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

Sara R. Collins, Jennifer L. Nicholson, Sheila D. Rustgi, and Karen Davis
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ABSTRACT: This report describes the 2008 presidential 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. Senators John McCain and Barack Obama would place the nation's health system on very different paths, with profound implications for the American people. Obama's proposal for mixed private–public group insurance with a shared responsibility for financing has greater potential to move the health care system toward high performance than does McCain's proposal to encourage individual market coverage through the use of tax incentives and deregulation. According to an estimate discussed in the report, in 10 years McCain's proposal would reduce the number of people who are uninsured by 2 million out of a projected 67 million, while Obama's plan would reduce the number of uninsured people by 34 million.

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ABOUT THE AUTHORS

Sara R. Collins, Ph.D., is assistant vice president at The Commonwealth Fund. An economist, she is responsible for survey development, research, and policy analysis, as well as program development and management of the Fund's Program on the Future of Health Insurance. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University.

Jennifer L. Nicholson is associate program officer for the Program on the Future of Health Insurance at The Commonwealth Fund. She is a graduate of the University of North Carolina at Chapel Hill with a B.S. in public health. While in school, she worked as an intern at a community health center and was a volunteer coordinator for a student-run health clinic. She is currently pursuing a master's degree in epidemiology at Columbia University.

Sheila D. Rustgi is program assistant for the Program on the Future of Health Insurance at The Commonwealth Fund. She is a graduate of Yale University with a B.A. in economics. While in school, she volunteered in several local and international health care organizations, including Yale New Haven Hospital and a Unite for Sight eye clinic. Prior to joining the Fund, she worked as an analyst at a management consulting firm.

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*.

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

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 continue to be structured around private insurance markets, with a supporting role played by public insurance programs. But their plans diverge significantly on the way a reformed system should operate. McCain would change the tax code to encourage people to buy coverage through the individual insurance market and effectively loosen state rules governing the sale of insurance by allowing people to buy policies across state lines. Obama would encourage the continuing participation of employers in the health insurance system, expand eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP), and create a new insurance market "exchange"—with consumer protections, choice of public and private health plans, and income-based premium subsidies—that would largely replace

the individual market. According to one estimate, discussed below, in 10 years McCain's proposal would reduce the number of people who are uninsured by 2 million out of a projected 67 million. Obama's plan would reduce the number of uninsured people by 34 million in 10 years.

McCain's Approach: Tax Credits for Individual Market Insurance. McCain proposes to expand coverage through the individual insurance market by replacing the current tax exemption for employer-provided health benefits with tax credits of $2,500 for individuals and $5,000 for families. Currently, premium contributions from employers are not treated as taxable income to employees. Under McCain's proposal, these contributions would be subject to income taxes. People could use their tax credits to offset the costs of employer coverage or coverage purchased on the individual market, and could deposit any remaining funds in health savings account (HSAs). He also would effectively deregulate individual insurance markets by allowing people to buy coverage across state lines. He has proposed federal funding to expand existing state high-risk pools for people who cannot gain coverage through the individual market because of their health conditions, with premium assistance for those with lower incomes.

Obama's Approach: Private and Public Group Insurance with Consumer Protections and Income-Based Subsidies. Senator Obama has proposed a plan for universal coverage that would build on the current system of mixed private and public group insurance. Some of its features are similar to the universal coverage law now being implemented in Massachusetts. All employers, other than small businesses, would be required to offer health insurance to their employees or contribute to the cost. Eligibility for Medicaid and SCHIP would be expanded. Small businesses, self-employed individuals, and people who do not have coverage through their employers, Medicaid, or SCHIP would be able to purchase a plan through a new insurance market called the National Health Insurance Exchange. Through this exchange, people could choose a private plan or a new public plan similar to that offered to federal employees and members of Congress. All insurance carriers would be required to offer plans to all applicants and could not charge premiums based on health status. Small businesses would be eligible for tax credits to offset their premium costs and individuals would be eligible for income-based premium subsidies. Obama has not yet defined the size of eligible small businesses and those not subject to the requirement to offer coverage.

KEY DIFFERENCES BETWEEN THE CANDIDATES' PROPOSALS

There are several differences between McCain and Obama's proposals to reform the health insurance system (Figure ES–1):

Figure ES-1. Key Differences Between the Presidential Candidates' Health Reform Plans

	McCain	Obama
Aims to Cover Everyone	Not a Goal	Goal
Rules for Individual Insurance Market	Minimum State Rules	Uniform National Rules
Employer Role in Providing Health Benefits	Reduce	Expand
Medicaid/SCHIP	Reduce	Expand
Families' Exposure to Health Care Costs	More	Less
Requirements to Have Coverage	None	Children Only
Leverage to Stimulate Improvement in Quality and Efficiency	No change from current system	More
Uninsured Covered After 10 Years*	2 million	34 million

* 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.
- **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 find 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 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 would help people who currently buy coverage on the individual market by giving them a tax benefit. But allowing health insurance to be sold across state lines would effectively remove consumer protections now in place in some states, such as community rating and guaranteed issue. This would reduce access to insurance 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 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

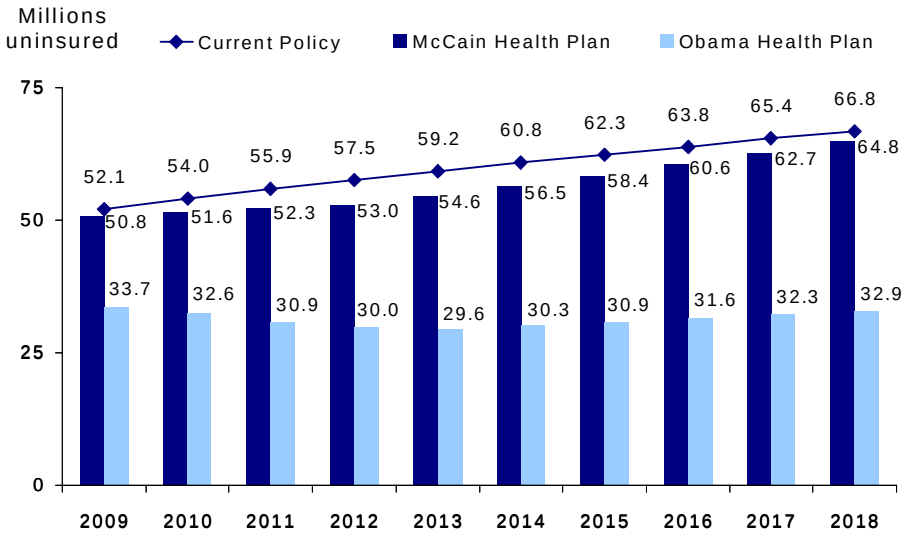
private plans sold through the exchange have benefits and cost-sharing similar to that available to federal employees and members of Congress.

