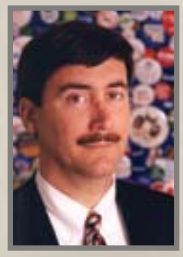

American Revolutionary:
Larry Sabato's plan to rewrite the U.S. Constitution

The Ripon Forum

October/November 2007
Volume 41, No. 5

Leading the Way

Schwarzenegger's Push for Health Care Reform

Plus: What other Governors are doing to reform health care in their states

And: The 800 pound gorilla that's being ignored in the 2008 Presidential campaign

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A Note from the Chairman Emeritus

States have been called the laboratories of our democracy. They're places where policy experiments are carried out. If the experiment is successful, the lessons are often applied nationwide.

When California voters approved a ballot initiative known as Proposition 13 in the late 1970s, for example, they were not only voting for a Constitutional Amendment that limited property taxes in the state, they were also setting the stage for the tax cuts Ronald Reagan enacted nationwide a few years later.

Similarly, when Wisconsin Governor Tommy Thompson signed into law a bill that reformed his state's welfare system in the early 1990s, he was not only enacting a piece of legislation that required people to work in order to receive a government check, he was also setting the stage for similar reforms that would be approved for the rest of the country later in the decade.

In this edition of The Ripon Forum, we look at another policy experiment being carried out in the states. In this case, though, there is not just one experiment underway – there are many. Across the Nation, Governors and State Legislatures are exploring ideas and pushing policy proposals intended to address what polls indicate is one of the top domestic concerns of the American people – health care.

We anchor our coverage with the experiment being pursued in California, where the State Legislature is meeting in Special Session to consider the health care reform plan being pushed by Governor Schwarzenegger. We take a look at this plan – the good and the bad. We also look at what other Republican Governors are doing to strengthen health care in their states, and consider a fundamental question in all of this – is reform even needed?

This edition of the Forum also includes an article about the Medicare Prescription Drug program by Gail Wilensky, who headed up Medicare in the first Bush Administration and offers her expert assessment of how well the plan is working nearly four years after its enactment.

We are also very pleased to feature a Q&A with University of Virginia Professor Larry Sabato, who discusses his new book on "A More Perfect Constitution."

As always, we hope you enjoy this edition and welcome your feedback. Please e-mail us at editor@riponsociety.org with any thoughts, comments, or ideas you may have.

Bill Frenzel
Chairman Emeritus
Ripon Society

A More Perfect Constitution

A Q&A with Larry Sabato

Dr. Larry J. Sabato is the Robert Kent Gooch Professor of Politics at the University of Virginia and the Founder and Director of the University's Center for the Study of Politics.

Dubbed by Fox News as "America's favorite political scientist," he is also a prolific author, having written over 20 books. His latest is "A More Perfect Constitution: 23 Proposals to Revitalize Our Constitution and Make America a Fairer Country." In it, he calls for, among other things, a Constitutional Convention to consider changes to our Nation's governing document.

The Forum asked him recently about the book and why he thinks we need "A More Perfect Constitution."

RF: Could you tell us a little bit about the book?

LS: Much of the Constitution's superstructure needs no fundamental fix, including the separation of powers, the system of checks and balances, and the Bill of Rights. The fault is not with these basics, and it's important to stress one fundamental truth from the outset: The framers of the Constitution did not fail us.

Our forefathers designed the best possible system that could be achieved at that moment in time. They understood that some of the necessary compromises in the Constitution were flawed, yet the Constitution of 1787 reached the pinnacle of equity in the world's history to that time. The framers left it to us, and expected of us, that we would continue at regular intervals to perfect their work. Yet, we avoid change—even a robust discussion of it—and prefer insufficient tinkering to the substantial reframing that is required.

My purpose in writing this book is to start a creative conversation – the kind of discussion Jefferson would have thought would happen naturally every couple of decades.

This book is an attempt to alter America's political ossification. I defy anyone to characterize this book ideologically. Some of my proposals are liberal, some moderate, some conservative, and most are structural, lacking any kind of ideological tilt or motive. I am trying to move the debate beyond divisive ideology, to the big picture of what makes our country and Constitution great, and how it can be improved.

I want to follow the founders and framers' advice and try to build a better mousetrap. That is what successful, championship countries do continuously. We have lost our way a bit on this score.

RF: What prompted you to write it?

LS: I come to this subject as an admirer of the magnificent achievements of the nation's founders and the Constitution's framers.

Like almost all Americans I grew up believing in the Constitution – every bit of it. But having chosen American politics as my primary passion in life, over decades of daily thinking about the issues that confronted the nation, I gradually began to see that parts of the system were no longer working very well, that the day-to-day, incremental political process was inadequate to fix the root causes of the system's dysfunction.

In this, I was encouraged by the bright young people in my classrooms, who asked good questions, pointed out

wrongs that needed righting, and were unwilling to accept 'that's how we've always done it' as the final, correct answer. My purpose in writing this book is to start a creative conversation – the kind of discussion Jefferson would have thought would happen naturally every couple of decades. If we choose to act, change will be the result.

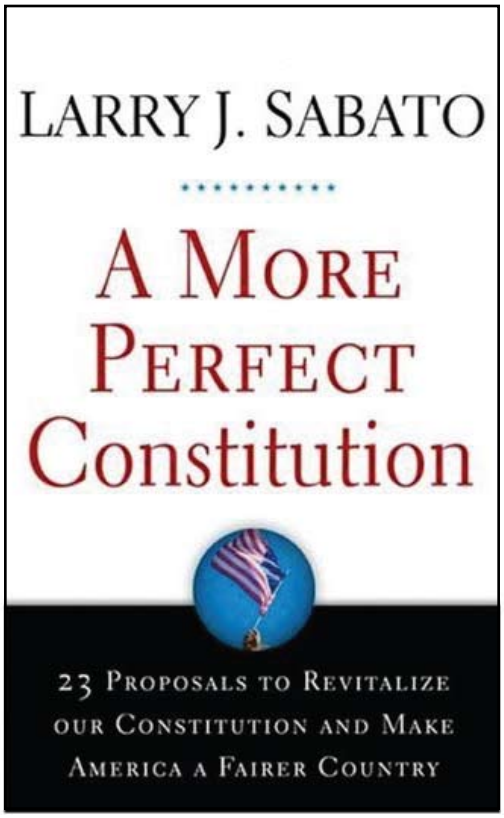
We the people can move the discussion about constitutional revision forward, and bring together like-minded citizens to participate in a movement to reform our own government and make it work better for our families, communities, and country.

RF: We face a host of challenges as a country -- from over 10 million unaccounted-for immigrants to a growing entitlement burden that is crowding out other national priorities. How would holding a Constitutional Convention help solve these kinds of problems?

LS: This is a great question because, on the surface, people may not see the connection between pressing headline issues and the Constitution. Yet every single thing the government touches relates directly or indirectly to the system we have created. When the system works well, the solutions to problems will be a bit easier to reach.

There's no more important issue than war and peace. Both the Vietnam and Iraq conflicts have illustrated a modern imbalance in the constitutional power to wage war. Once Congress consented to these wars, presidents were able to continue them for many years— long after popular support had drastically declined. A convention could limit the president's war-making authority by creating a provision that requires Congress to vote affirmatively every six months to continue American military involvement.

As for domestic issues, the structure of Congress directly affects all legislation, and its chances of passage. I've focused a great deal in this book on the Senate, because it is the graveyard for so many useful reforms. People are stunned to discover that if the 26 least populated states voted as a bloc, they would control the U.S. Senate with a total of just under 17% of the country's population. This small-state stranglehold is not merely a bump in the road; it is a massive roadblock to fairness that can, and often does, stop all progressive traffic. So to stress my point again, structure matters enormously.



Finally, I've tried to design a reasonable form of the Balanced Budget Amendment. Like the [U.S.] Comptroller General, I am pessimistic that we will come to grips with our $9 trillion national debt and $50 trillion in other promised obligations without a rational, phased-in amendment of this sort.

Americans respond to crises—but how much easier it would be if we could avert the crises years or even decades in advance. We would lessen the fiscal pain greatly.

RF: You are essentially calling on the States to rise up and call for a Convention that would radically reshape the federal government. Given that states are increasingly reliant on the Washington bureaucracy for a not insignificant part of their funding, do you think this is something they would really be inclined to do?

LS: From my earliest studies (on the American Governors and the fifty states in the 1970s), I have been a fan of federalism and the states. The states will be big winners if they pursue the route I have suggested leading to constitutional change. There are a dozen major examples, but let me offer one.

I propose a new Politics Article for the Constitution—needed because neither mass democracy nor political parties existed at the time of the Founders, and the lack of any rules or direction has led to the mess we are experiencing now in the presidential nominating calendar. My new system guarantees that every state and region will have an equal chance over time of going first, normally the most influential position in the primary calendar.

I'll grant you, Iowa and New Hampshire won't like this change, but the other 48 states—with 97% of the nation's population—will like it.

RF: One of the reasons the Founders were eventually able to reach agreement in Philadelphia in 1787 is that they met in private, thus allowing them to talk candidly about the problems facing our country at that time. Would private deliberations of this nature be needed if a Convention were held

today? With the 24/7 news media and the pervasiveness of special interest groups, would that even be possible?

LS: No doubt some delegates elected to the eventual Convention would have many off-the-record chats amongst themselves, and that's fine, but we are in a different era. This book welcomes mass participation in the process. Indeed, citizen activism is a necessity if a new Constitution is ever to come to be.

The Internet connects citizens into the process, above and beyond the ballot box. This is a good thing. Constitution re-making will be generational, and the discussion will last many years at all levels and in all communities. The very process makes people more civic minded and better informed. For those who worry about a "runaway Convention" or mob-ocracy, they can save the investment in Pepto-Bismol.

Thirty-eight states would still have to ratify each and every change to the Constitution. That means that successful changes will need a near-consensus to pass. Nothing from the Left is going to pass the Red States, and nothing from the Right will see the light of legislative day in the Blue States.

If anything, my process and the Constitutional Convention will empower moderates—the very people who are undervalued today, the very people who read this excellent magazine!

RF: In addition to revamping the three branches of government, you also write that a new Constitution should require the American people to serve as well – either in the military or through some other kind of mandatory national service. Why do you believe this is important?

LS: Enjoying the benefits of living in a great Democracy is not a God-given right. In exchange for the privileges of American citizenship every individual has obligations to meet, promises to their fellow citizens and posterity to keep.

A cultural sociability and an outgoing spirit, coupled with innate optimism and enthusiasm, infuses the American people. At the same time, it is obvious that – except perhaps in some wars – we have not been able to capture and channel the full energy of America's volunteer spirit as well as we could have. A constitutional clause can finally achieve the goal universally. Nothing can do more to make America a better, fairer nation, with everyone pulling his or her own weight.

There is no serious question that universal service would be in the short and long-term interests of the young. Their world view would be broadened enormously, and their lives would be far richer for the perspective they gain. This new constitutional provision can make America, more than ever before, an exemplar of idealism and a beacon of hope for people everywhere.

If anything, my process and the Constitutional Convention will empower moderates—the very people who are undervalued today...

