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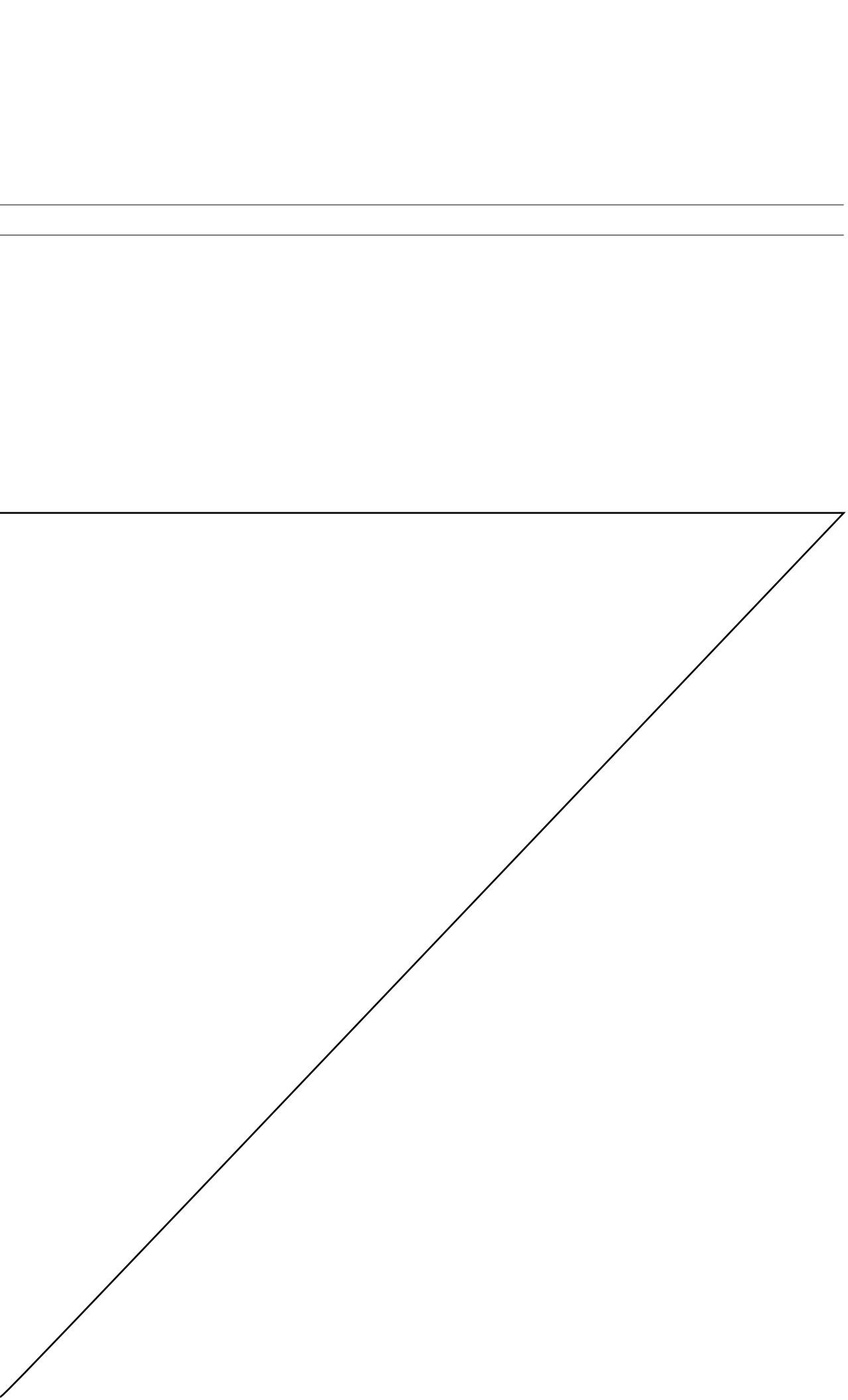
INTRODUCTION

With the 2008 presidential election just weeks away, health care reform is at the top of the nation's domestic policy agenda. The soaring costs of health care, along with a faltering economy and lackluster wage growth, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. A recent Commonwealth Fund study found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, were insured but had such high medical costs compared with their incomes that they were underinsured, reported a problem paying medical bills, or did not get needed care because of its cost. Over the past seven years, such problems have crept up the income scale among people with and without health insurance. Consequently, voters are calling for change: eight of 10 adults said in a May survey that the health care system is in need of a major overhaul or fundamental reform.

Both presidential candidates, Senator John McCain (R–Ariz.) and Senator Barack Obama (D–Ill.), have proposed plans to reform the health insurance system in the United States. They also have put forth ideas to improve the quality and efficiency of care. To inform the public discussion about possible paths to reform, this report describes the candidates' proposals, examines key differences in their vision of a future health insurance system, and evaluates the proposals against key principles outlined by the Commonwealth Fund Commission on a High Performance Health System.

DISTINCT APPROACHES TO HEALTH CARE REFORM

The presidential candidates' health care reform proposals offer fundamentally different visions of the future of health insurance in the United States. Both candidates propose reforms in which the health system would



individual market with an insurance exchange, in which small businesses and people without access to employer or public coverage could purchase a private health plan or a public plan with premium subsidies and tax credits. Insurers, including those selling policies outside the exchange, would be prevented from rejecting applicants or charging higher premiums because of preexisting conditions.

- **Reducing vs. expanding the role of employers in providing health benefits.** About 160 million people, more than 60 percent of the population under age 65, have insurance coverage through an employer. As stated above, McCain proposes to treat employers' contributions to employees' health insurance premiums as taxable income and provide tax credits for people to apply to their employer plans or to individual market plans. This change has the potential to reduce the incentive for many employers, particularly small employers, to continue providing health coverage to their employees. Obama's proposal would require all employers, other than small businesses, to offer coverage to their employees or pay part of the costs to cover them. This would allow most people to keep the coverage they have and maintain the more than $400 billion in employer contributions to health insurance currently in the system. He would provide tax credits to small businesses to buy coverage through the insurance exchange and would offer federal reinsurance for employers that experience catastrophic claims.

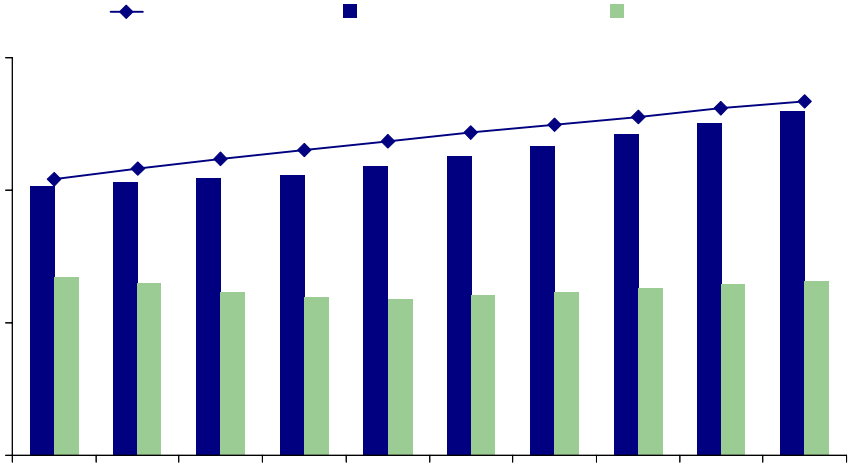
- **Reducing vs. expanding Medicaid and SCHIP.** McCain has said he would allow states to use Medicaid funds to enable purchase of private insurance by eligible families. To the extent that healthier Medicaid enrollees opted for private coverage, this option could fragment the program's risk pools into healthy and less healthy groups. Obama would raise income eligibility levels for Medicaid and SCHIP, allowing more people to join the programs. This would expand the large risk pools of Medicaid and SCHIP.

- **More vs. less exposure to health care costs.** McCain does not specify a standard floor for benefits and cost-sharing, which means that people buying coverage on the individual market with his new tax credits could face wide variations in their premiums, benefits covered, and out-of-pocket costs. He has said he would provide subsidies to help people with preexisting health conditions buy coverage in high-risk pools, though he has not specified the size of the subsidies or what household income levels would qualify. Obama would provide premium subsidies, on a sliding-scale based on income, for people to buy private or public plans through the insurance exchange; he has not specified the size of the subsidies or the eligible income levels. Obama would require that the public and

private plans sold through the exchange have benefits and cost-sharing similar to that available to federal employees and members of Congress.

- **No requirement vs. requirement to have coverage.** McCain would not require that people have health insurance. Obama would require that children have health insurance and has said he would consider a similar requirement for adults if substantial numbers of people do not buy coverage that is deemed affordable.

- **The same vs. more leverage to stimulate improvement in quality and efficiency.** Both candidates have proposed conceptual approaches to improving the quality and efficiency of care. The candidates agree that: the U.S. should change the way providers are paid; care, especially chronic disease care, should be better coordinated and managed; and preventive services should be covered and easily accessed. However, their proposals for health insurance reform could significantly affect their ability to achieve improvements in quality and efficiency throughout the system. Both candidates point to public programs such as Medicare, Medicaid, and SCHIP as places to implement quality and efficiency initiatives, such as paying doctors and hospitals on the basis of quality. But because McCain's reforms would entail even less oversight of private insurance markets than we have today, he would be limited to implementing such initiatives in public programs. In contrast, Obama's proposed creation of a new public plan and an insurance exchange would provide new and larger arenas in which to experiment with quality and efficiency innovations. He has also identified the Federal Employees Health Benefits Program (FEHBP) as an insurance program in which innovations in quality and efficiency might be pursued. For example, providers and health plans participating in public programs and the exchange could be required to develop chronic disease management programs. The more organized insurance markets ar



Source: L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans,* Urban Institute–Brookings Institution Tax Policy Center, Updated September 12, 2008.

* Estimates based on assumptions made by the Tax Policy Center about key details of the proposals that have not yet been made clear.
Source: L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans,* Urban Institute–Brookings Institution Tax Policy Center, Updated September 12, 2008.