- **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 are and the more standardized the system is, the more leverage points there will be to make improvements in quality and efficiency.

HOW MANY PEOPLE WOULD GAIN HEALTH COVERAGE AND WHAT WOULD IT COST?

The lack of detail in both candidates' proposals makes it difficult to estimate how many people would gain coverage under them and at what cost. Researchers at the Urban Institute–Brookings Institution Tax Policy Center made several assumptions about the proposals that enabled them to make the following preliminary estimates of the effects of the proposals on expanding coverage and the costs to the federal government over the next 10 years (Figures ES-2 and ES-3).

Figure ES-2. Estimated Number of Uninsured People Under Current Policy, McCain Health Plan, and Obama Health Plan



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.

Figure ES-3. Tax Policy Center Estimates of Coverage and Costs of Candidates' Plans

	McCain*		Obama*	
	Change in Uninsured (millions)	Federal Costs ($ billions)	Change in Uninsured (millions)	Federal Costs ($ billions)
2009	(1.3 m)	$185 b	(18.4 m)	$86 b
2013	(4.6 m)	$141 b	(29.6 m)	$160 b
2018	(2.0 m)	$64 b	(33.9 m)	$237 b
Total Cost (2009–2018)	—	$1,311 b	—	$1,630 b
Total Uninsured Not Covered, 2018 (Out of an Estimated 66.8 m)	64.8 m	—	32.9 m	—

* 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 the health care system toward high performance than does McCain's proposal to encourage individual market coverage through the use of tax incentives and deregulation (Figure ES-4). Compared with McCain's approach, 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 affordable coverage, however, the proposal is likely to fall short of achieving universal coverage.

Figure ES-4. How Well Do the Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Credits and Minimum State Rules for Individual Insurance Market	Mixed Private–Public Group Insurance with Premium Subsidies and Consumer Protections
Covers Everyone	0	+
Standard Benefit Floor	–	+
Premium/Deductible/ Out-of-Pocket Costs Affordable Relative to Income	–	+
Easy, Seamless Enrollment	0	+
Choice	+	+
Pool Health Care Risks Broadly	–	+
Minimize Dislocation, Ability to Keep Current Coverage	+	++
Administratively Simple	–	+
Improve Health Care Quality and Efficiency	0	+

0 = Minimal or no change from current system; — = Worse than current system;
+ = Better than current system; ++ = Much better than current system
Source: S. R. Collins, C. Schoen, K. Davis et al., *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund Commission on a High Performance Health System, Oct. 2007).

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

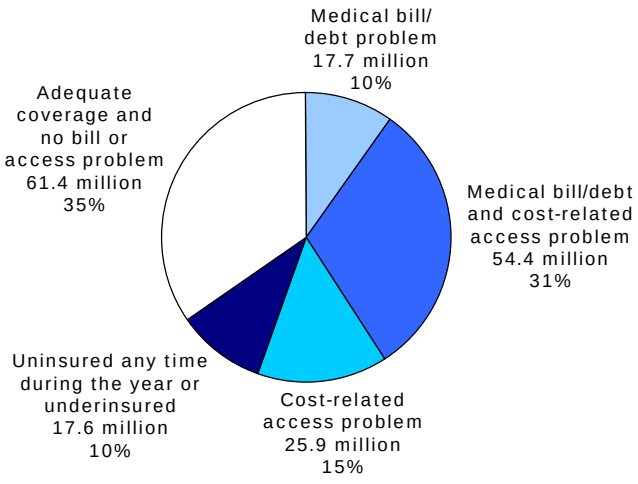
Universal coverage is a necessary, though not sufficient, condition for improving the performance of the health system. Moreover, how policymakers design health insurance reforms will affect whether everyone can have affordable insurance that covers essential services and whether sustained improvements 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

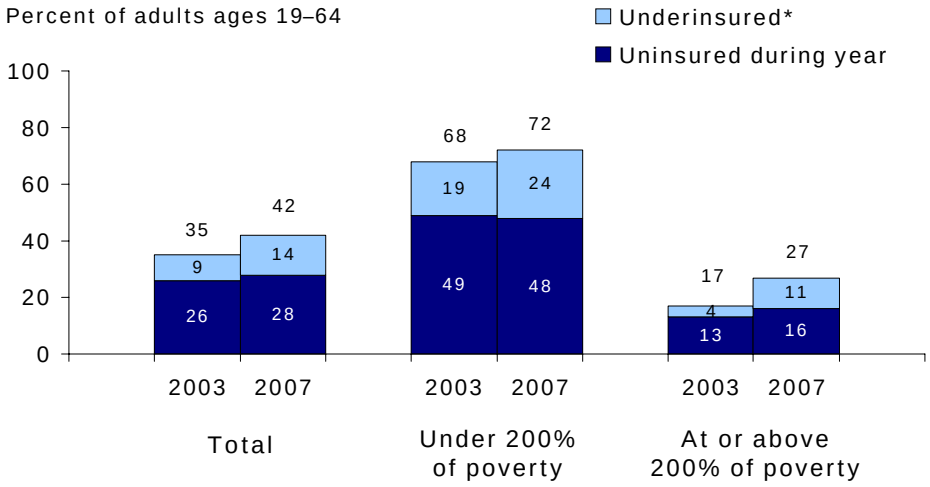
With the 2008 presidential election just weeks away, health care reform is at the top of the nation's domestic policy agenda. The soaring costs of health care, along with a faltering economy and lackluster wage growth, are leaving many working families without insurance or with medical expenses that 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).