RF: As part of the book, you conducted a poll to gauge people's reactions to some of the Constitutional changes being proposed in the book. Could you talk about the results of the survey? What changes earned the most support? What changes earned the least?

LS: In the fall of 2006 the highly respected Rasmussen Reports conducted a telephone survey on the topic of potential changes to the Constitution. Respondents were asked twenty six substantive questions about their reaction to various proposals.

In general these survey results bode well for the promise of serious debate about constitutional change. Of the seventeen reform proposals in this book that are included in the Rasmussen poll, eight of them already draw majority support. In fact, the proposal which garnered the most support of any in the survey was to require a mandatory retirement age for judges at 75 years (77% approval). Probably some respondents were expressing strong dislike for judicial law-making, while others simply preferred to avoid the hubris that comes with long tenure in any position of great power.

At the same time, Americans display a healthy degree of initial skepticism about many proposed alterations to their founding document.

Unsurprisingly, then, our survey found that proposals which would most radically alter America's constitutional machinery were met with more skepticism from the public. Therefore, the notion of a more representative Senate earned a 74% disapproval rating.

There is no doubt that the push for a major overhaul in government will be a slow, uphill, perhaps generational battle – and that is exactly as it should be. It is reasonable to assume that detailed discussion and debate over time would encourage growing acceptance of at least some currently alien constitutional reform ideas. Inarguably, additional debate would sink others, or cause still more creative proposals or compromises to be floated and accepted.

All of this is to be expected in the normal course of events leading to a Constitutional Convention.

RF: At this point, do you think there is support in Congress or among the States to undertake this kind of bold plan you are proposing? If not, what will it take for a plan like this to succeed?

LS: Goodness no, nor should there be. Constitutional revision is as serious a step as any democracy can take. It must be done with excruciating care, after lengthy discussion and debate for years on end. It may be decades before a Convention occurs. Or perhaps individual amendments drawn from the more popular of the ones I have suggested—or others offer on our website www.amoreperfectconstitution.com -- and this will be the result.

I honestly believe that no one with an open mind can read "A More Perfect Constitution" and conclude that nothing at all needs to be changed or reformed. At the very least, we'll do what Jefferson, Madison, Washington, and other Founders wanted us to do: think deeply and frequently about the Constitution. My book is meant only to stir the pot and start the debate. The worst that can happen is for Americans to go to their Constitution and read this brilliant text again.

As Chief Justice John Roberts recently remarked, "The one thing people don't do, and by that I mean law professors, judges, law students, not just normal everyday citizens who are engaged in other occupations, nobody reads [the Constitution]. We talk about it a lot. We have cases about it. But to actually sit down and read it doesn't happen that often and that is a very rewarding exercise.

With "A More Perfect Constitution," we're going to do something about this. **RF**

So Far, So Good

Competing Private Plans in Medicare Part D Succeed in Keeping Costs Down

GAIL WILENSKY

When the Medicare Modernization Act was signed into law in December 2003, there were many predictions of problems implementing the new drug benefit.

Questions were raised as to whether enough private drug plans would want to participate in the prescription drug program, with elaborate government fallback plans put in place in case they did not. Concern was raised whether seniors would be too confused by the details of the benefits to be able to choose a plan that made sense for them. And many in Congress bemoaned not only the lack of government-set pricing (as is the case in numerous other parts of Medicare), but also the inability of the government to "negotiate" prices in order to get drug prices down (despite the fact that Medicare doesn't have much of a history of "negotiating" prices.)

The Part D drug benefit is complicated — although so is the inpatient hospital coverage under Part A. Under Part D, there is a deductible, initially set at $250 (now set at $275), after which Medicare pays 75 percent of the drug costs for the first block of spending — initially set at $2250 and now set $2510. There is a period of spending when there is no coverage — the so-called "doughnut hole" – after which a catastrophic coverage kicks in and Medicare pays approximately 95% of any additional drug costs. The doughnut hole makes no policy sense — just a case of politics trumping policy.

Now that seniors are getting ready to enroll in the 2008 Part D Drug Plan, what have we learned? Well, the concern about too few plans was certainly misplaced.

Now that seniors are getting ready to enroll in the 2008 Part D Drug Plan, what have we learned? Well, the concern about too few plans was certainly a misplaced concern. As is now well-known, so many plans wanted to participate that in some areas of the country, seniors have had to choose from more than 40 plans. Perhaps, to no surprise, the concern has been raised as to whether there are too many plans — not too few.

In order to help stem confusion that could result either from the number of plan offerings or from the benefit itself, many groups have come forward to help seniors. The plans themselves have used multimedia resources to help seniors understand the benefit as well as promote their own products. Pharmacies have actively intervened to help seniors understand the benefits and choose plans and healthcare professionals, churches and aging agencies have also helped seniors in a variety of ways. The federal government has also committed both money and time to engage in outreach programs, and provide a lot of information on its website, Medicare.gov, including a drug plan cost estimator that helps seniors understand the advantages of various plan choices, given their prescription drug use history.

Of the more than 42 million people eligible for Medicare, more than 31 million people with Medicare now have prescription drug coverage. The challenges of bringing in low-income seniors who qualify for drug coverage at no or very low cost continue, as do the challenges of enrolling all qualified low income individuals in any of the programs geared for them. Federal, state and local officials continue to reach out to qualified individuals who have not yet enrolled. Early in October, Minnesota had federal, state and local Medicare officials visiting Minneapolis and Duluth offering to help people apply for the low-income subsidy. Other states

are trying a variety of strategies.

Perhaps the biggest success factor has been the lower than expected premiums for 2007. According to the Centers for Medicare & Medicaid Services, premiums for the basic drug benefit fell to an average of $22 per month in 2007 — over 40 percent less than the $37 a month that the coverage was originally projected to cost. This decline has been attributed by CMS to competition among the drug plans and the choices by seniors of more efficient plans with lower premiums.

The downside for the plans of the lower-than-expected drug costs for 2006 is that the Part D plans owe CMS $4 billion. Under a risk-sharing arrangement that was part of the initial legislation, the plans submitted bids for 2006 during the middle of the previous year based on expectations about number of enrollees and expected utilization. CMS pays the plans prospectively and then reconciles after the end of the plan year. Since the 2007 bids were substantially lower than the ones submitted in 2006, the final reconciliation for 2007 is likely to be much lower.

The average premium paid by beneficiaries for standard coverage in 2008 is expected to be almost 40 percent lower than was originally projected for the benefit when the legislation was passed in 2003. Nonetheless, seniors who want to stay in the plans they had previously chosen may have to pay substantially more — as much as a 20% increase according to one recent analysis. The question is what will seniors choose to do? Most seniors in stand-alone plans will have at least one plan with a premium less than the current plan and all seniors will have access to at least one plan that has a premium of less than $20 per month.

Despite the apparent success that the competing plans have had on premium charges and on moderating spending on prescription drugs and despite the conclusion of the Congressional Budget Office that government involvement in price negotiation will not lower costs, there are some in the Congress that continue to press for Medicare to use its muscle to negotiate for lower prices.

During the last round of consideration, even some of the mainstream papers not usually champions of concepts of competition in health care regarded prices under Part D as an issue that didn't need fixing.

Only time will tell whether the "price-setters" can be kept at bay. **RF**

Gail Wilensky is a senior fellow at Project HOPE and a commissioner on the World Health Organization's Commission on the Social determinants of Health. She was the HCFA administrator from 1990 to 1992 and the chair of the Medicare Payment Advisory Commission from 1997 to 2001.

Prescribing a Financial Fix for Post-Acute and Long Term Care

DAVID HEBERT

As we head into yet another Presidential race, it seems that every candidate is focusing on the need for health care reform and we have seen many proposals put forth into the court of public opinion.

While the goals of fixing a troubled and ailing healthcare system are laudable, it is greatly distressing that no candidate has included long term care – no addressing skilled nursing care, assisted living, hospice, or home care – in their reform plans. This is why long term care professionals are actively engaged in bringing long term care issues to the forefront as part of the 2008 presidential debate.

According to the U.S. Department of Health and Human Services, nearly 40% of all Americans will require nursing home care at some point in their lives. In addition, they estimate that by 2020, 12 million older Americans will need long term care services. These startling facts reveal one very important truth – that it is critical that policymakers address long term care reform now in order to prepare for America's future long term care needs.

As greater numbers of patients and residents enter our nation's long term care system, it is imperative that our policymakers address America's entitlement programs.

As greater numbers of patients and residents enter our nation's long term care system, it is imperative that our policymakers address America's entitlement programs. Unfortunately, at present, nursing facility care is predominantly funded by the overextended Medicaid and Medicare programs. Currently, 80 percent of the patients and residents receiving care and services in the nearly 1.5 million nursing facilities nationwide rely on funding from one or both of these programs to pay for their long term care. This strain on the system, coupled with the need to care for an ever increasing number of patients, clearly points to the need to address these programs, and soon.

The American Health Care Association (AHCA), the National Center for Assisted Living (NCAL) and our nearly 11,000 member long term care providers believe that a comprehensive long term care system should promote and integrate a comprehensive array of public and private financing options that meet consumer and family needs and respond to their preferences.

As long term care and post-acute care expenditures are expected to increase dramatically over the next fifty years due to the aging of the baby boom generation, the enormous financial pressure on federal and state budgets will continue to escalate. However, not only do state and federal governments need to plan for the future of long term care, but individuals must take personal responsibility in planning for their future care needs.

First off, we must clear up misconceptions about how long term care is financed in this nation. Many consumers are under the impression that these services are automatically funded by Medicare, Medicaid or their traditional health care insurance. However, Medicare has a limited benefit for post-acute long term care and in order for Medicaid to fund individuals' long term care and services, individuals must impoverish themselves. As well, many are unaware that health care insurance has no long term care benefit and that long term care insurance is a completely separate policy required to fund this type of care.

Personal investment and future planning through the purchase of a long term care insurance policy is one step to take the pressure off Medicare and Medicaid in their role of funding long term care. In order to encourage such personal responsibility, incentives must be built in to the system.

Through the Deficit Reduction Act of 2005, Congress took

initial steps to encourage purchase of long term care insurance policies by expanding the Long Term Care Partnership Program by lifting restrictions that had limited the program to four states. The Long Term Care Partnership Program is a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for long term care services. This was a critical first step in the direction of personal investment in long term care and services, but we must do more.

While this is an important effort to take pressure off the role of Medicaid in financing the long term care for millions of Americans, it must be complemented by efforts that build on the expansion of this laudable program.

Earlier this year, AHCA, NCAL and the Alliance for Quality Nursing Home Care entered into a partnership to develop real solutions to this long term care financing conundrum. Working in cooperation, these groups have developed a comprehensive plan, the "Long Term Care and Post-Acute Care Financing Reform Proposal." This includes workable, relevant policy proposals that meet the needs of patients while addressing the looming financing crisis.

AHCA, NCAL and the Alliance propose a new model for both financing and delivery of long term care and post-acute care that is sustainable, patient-centered, and lower cost. The proposal replaces the current patchwork financing with a voluntary federal system, increases private long term care financing, and rationalizes the post-acute and long term care delivery systems. Among other items, this model incorporates a new Medicare post-acute payment system to pay primarily based on the condition, needs and characteristics of the patient regardless of the post-acute care setting in which the patient receives care, and establishes a catastrophic federal long term care benefit which mandates individual commitment to planning and saving for their future long term care needs. A variety of vehicles may be used to meet this commitment including the purchase of an approved long term care insurance policy or investment in an approved savings vehicle dedicated for future long term care costs.