! If implemented in 2009, McCain's proposal is estimated to reduce the number of people who are uninsured by 1.3 million at a cost of $185 billion, though this does not include the effects of high-risk pools. About 20 million people would lose employer coverage under the McCain proposal, and 21 million would gain

coverage in the individual market. Obama's plan is estimated to reduce the number of uninsured people by 18.4 million in 2009 at a cost of $86 billion.

- In the first year, McCain's plan is estimated to cost more than twice as much as Obama's while covering 17 million fewer people because most of McCain's tax credits would likely be used by people who already have private health insurance.
- By 2018, McCain's plan is estimated to reduce the number of uninsured by just 2 million out of projected 66.8 million uninsured at a cost of $64 billion. Obama's plan is estimated to reduce the number of uninsured by 33.9 million in that year at a cost of $237 billion.
- Over the 10-year period, the Center estimates that the total federal cost of McCain's plan could reach $1.3 trillion and the cost of Obama's plan could reach $1.6 trillion.
- McCain's proposal is estimated to cover fewer people in future years and cost less over time because the tax credits would grow at the rate of consumer prices, which have historically grown more slowly than medical expenditures. This means that, over time, the value of the tax credits is expected to decline relative to premium costs. This has two implications: 1) fewer people would be able to afford to buy health insurance with their tax credits and 2) people with employer coverage will pay more taxes on employer-provided premium contributions, thus offsetting the federal government's cost of the tax credits over time.
- The Center estimates that McCain's high-risk pool proposal, if adequately financed, could add another $1 trillion to the cost of his plan over 10 years. This feature is likely to be expensive for two reasons: 1) allowing people to buy coverage across state lines would remove existing consumer protections in some states, leading many people who currently have coverage through those markets to the high-risk pools and 2) many people with health problems who lose employer-based coverage under McCain's proposal would seek coverage in high-risk pools.

WHICH PROPOSAL HOLDS THE GREATEST PROMISE?

To evaluate the candidates' proposals, the Commonwealth Fund Commission on a High Performance Health System identified several key principles for moving the health system toward high performance. They include:

- provision of equitable and comprehensive insurance for all;
- provision of benefits that cover essential services with appropriate financial protection;

- premiums, deductibles, and out-of-pocket costs are affordable relative to family income;
- health risks are broadly pooled;
- the proposals should be simple to administer, with coverage that is automatic and continuous;
- dislocation should be kept to a minimum—people could choose to keep the coverage they have; and
- financing should be adequate, fair, and shared across stakeholders.

Measured against these broad principles, Obama's proposal for mixed private–public group insurance with a shared responsibility for financing has greater potential to move pxe -1 5rpl 1 5rmmmmmmmmm

McCain's proposal to reform the health insurance system by relying on tax incentives and voluntary purchase of coverage in the individual insurance market with few ground rules is, by itself, unlikely to achieve universal coverage. Buying coverage in the individual market will continue to be challenging if tax incentives are not coupled with benefit standards, regulations against risk selection by carriers, and premium and out-of-pocket spending limits as a share of income. Insurers would still write individual policies rather than policies for a broad group of people. Moreover, because of the substantially higher administrative costs in the individual market, covering more people in this market would increase spending on insurance administration. Reliance on state high-risk pools to cover those denied policies in the individual market is also likely to be expensive.

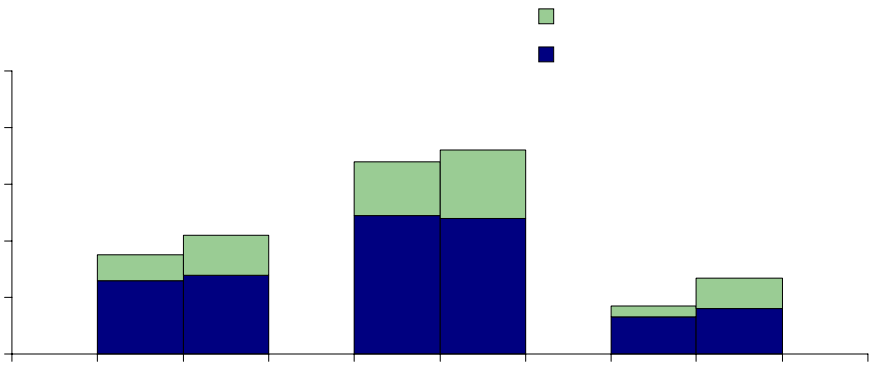
CONCLUSION

Universal coverage is a necessary, though not sufficient, condition for improving the performance of the health system. Moreover, how policymakers design health insurance reforms will affect whether everyone can have affordable insurance that covers essential services and whether sustained improvements in quality and efficiency are achievable. As presidential candidates, Senators John McCain and Barack Obama propose reforms that would place the nation's health system on very different paths, with profound implications for the American people. In the wake of the 2008 election, it will be critical for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to our worsening health system crisis.

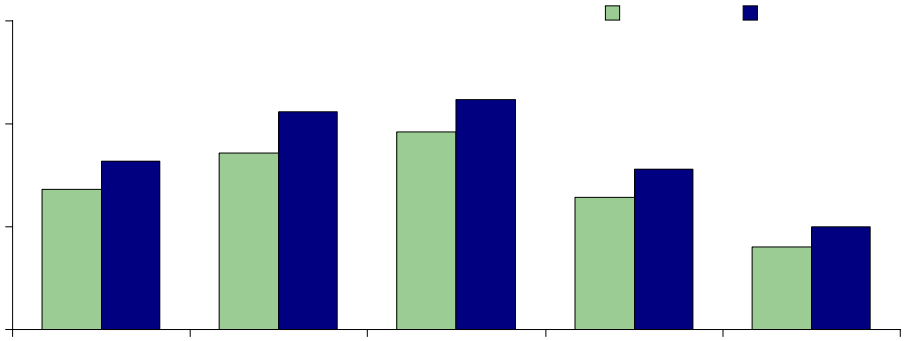
THE 2008 PRESIDENTIAL CANDIDATES' HEALTH REFORM PROPOSALS: CHOICES FOR AMERICA

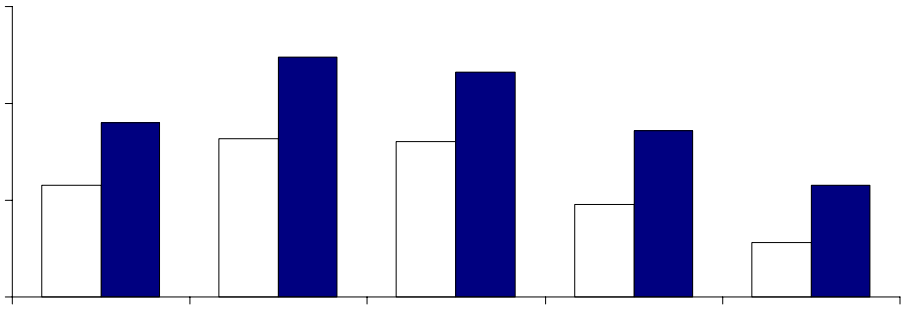
INTRODUCTION

With the 2008 presidential election just weeks away, health care reform is at the top of the nation's domestic policy agenda. The soaring costs of health care, along with a faltering economy and lackluster wage growth, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. A recent Commonwealth Fund study found that nearly two-thirds of working-age adults—an estimated 116 million people—either were uninsured for a time during 2007, were insured but had such high costs compared with their incomes that they were underinsured, reported a problem paying medical bills, or did not get needed care because of its cost (Figure 1). Over the past seven years, such problems have crept up the income scale among those with and without health insurance (Figures 2–4). Consequently, voters are calling for change: eight of 10 adults said in a May survey that the health care system is in need of a major overhaul or fundamental reform (Figure 5).



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).





care. To inform the public discussion about possible paths to reform, this report describes the candidates' proposals, examines key differences in their vision of a future health insurance system, and evaluates the proposals against principles outlined by the Commonwealth Fund Commission on a High Performance Health System.

KEY CONSIDERATIONS IN EVALUATING HEALTH REFORM PROPOSALS

The 2008 presidential candidates have put forth proposals to address critical weaknesses in our health care system. To help the public evaluate these policies, the Commonwealth Fund Commission on a High Performance Health System has identified key strategies for moving the health care system to a higher level of performance. The five strategies are:[1]

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- Coverage should be automatic and stable, with seamless transitions between plans to maintain enrollment.
- Provide a choice of health plans or care systems.

QUALITY, EFFICIENCY, AND COST CONTROL

To improve the quality and efficiency of care and control costs, reform proposals should adhere to the following principles:

- Foster efficiency by reducing complexity for patients and providers, and by reducing transaction and administrative costs as a share of premiums.
- Work to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimize dislocation, so that people can maintain current coverage if desired.
- Be simple to administer.
- Pool health risks across broad groups and over life spans, and eliminate insurance practices designed to avoid individuals with high health risks.
- Have the potential to lower overall health care cost growth.

FINANCING

In terms of financing, reform proposals should adhere to the following principles:

- Financial commitment is necessary to achieve these principles.
- Financing should be adequate and fair, based on the ability to pay, and should be the shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

2008 PRESIDENTIAL CANDIDATES' PROPOSALS

DISTINCT APPROACHES TO HEALTH CARE REFORM

The presidential candidates' health care reform proposals offer fundamentally different visions of the future of health insurance in the United States. Senator McCain would provide tax credits for obtaining insurance through the individual market, while Senator Obama would build on existing private and public forms of group insurance with new consumer protections and income-based subsidies.

McCain's Approach: Tax Credits for Individual Market Insurance.

