be in that position as well. That fear of losing one's healthcare, health insurance, is something Americans shouldn't have to feel. And there is also a problem with having 45 million uninsured, not just for those that don't have the insurance but for everybody, because the 45 million who don't have insurance, if they get sick, they go to the emergency room for care, and that's not ideal care, as you know. It's not the preventive care they need. It doesn't get them the prescription drugs to stave off an acute condition developing from a chronic condition. And the cost of the health provided there at the emergency room is not paid for by them because they don't have insurance. Who is it paid for by? Well, by the people who do have insurance. So not having insurance is not good for them, doesn't give them good quality health care, and it is not good for everybody else because they're having to pay for it through their taxes or their premiums. The problem of the uninsured is a problem for all Americans.

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There is another challenge. Portability. People are fearful that they might lose a job. If they lose a job, they might lose their insurance, particularly if they have a pre-existing condition when they go to get the next job. That shouldn't be something that Americans have to worry about. And finally, we need to find a way to reduce the rate of growth of spending in health care in our country. It is now 17-percent of our GDP. When I was a consultant in the insurance industry some years ago, the 1980s, it was 11-percent. The idea it would get to 17-percent was unthinkable, and it continues to move northward. Now, I know some people look at that slide and they say, that guy must be a Democrat up there. This is a Democrat issue. You're wrong. Health care is not a Democrat issue. It's a Republican issue. It's a Conservative issue. Democrats look at problems like this, and they have one answer. Government. We need bigger government, they say, so we can manage problems like this. That's the wrong answer. Conservative principles have the answer for health care. [Applause]

I think I'm going to be able to demonstrate to you today the conservative principles of personal responsibility and free market dynamics and choice and personal care. These kinds of elements allow us to reform health care in such a way that we can solve the problems that America faces in health care without having a government takeover, without having

socialized medicine with all its drawbacks and all its weaknesses.

Now, you might also say, yes, but getting there is going to be awfully expensive, isn’t it? How are we going to get people insured if they are 45 million without insurance? Boy, that must mean you’re planning on writing a big check. Well, I’m not. And one insight — you already know this but a lot of people don’t — one insight I want to make clear. We have 45 million people. You will hear this all the time, forty-million people without healthcare. No, that’s not true. We have 45 million people without health insurance, but they have health care in almost every case.

[Applause]

If somebody, let’s say, has a heart attack in their apartment and they have no insurance, they get picked up by the guy from EMS. They’re taken to the hospital. They’re stabilized. Maybe they do a bypass surgery, put in a stent. They give them medication. They return home. They get ongoing care. So they’re getting health care. They’re just not paying for it. No insurance company is paying for it. Who is paying for it? Well, the rest of society is, the taxpayers, the people who are buying insurance. Everybody else is paying for it, the medical profession; everybody is paying for it, but not the people who are sick. So we have 45 million people without health insurance, but they are getting care. So the money is

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already there. It's already being spent. And wouldn't it be smarter to take the money that is being spent on programs and on cost shifting and use that money instead to help people buy their own private insurance, get them insured rather than just handing out care at hospitals for free?

[Applause]

Now, my thoughts about this topic really flow from the experience I had as Governor of Massachusetts. I was in office for a short period of time and a friend came in said, Mitt, why did you run for office? I said I ran for office because I want to help people. And he said, well, if you really want to help people, find a way to get everybody in our state health insurance. And I said, Tom, that can't get done. I'm not going to raise taxes. I'm not going to have a government takeover. I'm not going to put in place Hillary care. I can't get that done. Well, it began to grate on me. And I thought if I were back in my private sector job, I would be bringing in people of all different backgrounds and I would study this issue and see if I we could come up with some answers. Our first year of work didn't accomplish very much. Our second year, we had a brainstorm about what we could do to get everybody insured with private market-based insurance, not needing new taxes.