We challenge the 2008 presidential candidates, as well as Congressional leaders and policymakers nationwide, to investigate the feasibility of such a plan – and look for ways to implement a program that effectively and proactively addresses the impending financing crisis in our nation's long term care system.

In these days and years leading up to the time when our Greatest Generation and Baby Boomers alike require critical long term or post-acute care services, it is imperative that providers and policymakers partner together to create real solutions to a real and growing healthcare concern. **RF**

David Hebert is the Senior Vice President of Policy and Government Relations at the American Health Care Association.

Entitlement Reform:
The 800 pound gorilla that's being ignored in the 2008 campaign

DAVID C. JOHN

So far, fixing entitlement spending seems to be 2008's stealth issue. Presidential candidates from both parties will, when asked directly, admit that spending on just three programs, Social Security, Medicare and Medicaid, is likely to move quickly from alarming to unsustainable. However, when asked what they would do about it, with just a few exceptions, the current presidential candidates quickly retreat into clichés.

This is somewhat understandable as there are no pleasant answers. Fixing entitlement spending without eliminating the rest of the federal government requires cutting benefits, raising taxes, or reorganizing the programs in some controversial and potentially scary way. In short, there is no solution that is guaranteed to bring a smile to a potential voter's lips, much less one that will inspire him or her to write a big check. The old standby of solving a problem by cutting waste, fraud and abuse just will not work.

Rather than discussing candidates' detailed positions on health care, this article will focus on both entitlements in general and Social Security in particular. Of the three big entitlement programs, Social Security is the easiest to fix in that it is simply a matter of increasing revenues or reducing benefits, and one does not have to focus on issues like medical technology, delivery systems, long-term care costs, etc. This approach to fixing Social Security regards adding personal accounts to Social Security as a way to make tax dollars go farther because contributions to the accounts grow faster than they would under the current system. However, all Social Security account plans that are funded out of current Social Security taxes also carry substantial transition costs as money that goes into them cannot be paid out in benefits.

Here are the facts according to the Congressional Budget Office: In 2005, spending on the three entitlement programs took up a total of 8.6% of this country's Gross Domestic Product (GDP). Social Security amounted to 4.4% of GDP, Medicaid accounted for 1.5% and Medicare for 2.7%. Between now and 2050, that total of 8.6% of GDP spent on entitlements will reach an astonishing 19.9%. At that point, Social Security spending will reach 6.9% of GDP, Medicaid 4%, and Medicare 9%.

Given that the average level of federal taxation over the past 45 years is just over 18% of GDP, the only way to pay for entitlements in 2050 will be to either get rid of the rest of the federal government or to raise taxes to levels unheard of in American history. Neither option is exactly attractive as a campaign theme.

Who's Saying What?

In this campaign, a couple of candidates are candid about entitlement spending. Former Alaska Democratic Sen. Mike Gravel happily discusses the size of the entitlement problem, and is unique among Democrats in proposing a fix for Social Security that includes a form of personal accounts. However, detail is lacking other than to propose that the current Social Security surpluses

be invested in stocks and bonds, and Gravel's support is so low that he is unlikely to have much influence one way or the other.

For the most part, Republicans acknowledge the problem with entitlement spending in general and Social Security in particular. They are uniformly opposed to raising taxes to solve the problem, and just as uniformly positive about adding some form of personal accounts to Social Security. Beyond that, specifics are very scarce. One can assume that talk about "difficult" choices is a code word for making benefit changes such as raising Social Security's retirement age or focusing benefits on those who need them the most, but no one says so directly.

Former Senator Fred Thompson openly discussed the problem of entitlement spending just after his official announcement, and pledged to make entitlement reform a cornerstone of his campaign. His official website says that, "In a few short years – not a generation from now – a fiscal tsunami that could imperil our security and economic prosperity will hit our nation and place an unfair burden of debt on our children and grandchildren." Good start.

For the most part, Republicans acknowledge the problem with entitlement spending in general and Social Security in particular ... Beyond that, specifics are very scarce.

Unfortunately, the solution that he proposes is not very clear. It appears to center on, "Leading and making the hard choices necessary, to include cutting wasteful government spending, to safeguard our security, promote our prosperity, and protect our children and grandchildren from fiscal calamity."

John McCain is equally candid about the problem. His website says that: "As president, John McCain is prepared to make the tough, fair, and responsible choices that honor our promises to current beneficiaries and to our children. Every year these decisions are delayed makes meeting this responsibility more difficult and expensive. Promises made to previous and current generations have placed the United States on an unsustainable budget pathway. Unchecked, Social Security, Medicaid and Medicare obligations will grow as large as the entire federal budget is now in just a few decades." Very good start.

He is equally candid about solutions, stating in a speech to the Economic Club of New York that: "I have long supported supplementing the current Social Security system with personal accounts, but not as a substitute for addressing benefit promises that cannot be kept. People of good faith in both parties agree that we must make the hard decisions to restore solvency to these programs and that personal accounts can ease the impact of slower benefit growth. But, too often, we prefer to nurture our own ambitions rather than defend the public interest. It is long past time for our two parties to sit down together and fix our pressing entitlement problems."

Mitt Romney is even more explicit about what he wants to do to fix Social Security. While his website has on it only a quote calling for the reform of entitlement programs, a link to an interview with his issues director, Glenn Hubbard, says that Romney, would look at "progressive" reforms of Social Security, including retirement age adjustment and indexing of benefits, where the reductions or modifications would not be "borne by the less well off." This is an honest, direct approach.

News reports state that Rudy Giuliani recognizes the problem with entitlement spending, but it is hard to find a mention of it on his website. Unlike McCain's and Romney's, his site has no search function, and his issues section links to either speech segments that mainly consist of slogans and platitudes or vague written policy statements. Giuliani is very explicit about how he wants to fix discretionary spending, but that level of candor does not seem to extend to entitlements.

Democrats are far less eager to talk about the need to fix entitlements, and are even less explicit about what they would do about the problem. Rather, Democrats discuss the individual entitlement programs. A search of websites found almost no mention of the need to fix entitlements, although they all had some level of health care reform, and most include a pledge to protect Social Security. Except for Gravel, Democrats are united against the "privatization" of Social Security, and while

Republicans focus on making "difficult" decisions, a code word for changing benefits, most Democrats propose increasing taxes. With few exceptions, Democrats oppose changing Social Security benefits, even for wealthy Americans.

Senator Barack Obama, in an Iowa op-ed, proposed eliminating Social Security's wage cap, which would require workers to pay payroll taxes on their entire income rather than just the first $97,000 as they do currently. In the same column, he also proposed to eliminate income taxes for retirees earning less than $50,000 annually. Since a large proportion of those income taxes are assessed on Social Security benefits, and were imposed in 1983 and 1993 to help fund both Social Security and Medicare, it is uncertain how much his combined plan would do to keep Social Security solvent. Obama also explicitly opposes both raising the retirement age and cutting benefits.

Former-Senator John Edwards has a more targeted Social Security tax increase in mind. Edwards would assess Social Security taxes on incomes of over $250,000, leaving them at the current level for those who earn less than that. Overall, he states that "financing of Social Security can only be solved by a package of reforms that has the support of both Democrats and Republicans." He also says he "supports a successor to the Greenspan commission appointed in 1981, dedicated to finding a solution that is non-ideological, strongly bipartisan, and committed to the goals of ensuring every American can retire with dignity and extending the life of the Trust Fund." This is probably the way that a successful Social Security reform plan will be developed, so he gets some credit here. Edwards also opposes cutting benefits or increasing the retirement age.

New York Senator Hillary Clinton also avoids speaking about entitlements. On Social Security, she is more explicit in what she opposes than what she supports. In addition to opposing personal accounts, Clinton also opposes raising payroll taxes or increasing the retirement age. Since if one takes raising taxes, changing benefits and introducing personal accounts off the table, nothing is left except hope and wishful thinking, there is a temptation to see the explicit promise to not raise payroll taxes as leaving room to supplement Social Security's payroll tax with general revenues. However, this approach would do nothing to reduce the problem of entitlement spending.

Bill Richardson has an even less realistic program. For Social Security, he wants to protect the surplus, and encourage the economy to grow. He also wants to increase benefits by allowing women who take time out of the workforce to raise children or care for an ill family member to receive Social Security credit as if they had been employed. While there is value in this and it is the practice in many European countries, such a benefit increase would be extremely expensive, and does nothing to fix the spending problem. As for Richardson's desire to solve Social Security's problem by economic growth, the Social Security Administration has modeled such an approach. It found a 97.5 percent chance that growth would not solve Social Security's problems.

Democrats are far less eager to talk about the need to fix entitlements, and are even less explicit about what they would do about the problem.

A current financial services commercial has a huge "800 pound gorilla" telling people that they need to make decisions about their financial futures. It is clear that those people would happily go to great lengths to ignore the gorilla. Entitlement spending plays the same role in the 2008 campaign. Some candidates, mainly Republican, at least acknowledge its presence, but virtually no one ventures an explicit solution.

At the very least, fixing the entitlement problem requires candidates to stop promising not to consider various approaches. Even if the final plan is developed by a commission similar to the 1983 one that wrote the last Social Security reform, pre-conditions that exclude certain items pretty much guarantee failure.

The American people deserve an honest discussion of the issue as part of campaign 2008. So far, the chance of that happening is very low. **RF**

David C. John is a Senior Research Fellow at the Thomas A. Roe Institute for Economic Policy Studies at the Heritage Foundation.

Leading the Way
Schwarzenegger's Plan to Reform Health Care in California

KIM BELSHÉ

Earlier this month, Governor Arnold Schwarzenegger submitted legislative language to the Senate and Assembly to continue the conversation in earnest and get health care reform resolved. We continue to strive for health insurance for all California families.

We need to find a solution this year -- a solution that achieves the Governor's goals of: coverage for all; affordability and cost containment; and, prevention, health promotion and wellness. The language the Governor submitted makes a number of changes but leaves intact the basic premise of the plan he introduced this past January.

As in January, Governor Schwarzenegger is committed to coverage for all. To achieve this goal, the Governor's plan requires all individuals to have a minimum level of health coverage. We believe this is the most effective strategy for ensuring all Californians are insured and fixing our broken health care system.

We also recognize that an individual mandate must be paired with a requirement that insurers offer health insurance. Market rules will be reformed so that health plans cannot deny coverage due to age, health status or pre-existing conditions. And, to ensure maximum value, insurers will be required to dedicate no less than 85 percent of premiums on patient care.

To help keep costs down and make health care affordable, Governor Schwarzenegger's plan would address the issue of the hidden tax that individuals and employers pay for the uncompensated care of the uninsured. While uninsured individuals can access health care services, far too often and for far too many, that care is provided in the most expensive, least appropriate setting possible – the emergency room.

It is morally right to treat people in their time of need, but when their bills go unpaid, the cost is shifted to those who have health insurance, something akin to a hidden tax.