Approaches to Health Reform: Massachusetts

In April 2006, Massachusetts passed legislation for comprehensive health reform. The legislation was intended to move the state toward universal coverage through a comb

Approaches to Health Reform: Building Blocks

In the May 2008 issue of Cathy Schoen and colleagues at The Commonwealth Fund outlined a framework for universal health insurance coverage in the article, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance."[7] The framework uses the "building blocks" of private markets and publicly sponsored insurance with broad risk pooling. This approach introduces a national insurance "connector" that would offer small businesses and individuals without access to employer coverage or public insurance a choice between a Medicare-like public insurance plan and private plans. All U.S. residents would be required to have health insurance and would have to provide evidence of coverage during annual tax filing. Everyone with health insurance would be eligible for advanceable, refundable tax credits for standard plan premium costs over 10 percent of adjusted gross income or 5 percent for those in lower-income households.

The framework would require that employers either provide health insurance for their employees or pay into a pool to cover the uninsured. Employers that choose to offer coverage would be required to contribute at least 75 percent of the premium, and to offer plans that meet minimum standards and cover at least 80 percent of their employees. Employers not offering coverage would pay a payroll tax of 7 percent of earnings up to a $1.25 per hour.

Medicaid and SCHIP would be expanded to cover more low-income people. All legal U.S. residents with incomes below 150 percent of poverty would be eligible for an SCHIP-type plan covering acute care services. Medicaid provider payment rates would be increased to Medicare levels and federal matching rates would be increased to SCHIP levels to help states finance the expansion. The new Medicare option offered through the connector also would be available for Medicare beneficiaries. Adults ages 60 to 64 would be able to buy in to Medicare and the two-year waiting period for Medicare for the disabled would be eliminated.

The new national insurance connector would offer a choice of private health insurance plans and the new Medicare public plan option to businesses with fewer than 100 employees, the self-employed, and anyone without employer insurance, Medicare, Medicaid, or SCHIP.

Using its Health Benefits Simulation Model, the Lewin Group estimates that, under the Building Blocks framework, the number of uninsured people would fall from an estimated 48.3 million in 2008 to 3.6 million in the first year of implementation. The federal costs of the program are estimated at $81.7 billion in 2008. However, if the coverage framework were implemented along with quality and efficiency improvements—including increasing the use of health information technology, creation of a center on medical effectiveness, provider payment reforms, an increase in the tobacco tax, lowering payments to Medicare Advantage plans to the level of traditional Medicare coverage, and allowing Medicare to negotiate prescription drug prices with pharmaceutical companies—Lewin estimates that federal costs could be lowered to $31 billion in the first year.[8]

THE PLANS

Following are summaries of the candidates' proposals and ideas about health care reform drawn from documents posted on their campaign Web sites as well as from public comments reported in the press and input from the campaigns. For more detailed descriptions of the health reform proposals, links to the candidates' Web sites are provided.

Senator John McCain

(www.johnmccain.com)

Overall approach: Tax incentives for individual market insurance.

Tax credits/subsidies: Individuals and families with private health insurance would receive refundable tax credits: $2,500 for individuals and $5,000 for families. Tax credits would be sent directly to insurance companies. Individuals who spend less than the tax credit could deposit the balance in health savings accounts (HSAs), which would be expanded.

Change in tax code: Reform the tax code to eliminate the bias toward employer-sponsored health insurance. Would replace the personal income tax exemption for employer-provided health benefits with the new tax credits. Employers' premium contributions to employees would become taxable income, but workers could apply the new tax credits to their premium costs.

Insurance markets: Individuals and families could purchase health insurance in the individual market from any willing insurer in any state. Professional and other organizations would be encouraged to sponsor health insurance for their members. Health insurance policies should be available to small businesses and the self-employed, should be portable across all jobs, and should bridge the gap between retirement and Medicare eligibility.

Guaranteed Access Plans or High-Risk Pools: People with preexisting health conditions who are not able to find coverage in the individual insurance market would gain coverage through high-risk pools, or Guaranteed Access Plans. States could join with other states to enlarge existing high-risk pools (34 states currently have them). There would be federal financial support and premium assistance for applicants below a certain income level.

States: States would be allowed to use Medicaid funds to enable purchase of private insurance by eligible families. States could offer tax credits for families to purchase private coverage; a financial risk-adjustment bonus would be provided to high-cost, low-income families. Doctors would be allowed to practice across state lines. States also could experiment with alternative insurance policies, alternative forms of health care access, and different licensing schemes for providers.

lower rates of obesity. Care management for the disabled and elderly covered by Medicaid and Medicare would be promoted.

Comparative effectiveness/quality improvement: More federal research funding would be dedicated to the care and cure of chronic disease and the treatment of patients with multiple chronic conditions. The development of national standards for measuring and recording treatments and outcomes would be facilitated. Government programs such as Medicare and Medicaid should lead the way in health care reforms that improve quality and lower costs.

Health information technology: Rapid deployment of modern information systems and technology that allow doctors to practice across state lines would be promoted. Telemedicine should be used to connect patients to community health clinics in areas where services and providers are limited.

Transparency: More information on treatment options and physician records would be made public. Transparency on medical outcomes, quality of care, costs, and prices would be required.

Provider payment reform: Pay only for quality care that is the right care: care intended to improve a patient's health. Medicare and Medicaid should be leaders in changing the way providers are paid to focus attention on chronic disease and managing treatment. Reform the payment systems in Medicare and Medicaid to compensate providers for diagnosis, prevention, and care coordination: a single bill should be paid for high-quality disease care to make providers accountable and responsible to patient needs. Medicare and Medicaid should not pay for preventable medical errors or mismanagement. Government should promote greater use of walk-in clinics in retail outlets.

Prescription drugs: Allow safe reimportation of drugs, faster introduction of generic drugs, and publication of drug prices.

Malpractice: Medical liability reform would eliminate lawsuits for doctors who follow clinical guidelines and adhere to patient safety protocols. While patients should have access to legal remedies in the case of bad medical practice, frivolous lawsuits and excessive damage awards would be eliminated.

Long-Term Care: Would develop strategies for home care, based on state-based experiments that give seniors a monthly stipend to hire workers and purchase care-related services and goods and that provide counseling and bookkeeping services.

Financing: None specified.

Senator Barack Obama

Plan for a Healthy America

(www.barackobama.com)

Overall approach: Mixed private–public group insurance with a shared responsibility for financing.

Requirements to have coverage: All children would be required to have health insurance. Obama would consider an individual requirement for adults if substantial numbers of people do not buy coverage that is deemed affordable.

Employer contribution: Employers would be required to provide "meaningful" coverage with a "meaningful contribution" to workers or contribute a percentage of payroll toward

the costs of a new national plan. Small businesses would be exempt, instead receiving refundable tax credits to purchase coverage. Young adults up to age 25 would be allowed to continue coverage through their parents' health plans.

Public program expansions: Expand eligibility for Medicaid and SCHIP and ensure these programs continue to serve their safety net function.

New national health plan: A new public health insurance plan, with benefits similar to those available to federal employees and members of Congress in the Federal Employees Health Benefits Program (FEHBP), would be open to individuals who do not have access to group coverage through their jobs or public insurance programs. It also would be open to people who are self-employed and small businesses. The plan would cover essential medical services including preventive, maternity, and mental health care as well as disease management, care coordination, and self-management of care. Participants would be charged fair premiums and low copayments for preventive services.

New national insurance exchange: A new National Health Insurance Exchange would allow individuals, small businesses, and those who are self-employed to purchase an approved private plan or the new public plan, with income-based premium subsidies and small business tax credits. The exchange would reform the private insurance market by creating rules and standards for participating insurance plans: insurers would have to issue everyone a policy with premiums that do not depend on health status. The exchange would require that all plans offered are at least as generous as the new public plan and meet the same standards for quality and efficiency. Insurers would have to justify above-average premium increases to the exchange. The exchange would evaluate plans and publicize the differences among them, including the costs of services.

Tax credits/subsidies: Individuals and families who do not qualify for Medicaid or SCHIP but still need assistance to purchase a health plan would receive income-related federal subsidies aimed at keeping health insurance premiums affordable. Subsidies can be used to buy into the new public plan or purchase a private plan. Small businesses would receive a Small Business Health Tax Credit, a refundable tax credit of up to 50 percent of premiums, with which to buy coverage for their employees.

Insurance market regulation: All insurers, including those not selling products through the exchange, would have to issue all applicants a policy and charge premiums that do not depend on health status. Insurers would be required to pay out a reasonable share of their premiums for patient care, relative to profits and administrative costs.

Reinsurance: Federal reinsurance for employer health plans would be established to reimburse employers for a portion of the catastrophic costs they incur above a certain threshold, if they guarantee savings are used to reduce worker premiums.

States: Would not replace existing state health care reform efforts, provided they meet the minimum standards of care of the national plan.

Prevention and chronic disease management: Participating plans in the new public plan, Medicare, and FEHPB would be required to utilize proven disease management programs. Support would be given to providers to put in place disease management programs and encourage team care through implementation of medical home models to improve coordination of care for people with chronic conditions. Would expand and reward employer programs such as onsite preventive services (e.g., flu vaccinations), provision of nutritious cafeteria and vending machine food, and exercise facilities.

Would work with schools to create healthier environments, including by providing contract assistance with vendors, grant support for school-based health screening programs and clinical services, and increased financial support for physical education. Would increase the number of primary care providers and public health practitioners through loan repayment, reimbursement grants for training curricula, and infrastructure support. Would require coverage of clinical preventive services such as cancer screenings and smoking cessation programs in all federally supported health plans, including the new public plan, Medicare, Medicaid, and SCHIP, and would increase funding for community-based prevention interventions. Federal, state, and local governments should work together to develop a national and regional strategy for public health and align funding mechanisms to support its implementation. The government must invest in public health workforce recruitment and the modernization of public health infrastructure, such as public health laboratories.

Comparative effectiveness/quality improvement: An independent institute would be established to guide reviews and research on the comparative effectiveness of various treatments. Hospitals and other providers participating in the new public plan would be required to collect and report data to ensure that standards for quality, health information technology, and administration are being met. Funding for biomedical research and research on the causes and treatments of autism would be strengthened.