Figure 1. Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007



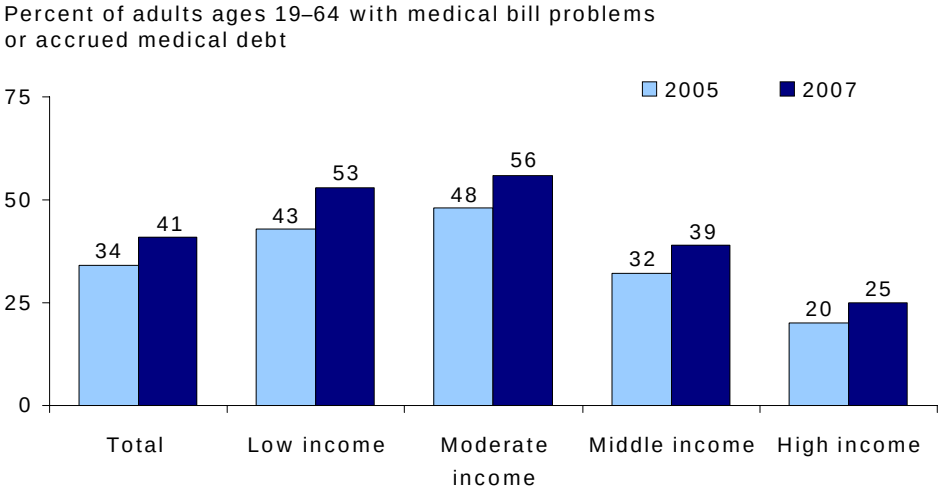
Note: Percentages may not sum to 100 percent because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 2. The Number of Underinsured Adults Under Age 65 Rose to 25 Million in 2007, Up from 16 Million in 2003



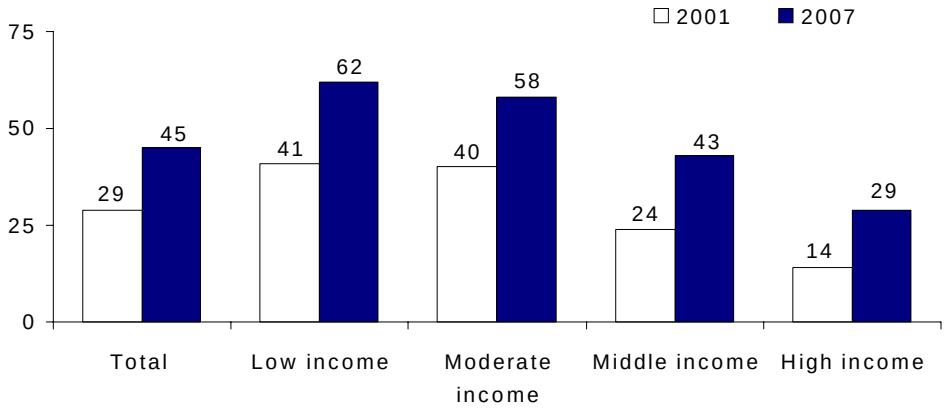
* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
Source: C. Schoen, S. R. Collins, J. L. Kriss, 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).

Figure 3. Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007



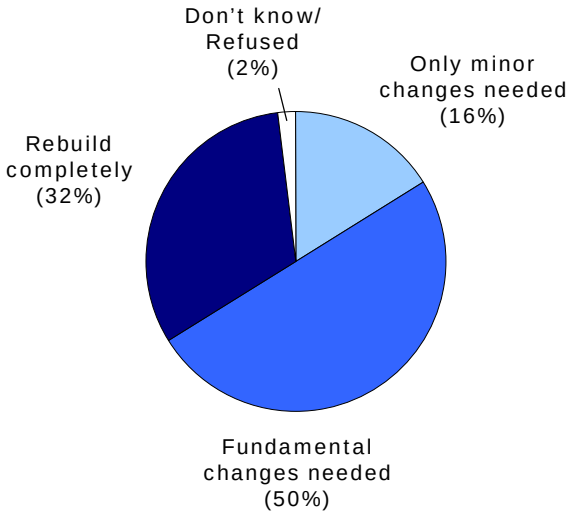
Note: Income refers to annual income. In 2005 and 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).

Figure 4. Cost-Related Problems Getting Needed Care Have Increased Across All Income Groups, 2001–2007



* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Note: Income refers to annual income. In 2001 and 2003 low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005 and 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, and 2007).

Figure 5. Which of the Following Comes Closest to Expressing Your Overall View of the Health Care System in this Country?



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

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 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]

- extending affordable health insurance to all;
- aligning incentives to reward high-quality, efficient care;
- organizing the health system to achieve accountable, coordinated care;
- investing in public reporting, evidence-based medicine, information technology, and infrastructure needed to deliver the best care; and
- exploring the creation of a national entity that would set goals for improving health system performance and recommend best practices and policies.

Universal coverage is a necessary, but clearly 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 be covered and sustained improvements in the quality and efficiency of care can be achieved. The Commission has identified the following principles of health care reform as essential in moving the health system toward high performance.[2]

ACCESS TO CARE

To expand access to care, reform proposals should adhere to the following principles:

- Provide equitable and comprehensive insurance for all.
- Insure the population in a way that leads to full and equitable participation.
- Provide a standard benefit package for essential coverage and financial protection.
- Premiums, deductibles, and out-of-pocket costs should be affordable relative to family income.

- 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. Senator McCain proposes to expand coverage through the individual insurance market by replacing the current tax exemption for employer-provided health benefits with tax credits. Currently, premium contributions from employers are not treated as taxable income. Under McCain's proposal, these contributions would be counted as part of employees' taxable income, subject to income taxes. People could use their tax credits to offset the costs of employer coverage or coverage purchased on the individual market. He also would allow people to buy health insurance in the individual market across state lines. He has proposed expanding existing state high-risk pools for people who cannot gain coverage through the individual market because of their health conditions, with federal financial support and premium assistance for those with lower incomes.