Emergency rooms throughout the state are struggling with the financial burden associated with the uninsured. It is morally right to treat people in their time of need, but when their bills go unpaid, the cost is shifted to those who have health insurance, something akin to a hidden tax. The hidden tax insured Californians pay in the form of higher premiums to subsidize care for the uninsured is estimated at $1,186 per year for families and $455 per year for individuals.

This hidden tax is even higher when underpayments from government programs such as Medi-Cal are added in. Taken together, it is estimated that families pay as much as 17 percent more in premiums due to the cost of uncompensated care for the uninsured and Medi-Cal underpayments. That's why the Governor's plan calls for $4 billion in additional Medi-Cal payments to ensure adequate compensation and to address the hidden tax.

A final essential element of the Governor's health reform plan includes strategies to keep Californians healthy and keep them from having to use expensive medical services.

Chronic illnesses, like diabetes,

and poor health choices, such as smoking and inadequate exercise and nutrition, drive up the cost of care. The Governor's proposal outlines a comprehensive prevention policy that encourages and rewards healthy behaviors, supports diabetes prevention and management and continues nation-leading innovative strategies to reverse obesity trends and reduce the smoking rate.

The proposal also includes measures to reduce medical errors by the use of electronic prescribing and the implementation of new health care safety measures and reporting requirements to keep Californians from expensive preventable procedures due to medical errors.

All Californians are hurt by our broken health care system and all Californians will benefit from comprehensive reform based on coverage for all, shared responsibility and balanced financing. Working together, we can achieve affordable health care, coverage for all and a healthier California. **RF**

Kim Belshé is the Secretary of the California Health and Human Services Agency.

SCHWARZENEGGER REFORM PLAN
Principles & Components

Core Principles:	*January Proposal*	*October Proposal*
Universal Coverage	Required all Californians to have health insurance coverage. Provided state financial assistance through a purchasing pool to Californians with incomes between 100-250% of the poverty level.	Maintains requirement that all Californians obtain coverage, and strengthens provisions to increase affordability for working families.
Affordability	Provided state financial assistance through a purchasing pool to Californians with incomes between 100-250% of the poverty level.	Increases affordability for working families even further by reducing the amount that low and moderate income individuals will have to pay for coverage in the state subsidized pool, limits premiums based on income, and creates a tax credit for individuals/families between 250-350% of the federal poverty level. The legislation also requires employers to offer employees IRS Code Section 125 plans. In addition, employers and their employees who choose a Health Savings Account health benefit product will receive tax savings consistent with federal law.
Guarantee Issue	Required insurance companies to guarantee coverage, with limits on how much they can charge based on age or health status, so that all individuals have access to affordable products.	Maintains guarantee issue by ensuring that all Californians will be able to buy health insurance regardless of their medical history or age. Phases in elimination of medical rating and protects consumers against significant rate spikes based on their health status by putting parameters on what insurers can charge above or below a standard rate.

Schwarzenegger Reform Plan

Principles & Components

Core Principles:	*January Proposal*	*October Proposal*
Financing	*Doctors' participation*: Required that doctors contribute a 2% fee to subsidize a purchasing pool for low income Californians and, in return, receive more insured patients and higher Medi-Cal reimbursement. *Employer Contribution*: Required employers with 10 or more employees who choose not to offer health coverage to contribute an amount equal to 4% of payroll toward the cost of employees' health coverage. *Lottery*: Not included.	The basic premise of shared responsibility is that everyone who benefits from the reforms must contribute in a meaningful way. Although doctors are no longer required to contribute to the financing under the Act, they have additional responsibilities and incentives to care for many newly insured individuals. Protects small businesses by basing contributions on payroll. Under the plan employers who do not offer health care coverage will make a contribution based upon a sliding scale fee from 0-4% based on their total payroll. The bill proposes to lease the California Lottery to help pay for health care costs.
Public Hospitals	Counties would retain $1 billion in current funding (primarily for outpatient services) and county and UC hospitals will retain $1 billion in federal Disproportionate Share Hospital (DSH) funds and in addition, some "safety net" funds for primarily inpatient services.	California's public hospitals make significant financial gains under the new reforms. In addition to the funding increases included in the January 2007 proposal, the new legislation includes $500 million in additional funding for public hospitals. The Act includes protections to support county hospitals in the context of universal coverage.
Minimum Benefit	$5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family.	Does not define the minimum health insurance level. Instead, it directs the Secretary of Health and Human Services to establish and adopt the minimum benefit level via the regulatory process, which then cannot be changed except by legislative action. The minimum benefit level must: cover medical, hospital, preventive and prescription drug services; promote access to care; and must be set at a level where premiums are affordable.

For additional information on the Scharzenegger reform plan, please visit http://gov.ca.gov/

It's Not Just in California

Across the Nation, Republican Governors are pushing to strengthen health care in their states. Here's a snapshot of their actions:

MOLLY VORIS

Alaska

Governor Sarah Palin, through Administrative Order 232, has established the Alaska Health Care Strategies Planning Council, which is charged with preparing and submitting a health care action plan to the Governor and legislature by January 1, 2008.

This plan must include a description of the current health care system in Alaska; an inventory and analysis of existing health care plans, reports, and initiatives; short-term and long-term statewide strategies to effectively provide access to quality health care for Alaskans, while reducing the costs of that care; and performance measures and accountability mechanisms to assess the success of those strategies.

Connecticut

Governor M. Jodi Rell has introduced a health care plan to provide access to care for all residents of Connecticut. The Charter Oak Health Plan will create a private-public partnership offering a state-defined benefit package through private insurers. The proposed plan will be available to adults who do not have insurance through their workplace.

There will be guaranteed issue for the health plan, and premium subsidies will be made available on a sliding scale for lower income individuals. The proposed plan includes reduced fees for preventive care and the assignment to a primary care physician. The target monthly cost for an unsubsidized member is $250, plus copayments and deductibles. The plan will be offered by insurers willing to participate in the plan, and the state will help connect people with the participating insurers. Governor Rell's proposal also includes premium assistance for Medicaid patients who already have coverage through an employer. This assistance would wrap around benefits to provide services that are not offered by the employer plan.

In Alaska, Governor Palin has established the Alaska Health Care Strategies Planning Council, which is charged with submitting a health care action plan to the Governor and legislature by January 1, 2008.

In addition, the governor's HUSKY Health 2007 initiative targets children who are eligible but not enrolled in the HUSKY program. It waives the premium for the first two months following birth of an eligible child, eliminating any possible reason for not enrolling a newborn. The new initiative also focuses on health coverage for school-aged children. The governor is proposing to require health insurance status notification at the beginning of every school year and providing referrals to the HUSKY Plan for uninsured children.

Florida

Governor Charlie Crist has proposed to reverse some administrative and policy barriers that limited enrollment periods, tightened eligibility standards, increased documentation requirements, and created a complex administrative process that contributed to declining

enrollment in the Kidcare program.

The governor is supporting improvements in the structure and administration of the Kidcare program to provide health care benefits to more children.

The state is proposing to consolidate the fragmented Kidcare program under the Agency for Health Care Administration to create a more efficient and effective program, which, in combination with a better outreach and eligibility determination process, will result in more insured children.

Other features of the proposed system include a simplified and uniform eligibility determination process, uniform benefits and standards between Medicaid and SCHIP, presumptive eligibility, no caps on private full pay participants, and a seamless transition between Medicaid and SCHIP funding.

Georgia

Governor Sonny Perdue announced the Health Insurance Partnership initiative, a new incentive to help Georgia's small businesses offer coverage for their employees.

Under this plan, the cost of health insurance will be split between the state government, employers and employees. The state will use its bargaining power to work with private insurance companies to reduce costs for small businesses. Business owners will then have the option of offering their employees reasonably priced health insurance.

The state incentive will be available to workers who earn up to 300% of the poverty level. A $20 million investment by the state, when added to inputs from the federal government, the employer and the employee, will amount to a total of $182 million in total investment, which, it is estimated, will help cover 30,000 people in the first year.

Indiana

Governor Mitch Daniels has signed into law a series of health reforms to improve access and quality of care in the state. Indiana has created a health insurance plan for adults and pregnant women with incomes below 200 percent of the poverty level.

Under the Healthy Indiana plan, participating individuals will have a Personal Wellness Responsibility (POWER) Account, which acts as an HSA, with $1,100 to cover the deductible. A private health insurance plan approved by the state is available to individuals after they have met the deductible and includes services, such as preventive care and disease management. The plan also includes $500 for preventive care, such as physicals, screenings, chronic disease management, and smoking cessation.

Governor Rell has introduced a health care plan to provide access to care for all residents of Connecticut. The Charter Oak Health Plan will create a private-public partnership offering a state-defined benefit package through private insurers.

In addition, the plan, which passed with overwhelming bipartisan support, includes a 44-cent increase on cigarettes that is estimated to discourage 40,000 fewer youth smokers and 23,400 fewer adult smokers. As a result, an extra $11 million will go toward childhood immunizations.

In addition, the governor's health care initiative includes increasing eligibility in the SCHIP program to 300 percent of the poverty level and providing presumptive eligibility for pregnant women. The plan also uses incentives for employers by providing a small business qualified wellness program tax credit (50 percent of creating a qualified plan) and a tax credit for small businesses for the cost of setting up a Section 125 plan ($50 per employee). The law also gives the Family and Social Services Administration Secretary the authority to develop a program that allows small businesses to purchase group health insurance together.

Minnesota

Governor Tim Pawlenty has proposed "Healthy Connections," a health reform plan to increase access to affordable insurance and enhance the quality and value of care.

The plan proposes to modernize the MinnesotaCare (MNCare) program by reducing the premiums for children by a third, expanding eligibility to 300 percent of poverty for children, and increasing subsidies in private coverage rather than the state-provided MNCare program for children above 200 percent of poverty. For this option, a standard benefit package, called MNCare II, will be developed by the state and offered in the private market to ensure basic services are covered and coverage is affordable.

The governor's plan requires insurers with more than 3 percent of individual market to offer the

MNCare II. Insurers can modify the benefit in order to make it attractive to parents of children who may be enrolled. The governor's plan creates the Minnesota Health Insurance Exchange, a connector model, to make coverage more affordable and portable. Employers will be able to use the Exchange to give their employees access to health care coverage, and the individual market will be folded into the Exchange.

The Exchange will monitor the products being offered and ensure they meet basic requirements. It will also collect premiums and make the premium payments to the plans, reducing the administrative burden for both individuals and employers. Employers with more than 10 employees will be responsible for establishing a Section 125 plan to ensure their employees can make tax-free deductions of their insurance premiums from their paychecks. To build on Minnesota's current quality of care programs, the governor proposes to continue to invest in interoperable health systems and to provide transparency of quality and cost data in order for consumers to make informed decisions about their health care.

In addition to Healthy Connections, Governor Pawlenty also signed into law an effort to convene a Health Care Transformation Task Force to develop a statewide plan to improve affordability, quality, access and health status of Minnesotans. Recommendations to reduce the state's health care expenditures by 20 percent will be made by January 2011.