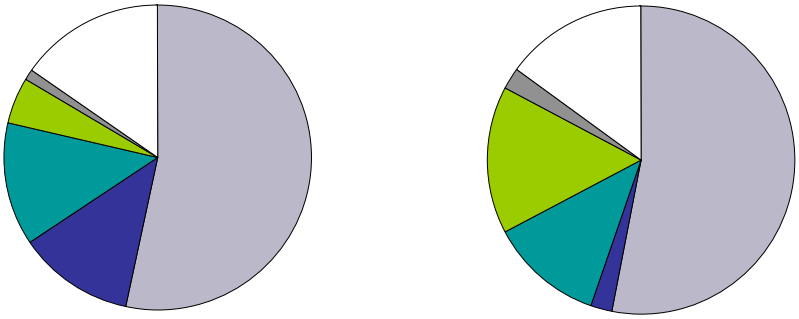
Health information technology: Would invest $10 billion per year over five years for nationwide adoption of standards-based health information technology systems,

Disparities: Would require hospitals and health plans to collect, analyze, and report health care quality disparities and hold them accountable for differences. Would diversify the workforce, implement and fund evidence-based programs such as patient navigator programs to reduce disparities, and expand the capacity of safety net institutions.

Malpractice: Strengthen antitrust laws to prevent insurers from overcharging physicians

ACCESS TO CARE

legislation implemented in Massachusetts, with the key difference being that Massachusetts requires everyone to have coverage while Obama would only require children to have coverage (see text box, Approaches to Health Reform: Massachusetts, on page 7). Obama's proposal also differs from Massachusetts' approach in that individuals and businesses would be able to choose between private and public health plans in the health insurance exchange, while Massachusetts' insurance exchange offers only private plans.



Source: "Kaiser State Health Facts," Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).
P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," Employee Benefit Research Institute, EBRI Issue Brief No. 321, September 2008.

Obama would provide income-based subsidies for households to offset the cost of insurance, but has not yet offered details on who would be eligible or what the magnitude of the subsidies would be. He also would provide refundable tax credits to small employers, worth up to 50 percent of their premium costs, but has not specified which small businesses would be eligible.

Senator McCain: individual insurance markets. In contrast to Obama's plan, McCain's proposal would make the individual insurance market central to the health insurance system. McCain would encourage people to buy individual market insurance through the provision of new tax credits and a fundamental change in the tax code that could shift the system away from employer-based coverage. His proposal could have the effect of reducing existing consumer protections that states have put in place for their individual insurance markets by allowing people to buy health insurance in any state. For people with preexisting conditions who are turned down for coverage in the individual market, he would provide federal financing to expand high-risk insurance pools that now exist in 34 states.

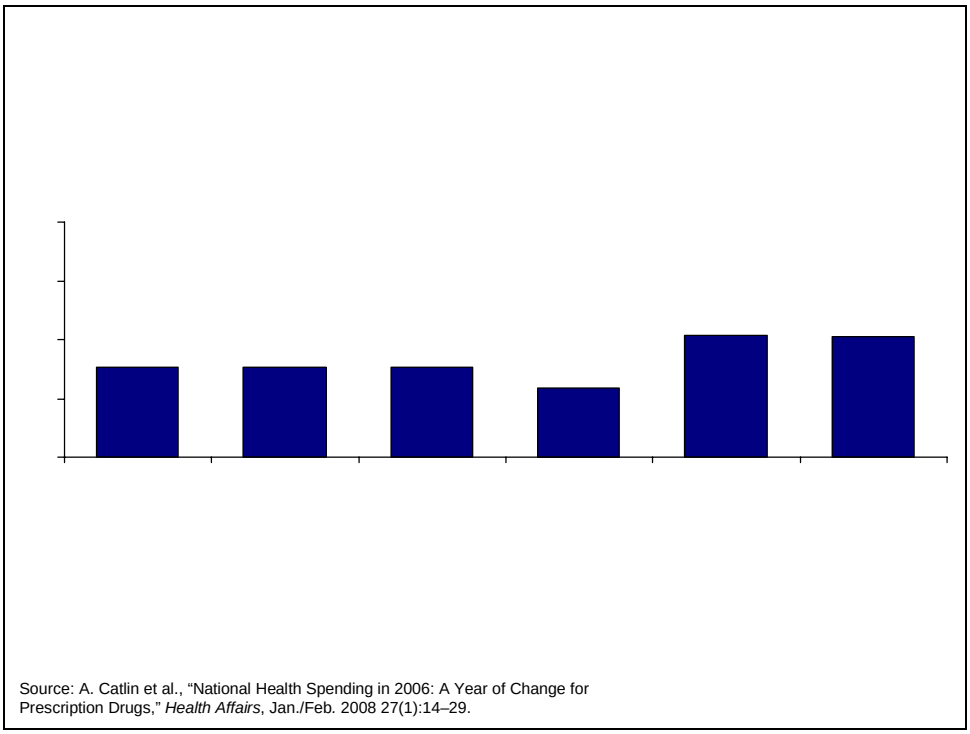
Under Obama's proposal, employer-provided health insurance would remain a central feature of the insurance system. By contrast, McCain's proposed changes to the tax code could significantly reduce the employer role in the system. Under current federal law, employers' contributions to employee premiums are excluded from income taxes. McCain proposes to eliminate this special tax treatment and replace it with refundable tax credits of $2,500 for an individual and $5,000 for families for any private health insurance, whether received from an employer or purchased in the individual market.

As Buchmueller and colleagues point out in their recent article, the tax benefits of employer-provided coverage are a major reason why so many employers offer coverage today.[10] In addition, they argue that the tax exemption provides an incentive for healthy employees to sign up for employer coverage, thus helping to offset the higher costs of older and sicker workers.

McCain's tax credits would not change medical underwriting practices in the individual market that make it difficult for older people or those with health conditions to find affordable coverage. In the absence of regulations against risk selection and the imposition of benefit standards, the value of McCain's tax credits would vary significantly based on age, health status, gender, and geographic differences in the cost of health care. Individual market plans often do not cover mental health services, certain preventive services, and other types of care; few even offer maternity coverage. This

means that people who are currently uninsured or who lose employer-based coverage might not be able to find affordable plans that offer the coverage they need in the individual market, even with the help of the tax credit. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that 48 percent of adults with health problems who had individual coverage, or had thought about or tried to buy a plan in the individual market in the last three years, found it very difficult or impossible to find coverage they needed; 71 percent found it very difficult or impossible to find a plan they could afford; and 33 percent said they were turned down or charged a higher price because of a preexisting condition.[11] Ninety-two percent said they never bought a plan.

Covering more people through the individual market, which has considerably higher administrative costs than group insurance, could fuel growth in the nation's health administration costs. The costs of health insurance administration are one of the fastest-growing components of national health expenditures—rising by more than 10 percent per year since 2000, compared with overall health expenditure growth of 7.7 percent (Figure 8).[12]



Source: A. Catlin et al., "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs*, Jan./Feb. 2008 27(1):14–29.

Obama proposes to broaden insurance market rules by requiring all insurers to issue policies to applicants and banning medical underwriting, while McCain proposes to loosen rules. McCain would allow people to buy health insurance across state lines. As Buchmueller and colleagues point out, this means that insurance carriers would no longer need a state license to sell health insurance and thus could establish charters in states with few regulations, as credit card companies can do now.[15] People who currently have individual insurance market coverage and enjoy certain state-specific protections would eventually lose those protections. These include regulations against risk selection such as guaranteed issue and community rating, benefit requirements such as mental health parity and cervical cancer screenings, and procedural requirements such as external review of disputed decisions by managed care plans. In the end, it could be very difficult for people with health problems or health risks to gain access to health insurance in the individual market anywhere in the United States.

For people denied coverage in the individual market, McCain has proposed expanding state high-risk pools and providing premium subsidies to those who need them. In 2006, 34 states were operating such pools, which are insurance programs created by state law for people with health conditions who are either unable to gain adequate coverage through the individual market or are charged exorbitant premiums. At the end of 2006, about 190,000 people were covered through high-risk pools nationwide, with enrollment ranging from about 350 people in Florida and West Virginia to 29,000 people

in Minnesota.[16] Following voluntary guidelines established by the National Association of Insurance Commissioners, most states impose premium caps for their high-risk pools, ranging from 125 percent of average individual market rates in Minnesota and Oregon to as high as 250 percent in Florida. There is tremendous variation in what the plans cover as well as in the deductibles and maximum annual and lifetime benefit limits. For example, the Idaho plan with the most enrollees has a $5,000 deductible, the highest among the states, compared with a $500 deductible for the most popular plan in South Carolina. Five states have annual maximum benefits ranging from $75,000 to $300,000. Thirty-one states have maximum lifetime limits, ranging from $500,000 in Louisiana and Oklahoma to $5 million in Florida and Minnesota, though most have limits of $1 million. Several states provide discounts or premium support for lower-income enrollees, but the generosity of the support varies widely.[17]

Even though premiums in high-risk pools are high, they have not been sufficient to finance the expensive claims made in these pools. On average, premiums provide just 61 percent of the funding for high-risk pools, ranging from 30 percent in Florida to 90 percent in West Virginia.[18] Minnesota—which has the highest enrollment of all states, at more than 29,000 in 2006—faced claims expenses equivalent to nearly 200 percent of premiums collected. New Mexico's ratio was nearly 400 percent. States have struggled to make up the difference using a combination of approaches, including assessments on insurance carriers (28 states), state revenue funds such as general revenues and tobacco taxes (nine states), and provider assessments (four states). Many states also receive federal grants directed toward specific initiatives, such as premium subsidies. But states also have tried to reduce their costs by: limiting enrollment; closing the pools to new enrollment (Florida's pool has just 382 members and has been closed to new enrollment since 1991); limiting the amount of time someone can be in the pool (California enrollees are limited to 36 months of continuous coverage, after which they are eligible for guaranteed issue coverage in the individual market); negotiating more favorable provider payment rates; and increasing premiums, deductibles, and copayments. Most states impose waiting periods for preexisting conditions, ranging from two to 12 months.