Let me tell you why we focused on the issue of health care reform in our state. We had 460,000 or so uninsured. Our

premiums were high, rising fast. If you lost a job, you were afraid of losing coverage. Individuals in small businesses were having a hard time getting insurance. It seems the insurance companies are really good at marketing and servicing big companies, big groups, but if you've got two employees, the insurances companies just didn't have much attention to pay to you. And we were spending about $1.3 billion in our state, giving out free care, payments to hospitals and other providers that were giving out free care and that number was growing. Those were the problems. We began by saying, just who the heck are the uninsured? We imagined that these are people who are poor and single moms. That's what we figured we had. How are we going to insure all those poor single moms? And we found, much to our surprise, that that did not represent our uninsured. Frankly, the largest group of our uninsured were people who were making $53,000 a year or more. For a family of four, that's three times the federal poverty level. These are people who could afford insurance. They just weren't buying it. That's 204,000 people. Low income, that's working poor that really would have a hard time buying insurance. That was about 150,000 people. And then, much to our surprise, there were 106,000 uninsured in our state that qualified for Medicaid but had never signed up. So as we looked at our population, we realized we were going to have to follow different approaches for the different types of people that didn't have insurance.

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For the higher income people, the people earning over three times federal poverty, we talked to them and we said, why don't you have insurance? And they had three things, roughly, that they said that stuck with us. One, was they said, it's just too expensive. And we looked at the premiums and it was expensive. They said, number two, if I'm working as part-time worker at multiple places, or if I'm working as a sole proprietor, it's hard to get an insurance company that will even talk to me. And number, three – and this was the most troubling of all – we heard a lot of people say, why should I buy insurance? If I get sick, I can go to the emergency room and get treated for free. Americans aren't stupid. If we're given stuff out free, why pay for it? So we recognized we had to make some changes, and one was to get the cost of insurance premiums down so people in the middle incomes could buy insurance and afford it. And deregulation and market reform was one place that we went to work. For low income people, we said we're going to put in place a principle of personal responsibility, insisting these folks provide what they can towards their health care, and the state is going to pick up the rest of the cost of their insurance premium. And finally, with regards to the Medicaid eligible, we put in place a portal on the computer that allowed hospitals and providers to instantly check whether someone was qualified for Medicaid, and if they were, we sign them up on the spot.

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Now, let me talk first about the middle income group and the market reforms we decided to put in place. I won't go into this in great depth, but the existing programs in our state have all sorts of regulations, and the reforms we made did a number of things. We combined our individual and small group pool so we could pool more individuals to be able to purchase insurance on a cost-effective basis. We expanded health savings account options. We encouraged provider networks — they had been discouraged before — and a number of other things that made us more competitive. Now, I would also note that I wanted to do more in terms of reforms. I wanted to get rid of all mandates, and the legislature said no. And because there are 86-percent Democrats in my legislature, they got the last word on that one. So we had some differences, but we put in place a number of reforms. And let me show what the impact was on premiums. I am going to use as an example an uninsured individual living in Boston, Massachusetts, 37 years old, male or female. As we began this program, the cost of the premium for that individual would be approximately $335 a month. The deductible was $5,000, and there was no drug coverage. Post reform, the column on the right, the premiums went down to $175 a month. The deductible was now $2,000 and prescription drugs were covered. So we got the prices down by deregulating our state market. But they said there was another problem. The other problem, I remember they said, is no one

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wants to sell to them. They had a hard time getting serviced. And so we talked to our friends at the Heritage Foundation, and they came up with a very interesting idea they had been working on. We initially called it an exchange then we changed the name to a connector, or the legislature did, called it a connector. But it basically was a little agency we set up that collected the premiums from individuals and passed it along to their insurance company. So we did the marketing and the processing with the little agency set up so that it could flow to and from the insurer and the insured. And it had one more very important feature and that's at the bottom of the slide. By flowing that through this connector, by flowing people's premiums through our little state connector, we were able to qualify under Department of Labor Provision Section 125, so that their premiums could be tax deductible. So an individual buying their own insurance in our state — let's say a pizza shop worker that wanted to buy his or her own insurance — was able to buy it. And by virtue of this little setup, buy it in federal dollar tax-free ability, and that made a difference.