Obama's Approach: Private and Public Group Insurance with Consumer Protections and Income-Based Subsidies. Senator Obama has proposed a plan for universal coverage that would build on the current system of mixed private and public group insurance. All employers, other than small businesses, would be required to offer health insurance to their employees or contribute to the cost. Eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP) would be expanded. Small businesses, self-employed individuals, and people who do not have coverage through their employers, Medicaid, or SCHIP would be able to purchase a plan through a new National Health Insurance Exchange. Through this exchange, people could choose either a new public plan similar to that offered to federal employees and members of Congress or a private plan. Small businesses would be eligible for tax credits to offset the premium costs of plans purchased through the exchange and individuals would be eligible for income-based premium subsidies. All insurance carriers, including those selling policies outside the exchange, would be required to offer plans to all applicants and could not charge premiums based on health status. Children would be required to have health insurance and young adults up to age 25 would be able to stay covered under their parents' policies. Although Obama's proposal does not mandate adults to obtain coverage, it is in other ways similar to the universal coverage law now being implemented in Massachusetts and to a framework for universal coverage outlined by Schoen et al. in *Health Affairs* in May 2008 (see text boxes below).

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 combination of changes to the system: public insurance expansions, subsidized private insurance, individual and employer requirements, and reforms to the insurance market. All state residents are required to have health insurance that meets certain benefit requirements.

The Massachusetts health reform law requires that employers either provide health insurance for their employees or pay into a pool to cover the uninsured. Employers with more than 10 full-time workers that do not contribute at least 33 percent of premium costs for full-time employees or do not cover at least 25 percent of eligible employees are required to make an annual per worker "fair-share contribution" of $295 to the state.

MassHealth, Massachusetts' SCHIP program, was expanded to cover children in families with incomes up to 300 percent of the federal poverty level.

The law also created the Commonwealth Health Insurance Connector Authority, an insurance exchange that offers small businesses and individuals a selection among private health insurance plans. The Commonwealth Care Health Insurance Program provides subsidized health insurance through the Connector to uninsured adults under 300 percent of poverty, with premiums and cost-sharing on a sliding scale based on income. Adults in households with incomes under 150 percent of poverty pay no premiums, no deductibles, and modest copayments. Those with incomes between 150 and 300 percent of poverty pay premiums on a sliding scale ranging from up to 2 to 5 percent of income, with no deductibles and copayments that differ, depending on the level of the premium.[3] The plans cover inpatient care, outpatient care, preventive health care, behavioral health services, and prescription drugs; plans for adults with incomes below 100 percent of poverty also cover dental care. For the purposes of the state requirement to have health insurance, Massachusetts defined affordable plans as those with premiums of no more than 5 to 9 percent of income for those earning between 300 and 500 percent of poverty. Beginning in January 2009, individuals must have insurance that covers comprehensive benefits defined by the Connector authority, including prescription drugs, no annual or per-sickness benefit maximums, limits on deductibles of no more than $2,000 for individuals and $4,000 for families, limits on prescription drug deductibles to no more than $250 for individuals and $500 for families, and an in-network out-of-pocket maximum of $5,000 for individuals and $10,000 for families.

The number of people enrolled in private or subsidized health insurance programs in Massachusetts increased by more than 439,000 between the start of health reform in June 2006 and March 31, 2008.[4] The uninsured rate for adults ages 18 to 64 dropped by half in the first year of implementation, with only 7 percent of nonelderly adults in the state uninsured by the fall of 2007.[5] Massachusetts' health reform also has led to improved benefits and lower premiums. An uninsured 37-year-old male faced a monthly premium of $335 with a $5,000 deductible prior to health reform, compared with a $184 monthly premium and a $2,000 deductible post-reform.[6]

Approaches to Health Reform: Building Blocks

In the May 2008 issue of *Health Affairs,* 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.

Prevention and chronic disease management: Coverage of preventive services would be promoted, as would smoking cessation programs. Patients would have a larger role in both prevention and care and take on more decisions and responsibility for their care. Public health initiatives would encourage individuals to prevent chronic disease, receive appropriate tests for early detection, and follow treatment guidelines after disease develops. Parents would be responsible for ensuring children are taught about health, nutrition, and exercise. Children should be provided healthy dietary choices in schools. Public health leaders, including the next president, must promote

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, including electronic health records. Requirements for full implementation of health information technology would be phased in with the necessary federal resources. Would ensure that information technology systems are developed in coordination with providers and frontline workers, including those in rural and underserved areas. Patient privacy would be protected.

Transparency: 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. Health plans would be required to disclose the percentage of premiums that goes to patient care versus administration.

Patient safety: Would support hospitals and physician practices in their efforts to prevent medical errors.

Provider payment reform: Would accelerate efforts to develop and disseminate best practices and align provider reimbursement with provision of high-quality care. Providers who see patients enrolled in the new public plan, plans in the National Health Insurance Exchange, Medicare, and FEHBP would be rewarded for achieving performance thresholds on physician-validated outcome measures.

Prescription drugs: Would allow the federal government to negotiate directly with pharmaceutical companies under the Medicare prescription drug benefit. Would allow U.S. residents to purchase medication from Canada and other developed countries, if the drugs are safe and prices are lower. 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.

Medicare private plans: Would eliminate extra subsidies to private Medicare Advantage plans and pay them the same amount that it costs to treat the same patients under regular Medicare.

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 for malpractice insurance. Would also promote new models for addressing physician errors to improve patient safety, strengthen the doctor–patient relationship, and reduce the need for malpractice suits.

Financing: Would finance by allowing the tax cuts for households with incomes of $250,000 and above to expire and with revenue from the employer contribution.

HOW WELL DO THE CANDIDATES' PROPOSALS MEET PRINCIPLES FOR HEALTH INSURANCE REFORM?