Relying on high-risk pools as a key part of our health insurance system is likely to be very expensive, given the financing history of the pools and the fact that premiums have proven unaffordable for people with low and moderate incomes. In addition, allowing people to purchase coverage across state lines would mean that even fewer people with health problems would be able to buy coverage on the individual market, thus increasing pressure on high-risk pools.[19] The Tax Policy Center points out that, if the removal of the employer benefit tax exemption caused many employers to drop

coverage, many employees with high risks could end up in high-risk pools.[20] The Center estimates that, if the pools were financed adequately and coverage made affordable as McCain has proposed, this feature alone could cost up to $1 trillion over 10 years.

How Many People Might Ultimately Gain Coverage Under the Two Proposals?
The lack of details in the candidates' proposals makes it difficult to estimate how many people might ultimately gain coverage under each approach. But researchers have made assumptions about aspects of the proposals that provide rough estimates.

Senator Obama's proposal. Prior analyses have shown that an individual requirement to have health insurance coupled with an automatic enrollment mechanism, such as through the tax system, is necessary to come close to covering everyone through a mixed private–public approach.[21] Cathy Schoen and colleagues at the Commonwealth Fund outlined an approach that is similar to Obama's proposal, but includes an individual mandate and automatic enrollment through the tax system (see text box, Approaches to Health Reform: Building Blocks, on page 8).[22] In microsimulation modeling by the Lewin Group, researchers found that such a proposal would cover 99 percent of the population in 2008, leaving about 3.6 million uninsured. Fewer people would likely be covered under Obama's proposal than under the Schoen et al. proposal, since Obama's proposal only requires children to have health insurance. But the number of people covered under his plan will also depend on details he has not yet specified, including: new eligibility guidelines for Medicaid and SCHIP; the amount of premium subsidies for coverage through the Insurance Exchange, as well as what household incomes would be eligible for the subsidies; the amount of the tax credits for small businesses and which small businesses would be eligible; how easy it is for people to become enrolled; and how requirements for children to have coverage would be enforced.[23]

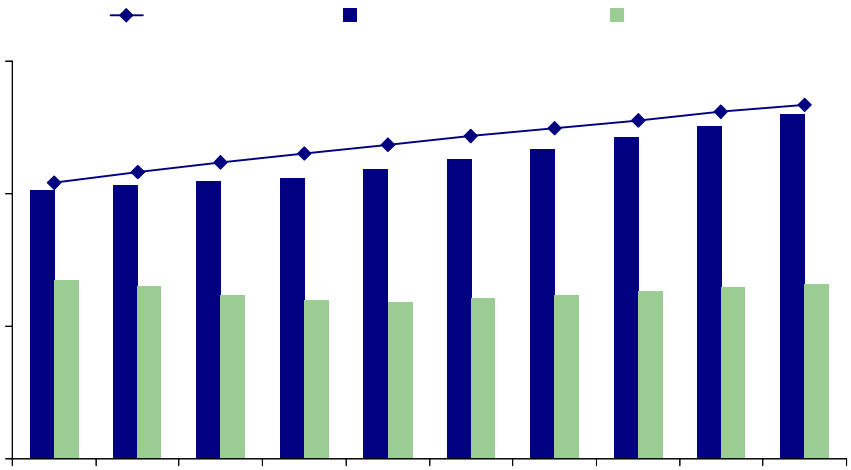
To provide preliminary estimates of the number of people who could eventually be covered under Obama's proposal, the Tax Policy Center made several assumptions, including:

between 100 and 150 percent of poverty would pay no more than 3 percent of their income on premiums; those at 150 to 200 percent of poverty would pay no more than 6 percent of their income; those at 200 to 250 percent of poverty would pay no more than 9 percent of their income; those at 250 to 300 percent of poverty would pay no more than 12 percent of their income; those at 300 to 350 percent of poverty would pay no more than 16 percent of their income; those at 350 to 400 percent of poverty would pay no more than 20 percent of their income; and those with incomes over 400 percent of poverty would receive no subsidy.

! **Employer requirement.** The Tax Policy Center assumes that employers with 10 or more employees who do not offer coverage would pay 6 percent of wages, up to 80 percent of the average premium paid by firms of the same size for single coverage.

! **Small business tax credits.** The Center assumes that tax credits are equivalent to 50 percent of premiums for businesses with fewer than 10 employees and 10 percent for firms of 10 to 24 employees.

Under these assumptions, the Tax Policy Center estimates that Obama's proposal would reduce the number of uninsured by 18.4 million in 2009 and by 33.9 million by 2018 (Figure 9). Because of the requirement that all children have health insurance, most children would be covered, but about 32.9 million adults would lack health insurance in 2018 (out of an estimated 66.8 million uninsured people that year).



Source: L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans,* Urban Institute–Brookings Institution Tax Policy Center, Updated September 12, 2008.

Senator McCain's proposal. McCain's proposal is expected to fall far short of universal coverage; indeed, he has not named universal coverage as a goal. The effect his approach would have on the number of people covered would depend on employers' decisions to drop or continue offering coverage, whether the new tax incentives would retain their value over time, and the number of people who would buy coverage in the individu

Buchmueller and colleagues estimate that removing the tax exemption for employer-provided health benefits would cause many employers to drop coverage, such that 20 million people would lose access to employer health benefits. The Tax Policy Center arrives at a similar estimate.[24] Buchmueller et al. note that [redacted] insurance could be even hig[redacted] workers ou[redacted] pool and increasing the lik[redacted] discontinue coverage.

[redacted] Buchmueller et al. estimate that, under the McCain proposal, 21 mi[redacted] in the individual market. This would include those who lose coverage throug[redacted] more uninsured

Another important difference between the benefit tax exclusion and McCain's tax credits ~~is the fact that the employer benefit tax exclusion automatically adjusts to~~ medical price inflation. The McCain campaign has said that his proposed tax credits would be

Do the Proposals Provide a Standard Benefit Plan for Essential Coverage with Financial Protection?

Proposals that define a standard health benefit package, including cost-sharing, would improve coverage for the millions of Americans whose current health insurance provides inadequate protection. Such proposals also would provide comprehensive access to care for people who become newly insured. Standard benefit packages could ensure that people have access to essential preventive services like vaccines and to programs to manage chronic health conditions.

By expanding access to Medicaid and SCHIP, Obama's proposal would improve benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults in families with low to moderate incomes. Obama would require that, in satisfying the employer requirement to offer or contribute to the cost of coverage, employers must offer "meaningful" coverage with a "meaningful" contribution to workers. Obama's new National Health Insurance Exchange would require that all approved private plans are at least as generous at the new public plan, which would have benefits similar to a standard plan offered through FEHBP.

In contrast, McCain does not propose a standard set of covered benefits. People could continue to get coverage through their employers, if it is offered to them, or buy coverage on the individual insurance market. Those using the tax credits to purchase coverage on the individual market could -1 (era 12(em) 7 u4Tm /F2 0 0) 1 (i)h -1 (e)(n) -1 Those 0hET BT 1

though he has not said what the size of the subsidies would be or specified the income levels of households that would be eligible. McCain would repl

Obama indirectly addresses the issue of underinsurance by proposing that the new public plan have benefits similar to those available to federal employees and members of Congress and that private plans offered through his health insurance exchange meet the

McCain's tax credits would make health insurance more affordable for people who need to purchase coverage on the individual market. In theory, by separating coverage from employers, his proposal also would make coverage portable, with people able to take their health plans from job to job. But because McCain would allow interstate purchase of health coverage, leaving the individual market even less regulated than it is today, it would be harder for people with health problems and who are older to find affordable coverage that meets their health needs. Shifting the insurance system away from the relative security of employer group coverage could exacerbate the complexity of the system, making access to insurance more uncertain and increasing the potential for "churning" when people gain and lose coverage.

Do People Have a Choice of Health Plans or Care Systems?

Although many Americans currently have little choice of health plan or provider, surveys show they highly value having such choices and are more satisfied when they have more choices. In a 2005 analysis of the Commonwealth Fund Biennial Health Insurance Survey, nearly three of five adults under age 65 with employer-based coverage said it was very important that their employer offer a choice of health plans.[33] Having a choice of provider was even more important to adults' overall satisfaction with their health care than having a choice of health plan.[34]

Reflecting this strain of public opinion, both candidates' proposals emphasize a choice of health plans. The new insurance exchange proposed by Obama would include a range of private health plans in addition to a public health plan option, similar to Medicare, all of which would have a standard set of covered benefits. His proposal emphasizes that people would not be forced to change plans. They could choose to stay in their employer-based coverage if their employer continues to offer it.

McCain's proposal, which would provide tax incentives for people to buy coverage in the individual market, also would allow for choice of plans and benefit combinations. Equalizing the tax treatment of employer-based and individual market insurance would mean that people would have more options for coverage and could choose between more comprehensive plans w

QUALITY, EFFICIENCY, AND COST CONTROL

Do the Proposals Pool Health Care Risks Broadly?

The purpose of insurance is to pool risks so that people in good health subsidize those who become sick, the young support the old, able-bodied individuals support accident victims, and so forth across the life span. Life is uncertain and insurance coverage, whether for material belongings or health, protects against financial ruin in the event of a catastrophe, accident, or illness. The broader and more diverse the risk pool, the less likely it is that one event will cause financial ruin for an individual, a group, or an insurance carrier. In addition, with a broad and diverse risk pool, individual premiums will be lower.