[Applause]

Now, here comes the most controversial part of what we did. We said for middle income citizens, now that we've got your premiums down, in some cases cut by as much as 50-percent, and now we have got this connector so that you can pay for premiums in pretax dollars, and now we have insurance companies

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that are willing to deal with you even though you are a one or two-person operation, now that we have done that, why is it you don't have insurance? And we said, you know what? We're going to tell you, you either buy insurance or you pay your own way. No more showing up and getting free care. We said, the end to free riders.

[Applause]

And we call that mandate. We say, for people who can afford insurance, you either buy the insurance or you pay your own way. Now, my legislature made a little change there too. They just said, hey, buy your insurance. If you can't, pay your own way. I tried to change that, but we agreed to disagree. But in our state right now, you buy insurance if you are making three times federal poverty or more. No more free ride.

Now, how about low income people? What do we do there? Well, people typically, when they are thinking about low income folks, say, well, in order to get more of them insured, we've got to give more people Medicaid. And they go to the federal government and ask to put more people on Medicaid. But Medicaid is not a good insurance product. Medicaid was designed for the poor.

[Applause]

And you know some of the reasons. One is Medicaid is 100-percent free. Let's say you have a person that is making

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2.7 times federal poverty level. Well, is it fair that they don't pay anything, no part of their premium at all, no co-pays, no deductible, just entirely free? And by the way, if they suddenly earn a little bit more money, if their employer gets them an extra $500 a year — bingo, they are no longer qualified and they lose all coverage. So whoever is going to go over that level? And by the way, if you are single and earning just under that level, but if you got married that would push your combined income above that level. You would lose Medicaid, so let's not get married. Think of the incentives we had in our system. Medicaid is not the right way to help people, the working poor, get insurance. So we said instead, you know what we are going to do? We are going to help people buy their own private insurance, not Medicaid, not a government plan. Private insurance. Go the companies out there. Pick the policy that you would like. You pay what you can afford, according to our sliding scale, and we will pick up the rest. It allows a sliding scale of what they are paying, and, of course, a glide path to self-sufficiency. As their income gets up and up and up, they pay a larger and larger share, until finally they are paying the whole premium themselves. And the key thing here to make this work was this. We went to our friends in the federal government. We laid this plan out. We said, instead of putting more people Medicaid in the future, we can get people insured with private insurance.

But you know that money you send us to help care for the uninsured in our state? You know that money you send us? Would you let us use that money, instead of going to payments to hospitals and other providers, would you let us use that money to help people buy insurance instead? And Secretary Tommy Thompson and Secretary Mike Levitt, they looked long and hard and said, yes. And it was Senator Kennedy and I — we did this on a bipartisan basis. We needed those dollars, those federal dollars and our state dollars, our matching funds, to be allowed to help people buy insurance. And you know what? It cost less money to get people insured than it was costing us to hand out free care.

Now, let me just show what the schedule looked like to give you a sense of what people were paying. This happens to be for a single person, and it is actually a couple of years old. This is 2004 data, but it gives you a sense of it. Let's say somebody is earning $9,800 dollars a year. What they pay for their health insurance? They pay nothing. Now, again, here is another little difference between me and my legislature. I wanted them to pay like a buck a week, but they said, no, make it free. Well, they got the last word on that one. I thought everybody should pay something. But as you get a little higher, $14,700, people in that category, they are going to pay $18 a month. Not a lot. The state picks up the rest and so forth. And when they get above 300-percent, the

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person is picking up their entire premium. And, as a result, people have an incentive to keep getting higher and higher incomes, and they are paying for the portion of their premium, which they can afford.