Missouri

Because Missouri's Medicaid program is sunsetting in 2008, Governor Matt Blunt is in a unique position to reform the Medicaid program and address the issue of the uninsured simultaneously.

The proposed redesigned Medicaid program, called MO HealthNet, focuses on prevention and wellness. MO HealthNet participants will be assigned to a health care home and will undergo a health care assessment to determine any chronic conditions that require management. In addition, the new Medicaid program stresses the importance of electronic health information technology. A health care home coordinator is responsible for monitoring the patients' conditions and sharing information electronically with the participant. The governor's plan to expand coverage to the uninsured also stresses the importance of prevention, wellness, and consumer engagement.

Under Governor Daniels' Healthy Indiana plan, participating individuals will have a Personal Wellness Responsibility (POWER) Account, which acts as an HSA, with $1,100 to cover the deductible.

The proposal requires the purchase of insurance premiums with tax-free dollars through the use of Section 125 plans set up by employers. The plan also allows for portability of health insurance to allow workers to stay insured when changing jobs. The proposal aims to increase enrollment in the state's high-risk pool by easing enrollment requirements for the program.

Mississippi

Last year, Governor Haley Barbour kicked off his "Healthy Mississippi" initiative to promote disease management and improve health care at a lower cost. Governor Barbour proposed and the Legislature passed the "Mississippi Healthy Students Act" this year, which requires 150 minutes of physical activity-based instruction per week and 45 minutes of health education instruction for K-8th grade students.

Additionally, the Governor has partnered with Blue Cross Blue Shield to promote the Let's Go Walkin' Campaign to get Mississippians active and raise awareness of the benefits of exercise. Nearly 23,000 packets and pedometers have been sent to individuals, churches, schools and businesses in 79 counties to serve as a tool to encourage healthy choices.

Governor Barbour has developed "Healthy Mississippi – A Worksite Wellness Program" to improve the overall health of state employees. It is a comprehensive program that will be customized to meet an agency's specific needs and challenges. The state employee insurance plan provides 100 percent pre-deductible coverage up to $250 for an annual wellness exam and an additional $50 for the completion of a health risk assessment.

In addition, the Barbour Administration is protecting the solvency of Mississippi's Medicaid program, while serving those who truly need it. Medicaid offers free annual physical exams to recipients, checking for diabetes and high blood pressure, and to make sure their medications are accurate.

Nebraska

Due to increasing costs of the state employee health insurance and increased expenditures for medications treating hypertension, diabetes, high cholesterol and depression, Governor Dave Heineman has established steering and advisory committees to address the wellness of state employees.

The program made a health appraisal survey available to state employees and is addressing the need for improved physical activity, nutrition, and smoking cessation. The program has requested proposals from organizations to offer tobacco cessation classes under contract for state employees.

The state is also providing literature outlining the variety of services offered by the Tobacco Free Nebraska program to all state employees. In addition, a website is being developed to provide health supports and a source for sound medical information for employees.

Rhode Island

The Rhode Island Office of the Health Insurance Commissioner created a "wellness health benefit plan" that insurers are required to offer to employers with fewer than 50 workers purchasing health plans.

The insurers will be required to offer a plan that is aimed at improving the health of its members by focusing on five wellness initiatives, including selecting a primary care physician and completing a health assessment. In addition, enrollees must pledge to maintain a healthy weight or participate in a weight management program, remain smoke-free or participate in a smoking cessation program, and participate in disease and case management programs, if necessary. It also requires participation in a wellness program and tiered physician networks.

The plan is expected to lower costs based on prevention incentives offered to enrollees. There are Basic and Advantage plans with different cost-sharing tiers, but the premiums for each plan will be the same. The average premium cannot exceed 10 percent of average wages in the state, and in 2007, will be $309 or $322 per month per individual, depending on the insurer. The wellness health benefit plan will be available in October 2007.

In South Carolina, Governor Sanford is proposing to increase access to affordable insurance by allowing small businesses to pool together to purchase health insurance as a "health group cooperative."

South Carolina

Governor Mark Sanford is proposing health reform activities to encourage greater use of the private marketplace to provide more affordable access to health insurance.

The governor is planning to establish a separate, standalone CHIP program that has a benefit package modeled after the federal or state employee benefit plan. By establishing a separate program, more funds will be available to expand eligibility to 200 percent of poverty. In addition, the separate SCHIP program will institute monthly premiums in an attempt to engage consumers and encourage personal responsibility. The premiums will discourage those currently in an employer-sponsored plan from dropping their employer coverage to enroll in the SCHIP program.

The governor is also proposing to increase access to affordable insurance by allowing small businesses to pool together to purchase health insurance as a "health group cooperative." By pooling their employees together, the small businesses will be able to negotiate lower premiums. The proposal also requires a report in 2010 to measure the effectiveness of the health group cooperatives. Governor Sanford's reform initiatives also include quality improvement and measurement. The governor is proposing to require all hospitals in the state to collect data on deaths resulting from hospital-acquired infections.

The hospitals would be required to submit the information to the state, which would then provide the data to the public. In addition, the state is planning to make e-prescribing more seamless by providing standards for the transmission of electronic prescriptions.

South Dakota

Governor Mike Rounds and the South Dakota legislature have created a task force to recommend solutions for the problem of the uninsured in

the state.

The initiative, called Zaniya, which is the Lakota Sioux Indian word for "taking care of the health and well being of your people," is made up of over 50 individuals. The task force will review public program expansions, private marketplace expansions and changes, and improving Indian Health Services both on and off the reservations.

Texas

Governor Rick Perry is proposing a premium assistance program to help low-income uninsured working adults to have access to affordable health insurance.

The state will offer varying levels of premium assistance based on a sliding scale. Participating plans must be certified by the state. The plans include a minimal deductible and copayments, which can be paid for by individuals out of an HSA that is set up by the state.

Utah

Governor Jon Huntsman has created an initiative to make health insurance more affordable by lifting the cap placed on SCHIP enrollment due to budgetary constraints.

In addition, the state is creating the Utah Health Insurance Exchange, which will offer affordable and portable health insurance to residents of the state. Paired with the Exchange, the governor's plan utilizes Section 125 plans. The design allows businesses to be able to offer insurance to their workers through the Exchange and to pay for the premiums tax-free.

Vermont

Governor Jim Douglas created a program that extends affordable insurance coverage while reducing health care costs through several quality improvement initiatives.

Individuals without access to an employer-sponsored insurance plan will be offered a Catamount Health plan, which is provided by private insurers and must offer a standard set of benefits defined by the state. Premiums will range from $60 per month for individuals with household incomes below 200 percent of poverty, to $135 per month for individuals with household incomes between 275 and 300 percent of poverty.

In addition, employers are required to pay $365 annually for each full-time employee if the employer does not offer insurance, only offers insurance to some workers, or some employees remain uninsured. This requirement is applicable to all employers with nine or more employees in 2007 and increasing to employers with five or more employees starting in 2010. Low-income, uninsured Vermonters with access to an employer-sponsored insurance plan will be offered premium assistance. Vermonters eligible for the state's Medicaid program with access to approved employer-sponsored insurance will also be offered premium assistance to participate in employer-sponsored insurance.

A chronic care management system will be created to manage the chronic conditions of individuals enrolled in Medicaid and the State Children's Health Insurance Program, Dr. Dynasaur. The law also proposes steps to control costs and cost shifts within the health care system by promoting healthy behaviors through a grant program to fund community health and wellness programs.

In addition, the state will adopt rules to permit health insurance companies to offer premium discounts or other incentives—known as a Healthy Choices Discount—to people who participate in health promotion or disease prevention programs such as smoking cessation. RF

Utah Governor Huntsman has created the Utah Health Insurance Exchange, which will offer affordable and portable health insurance to residents of the state.

Molly Voris is a Senior Policy Analyst in the Health Division of the National Governors Association. The above snapshot is drawn from a July report entitled, "Leading the Way: State Health Reform Initiatives," which can be found at www.nga.org. The summaries for GA and MS were not included in the report.

Schwarzenegger's Health Care Plan:

A Bridge too Far, or a Bridge to Nowhere?

DIANA ERNST

When Arnold Schwarzenegger introduced a plan this past January to reform California's health care system, many people said there was little chance the plan would ever be approved. The issues were too formidable, they claimed; the political hurdles, too high to overcome.

Nine months later, the California Legislature is meeting in a special session to consider a revised version of the Governor's plan. In looking at this revised proposal, the question that people should be asking is not whether it is a bridge too far politically, but rather, from the standpoint of good policy, whether it is a bridge to nowhere – an ill-conceived boondoggle that will cost too much and benefit too few.

The Governor has said he would "never close the door on anything," and his revised plan is proof. Perhaps the biggest highlights are that it will cost $5 billion more than the plan introduced in January, and would rely on the lottery to fund health care. The Governor has said that funding to replace the lottery (truly reliable funding) would have to be set later.

Under the new plan, California's workers, providers and individuals would still collectively strain to insure the state's uninsured. All Californians would have to buy health insurance, insurers would be subject to guaranteed issue, and hospitals would still be under the gun for 4% of revenues, but only after a few stipulations from the California Hospital Association.

Perhaps the most significant of these stipulations is that hospital taxes would be kept separate from California's general fund, and they would first go to increase Medi-Cal (Medicaid) payments to hospitals, and then to California's uninsured.

Of course, these increases will be soaked up quickly. The Medicaid bureaucracy owes providers some $750 million in reimbursements. As a result, fewer doctors are participating. Two long-term care facilities have already filed suits against the state of California for not providing requisite Medi-Cal payments. In fact, Medi-Cal is second only to Texas for the highest Medicaid bill in the U.S., at $35 billion. Nevertheless, Governor Schwarzenegger wants to expand Medi-Cal and related programs for 900,000 more Californians.

Amidst protests from the California Medical Association, the governor's new plan would no longer tax doctors 2%, but it would still tax employers -- this time, based on payroll rather than the number of employees. If the business' payroll is more than $100,000 and you don't already offer health benefits, then you will pay a health care fee on a sliding scale from 0-4 %.

Perhaps the single best aspect of the Governor's revised plan is to align state tax laws with federal laws by allowing Californians to make pre-tax contributions to Health Savings Accounts (HSAs), a kind of 401(k) for health. HSAs paired with high-deductible health plans will encourage Californians to save for health care rather than depending on employers or the government. More than a third of today's HSA owners were previously uninsured.

Schwarzenegger is working towards a finance proposal for the November 2008 ballot. If he really does intend to "keep the door open" through this process, then he should follow the lead of State Senate Republicans to fix, rather than force, insurance.

The state should reform "scope of practice" laws affecting nurse practitioners, who are qualified to provide basic, affordable health care. This would allow Californians to take advantage of retail-based "convenient clinics," a competitive answer to emergency rooms for basic services. Also, costly government-mandated health benefits force Californians out of individual insurance. Insurers need to compete with each other to meet the needs of individual patients.

These incremental, common sense steps may not provide for dramatic headlines. But they will provide people with a bridge that leads to a better health care system – a system that is defined not by government taxes or mandates, but by choice, quality and cost-effective care. **RF**

Diana Ernst is a Health Care Policy Fellow at the Pacific Research Institute.

Health Care Reality Check:

The goal of any reform plan should be the same as the Hippocratic Oath: First, do no harm.