Insurance carriers sell polices in three different markets—large employer group, small employer group (firms with fewer than 50 employees), and individual—in each of the 50 states and the District of Columbia.[35] Because of the voluntary nature of health insurance in the U.S., people who are not covered through the broad risk pools of large companies must buy coverage either as small businesses or individuals. To avoid the expense of health insurance, small businesses and individuals might wait until they are more likely to need insurance, such as when an employee or family member develops a health problem or plans on becoming pregnant. This is known as adverse selection and is a serious threat to the viability of carriers selling in the small group and individual markets. The drive to protect against it is the overriding dynamic in those markets. Given the challenge of selling policies in the small group and individual insurance markets, many carriers simply choose to avoid them—particularly the individual market—unless state regulations require carriers that sell in the large group market to also sell in the small and individual markets. Swartz reports that, in 1997, merely 700 carriers sold individual policies in the U.S., compared with 2,450 carriers in the small and large group markets.[36]

From the perspective of both efficiency and equity, the advantages of group insurance such as employer-based coverage, Medicare, Medicaid, and SCHIP are considerable. There are economies of scale inherent in selling plans to groups rather than individuals.[37] Employer coverage forms natural risk pools: people of all ages and health status enroll when they take a job rather than when they are sick, reducing the potential for adverse selection. The lack of underwriting in the large employer group market also ensures that workers are not excluded from coverage, or charged different premiums, on the basis of health status or age. Premiums in the employer group market are more in line with actual medical expenditures than those in the individual market. Administrative costs consume from 25 percent to 40 percent of each premium dollar in the individual

market and 15 percent to 25 percent of small group premiums, compared with 5 percent to 15 percent for large group coverage.[38] The costs of marketing insurance in the individual and small group markets are particularly high. A 2003 study found that the costs of commissions alone in the small group market ran from 4 percent to 11 percent of premiums.[39] Proposals that increase coverage through the individual market have the potential to devote larger shares of premiums to administrative costs and drive up total costs overall. In contrast, those that provide group coverage—especially through the Medicare program—have the potential to significantly lower overall administrative costs.[40]

Obama's proposal would build on the strength of large risk pools by requiring that employers either offer coverage or help finance it. It also would expand the large risk pools of public insurance by expanding eligibility for Medicaid and SCHIP, both of which operate with lower overhead than individual or small group insurance markets.

Obama proposes to replace the inefficiencies and inequities inherent in the current individual market with a National Health Insurance Exchange. Paul Ginsburg has defined an insurance exchange as "a marketplace managed by government (or by a private entity operating under rules established by government) in which individuals choose among health insurance products offered by competing carriers."[41] There are several examples of such exchanges, with varying characteristics. Massachusetts established an exchange, which it refers to as a Connector, as part of its universal coverage law. The Connector merges non-group and small group markets into one risk pool, which is subject to modified community rating and guaranteed issue. The same rules also apply to individual policies sold outside the Connector, to prevent adverse selection by people with poor health risks into the Connector. People who receive premium subsidies are required to buy their health plans through the Connector, and an individual mandate to buy insurance helps ensures a diverse risk pool. FEHBP is another example of an exchange, in which federal employees across the country must use their employer-provided contributions to buy plans selected through the federal program. As Ginsburg points out, such a requirement is critical to creating a diverse risk pool. It is also important that the rules that apply to carriers selling plans in the exchange also apply to those selling in the individual and small group markets, as is the case in Massachusetts. This ensures that people in good health who are not eligible for premium subsidies would not seek better rates outside the exchange, leaving a less healthy pool in the exchange. Obama has said that new rules would apply to all health plans operating in the United States, not just to those selling products through the exchange.

Another key element of insurance exchanges is a mechanism to equalize risk across insurance plans competing in the pools. Neither FEBHP nor the Massachusetts Connector has such a mechanism. Ginsburg points to the example of the Medicare Advantage program, in which the federal government's payments to health plans reflect the health risks of those enrolling in the plans, though the premiums paid by beneficiaries are the same. There are similar examples in Europe of risk equalization strategies, such as the Netherlands' Risk Equalization Fund.[42] Such strategies might be enhanced to encourage carriers to provide services, such as chronic disease management programs, that would attract people with higher health risks.

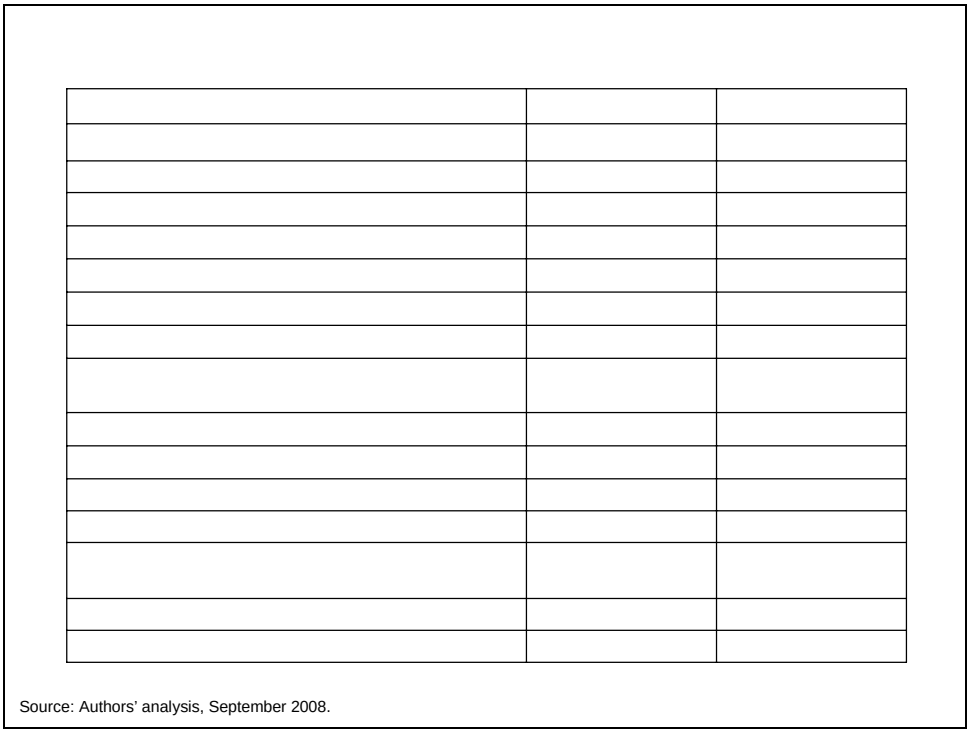
Other issues to consider in creating insurance exchanges include: What type of public entity would be set up to govern the exchange and what powers would it have? Would the entity operate at a national or regional level, or some combination thereof (i.e., national with regional arms)? How would people become enrolled, and how would contributions to their premiums from employers (in the case of an employer mandate) or from government tax credits or subsidies be collected and distributed? Assuming that market rules governing the exchange (e.g., guaranteed issue and community rating) also would govern individual and small group insurance markets to prevent adverse selection, how would the federal government accomplish this?

McCain proposes to increase insurance coverage through the individual insurance market through new tax incentives and deregulation of state markets. But buying coverage in the individual market will continue to be challenging if tax incentives are not coupled with benefit standards, regulations against risk selection, and premium and out-of-pocket spending limits as a share of income. Providing incentives for coverage in the individual market without an individual mandate or regulations against risk selection would not pool risks. Insurers would still write individual policies rather than policies for a broad group of people.

Because the individual insurance market has comparatively higher costs than group insurance markets, covering more people through this market would increase annual spending on insurance administration. Supporters of McCain's proposal argue that, if consumers spent more of their own money on health insurance and health care, they would be more cost-conscious, seek out lower-cost providers, and avoid marginal or unnecessary care. Still, it is likely that a considerable share of their premiums would continue to cover non-medical expenses.

However, his proposal would expand group coverage, such as large employer insurance, Medicaid, and SCHIP, and retain the Medicare program, all of which have lower administrative costs than individual and small group insurance.[45] The proposal also would replace the individual insurance markets with a new group insurance exchange, which would reduce the comparatively higher insurance administrative costs associated with the non-group market. In addition, Obama

Both of the presidential candidates have proposed conceptual approaches to improving quality and efficiency. There is greater agreement between McCain and Obama on these issues, at least on basic concepts, than on expanding health insurance coverage (Figure 10). However, the candidates' health insurance reform proposals would significantly affect their ability to achieve improvements in quality and efficiency throughout the health system. Both candidates could use public programs such as Medicare, Medicaid, and SCHIP to implement initiatives such as paying doctors and hospitals on the basis of quality. But because McCain emphasizes even less oversight of private insurance markets than we have today, he is limited to public programs to spur new initiatives; indeed, he has said that public programs should take the lead on provider payment innovation. In contrast, Obama would be able to mandate performance-related payment systems and other innovations in Medicare, Medicaid, SCHIP, and the new insurance exchange. He has also identified the FEHBP as an insurance program in which innovations might be pursued. For example, participating providers and health plans in each of the public programs and in the exchange could be required to develop chronic disease management programs. The more organized markets are, and the more universal, standardized, and coordinated the system is, the more leverage points there will be for system-wide improvements in quality and efficiency.



Source: Authors' analysis, September 2008.

As noted above, the Commonwealth Fund Commission on a High Performance Health System recommends four key strategies—in addition to providing universal

coverage—for the next president and Congress to improve the quality and efficiency of care and move the health care system to a higher level of performance. The following summarizes what the candidates are proposing in three of these areas.[49]

Aligned incentives and effective cost control

McCain proposes to reform the payment systems in Medicare and Medicaid to compensate providers for diagnosis, prevention, and care coordination. He has said that the programs should pay a single bill for high-quality disease care to make providers accountable and responsible to patients' needs. In addition, he believes that Medicare and Medicaid programs should not pay providers for preventable medical errors or mismanagement. Obama would accelerate efforts to develop and disseminate best practices and align provider reimbursement with the provision of high-quality care. He has said that providers who see patients enrolled in the new public plan and private plans in the National Health Insurance Exchange, Medicare, and FEHBP would be rewarded for achieving performance thresholds on physician-validated outcome measures.

McCain would promote care management in Medicaid and Medicare for disabled and elderly people. He also has said he would dedicate more federal research funding to the care and cure of chronic disease and the treatment of patients with multiple chronic conditions. He would use public health initiatives to encourage individuals to prevent chronic disease, receive appropriate tests for early detection, and follow treatment guidelines after disease develops. Obama would require participating insurance carriers in his new public plan, Medicare, and FEHBP to use proven disease management programs. He also would provide support to providers to develop disease management programs.