Now, a couple of things. We didn't blow up the system that already existed. We wanted to make sure we did no harm. Most people get their insurance through their employer. We didn't want to end that, so we kept that program in place. So employers remain a cornerstone of health insurance in our state, but the individual market, people buying their own insurance, is now an option. Medicaid rate increase was given to doctors and hospitals to address the problem of cost shifting. [Applause] Cindy helped me on this. I think we went from 70-percent of the Medicaid rate for Medicaid. We went from 70-percent to 95-percent. [Applause] So moved the reimbursement rate up to end the problem of the cost shifting we had. And we also improved rates for community health centers. We needed more clinics as part of this plan. And we put in place a series of cost and quality initiatives, health care initiatives. One, we established a site for transparency information. We put in place prevention programs for a number of serious diseases and a very substantial public health awareness program. So it was more than, if you will, just the care for the uninsured that were part of our plan.

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And how are things going? Well, it's early to tell, but I like the signs. First, for the people who are Medicaid eligible. We had 106,000 of those, remember? We have signed up approximately 70,000 of those, so made real good progress getting them signed up. People that were the working poor, one to three times federal poverty level, we had about 150,000 of them. Approximately 105,000 have signed up. These are people who were uninsured are now insured. That means they see a primary care physician. They get to a clinic. They get preventative care. They get better health care. And they are now paying a portion of their premium. Don't forget that. I didn't make that point as I went back here. See those dollars there, $18, $40, $70? These were people that used to just go get free care. Now, they are paying something. Now, they know that their health care makes a difference to their pocketbook. They are part of the system. That is part of the revenue that came in. No more free ride. Everybody pays what they can afford.

And the final group, which are people earning over three times federal poverty level, the teeth in our enforcement mechanism don't kick in until probably next April, when they get their tax bill. Because if they haven't bought insurance, they are charged $100 a month for not having bought insurance. So that is just getting started. [Applause] We are getting people on their way.

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Couple of principles. One, you have got to reform the insurance market to get better products available to the consumer, lower price products. Two, you have to have non-discriminatory tax treatment for individuals. And that's why we put that connector in place. [Applause] You don't want to have companies getting a better deal. We felt it was important to help low income purchase private insurance not government care, and we used the money we were already spending to help care for the uninsured. We used that money to instead help people buy their own insurance. We brought everybody into the system, and we created a mechanism to control cost and provide sustainability in the system.

Well, the nation has some challenges too. And I am going to draw from the learning of my Massachusetts experience and apply what I think we ought to do as a nation. First, you know the cost of health insurance is rising sharply here as well, across the country. I was in Manchester, New Hampshire not too long ago, and a young woman named Michelle Griffin, who is a waitress behind the counter, said she was insured. Both she and her husband work. They both have insurance, but she said the deductibles and the co-pays and the cost of premiums were basically getting beyond their reach. They had a child or two that were sick. And she said, we just can't make ends meet any more. And she was highly emotional. And I understood why. There are people all over the country wondering, with premiums

getting higher and higher and higher, how can we afford to keep our health insurance, but how could we possibly not care for our children? So we have got to find a way to get the cost of health insurance down. We have approximately 45 million people without insurance and that's a number which is frightening, not only for them, as I have described, but for others who think they might fall in that category some day. There are a lot of people who fear that if they lose their job and particularly, if they have a pre-existing condition, that they are not going to get reinsured somewhere else. You have some employers around the country that think it is just too expensive. I can't keep up. Like the DeWolfes, I have got to drop coverage. And, finally, you are seeing spending at 17-percent of GDP.

Now, as we think about health care reforms at the national level, we have got to be careful and deliberate. The work we did in Massachusetts, we didn't get a bunch of politicians in a room and say, who wants to do this? This would be popular. Here is an idea that will go over well with the media. No, I got the head of a consulting firm. I got an old partner of mine from the venture capital world. I got an investment banker from J.P. Morgan. I got a professor from MIT. We worked with doctors, hospital administrators, other health care professionals, actuaries from the insurance world. I worked with some people who had government experience. A couple of them are here today. We worked together with folks

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to make sure that what we did was done deliberately and carefully, not stepping in to blow up a system where, in our state, 93-percent of the people had insurance. We didn't want to ruin that system. We wanted to care for the 7-percent, not take the whole thing apart to solve the problem of the 7. And so, as you think about what we have to do nationally, the first rule is, first, do no harm. Don't blow up the good we have in our system.