Assessing the presidential candidates' health insurance reform proposals against the principles for reform described above helps to illustrate their differences as well as their strengths and weaknesses. The proposals use different mechanisms to address the problems of inadequate access to care, variable quality, and high costs (Figure 6). The inclusion or omission of certain features has significant implications for the number of people who will ultimately become covered, the cost to stakeholders and the overall health system, equity in access and financing, and improvements in the quality and efficiency of care. Raising the right questions and weighing the evidence will help shape consensus.

Figure 6. Features of Candidates' Approaches to Health Care Reform

	McCain	Obama
Aims to Cover Everyone	No	Yes
Individual Requirement to Have Health Insurance	No	Children only
Employer Contribution	No	Offer or contribute % of payroll, small businesses exempt
Health Insurance Exchange	No	Yes
Medicaid/SCHIP Expansion	No	Yes
Premium Subsidies and Tax Credits	Tax credit $2,500 for individuals, $5,000 for families	Sliding-scale premium subsidies based on income
Standard Benefits Package	No	Yes
Consumer Protections Against Underwriting on Basis of Health	High-Risk Pools	Guaranteed Issue, Community Rating
Tax Credits for Small Businesses	No	Yes
Federal Reinsurance for Businesses for High Health Care Costs	No	Yes

Source: Authors' analysis, September 2008.

ACCESS TO CARE

Do the Proposals Have the Potential to Cover Everyone?

The candidates differ markedly on the goal of providing coverage to everyone. Senator Obama supports the goal of universal coverage. While Senator McCain discusses expanding access to health insurance coverage, he has not said that covering everyone is a goal.

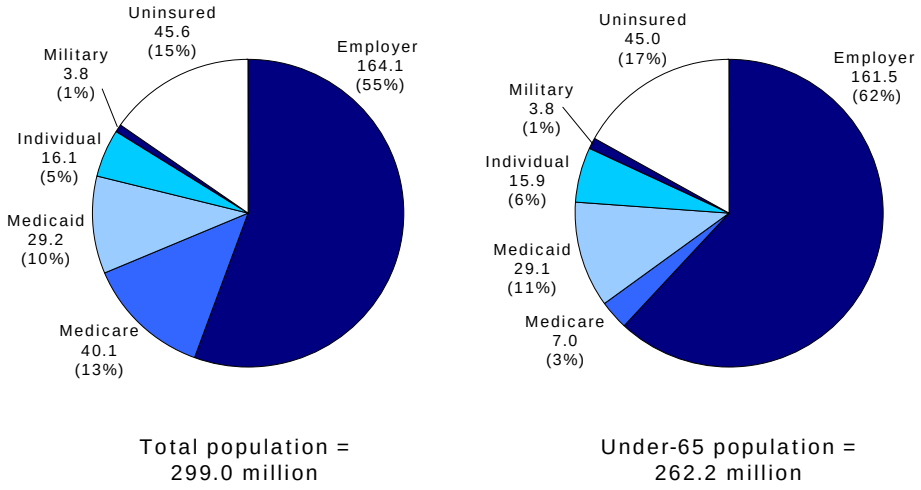
Both candidates propose reforms in which the health system would continue to be structured around private insurance markets, with a supporting role played by public insurance programs. Yet, their ideas on how a reformed system should operate diverge significantly. Obama's reformed health insurance system would be based primarily on broad private and public group risk pools, with regulations that prevent insurers from rejecting applicants or charging higher premiums because of preexisting conditions. McCain's reformed system, instead of pooling risks, would rely on individual insurance markets without consumer protections and separate high-risk pools for people with health problems. The two candidates also differ dramatically on requirements for employers and households to participate in the health system.

Senator Obama: group insurance markets. The largest gap in the health insurance system occurs when people do not have access to employer coverage but have incomes that are too high to qualify for Medicaid or SCHIP. The individual insurance market—in which about 7 percent of the under-65 population buys coverage—has proven largely inadequate to stem the rising tide of uninsured people (Figure 7). While the number of people who have lost coverage through their employers has risen steadily over the past few years, the share of the population that buys coverage in the individual insurance market has stayed relatively constant over time.[9] Obama proposes to fill this gap in three ways: 1) shoring up employer-based health insurance by requiring all employers, other than small businesses, to offer coverage or contribute to the cost of their employees' health insurance; 2) expanding eligibility for Medicaid and SCHIP; and 3) creating a new insurance "market," called a National Health Insurance Exchange, with ground rules designed to protect consumers, in which small businesses and people without access to employer coverage, Medicaid, or SCHIP could purchase a private health plan or a new public plan, with premium subsidies and tax credits for eligible families and small businesses. This three-pronged approach builds on existing large group risk pools (large employer groups and public insurance programs), which have lower administrative costs than in the individual insurance market. In addition, it attempts to repair the inefficiencies and inequities of the individual market through broader risk pooling, ground rules, and benefit standards. The approach is similar to health reform

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.

Figure 7. Sources of Health Insurance Coverage in the United States, 2007

Numbers in millions, 2007



Source: Analysis of the March 2008 Current Population Survey by B. Mahato for The Commonwealth Fund.

Obama proposes to regulate the behavior of all private insurance carriers, even those that do not offer plans through the National Health Insurance Exchange, with ground rules designed to protect consumers. Currently, only a handful of states regulate their individual insurance markets to ensure that older people or those with health problems can gain access to a health plan. Because carriers selling policies in this market individually underwrite each applicant, people in poor health or those with a greater likelihood of needing expensive health services—such as women of childbearing age or older adults—may be charged a high premium, have a health condition (such as pregnancy) excluded from coverage, or not be offered a policy at all. Massachusetts, New Jersey, and New York impose particularly strong regulations on their markets, including "pure" or "modified" community rating (i.e., people with health problems cannot be charged substantially higher premiums than healthier applicants) and guaranteed issue (i.e., anyone who applies must be offered a policy).

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.