MICHAEL TANNER

Health care reform is once again at the top of the nation's political agenda. But in developing health policy, it is vital to keep in mind one pertinent fact: for all its problems, the United States offers the highest quality health care in the world.

Most of the world's top doctors, hospitals, and research facilities are located in the United States. Seventeen of the last 25 winners of the Nobel Prize in Medicine either are U.S. citizens or work in this country. U.S. companies have developed half of all the major new medicines introduced worldwide over the past 20 years.

In fact, Americans played a key role in 80% of the most important medical advances of the past 30 years. Nearly every type of advanced medical technology or procedure is more available in the United States than in any other country. By almost any measure, if you are diagnosed with a serious illness, the United States is the place you want to be. That is why tens of thousands of patients from around the world come to this country every year for treatment.

Of course, critics of American health care often point out, other countries have higher life expectancies and lower infant mortality rates, but those two indicators are not a good way to measure the quality of a nation's health care system. In the United States, very low-birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low-birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low-birth-weight infants are not included when infant mortality is calculated.

And life expectancy is a poor measure of a health care system. Life expectancies are affected by exogenous factors such as violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health care. Consider the nearly three year disparity in life expectancy between Utah (78.7 years) and Nevada (75.9 years), despite the fact that they essentially have the same health care systems. In fact, these exogenous factors are so distorting that if you correct for homicides and accidents, the U.S. rises to the top of the list for life expectancy.

On the other hand, when you compare the outcome for specific diseases like cancer or heart disease, the United States clearly outperforms the rest of the world. Take prostate cancer, for example. Even though American men are more likely to be diagnosed with prostate cancer than their counterparts in other countries, they are less likely to die from the disease. Less than one out of five American men with prostate cancer will die from it, but 57% of British men and nearly half of French and German men will. Even in Canada, a quarter of men diagnosed with prostate cancer die from the disease.

Similar results can be found for other forms of cancer. For instance, just 30% of U.S. citizens diagnosed with colon cancer die from it, compared to fully 74% in Britain, 62% in New Zealand, 58% in France, 57% in Germany, 53% in Australia, and 36% in Canada.

Similarly, less than 25% of U.S. women die from breast cancer, but 46% of British women, 35% of French women, 31% of German women, 28% of Canadian women, 28% of Australian women, and 46% of women from New Zealand die from it.

The same U.S. advantage can be found for outcomes with other diseases, ranging from AIDS to heart disease. This should not be surprising. The one common characteristic of all national health care systems is that they ration care. Sometimes they ration it explicitly, denying certain types of treatment altogether. More often, they ration more indirectly, imposing global budgets or other cost constraints that limit the availability of high-tech medical equipment or imposing long waits on patients seeking treatment.

For example, more than 750,000 Britons are waiting for admission to National Health Service hospitals at any given time, and shortages force the NHS to cancel as many as 50,000 operations each year. Roughly 90,000 New Zealanders are facing similar waits. In Sweden, the wait for heart surgery can be as long as 25 weeks, while the average wait for hip replacement surgery is more than a year.

And, in Canada more than 800,000 patients are currently on waiting lists for medical procedures. A study in the Canadian Medical Association Journal found that at least 50 patients in Ontario alone have died while on the waiting list for cardiac catheterization. And Canadian Supreme Court Chief Justice Beverly McLachlin wrote in a 2005 decision striking down part of Canada's universal care law, that many Canadians waiting for treatment suffer chronic pain and that "patients die while on the waiting list."

...in developing health policy, it is vital to keep in mind one pertinent fact: for all its problems, the United States offers the highest quality health care in the world.

Obviously, there are problems with the U.S. system. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes. Health care reform is not a choice, but a necessity.

But in pursuing reform, we should be guided by the Hippocratic Oath: First, do no harm. We should make very certain that the cure is not worse than the disease.

We must do nothing to undermine the free-market health care system that gives us the world's best care. **RF**

Michael Tanner is the Director of Health and Welfare Studies at the Cato Institute.

From Barefoot Doctors to Red Envelopes

China's health care system is weighed down by a legacy of government control.

MARY A. BRAZELTON

As Beijing prepares to host the Olympic Games in August 2008, the entire People's Republic of China is preparing for a celebration of its newfound economic and political preeminence. Schoolchildren across the country are taking part in performances devoted to the advent of the Games; signs urge pedestrians to "promote Chinese culture" by being more polite; and whole neighborhoods are being razed in order to make way for shiny new stadiums and high-rise apartment buildings.

These would all seem to be indicators of China's great progress and ascent as a developed nation. But in some respects, China still has a long way to go. Pollution, human rights, freedom of the press: all have received attention in the Western media as areas of conduct for which the People's Republic has received international censure. However, one of the most critically underdeveloped aspects of Chinese government and society – and one from which we have much to learn in the U.S. – is something that we often take for granted: the availability of basic health care.

The average American would find a Chinese hospital surprisingly dirty, crowded, and dark. It is not unheard of for disposable syringes to be reused over and over again without disinfection, IV drips to be filled with fake protein plasma, and rat poison to be found in hospital food. The hallways are full of families who have traveled a long way from their home villages to visit a city hospital. They must pay exorbitant prices in order to receive a very low level of care. The situation for most patients has become so dire that in November 2006, over two thousand people in Sichuan Province rioted in anger at the high cost and low quality of health care available there.

A baby with respiratory problems and an adult with high blood pressure wait to see the doctor in Li Jia Wa Zi village in China in April 2006. Ma Dong Ji, center, is the only doctor practicing in this mountainous region. He travels by scooter and receives a portion of medicines from the government, the remainder coming from private NGOs. *Source: Corbis.*

How did health care in China get this bad? And could it happen in the U.S.?

The case of China provides us with a unique and important example of a country that has functioned under both socialized and free-market medicine. Medicine in China is in a sorry state today in part because of the government's longstanding reliance on a national health care system – one that failed to provide advanced health care to its citizens and overburdened the national economy. In studying the evolution of China's health care system, American policymakers can better understand the risks involved in both systems as they consider the prospects of universal health insurance in the U.S.

China's health care infrastructure has its roots in Communist policies of the 1960s and 1970s that gave universal but basic medical care to the entire nation. In the early days of the People's Republic, Mao Zedong set up a highly effective system in which "barefoot doctors" were given a minimal amount of medical training and sent into the countryside to treat villagers with a combination of modern Western and traditional drugs. In urban centers, free clinics and hospitals were set up for citizens.

The government's emphasis was on making basic public health available to as much of the population as possible – and to an extent, they succeeded. Thanks to the work of barefoot doctors, there was a dramatic improvement in basic care availability. The life expectancy of Chinese citizens jumped from 35 to 68 years between 1952 and 1982. Citizens had access to Western medicine for the first time in many rural areas, and infant survival rates surged. In fact, the rapid advances in quality of care made under Mao are considered one of the chief administrative achievements of the Communist regime to date; economist and Nobel laureate Amartya Sen has touted the system as a model of socialized

medicine.

However, China's national health care system demonstrated some characteristic pitfalls. For instance, during the Cultural Revolution of the 1960s, many surgeons and advanced specialists received censure for their elite social standing, and were sent to rural labor camps for "re-education." Uneducated revolutionaries were left in charge of China's national health system, with correspondingly disastrous results. Professional schools were shut down, and an entire generation of medical students was barred from receiving a suitably rigorous education.

The horror stories of doctors in the Cultural Revolution may seem extreme, but their implications are applicable to a broader perspective on universal health care as we consider an American plan for nationwide coverage. While instituting national health care in the U.S. clearly would not involve the mandatory assignment of medical leaders to rural fieldwork, it could have a detrimental effect on American health care professionals. In a universal health care scheme, for example, U.S. doctors would face the risk of losing their salaries and clinical autonomy to a big government bureaucracy that could eventually dictate who gets seen, at what time, and what course of treatment to take.

Perhaps the most important point for American policymakers to consider is that the successes of universal health care in the U.S. would be limited by a resulting lower quality of medicine. Communist health care demonstrated that nationalizing medicine could be accomplished with relative facility, but totally modernizing it was a much more difficult and expensive task.

The old Communist system of medicine died out in the wake of Mao Zedong's death and Deng Xiaoping's rise to power, when the government moved to privatize many state industries in the 1980s and 1990s as part of a push to modernize the economy. At this time, the People's Republic abandoned much of its financial support for medicine. With only minimal official control or support, the costs of medical care skyrocketed up to market-competitive levels while its quality remained low – resulting in the dirty, crowded hospitals still functioning in many cities and rural areas today.

Furthermore, rampant corruption was soon pervasive in hospitals and clinics. For instance, the government's attempts to keep prices artificially low created a common situation known as "the red envelope" in which surgeons often demand extra payment from a patient before performing a procedure; the bribes are handed over covertly in traditional red packets filled with cash.

The deplorable situation of China's market-based medicine ultimately has its roots in the nationalized medicine of the 1950s and 1960s. As a state-run system, health care had grown too financially burdensome for the Chinese economy to support. As procedures became more advanced, costs rose, so that privatizing medicine merely shifted the growing cost burden of increasingly advanced care from the government to the people themselves.

Communist health care demonstrated that nationalizing medicine could be accomplished with relative facility, but totally modernizing it was a much more difficult and expensive task.

Where the Chinese government did retain some control over the costs of medicine, the result was disaster. When state-run medicine was dissolved, local governments were left with the responsibility of providing health care to citizens; with fewer resources available, these administrations could not afford the hospitals and health care facilities that the national government had provided. Private entities bought many of these facilities and began to provide health care at increasingly high costs. Meanwhile, Communist work units were dissolved as part of a push for privatization of industry, and the universal health insurance system that had been in place until now was also totally dismantled.

According to Princeton economist Gregory Chow, the result was that the catastrophically low supply of available health care could not meet the growing population's demand for it, prices skyrocketed, and subsequently a vast percentage of Chinese workers – especially in rural areas – ended up without minimal medical access. In short, the government's retention of partial control over health care contributed to the poor quality of medical care available today by manipulating the "free-market" health care system.

What lessons can U.S. lawmakers learn from China's failed experiences with state-run and market-based health care? One is that they must not underestimate the sheer cost of socialized health care. Just as China's national economy couldn't support it, our government faces the prospect of limiting the amount and quality of routine care available to American citizens if it chooses to take control of the country's medical system.

Another important take-away message is the more grievous error of mixing two disparate systems of health care; as China's example demonstrated, applying market principles to socialized medicine resulted in a severe discrepancy between the supply and demand for health care with disastrous consequences. For U.S. policymakers attempting to achieve the opposite transition – to nationalize a market-based system of health care – the consequences could be equally severe.

As Congress tackles this issue, it must take care not to sicken our already-struggling health care system by reforming it too hastily – and more importantly, it must not forget that the health of the American people is at stake. **RF**

Mary A. Brazelton is a student at Harvard University and editor for the school newspaper, The Crimson. An editorial assistant at the Ripon Forum this past summer, she is completing her undergraduate thesis on the history of American medical education in China.

Should SCHIP be Expanded?

Yes, the program is working, and America's families need the coverage it provides

OLYMPIA J. SNOWE

As most everyone knows, the problem of the uninsured touches communities all across our country.