McCain would promote coverage of preventive services in health plans. He says that government should promote greater use of walk-in clinics in retail outlets, to better serve people's needs for care. Obama would require coverage and low copayments for preventive services such as cancer screenings and smoking cessation programs in all federally supported health plans. He would expand and reward employer prevention programs such as onsite preventive services (e.g., flu vaccinations), provision of nutritious cafeteria and vending machine food, and exercise facilities. He would provide grant support for school-based health screening programs and clinical services. Obama would increase the number of primary care providers through loan repayment, reimbursement grants for training curricula, and infrastructure support to improve working conditions.

McCain would allow safe reimportation of prescription drugs, faster introduction of generic drugs, and publication of drug prices. Obama would also allow safe reimportation of prescription drugs. He would increase use of generic drugs in the new public plan, Medicare, Medicaid, and FEHBP and prohibit large drug companies from preventing generic drugs from entering markets. Obama would allow the federal government to negotiate directly with pharmaceutical companies under the Medicare prescription drug benefit.

Obama would require health plans to disclose the percentage of premiums that goes to patient care versus administration and require insurers to pay out a reasonable share of their premiums for patient care. He also would eliminate the extra subsidies now provided to private Medicare Advantage plans and pay them the same amount that it costs to treat the same patients under regular Medicare.

Accountable, coordinated care

McCain has said that, in the Medicare program, he would place patients at the center of care, with care coordinated by collaborating providers. He believes that all patients should be given a larger role in both prevention and care, putting more decisions and responsibility in their hands. As stated above, McCain says that government should promote greater use of walk-in clinics in retail outlets. Obama would provide support for providers to implement medical home models of care management and team care to improve care coordination for people with chronic conditions.

Obama would require hospitals and health plans to collect, analyze, and report health care quality disparities and hold them accountable for differences. He would diversify the workforce, implement and fund evidence-based programs such as patient navigator programs to reduce disparities, and expand the capacity of safety net institutions.

McCain would promote rapid deployment of modern information systems and technology that enable doctors to practice across state lines, and would promote the use of telemedicine to connect patients to community health clinics in areas where services and providers are limited. Obama would invest $10 billion per year over five years for nationwide adoption of standards-based HIT systems, including electronic health records. He has said that requirements for full implementation of health information technology would be phased in with the necessary federal resources. Obama would ensure that HIT systems are developed in coordination with providers and frontline workers, including those in rural and underserved areas, and would protect patient privacy.

Investment in public reporting, evidence-based medicine

McCain would facilitate the development of national standards for measuring and recording treatments and outcomes. He also has said that government programs such as Medicare and Medicaid should lead the way in health care reforms that improve quality and lower costs. Obama would establish an independent institute to guide reviews and research on the comparative effectiveness of alternative treatment options. Hospitals and other providers participating in the new public plan would be required to collect and report data to ensure that standards for quality, health information technology, and administration were being met.

McCain believes that more information on treatment options and physician records must be made public. He would require transparency on medical outcomes, quality of care, costs, and prices. Obama would require hospitals and other providers to collect and publicly report measures of health care costs and quality, including data on preventable medical errors, nurse staffing ratios, hospital-acquired infections, disparities in care, and costs.

McCain would promote smoking cessation programs and seek to lower obesity rates. He believes that parents should be responsible for ensuring children are taught about health, nutrition, and exercise and children should be provided healthy dietary choices in schools. Obama would require coverage and low copayments for smoking cessation programs in all federally supported health plans. Obama would work with schools to create healthier environments, including by providing contract assistance with vendors and increased financial support for physical education. Obama would increase the number of public health practitioners through loan repayment, reimbursement grants for training curricula, and infrastructure support to improve working conditions. Federal, state, and local governments would work together to develop a national and regional strategy for public health and align funding mechanisms to support its implementation. Obama believes the government must invest in public health workforce recruitment and modernization of public health infrastructure, such as public health laboratories.

What Will the Proposals Cost and Do They Have the Potential to Achieve Overall System Savings?

Both McCain and Obama have provided broad outlines of a reformed health insurance system and their approaches to improve the quality and efficiency of care. However, the details of their proposals, which have not yet been made clear, will determine the costs borne by employers, individuals, the government, and other stakeholders as well as the

overall health system expenditures.[50] Key features that will have significant implications

McCain's plan would reduce the number of uninsured by just 2 million out of projected 66.8 million uninsured at a cost of $64 billion. Obama's plan would reduce the number of uninsured by 33.9 million in that year at a federal cost of $237 billion.

* Estimates based on assumptions made by the Tax Policy Center about key details of the proposals that have not yet been made clear.
Source: L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans,* Urban Institute–Brookings Institution Tax Policy Center, Updated September 12, 2008.

McCain's proposal would cover fewer people in future years and cost less over time because the annual growth in the tax credits would be pegged to consumer prices, which grow more slowly than medical costs. This means that the value of the tax credits is expected to decline relative to premium costs. This has two implications: 1) fewer people would be able to afford to buy health insurance with their tax credits and 2) people with employer coverage would pay more taxes on employer-provided premium contributions, offsetting the costs to the federal government of the tax credits over time.

Over the 10-year period, the Center estimates that the total federal cost of McCain's plan could reach $1.3 trillion and the total federal cost of Obama's plan could reach $1.6 trillion. But the estimates for the McCain proposal do not include the cost of his proposed high-risk pools, which would cover people who cannot find coverage on the individual market. This feature of the McCain proposal could be very expensive for two reasons: 1) allowing people to buy coverage across state lines would remove existing consumer protections in the states that require guaranteed issue and community rating, leaving many people who currently have coverage through those markets to go to the high-risk pools and 2) both the Tax Policy Center and Buchmueller et al. estimate that 20

million people would lose employer coverage as a result of the elimination of the employer benefit tax exemption, leading many with health problems to seek coverage in high-risk pools.[51] The Center estimates that McCain's high-risk pools, if financed adequately and coverage made affordable as he proposes, could add an additional $1 trillion to the cost of his plan over 10 years.

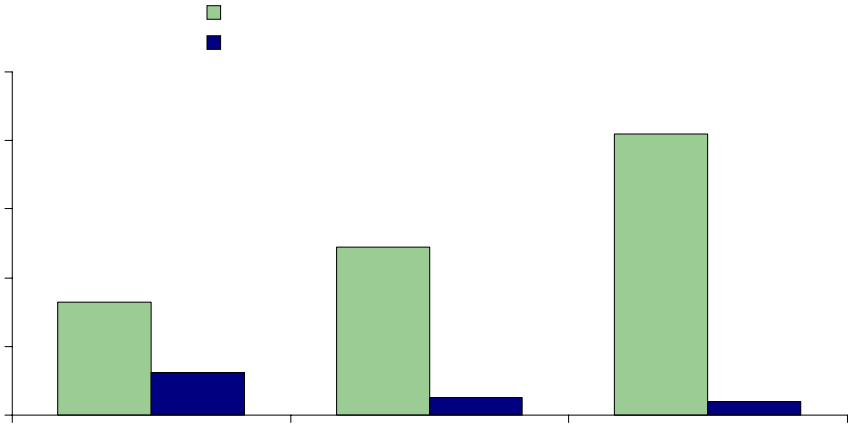
Potential for Savings

The candidates' strategies for improving the quality and efficiency of care would affect costs and health system savings over the long term. A report by the Commonwealth Fund Commission on a High Performance Health System, , examined the impact on health care costs of several strategies to improve quality and efficiency, some of which have been proposed by the presidential candidates (Figure 12).[52] These include: increasing the use of health information technology and comparative effectiveness evidence in insurance benefit design; promoting better health and disease prevention, for example through efforts to reduce tobacco use and obesity; aligning incentives to improve quality and efficiency, such as paying hospitals for improved outcomes; and correcting price signals in health care markets, for example by allowing Medicare to negotiate drug prices with pharmaceutical companies.

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
* In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.
Source: C. Schoen, S. Guterman, A. Shih et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).

the options include initial investments such as expanding the use of health information technology that would result in returns in later years. Potential health system savings from these strategies ranged from $9 billion to $368 billion over 10 years.[53] For example, by promoting the diffusion of health information technology through a 1 percent assessment on insurance premiums and Medicare outlays, net health system savings could reach $88 billion over 10 years. Establishing a center on medical effectiveness, along with the creation of payment and cost-sharing incentives for providers and consumers to draw on the results of medical effectiveness research, could yield savings of up to $368 billion over 10 years, shared across all payers. Implementing a medical home model within the Medicare program in which primary care providers are paid for improved care coordination, care management, and improving access to appropriate care

were coupled with efforts to reform how the United States pays for health care, invest in better information systems, and adopt initiatives to improve public health.



* Selected options include improved information, payment reform, and public health.
Data: Lewin Group estimates of combination options compared with projected federal spending under current policy.
Source: Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 2007).

KEY DIFFERENCES BETWEEN THE CANDIDATES' PROPOSALS

In summary, the key differences in the way Senators McCain and Obama would reform the health insurance system are the following (Figure 14):

* Estimates of uninsured covered from L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans,* Urban Institute–Brookings Institution Tax Policy Center, Updated September 12, 2008.

- **Aiming to cover everyone.** While McCain proposes to expand access to health insurance coverage, he has not said that covering everyone is a goal. Obama supports the goal of universal coverage. The Tax Policy Center estimates that, in 10 years, McCain's plan would cover about 2 million people out of an estimated 66.8 million uninsured. Obama's proposal is estimated to cover about 33.9 million people, or half the uninsured in that year.