[Applause]

We have the best quality health care in the world. That we have. We are not going lose that. We are also the innovation capital of the world for health care. And we have positive cures and outcomes, which are the envy of the world. The medical profession does attract from among the best and brightest in all different levels in the medical field. Individuals have a choice and are able to guide their own care. Health care is provided access in rural markets. We want to make sure that that continues in our country. We don't want to destroy the large employer market. We have got a lot of people that get their insurance from their employer, and they are happy with that. We don't want to blow that up. And, finally, we do not want to have Europe-like rationing, telling our people that they can't get the care that they need and they afford.

[Applause]

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Now, my experience is that effective health care reform that is going to reduce cost and get more people insured has to begin at the state level. Now, why do I say that? Let me show you some information. It will be hard to pick it all out here, but this shows the average annual health insurance premium by state in the individual market, meaning non-family, but individuals. And just to give you a sense, California is less than $2,000 a year for an individual. New Jersey is over $6,000 for an individual. Florida is just under $3,000 for an individual. And Massachusetts, by the way, we are up there. We are that bright yellow. We are also one of those over $6,000 states. That was before our reform. So very different insurance prices in different markets. And why are the prices so different? Well, because the insurance market has different mandates and regulations and requirements, and as result of those differences the price of the policy is dramatically different.

What other differences between states? Well, the-percentage uninsured is quite different. In my state, it was 7-percent. In Texas, it is 25-percent. So what works in Massachusetts probably won't work in Texas. It's going to need a different plan. And in Florida, you are approximately 20-percent uninsured. So you are seeing some pretty big variations between different states. How about the-percentage of population over 65 years of age? Again, yes, you have a

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significant number there. And then we turn to-percent receiving Medicaid by state — Maine, Vermont, Mississippi — over 20-percent of the people are receiving Medicaid care. You are somewhere between 10 to 13-percent that are on Medicaid. And so as I look at that and consider the experience I have had throughout my life, I recognize that the principle of federalism that Teddy Roosevelt fought so hard for is needed in health care. A one-size-fits-all national health care system is bound to fail. It ignores the very dramatic differences between states, and it relies on a Washington bureaucracy to manage. You think about this. I do not want the guys that ran the Katrina cleanup running our health care system.

[Applause]

So in my review, health care reform has to take a federalist approach. And the federal role, therefore, is to facilitate and encourage reforms, like Tommy Thompson and Mike Levitt did for us, giving us flexibility in our funding so we could create our own program. But we don't mandate those reforms. We let states decide how they are going to craft their own program. States are able to craft programs that match their unique needs and, of course, we let states remain as the laboratories of innovation. And by the way, I like the plan we came up with in Massachusetts. I wouldn't be surprised if some other states say, I like that. We are going to copy it. And I would be proud if they did. Some states will find

they have got better answers than we came up with, I'm sure. And if they do, hats off to them. We'll all copy them. But I like what we came up with. But I'm going to let other states make their own choice and decide whether our plan is right for them or whether they have better ideas.

Now, let me just remind you of the things we are trying to do. One, get the cost down. Two, get everybody insured. Three, make sure people don't worry about losing insurance. And four, reduce the growth rate of health care spending. And the outline to get that done has six major steps. One, establish federal incentives to deregulate and reform state health insurance markets. Two, redirect federal spending on free care to help low income people purchase insurance. Three, institute enhancements for health savings accounts. And, finally, give full deductibility of all qualified medical expenses. Promote innovation in Medicaid. Implement medical liability reform. And bring market dynamics to health care.

[Applause]

You like that. Good.

[Applause]

Thank you.