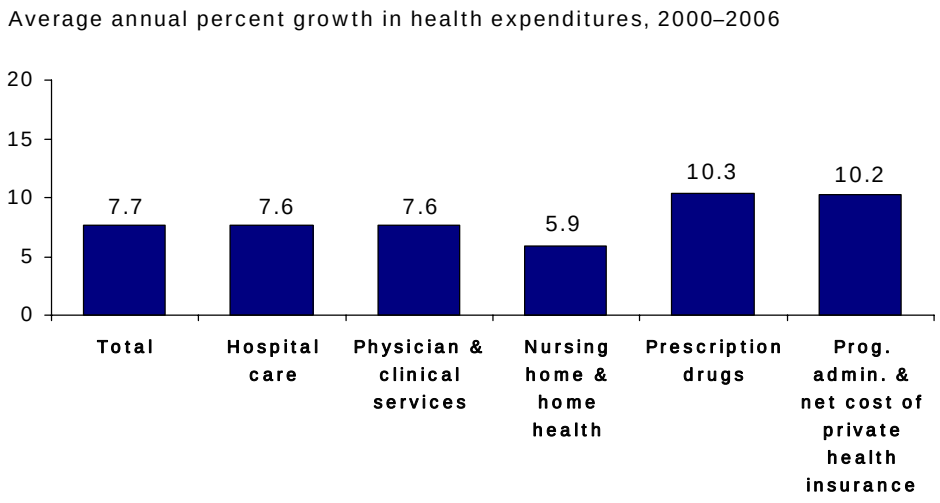
As Buchmueller and colleagues point out in their recent *Health Affairs* article, the tax benefits of employer-provided coverage are a major reason why so many employers offer coverage today.[10] In addition, they argue that the tax exemption provides an incentive for healthy employees to sign up for 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] Administrative costs in the individual market run from 25 percent to 40 percent of premium dollars, compared with 10 percent in the large employer group insurance market and 2 percent in Medicare.[13] These costs include expenditures spent on underwriting each policy sold plus those related to marketing and profits. There are also economies of scale inherent in writing policies for groups of individuals, compared with writing policies for individuals. Buchmueller and colleagues estimate that a family that moved from employer coverage to the individual market would pay on average $2,000 more for a comparable policy, with far less of the premium going to cover actual medical expenditures as opposed to administrative costs.[14]

Figure 8. Health Expenditure Growth 2000–2006
for Selected Categories of Expenditures



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:

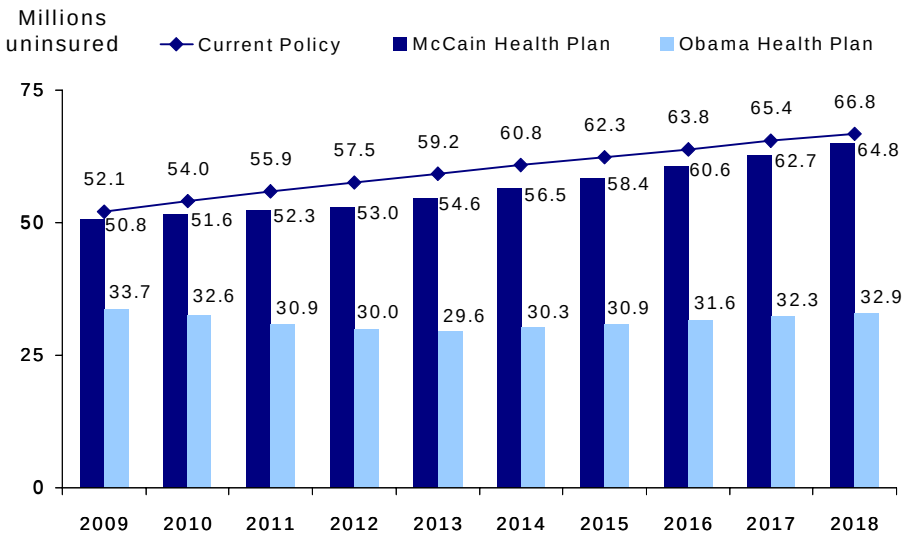
- **Medicaid and SCHIP.** Adults and families with incomes up to 100 percent of the federal poverty level would be eligible for Medicaid. Children under 18 in households with incomes up to 300 percent of poverty would be eligible for SCHIP.
- **Premium subsidies.** The Tax Policy Center assumes a premium subsidy schedule that is less generous than that modeled by Schoen et al. and what is in currently in place under the Massachusetts universal coverage law (see text boxes, Approaches to Health Reform, on pages 7–8). The Center assumes that people with incomes

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).

Figure 9. Estimated Number of Uninsured People Under Current Policy, McCain Health Plan, and Obama Health Plan



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 individual market.

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 the number losing insurance could be even higher, since their estimate does not include the effect of healthy workers opting out of employer coverage, leaving a sicker risk pool and increasing the likelihood that employers would eventually discontinue coverage.

The Tax Policy Center and Buchmueller et al. estimate that, under the McCain proposal, 21 million people would buy coverage in the individual market. This would include those who lose coverage through their employers and those who were uninsured. This means that McCain's proposal would result in a net gain of 1 million people covered during the first year it is implemented (Figure 9).

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 pegged to growth in consumer prices, which have historically climbed more slowly than medical expenditures. This means that the value of the tax credits would decline over time relative to premiums, such that fewer people would be able to afford to purchase health insurance in future years. The Tax Policy Center finds that, by 2013, McCain's proposal would reduce the number of uninsured by 5 million. After that, as the value of the tax credit declines relative to premiums, the number of uninsured people would climb again. By 2018, the plan would reduce the number of uninsured people by just 2 million, leaving an estimated 65 million people uninsured.

The Tax Policy Center did not estimate the effect of McCain's proposal to expand high-risk pools on the uninsured. Buchmueller et al. estimate that an annual infusion of $7 billion to $10 billion in extra funding for the pools, which the McCain campaign has proposed, would cover 3 million additional people.[25]

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 choose between more comprehensive plans with higher premiums and less comprehensive plans with lower premiums. People with lower incomes, however, would have less discretion to select among plans. As Buchmueller et al. suggest, insurance carriers might create bare-bones policies with premiums set at levels close to the amount of the tax credit. As the credit loses value over time relative to premium growth, these plans would likely become skimpier. Many people with health problems would have little control over their benefit packages. In a deregulated insurance market, benefit packages and premiums could be determined by preexisting conditions, gender, and age. People with health problems would be at risk of being charged a much higher premium for coverage, having their health problem excluded, or being denied coverage altogether. McCain has said that he would make premiums affordable in his Guaranteed Access Plans or high-risk pools, but he has not said what the plans would have to cover.