Thankfully, we have made tremendous strides in dramatically lowering the number of uninsured children through SCHIP which, time and again, has proved to be both a successful program and a saving grace for millions of American families who otherwise simply could not afford to pay for their children's health care.

The stakes could not be more monumental. The quality of the health care that one receives as a child can have dramatic implications later in life. And there is not a family in America who does not want to provide the most comprehensive health coverage possible for its children.

While some may mistakenly characterize SCHIP coverage as a welfare benefit, what they may not realize is that nearly 90 percent of uninsured children come from families where at least one parent is working. Today, fewer than half of parents in families earning less than $40,000 a year are offered health insurance through their employer – a 9 percent drop since 1997. And for many working families struggling to obtain health care, if benefits are even accessible to them, the costs continue to rise, moving further out of their reach.

In my own state of Maine, a family of four can expect to pay $24,000 on the individual market for its coverage. For most families, taking this path is unrealistic and unworkable, especially when factoring the cost of mortgages, heating bills, and myriad other financial pressures. With lives literally hanging in the balance, we ought to be building on what works.

We are the wealthiest Nation on Earth, and if we are unable to provide health insurance and medical care to our young people, then what does that say about our values?

Regrettably, we have heard a litany of reasons why we shouldn't cover more children through SCHIP. Some have expressed concerns about the size and cost of the package. I would respond that it should inject a dose of reality on the magnitude of the problem. States have responded to the call of families who are struggling every day with the cost of health insurance and are assuming a tremendous burden in the absence of Federal action.

In addition, we should bear in mind that this bill is $15 billion below the amount we provided for in the budget resolution. Again, this bill is the product of compromise. Some of us wanted to go further. Senator Jay Rockefeller (D-WV) and I, for example, introduced legislation to reauthorize the program at the full $50 billion -- a bill that garnered 22 bipartisan cosponsors.

Although there were compromises made along the way on various policy positions, one point is not up for discussion -- simply maintaining the status quo of current levels of coverage is unacceptable. And while the Congress and the White House argue over philosophical differences, children are either going without coverage, or their parents are financing their care on credit cards, hoping they can stay on top of their debt.

We are the wealthiest Nation on

(see Snowe, page 30)

Should SCHIP be Expanded?

No, it will result in bigger government, not better care for our kids

DAVE CAMP

Lacking the overwhelming bipartisan accord that created the State Children's Health Insurance Program nearly a decade ago, Democrats in Congress have instead opted for a massive liberalization of the program that dilutes its primary mission: covering children.

This bill, as passed by the House (where there wasn't a chance to amend the bill) and Senate, clearly isn't about helping low-income children. If it was, it would have support from both parties and the president would be eagerly waiting to sign it into law. This is a missed opportunity.

Virtually everyone supports providing health insurance to low-income children. But when a federal health program for children starts covering not only families, but childless adults making three and four times the poverty level, it has unmistakably lost its focus.

It is plain to see that Democrats want taxpayers to fund and the federal government to directly provide health care benefits to millions of more Americans — even for those families making over $80,000 a year. They are using SCHIP as a vehicle, and the children it is intended to cover as a shield, to get one step closer to total government control over our health care system. This kind of medicine needs more than a teaspoon of sugar to swallow.

The current plan to expand the State Children's Health Insurance Program is in dire need of a second opinion. Instead of moving further and further away from the core mission, we should be reforming the program to ensure it is truly helping America's uninsured children.

...when a federal health program for children starts covering not only families, but childless adults making three and four times the poverty level, it has unmistakably lost its focus.

Let's look at some facts about the "new, improved" SCHIP:

1. Shifting, not adding, insurance -- The non-partisan Congressional Budget Office stipulates that the proposed expansion of SCHIP would cover an additional 5.8 million Americans at a cost of $35 billion. Alarmingly, CBO also states that more than one out of every three of those individuals (some children and some adults) already has private insurance. Some experts suggest that number is as high as six in 10.

Either way, it is clear that the SCHIP bill does little more than move children and upper-income families from private insurance plans to taxpayer-funded plans. That is why it should not surprise anyone that when HillaryCare first came about, one of three options to obtain universal, government coverage followed this exact model: start with kids, move on to the entire family, and soon you will have everyone enrolled in a government program.

That kind of slow creep is a prescription for the government largess that stifles economies and unduly burdens taxpayers. It is not a prescription for reducing the number of uninsured Americans.

2. States get more money, but some states don't -- States and

(see Camp, page 30)

(Camp, cont'd. from page 29)

children advocates should take a second look at this bill. Because of shoddy funding sources, this bill is likely to harm more states and health care programs than it purports to help. A Heritage Foundation study showed that as many as 28 states, including my home state of Michigan, stand to have a net loss of $10 to $700 million in revenue.

3. Kids born today lose coverage at age six -- Supporters of this SCHIP expansion state that the program is fully funded. However, when you look closely at the details you find a giant funding cliff after five years. In year six, after five straight years of increases, funding reverts to 65% below current levels. That is quite a budgetary slight-of-hand given that the program's average cost is pegged at roughly $12 billion a year. So, what happens in year six? Do taxes go up to cover the shortfall? Is coverage eliminated for millions of kids that just entered the program?

4. With apologies to the American Cancer Association: Light up…it's for the kids -- As ridiculous as the assumption that the program costs nothing after five years, is the assumption that there will be 22 million new smokers to pay for this program. Being built upon the foundation of a new federal 61 cent per pack tax on cigarettes, the program will quickly go up in smoke.

Over the years we have learned that the more we tax any activity, but especially cigarettes, the less likely people are to engage in the activity. To that end, cigarette taxes have been a great health care policy. Even if we forget how terribly regressive this tax is – falling heaviest on lower-income Americans (those ironically targeted for help under SCHIP) – it is clear that a cigarette tax may be the worst possible stream of revenue for an ongoing program.

This bill is designed poorly, funded poorly and will do little to help lower-income Americans obtain health care coverage. The president should veto this bill and Congress should work in a bipartisan fashion — as we did nearly ten years ago when the program was created — to make certain children in America have access to the health care system. **RF**

Dave Camp represents the 4th District of Michigan in the House of Representatives. He serves as the ranking member of the Ways and Means Health Subcommittee.

(Snowe, cont'd. from page 28)

Earth, and if we are unable to provide health insurance and medical care to our young people, then what does that say about our values?

Some of my colleagues contend that the SCHIP reauthorization we are considering is the first step toward government-run health care and that we will substitute public coverage for private insurance. The fact is that this SCHIP program came into being ten years ago. We haven't seen that evolve from the SCHIP program. We didn't see it materializing into a government-run health care program, as many have alleged here today. It absolutely hasn't happened. What we did was identify a need and address it in a bipartisan manner.

These claims ignore the fact that today 73 percent of the children enrolled in Medicaid received most or all of their health care services through a managed care plan. In fact, America's Health Insurance Plans, AHIP, a national association representing nearly 1,300 member companies, has recently endorsed this legislation, stating "it repairs the safety net and is a major movement toward addressing the problems that States and Governors have been trying to address, which is how to get access for children.'' The bill also helps shore up employer-based coverage by granting states the option to subsidize employer-sponsored group health coverage for families that find the coverage beyond their financial means.

Some have also argued that SCHIP should reduce coverage for adults, especially childless adults. While I believe that coverage for adults can have a clear benefit for children – both in terms of enrollment of children as well as the simple fact that health problems for a working parent can lead to economic insecurity for the family – this approach represents an area where we had to compromise. But I find it contradictory that the Bush Administration, which has been so vocal in its opposition to the cost and scope of the compromise package, granted the majority of the fourteen adult coverage waivers granted over the past ten years and renewed a waiver for adult coverage in May!

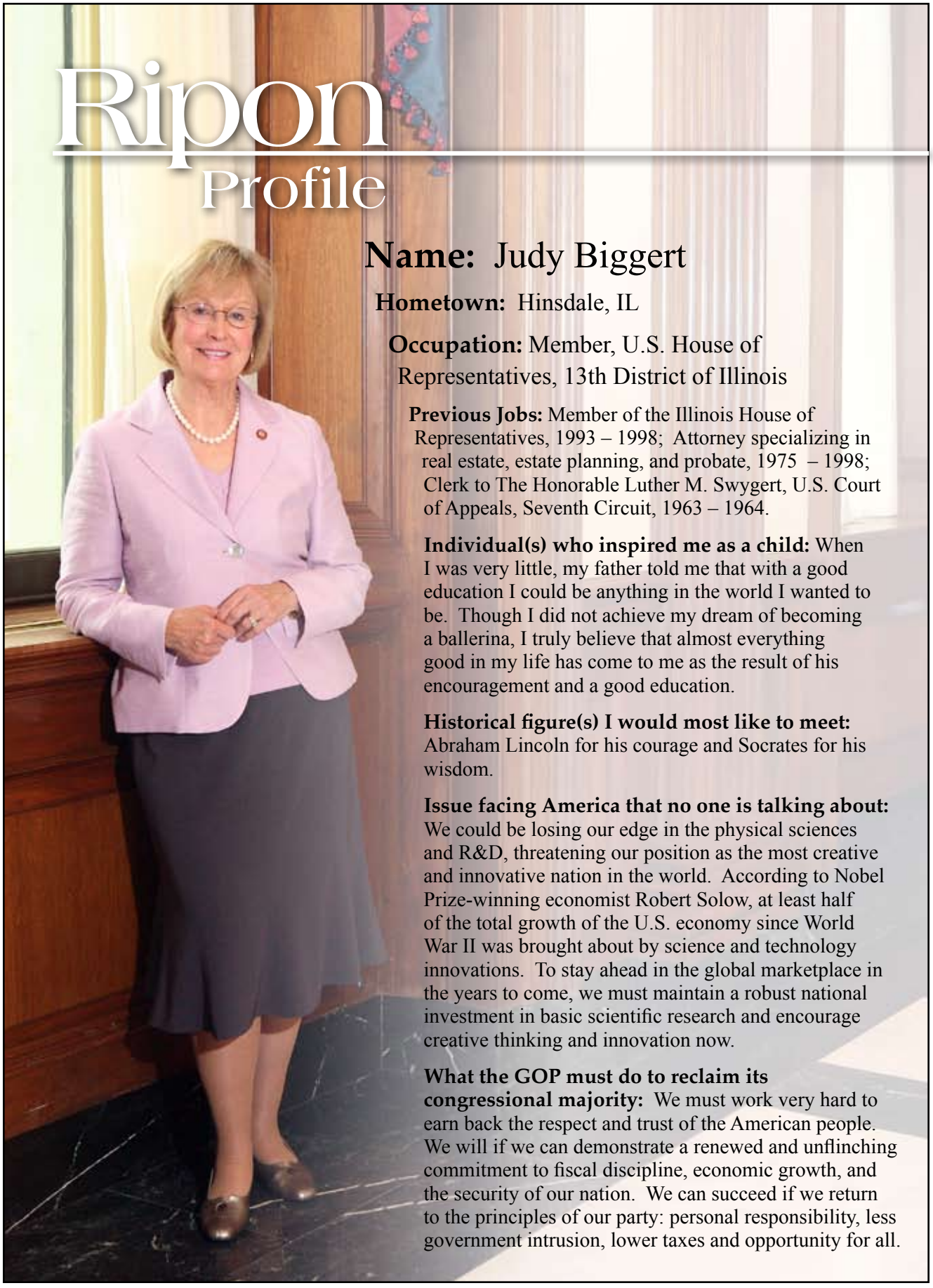
Frankly, I believe the President's decision to veto this bill is an outrage, and a decision that seriously misjudges the genuine concern Americans have about access to care -- particularly for children. In a March New York Times/ CBS News poll, 84 percent of those polled said they supported expanding SCHIP to cover all uninsured children. A similar majority said they thought the lack of health insurance for many children was a ``very serious'' problem for the country.