- **Minimum state rules vs. uniform national rules for the individual insurance market.** Policies in the individual market are individually underwritten in all but a few states, making it difficult for older people or those with health problems to gain coverage at affordable rates. Consequently, only about 7 percent of the under-65 population buys coverage in the individual market. This has changed little over time, despite the growing number of people who have lost access to employer-based health insurance. Individually underwritten policies also increase administrative costs and reduce the potential for economies of scale. McCain would change the tax code to encourage more people to enroll in the individual market and allow people to buy policies across state lines. This change helps people who currently buy coverage on the individual market and do not receive a

tax benefit. But allowing purchase across state lines would effectively remove consumer protections, such as community rating and guaranteed issue, now in place in some states. This would reduce access for older people and those with health problems and increase access for young and healthy people. McCain proposes to cover people with preexisting health conditions by using federal funds to expand high-risk pools, which now cover fewer than 200,000 people in 34 states. Obama, in contrast, would largely replace the individual market with an insurance exchange in which small businesses and people without access to employer or public coverage could purchase either a private health plan or a public plan with premium subsidies and tax credits. Insurers, including those selling policies outside the exchange, would be prevented from rejecting applicants or charging higher premiums because of preexisting conditions.

- **Reducing vs. expanding employer health benefits.** McCain proposes to treat employers' premium contributions to employees as taxable income and provide tax credits for people to apply to their employer plans or individual market plans. This change has the potential to reduce the incentive of many employers, particularly small employers, to continue providing health coverage to their employees. Obama's proposal would require all employers, other than small businesses, to offer coverage to their employees or pay part of the costs of covering their employees. This would enable the nearly 160 million people with employer benefits to keep the coverage they have and maintain the more than $400 billion in employer contributions to health insurance currently in the system. Obama also would provide tax credits to small businesses to buy coverage through the insurance exchange and would offer federal reinsurance for employers that experience catastrophic claims.

- **Reducing vs. expanding Medicaid and SCHIP.** McCain has said he would allow states to use Medicaid funds to enable purchase of private insurance by eligible families. To the extent that healthier Medicaid enrollees opted for private coverage, this option could fragment the program's risk pools into healthy and less healthy groups. Obama would raise income eligibility standards for Medicaid and SCHIP, allowing more people to become eligible. This would expand the large risk pools of Medicaid and SCHIP.

- **More vs. less exposure to health care costs.** McCain does not specify a standard floor for benefits and cost-sharing, which means that people buying coverage on the individual market with his new tax credits could face wide variations in premiums, benefits covered, and out-of-pocket costs. He has said he would provide subsidies to help people with preexisting health conditions buy coverage

in high-risk pools, though he has not said what the size of the subsidies would be or what household income levels would qualify. Obama would provide sliding-scale premium subsidies based on income for people to buy private or public plans through the insurance exchange, though he has not said what the size of the subsidies would be or specified the income levels of households that would be eligible. Obama would require that the public and private plans sold through the exchange have benefits and cost-sharing similar to that available to federal employees and members of Congress.

- **No requirements vs. requirements to have coverage.** McCain would not require people to have health insurance. Obama would require that children have health insurance and has said he would consider a similar requirement for adults if substantial numbers of people do not buy coverage that is deemed affordable.

- **The same vs. more leverage to stimulate improvement in quality and efficiency.** Both candidates have proposed conceptual approaches to improving the quality and efficiency of care, including changing the way providers are paid, better coordinating health care, particularly for people with chronic conditions care, and improving coverage of and access to preventive services. However, their health insurance reform proposals could significantly affect their ability to achieve such improvements throughout the health system. Both candidates point to public programs such as Medicare, Medicaid, and SCHIP as places to implement initiatives such as paying doctors and hospitals on the basis of quality. But because McCain emphasizes less oversight of private insurance markets than we have today, he would be limited to implementing new initiatives in public programs. In contrast, Obama's proposed creation of a new public plan and an insurance exchange would provide new arenas in which to experiment with quality and efficiency innovations. He also has identified FEHBP as an insurance program in which innovations in quality and efficiency might be pursued. For example, providers and health plans participating in each of the public programs or the exchange could be required to develop chronic disease management programs. The more organized markets are and the more universal, standardized, and coordinated the system is, the more leverage points there will be to make improvements in quality and efficiency.

WHICH PROPOSALS HOLD THE GREATEST PROMISE?

Measured against the broad principles articulated by the Commission, Obama's proposal for private–public group insurance with a shared responsibility for financing has greater potential to move the health system toward high performance than does McCain's proposal to encourage individual market coverage through the use of tax incentives

(Figure 15). Obama’s approach could provide more people with affordable health insurance that covers essential services, achieve greater equity in access to care, realize efficiencies and cost savings in the provision of coverage and delivery of care, and redirect incentives to improve quality. In the absence of a requirement that everyone has coverage, however, the proposal is likely to fall short of universal coverage.

–	+
+	++
–	+
0	+

CONCLUSION

Universal coverage is a necessary, though not sufficient, condition for improving the overall performance of the health system. Moreover, the way in which policymakers design health insurance reform will affect whether everyone can have affordable insurance that covers essential services and whether sustained improvements in quality and efficiency can be achieved. As presidential candidates, Senators John McCain and Barack Obama propose reforms that would place the nation's health system on very different paths, with profound implications for the American people. In the wake of the 2008 election, it will be critical for policymakers to forge consensus around strategies for reform that have the greatest potential for success and move forward with pragmatic solutions to our worsening health system crisis.

NOTES

[1] For more detail, see The Commonwealth Fund Commission on a High Performance Health System, _____ _____ (New York: The Commonwealth Fund, Nov. 2007).

[2] For more detail, see S. R. Collins, C. Schoen, K. Davis, A .K. Gauthier, and S. C. Schoenbaum, _____ (New York: The Commonwealth Fund, Oct. 2007).

[3] J. E. McDonough, B. Rosman, M. Butt et al., "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," Web Exclusive (June 3, 2008):w285–w297.

[4] Massachusetts Division of Health Care Finance, (Boston: Aug. 2008).

[5] S. K. Long. "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," Web Exclusive (June 3, 2008):w270–w284.

[6] J. Kingsdale, Executive Director, Commonwealth Health Connector, "Design of Connector as an Element of NHI," July 23, 2008.

[7] C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health nsurance," May/June 2008 27(3):646–57.

[8] K. Davis, C. Schoen, and S. R. Collins, _____ _____ (New York: The Commonwealth Fund, May 2008).

[9] C. DeNavas-Walt, B. D. Proctor, and J. C. Smith, (Washington, D.C.: U.S. Census Bureau, Aug. 2008).

[10] T. Buchmueller, S. A. Glied, A. Royalty et al., "Cost and Coverage Implications of the McCain Plan to Restructure Health Insurance," Web Exclusive (Sept. 16, 2008): w472–w481.

[11] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, _____ _____ _____ (New York: The Commonwealth Fund, Sept. 2006).

[12] A. Catlin, C. Cowan, M. Hartman et al., "National Health Spending in 2006: A Year of Change for Prescription Drugs," , Jan./Feb 2008 27(1):14–29.

[13] K. Davis, B. S. Cooper, and R. Capasso, _____ _____ (New York: The Commonwealth Fund, Nov. 2003).

[14] Buchmueller et al., "Cost and Coverage Implications," 2008.

[15] Ibid.

[16] National Association of State Comprehensive Health Insurance Plans, (St. Louis Park, Minn.: NASCHIP, 2008).

[17] L. Achman and D. Chollet, _____ _____ (New York: The Commonwealth Fund, Aug. 2001).

[18] NASCHIP, 2008.

[19] Buchmueller et al., "Cost and Coverage Implications," 2008.

[20] L. Burman, S. Khitatrakun, G. Leiserson et al., (Washington, D.C.: Urban Institute and Brookings Institution, Sept. 12, 2008).

[21] Collins et al., 2007; J. M. Lambrew and J. Gruber, "Money and Mandates: Relative Effects of Key Policy Levers in Expanding Health Insurance Coverage to All Americans," , Winter 2006/2007 43(4):333–44; and K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," Web Exclusive (Apr. 23, 2003):w3-199–w3-211.

[22] Schoen et al., "Building Blocks for Reform," 2008.

[23] Sherry Glied has pointed out the wide variation in mandate compliance in different industries in the United States as well as in health insurance systems in Europe, concluding that high compliance depends critically on three factors: 1) whether it is easy and inexpensive to comply; 2) whether noncompliance penalties are stiff, but not excessive, and carry a perception that they will be enforced; 3) whether there is a specified sign-up period as in the case of Switzerland and the Netherlands. See S. A. Glied, J. Hartz, and G. Giorgi, "Consider It Done? The Likely Efficacy of Mandates for Health Insurance," , Nov./Dec. 2007 26(6):1612–21.

[24] Burman et al., 2008.

[25] K. Sack, "McCain Plan to Aid States on Health Could Be Costly," , July 9, 2008; Buchmueller et al., "Cost and Coverage Implications," 2008.

[26] G. Claxton, J. R. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms," Web Exclusive (Sept. 24, 2008):w492–w502.

[27] Buchmueller et al., "Cost and Coverage Implications," 2008.

[28] C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Web Exclusive (June 10, 2008): w298–w309.

[29] See http://www.opm.gov/insure/08/brochures/pdf/71-005.pdf.

[30] America's Health Insurance Plans, (Washington: AHIP, 2007), http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

[31] G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," Sept./Oct. 2007 26(5):1407–16.

[32] L. J. Blumberg, J. Holahan, J. Hadley et al., "Setting a Standard of Affordability for Health Insurance Coverage," Web Exclusive (June 4, 2007):w463–w473.

[33] J. L. Lambrew, _____ (New York: The Commonwealth Fund, Sept. 2005).

[34] Ibid.

[35] K. Swartz, (New York: Russell Sage Foundation, 2006).

[36] Ibid.

[37] Buchmueller et al., "Cost and Coverage Implications," 2008.

[38] J. Gabel, K. Dhont, and J. Pickreign, _____ (New York: The Commonwealth Fund, May 2002); M. A. Hall, "The Geography of Health Insurance Regulation," , Mar./Apr. 2000 19(2):173–84; M. V. Pauly and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets,"