Are Premiums, Deductibles, and Out-of-Pocket Costs Affordable Relative to Family Income?

The design and size of new premium subsidies and tax credits will have a significant impact on the share of income that families spend on health care. Obama has said he would make premiums affordable by providing sliding-scale subsidies based on income,

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 replace the employer benefit tax exemption with refundable tax credits of $2,500 for individuals and $5,000 for families. Compared with a standard income tax deduction proposed by other candidates in the primaries and the Bush Administration as a replacement for the employer benefit tax exemption, refundable tax credits are better targeted to lower-income families who do not pay taxes (a person who does not pay income taxes cannot take a tax deduction) and do not favor those in higher-income tax brackets. Still, McCain's proposed tax credits fall well short of the average premium in employer-based health plans, which in 2008 was about $12,680 for a family policy and $4,704 for a single policy.[26] Buchmueller et al. estimate that an equivalent plan in the individual market would cost at least another $2,000 due to underwriting and other administrative costs.[27] Making up the difference between the tax credit and the premium would pose a greater burden for low- and moderate-income households. And purchasers of coverage in the individual insurance market would find that the value of the credit would vary by state, health status, gender, and age, among other factors.

But premium costs are only part of the health care expenses faced by families. Deductibles, copayments, out-of-pocket spending limits, covered services, and annual or lifetime limits on coverage affect what people pay for health care during the year. Indeed, there has been a significant increase over the past few years in the number of insured adults who have such high out-of-pocket costs relative to their incomes that they are effectively "underinsured." Cathy Schoen and colleagues found that 25 million adults under age 65 were underinsured in 2007, up from 16 million in 2003 (Figure 2).[28] Drawing on the 2003 and 2007 Commonwealth Fund Biennial Health Insurance Surveys, the researchers defined people as underinsured if they: spent 10 percent or more of their taxable income on out-of-pocket costs, excluding premiums; spent 5 percent or more on out-of-pocket costs, excluding premiums, if they had incomes under 200 percent of poverty; or if their deductibles amounted to 5 percent of more their income. According to this definition, about a quarter of adults in lower-income families were underinsured in 2007, up from 19 percent in 2003. During this period, exposure to high health costs moved dramatically up the income scale. The share of adults with incomes at 200 percent of poverty or higher who were underinsured nearly tripled over the four-year period, climbing from 4 percent in 2003 to 11 percent in 2007. People who were underinsured reported high rates of problems in getting needed care due to costs, such as filling prescriptions, as well as problems paying medical bills. In fact, rates of such problems among the underinsured were nearly as high as the rates reported by people who were uninsured for a time during the year.

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 same standard. Currently, the FEHBP plan with the highest enrollment is the Blue Cross Blue Shield Standard Plan option. The annual deductible for that plan is $300 per person and copayments are $15 per physician visit for in-network providers. There are separate $100 deductibles for hospital admissions and room and board. Prescription drug copayments range from $10 for mail order generic drugs to 25 percent coinsurance for brand name drugs at local pharmacies to 45 percent coinsurance for out-of-network pharmacies.[29]

McCain does not address the growing problem of underinsurance. By encouraging a shift away from the employer market toward the individual market, without specifying a standard set of benefits, his proposal might leave many people facing higher deductibles, higher out-of-pocket costs, and higher premiums. Average deductibles in the individual market are substantially higher than those in Blue Cross Blue Shield's Standard Plan and average employer group plans. According to the Association of Health Insurance Plans, the health insurance industry association, average weighted deductibles for preferred provider organization (PPO) and point-of-service plans sold in the individual market were about $2,750 in 2006–07 and average weighted copayments for primary care physician and specialist visits ranged between $29 and $37.[30] These costs are considerably higher than in employer-based PPO plans, which in 2007 had an average per-person deductible of $461 and average copayments of $19 to $24 for in-network primary and specialist physician visits.[31]

Blumberg and colleagues argue that standards for health insurance affordability should take into account both premiums and out-of-pocket spending.[32] Notably, individual insurance market plans often have low premiums but high deductibles or other cost-sharing that can lead to high out-of-pocket spending. In implementing legislation to provide universal coverage, Massachusetts sought to make both premiums and out-of-pocket costs affordable (see text box, Approaches to Health Reform: Massachusetts, on page 7).

Would the Proposals Make It Easy to Find Health Coverage and Stay Enrolled?

Obama's new regulated group insurance market, the National Health Insurance Exchange, would fill a major gap in the current system. People who lose coverage through an employer would be able to turn to the exchange as an affordable place to purchase health insurance coverage that has regulations against risk selection and standard benefits. This could reduce the length of time that people are uninsured as they move from one form of coverage to another. Developing a way for people to easily sign up for coverage, such as when they file taxes, would help make such transitions seamless.

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 with less cost-sharing and higher premiums and less comprehensive plans with greater cost-sharing and lower premiums, or some combination thereof. In addition, allowing people to buy coverage in any state, as McCain has proposed, would provide a greater range of choices. However, older people, those in poor health, and those with low incomes would have fewer choices in the individual market than those who are younger, in good health, or who have higher incomes.

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.

Do the Proposals Minimize Dislocation? Could People Maintain Their Current Coverage?

A contributing factor to the defeat of the Clinton Administration's health care reform plan in 1993 was the exploitation of the public's fear of moving from familiar coverage—mostly employment-based—to a new approach. Recent surveys by the Employee Benefit Research Institute show that Americans continue to place a high value on employer-based coverage. More than three-quarters of employees enrolled in employer-based insurance said they would prefer to receive employer coverage rather than an increase in taxable income equivalent to the cost of their premium.[43]

From a pragmatic perspective, it would be simpler to allow people to remain with their current coverage, as long as it met minimum benefit and affordability standards, than to move them to new forms of coverage. Ginsburg points out that this would allow relatively untested strategies, such as insurance exchanges, to be implemented and fine-tuned among a segment of the population that lacks coverage, rather than among everyone with private insurance.[44] Moreover, by maintaining employer coverage, the system would continue to reap the efficiency benefits of large-employer risk pools. Finally, allowing people to remain covered by employers would retain a substantial source of financing.