SCHIP has been the most significant achievement of the Congress over the past decade in legislative efforts to assure access to affordable health coverage to every American. We must not undermine the demonstrated success of this program over the past decade.

Compromise on both sides of the aisle helped us create this program ten years ago, and, hopefully, a renewed sense of bipartisan commitment will help us overcome the objections before us and successfully reauthorize this vital program. **RF**

Olympia J. Snowe represents the State of Maine in the U.S. Senate. She serves on the Health Subcommittee of the Senate Finance Committee.

Ripon Profile



Name: Judy Biggert

Hometown: Hinsdale, IL

Occupation: Member, U.S. House of Representatives, 13th District of Illinois

Previous Jobs: Member of the Illinois House of Representatives, 1993 – 1998; Attorney specializing in real estate, estate planning, and probate, 1975 – 1998; Clerk to The Honorable Luther M. Swygert, U.S. Court of Appeals, Seventh Circuit, 1963 – 1964.

Individual(s) who inspired me as a child: When I was very little, my father told me that with a good education I could be anything in the world I wanted to be. Though I did not achieve my dream of becoming a ballerina, I truly believe that almost everything good in my life has come to me as the result of his encouragement and a good education.

Historical figure(s) I would most like to meet: Abraham Lincoln for his courage and Socrates for his wisdom.

Issue facing America that no one is talking about: We could be losing our edge in the physical sciences and R&D, threatening our position as the most creative and innovative nation in the world. According to Nobel Prize-winning economist Robert Solow, at least half of the total growth of the U.S. economy since World War II was brought about by science and technology innovations. To stay ahead in the global marketplace in the years to come, we must maintain a robust national investment in basic scientific research and encourage creative thinking and innovation now.

What the GOP must do to reclaim its congressional majority: We must work very hard to earn back the respect and trust of the American people. We will if we can demonstrate a renewed and unflinching commitment to fiscal discipline, economic growth, and the security of our nation. We can succeed if we return to the principles of our party: personal responsibility, less government intrusion, lower taxes and opportunity for all.

Above All, Try Something

When it came to policymaking, Franklin Roosevelt once offered this piece of advice: "It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something."

Today across America, Governors are following this advice and moving ahead with various policy proposals that may or may not succeed. Health care is a good example. In state after state, Governors are taking action to make health care more affordable and accessible to the people they lead.

In Georgia, for instance, Sonny Perdue recently announced the Health Insurance Partnership initiative, a new incentive to help small businesses offer coverage for their employees. In Connecticut, Jodi Rell has created a private-public partnership offering state residents a state-defined benefit package through private insurers. And in Minnesota, Tim Pawlenty has established "Healthy Connections," a health reform plan to increase access to affordable insurance and enhance the quality and value of care.

Surprisingly, these and many other efforts to improve health care in states are being led by Governors who are Republicans. This is surprising because if you have been following the news coming out of Washington this fall, the perception is that Republicans are against doing anything about health care. Indeed, in the debate over expanding the State Children's Health Insurance Program (SCHIP), battle lines have been drawn that depict Democrats as being in favor of improving health care for children and Republicans as being opposed. Of course, the story is more complex than that, and there are valid arguments on either side. But in the battle of perceptions, Republicans in Washington are losing the health care debate.

There are several reasons for this, not the least of which is the core governing philosophy of both political parties. Democrats tend to favor direct federal assistance to help people who are in need, while Republicans generally believe the role of government should be to create the conditions and lower the barriers so individuals can succeed. The higher ground is easier to acquire when you are throwing cash down from the top of a hill. That's why Democrats usually have the advantage in most domestic policy debates. It's also why the GOP usually ends up with a much harder sell.

But you've got to have a message before you can make the sale. Unfortunately, when it comes to health care, Republicans in Washington haven't had much to promote. As a result, they are left arguing about numbers, criticizing, for instance, the fact that the Democrats' proposal would expand SCHIP benefits to people who live at 300% of the poverty line. That's obviously a relevant point. But how many people know what that actually means in terms of income? I didn't until I checked, and yet that has been one of the main Republican talking points in the SCHIP debate. It brings back memories of the 1995 government shutdown, when Congressional Republicans got bogged down talking about the difference between CBO and OMB numbers when it came to balancing the budget, while Bill Clinton simply talked about the fact that senior citizens might not be receiving their Social Security checks if a shutdown were to occur. We all remember who won that debate.

One of the few issues these days where Republicans still hold an advantage over Democrats is terrorism. There's a reason for that. Ever since 9/11, the GOP has done an exceptional job of personalizing the war on terror. A dirty bomb in the mall. A shoe bomb on a plane. A chemical attack on the subway. Republicans have succeeded in bringing this issue home to the American people. To communicate their goals on health care, they've got to figure out a way to do the same thing. And just as importantly, they've got to do it in a tone that conveys both empathy and humility – a tone that not only says "I understand what you're going through," but also acknowledges that "There, but for the Grace of God, go I."

...you've got to have a message before you can make the sale. Unfortunately, when it comes to health care, Republicans in Washington haven't had much to promote.

In that regard, it does Republicans absolutely no good when a conservative commentator such as Michelle Malkin stakes out the home of a 12 year old boy to refute claims, made by Democrats, that he is the type of young person who will benefit by SCHIP being expanded. The GOP should condemn these kinds of actions and tactics for what they are: mean-spirited and petty. It's not the boy's fault he has been brought into this debate. Republicans use kids as political props, too. It doesn't matter if it's right or wrong. It's politics, and politics is about people's lives.

When it comes to health care, Republican Governors around the Nation seem to understand that. Republicans in Washington often give off the impression that they don't. But it's not too late for them to change this perception.

All they have to do is follow FDR's advice -- they have to try something. If it fails, admit it frankly, and try something else. But above all, try *something*. **RF**

Louis M. Zickar is the Editor of The Ripon Forum.

IT'S 2007, NOT 1977

Congress is playing '70s-style energy politics. What about America's energy future?

The 1970s was a bad decade for fashion, hairstyles and, especially, energy policy.

So why are some in Congress playing '70s-style energy politics, pushing the kind of gasoline price controls and energy tax hikes that led to gasoline shortages, long lines at the pump and increased imports?

These schemes will increase the cost of energy for American consumers and businesses. They'll curtail access to America's plentiful domestic energy resources and restrict advanced energy research.

The U.S. Department of Energy predicts Americans will need 28 percent more energy by 2030. It's time for energy policies that ensure future generations have the energy they'll need at home and on the job.

Tell Congress you oppose new energy taxes and price controls. Because it's time for real energy policies, not old-fashioned energy politics.

EnergyTomorrow.org

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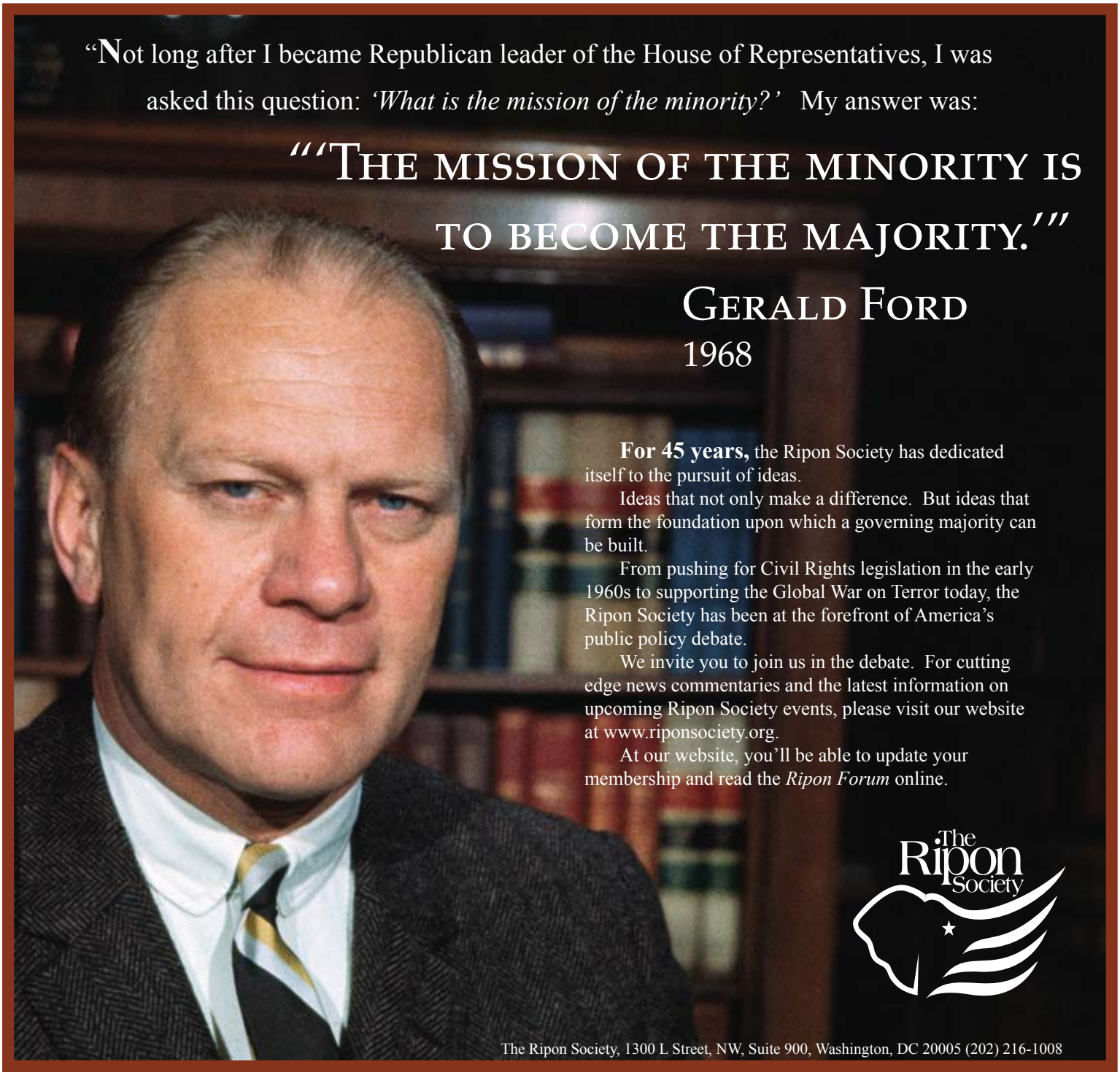

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