[Applause]

Thank you. We are going to go one-by-one here. We have got to deregulate and reform some of our state insurance markets, some more than others. Each state can decide how much

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they want to do. But the overregulation of state health insurance markets drives up the cost of coverage and dissuades people of middle incomes from buying coverage. And I mentioned this, California has got their rate down to $1,885 a year for an individual. That is the average. And New Jersey, given all their regulations, is at $6,000 a year. No wonder you are going to have a lot of people in New Jersey that don't buy insurance at that high level. And there are lot of mandates, of course, mandate in the broadest sense, regulations and overregulation that drive up the cost of insurance. Community rating, direct access to specialists, mandated benefits, guaranteed issue, any willing provider, health plan liability, provider due process. Some of these, by the way, I like, and we put in our final plan. Some I don't. States can pick and choose among them, but they overall can become a very expensive burden on our health insurance market and do what I just described, which is create very different prices among difference states for health insurance. And therefore, we are going to have to create, in my view, federal incentives — and I'll talk about what they are — federal incentives to states for the state to deregulate and reform their own health insurance market. States reform their markets to reduce insurance premiums and to facilitate consumer choice. The federal incentive is this: We will give states access to federal funds that help them in their low income, uninsured

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program. We will give them that flexibility that Tommy Thompson and Mike Levitt gave to us. We will give them the same flexibility, but only if they put in place the reforms that get the price of policies down.

Now, by the way, there is an alternative that people talk about. Why not just let people buy insurance from any state they want to? Why not say to the people in New Jersey, for instance, hey, we are going to have a federal law that says New Jersey can't keep you from buying a policy from California. And that has good features and there is nothing really wrong with it, but there are a couple of problems I would mention. One is that you would lose the benefit of the directed networks that California has. That is, by the way, one of the reasons their premiums are so low. And you would also have some difficulty handling problems if an insurer did not perform. How do you know if that is real insurance company if it comes from some other place? And if they don't pay up when they are supposed to, and you are in New Jersey, how are you going to get somebody in California or Vermont or wherever to pay up? So there are some problems. The biggest concern I have is this: it is a big statement by the federal government. If the federal government comes in and says, look, we are going to usurp the right of the state to decide who sells insurance in the state and tell all of you that you must accept policies from any state. You know what comes next? Someone is going to

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say, well, who is going to regulate this? Who is going to regulate these national companies? Well, we will have the federal government, of course. We will set up a regulator. Then the federal government is going to be told, well, someone has got to decide what is a good policy and not a good policy. So the federal government will start telling you what has to be in a policy. And that is why I call it the camel's nose under the tent. I get nervous when we start giving to the federal government more authority and more responsibility because, ultimately, they want to end up running everything. So my first objective and the first priority is let's help states reform their markets so we can get prices down.

Let's turn to a second issue, the uninsured. Who are the uninsured? You have heard, we have got 45 million people that don't have insurance, but just like Massachusetts they are not all the same. Roughly 14.7 million – that's the portion in yellow – are people who are eligible for current government programs and have never signed up. Now, by the way, there are some people who believe a lot of those folks have signed up and the statistics just aren't right and, therefore, the 45 million total isn't right either. But at least about 15 million of the 45 million are people that don't need other help. They are already able to receive federal support. And then you also look at the middle income. We have got about 11 million that are earning over 300-percent of the federal poverty level,

another 7 million that are 2 to 300-percent over federal poverty level. So we have got some 18 million who, depending on the state and the cost of insurance, ought to be able to buy their own insurance. We only have about 12 million — it depends on that 7 million number in the middle there — 12 to 19 million that are going to need help of some kind to be able to get insurance. So as we think about covering these folks, we have got to recognize that the problem is not getting 45 million insured. If you will, a subsidy program for 45 million. No, it is a program to help those 12 million or perhaps as many as 19 million. And how do you go about doing that? Well, you do just as Tommy Thompson and Mike Levitt did for us. You permit states to redirect existing federal and state resources that are now being set up by them to instead help low income people purchase their own private insurance. And you let states craft their own programs, just like we did in Massachusetts. And they can do what we did. They can have the sliding scale, just like we did. And if they want to, they can have the mandate that we had. I think it is a good idea. Other states may decide to take a different path, but they will create their own programs to get their populations insured.

And here is a key point. We spend tens of billions of dollars right now at the state and federal level sending payments out to give care to the uninsured. We are going to redirect that money to help people buy insurance and it will

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not cost us more money, and the reason is because we are only dealing with 12 to 19 million people, not 45 million, and we do not need new spending and new taxes.

[Applause]

Let's talk about taxes for a minute. The tax code penalizes individuals who don't get insurance through their employer, as we have described. And, as a result of that, there really isn't a robust consumer-driven health insurance market in this country. And the tax code also creates an incentive for over insurance. Let me describe why that is. If you are an employee signing up for an insurance plan, you know that if you get a plan that has high deductibles and high co-pays, that those high deductibles and high co-pays are not tax deductible. So you prefer instead to get a plan that has very low deductibles and low co-pays because those things are deductible. Individuals don't get exactly the plan they would have. The tax code is driving them to a policy that has got huge premiums but not the kind of deductibles that would otherwise make sense, and it leads to unnecessary and excessive spending. The answer: Enhance HSAs. Eliminate the minimum deductible requirement and HSAs. Number two, full deductibility of all qualified medical expenses. That means the whole thing, premiums contributions to premiums, out-of-pocket spending, deductibles and copayments.

[Applause]

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Now, of course, to get the full deductibility, people have to have at least a catastrophic coverage policy. This will help reduce the cost of health care for everybody, because they are not only getting the deduction of their premium, they are getting the deduction of their co-pays and the deductibles and other medical expenses. It will also create a consumer market because for the first time, companies will be happy to sell directly to individuals because individuals don't care if they buy the product through their employer or they get it individually. Some 2 to 6 million people are estimated to be willing to purchase private coverage, if we make this change. So we will get people that were uninsured into the insurance pool. It promotes smarter health care spending because we now disincentivise [misspelled?] people getting higher deduction policies.

And, finally, a study that we done by John Cogan and Glen Hubbard suggests that this change will result in a 6.2-percent reduction in overall U.S. health care spending. Now, how about Medicaid?

[Applause]

Yes, thank you. I'm going to see us promote Medicaid improvements and reform. How do you do that? Well, you know that federal Medicaid spending is out of control. One hundred eighty-one billion spent on Medicaid a day to grow to 17 billion by 2017. And because the state spending is matched, it

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makes it difficult to constrain expenditures. The states are also powerless to reform and innovate themselves. Because of the convoluted bureaucratic process in Washington, it takes months or even years for reforms to go through. And, of course, the restrictions by Washington limit innovation. The answer here is to give states complete and full flexibility to structure their Medicaid programs to meet the needs of their people and just block grant to them federal funding. Let states run their own Medicaid program.

[Applause]

And by the way, that is the same approach that we took in Welfare reform. We said, states, you create your programs. We are going to block grant the money to you. It has worked in Welfare reform. It is time to work in Medicaid reform. The states have the incentive and the know-how to meet their citizen's needs to rein in unnecessary spending and innovate. Florida, of course, has a voucher program going on now, which is of great interest to all that are watching it. Utah has a cost-sharing program for Medicaid recipients, where they pick up a portion of the cost. States, of course, would be free to use their funding if they wanted to help the growth of private insurance by helping the low income people become insured. And, of course, states would be free of the extraordinary bureaucratic burden posed by Washington.

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Now, there is another problem that you are probably more familiar with than I, like all of the ones I have talked about so far, and that is the cost of malpractice premiums, which have skyrocketed, particularly over the last couple of years. This has a lot of negative implications. One, of course, is that a lot of doctors are leaving certain regions of the country, where the increase has been greatest. It also is expensive for you to get insurance, and that is a cost you have to pass along to everybody buying insurance. And, of course, the cost of defensive medicine is certainly well in addition to the cost burden that is associated with this malpractice explosion. And, as a result, it is time to enact federal caps on non-economic and punitive damages. End it.

[Applause]

Thank you. I was afraid that was going to unpopular in this room, but I'm glad. Lottery size awards and frivolous lawsuits may enrich trial lawyers, but they put a huge burden on doctors, on hospitals and, through defensive medicine, on the entire population. Every citizen is paying an exorbitant cost for this kind of system, and I would like to see other state reforms put in place as well. We would like to encourage health courts and alternative dispute resolution and sanctions associated with repeated filings of frivolous lawsuits.

[Applause]

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The sixth topic is too big, given how much time I have already taken, and so we will get another presentation in great depth on this at some point. But let me just make a couple of headline points. We need to bring some of the market dynamics that exist in the rest of the private sector to the health care world in a more abundant way. The regulatory burden that has been placed on health care over time has stifled the kind of modernization and innovation and consumer-driven improvements that propelled other parts of our private sector in this country. As you see, there is limited information technology compared to the private sector. There are limited types of provider options in lots of parts of our country. Consumers are generally uninformed about their choices and alternatives. And consumers often have no stake at all in the cost of health care once they hit their deductible threshold on their policy. And these things just aren't productive to create a market-driven health care system. And so I would like to see us put in place a series of incentives to promote information technology and EMR, to establish cost and quality transparency, to authorize more health savings products, and coinsurance. I happen to be a big believer in coinsurance. Back to the future, if you will. Back in the '50s and '60s, people used to take a-percentage of their health care cost and pay that-percentage all the way up. It made people care about how much something was going to cost and how well they were. I would

also like to establish more provider options. Look, market dynamics have sharply improved the cost and quality of America's other goods and services. And rather than socialized medicine and allow the government bureaucrats to run our health care system, we should instead bring in the dynamics of a free market system into health care to make it even more robust.

[Applause]

Now, let me just tell you what we have done. At the beginning you must have said, well, this can't get done. There is no way the guy is going to be able to get health insurance costs down, get more people insured, all of them, ultimately, and the risk of losing insurance and then reducing the growth of health care spending. But we have. We can have insurance more affordable for all Americans. First, by having full tax deductibility of all medical expenses, by reforming state insurance markets to get more affordable products, by reforming medical liability, and by putting in place some of the technology and a free market dynamics I described. We can get every American insured by making sure that we have affordable policies for middle income Americans. That is by doing the things in number one there and by putting in place a premium assistance program, a support program for low income individual, fashioned state by state. And I hope a lot of people copy the Massachusetts plan or come up with one better. But we are going to get everybody insured. Number three, we

are going to end the risk of losing insurance because we are going to now have an individual market, where people can buy their own insurance if they want to and keep it from job to job to job. And if they worry about becoming poor, we are going to have in place a support program for the low income individuals to make sure they keep their insurance. And, finally, through the means I have just described, we can reduce the growth of U.S. health care spending.

Now, is this perfect? No. I don't know how you come up with something that is perfect, but it is a great step forward, a huge leap forward. We are not going to let perfection become the enemy of the good. We can get our health insurance premiums down. We can reform our system such that states are finding a way to get all their citizens insured. We can do it without government takeover, without socialized medicine. I know that it is going to have to be done on a bipartisan basis. That is how we did it in my state. My legislature, as I said, was 85-percent Democrat. How did we get our plan done? We both worked on it. We all take credit for it. Both sides deserve a lot of credit for it. When it was all said and done, by the way, and the vote of the legislature occurred — we have combined, House and Senate, 200 legislators — it passed 198 to 2. We can make something like this work in this nation by giving states the flexibility to

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create their own plans and using our federal funds to help them in doing so.

Now, we don't need to move towards socialized medicine or a government takeover. That is so frightening to me. I love what P.J. O'Rourke said. He said, "If you think health care is expensive now, just wait until it's free." We are not going in that direction. Instead, Conservative principles, Republican principles, individual responsibility, individual initiative and a free market system, these are the principles that will allow health care to perform brilliantly, continue to do the great things it has done in the past and take the miracle of American medicine to more and more homes in a more affordable way.

Thank you so much for being here today. Appreciate your help. Thank you.

[Applause]

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