Obama's proposal would allow people with employer-based health insurance to retain their coverage, if their employers chose to continue offering it. They would not have to move to a new type of coverage or change providers.

McCain, by contrast, proposes a radical change in the tax treatment of employer-based health benefits that could significantly reduce the number of Americans with employer-based insurance. Indeed, shifting health insurance away from the employer-based system is one of the stated goals of his health proposal. By replacing the employer benefit tax exemption with new tax credits, the proposal would eliminate one of the main reasons U.S. employers choose to offer health benefits. Buchmueller et al. and the Tax Policy Center estimate that 20 million people in employer-based plans would lose their coverage under the McCain proposal, as employers discontinued their health benefits as a result of the change in the tax exclusion.

Would the Proposals Be Simple to Administer?

The U.S. insurance system is highly fragmented and complex, with people receiving coverage through multiple, competing carriers. By building on the current structure of the health insurance system, Obama's proposal would retain much of its complexity.

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 would include a choice of a public plan in the exchange. In an analysis of a similar proposal, Cathy Schoen and colleagues estimate that two-thirds of new enrollees in an insurance exchange or connector would select a Medicare public plan option because its premiums are likely to be more affordable than the private plan options (see text box, Approaches to Health Reform: Building Blocks, on page 8).[46] Partly as a result, administrative costs overall would decline by an estimated $15.4 billion in the first year of implementation.

McCain's proposal to expand insurance coverage in the individual insurance market has the potential to further fragment risk pools and exacerbate administrative complexity. In addition, with people moving from employer group coverage to the individual market, there could be an overall increase in the costs of administration. In a prior analysis of the Bush Administration's proposal to replace the employer benefit tax exemption with a new standard income tax deduction, the researchers estimated that the number of people in the individual market would increase by 20 million and the costs of insurance administration would climb by $5.5 billion in the first year.[47] Prior research also suggests that there could be high costs associated with administering tax credits for use in the individual market. Dorn examined the costs of administering Health Coverage Tax Credits, which are refundable tax credits created under the Trade Act of 2002. The tax credits subsidize 65 percent of the costs of private insurance premiums for certain workers who lose their jobs through international trade.[48] He found that federal administrative costs and private health plan administrative costs comprised 34 percent of total spending on the program.

Do the Proposals Have the Potential to Improve Health Care Quality and Efficiency?
The fact that a substantial number of people lack health coverage and are therefore largely outside of the health system poses a significant barrier to improving the quality and efficiency of care. Proposals that aim to insure everyone with benefit packages that cover essential services would help ensure the entire population has access to preventive care and timely, essential medical care across their life span. But other significant changes are needed to improve quality and efficiency in a systematic, sustainable way.

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.

Figure 10. Where Candidates Stand on Health Care Reform Features

	McCain	Obama
Candidates Agree		
Expand coverage	Yes	Yes
Health IT	Yes	Yes
Transparency	Yes	Yes
Malpractice reform	Yes	Yes
Prevention	Yes	Yes
Pay-for-performance	Yes	Yes
Comparative effectiveness/ quality measurement	Yes	Yes
Candidates Differ		
Universal coverage	No	Yes
Requirements to have coverage	No	Children only
Employer contribution	No	Yes
Changes to employer benefit tax exemption	Yes	No
Regulation of insurance markets	No	Yes
Financing source	No	Yes

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

Payment reform. 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.

Chronic disease management. 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.

Increased prevention. 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.

Prescription drugs. 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.

Administrative efficiency. 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

Chronic care coordination. 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.

Reducing disparities. 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.

Health information technology (HIT). 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

Comparative effectiveness and 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.

Transparency of health care information. 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.

Health promotion and public health. 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 for stakeholder and health system costs include:

- the extent of participation of employers, including the presence of an employer requirement to offer coverage or pay a contribution;
- the extent of participation by individuals, including requirements to have health insurance;
- the generosity of benefit packages;
- the contributions by employers, individuals, and other stakeholders;
- the degree to which risks are pooled;
- the choice of a public plan option similar to Medicare in new group insurance exchanges;
- the extent to which private insurers are regulated, including restrictions against risk selection and rules that set the minimum percent of premiums that must be spent on patient care;
- the size of subsidies to offset premiums and out-of-pocket costs and standards for who receives them; and
- the new income eligibility limits in Medicaid and SCHIP, spending requirements on these programs for states, and changes in participating providers' reimbursement rates.

Federal Costs of the Proposals

As noted above, Burman and colleagues at the Tax Policy Center made several assumptions about the candidates' proposals that allowed them to estimate the number of people that would potentially be covered and what it would cost the federal government over the next 10 years. The Center estimates that, if the plans were implemented in 2009, McCain's proposal would reduce the number of uninsured by 1.3 million at a cost of $185 billion, though this does not include the coverage or cost implications of his expanded high-risk pools (Figures 9 and 11). Obama's proposal would reduce the number of uninsured people by 18.4 million at a cost of $86 billion. McCain's plan would cost more than twice as much as Obama's in the first year while covering 17 million fewer people because most of McCain's tax credits would be used by people who already had private health insurance. By 2013, the Center estimates that McCain's proposal would cover about 4.6 million people at a federal cost of $141 billion, while Obama's proposal would cover 29.6 million people at a cost of $160 billion. After 10 years, in 2018,

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.

Figure 11. Tax Policy Center Estimates of Coverage and Costs of Candidates' Plans

	McCain*		Obama*	
	Change in Uninsured (millions)	Federal Costs ($ billions)	Change in Uninsured (millions)	Federal Costs ($ billions)
2009	(1.3 m)	$185 b	(18.4 m)	$86 b
2013	(4.6 m)	$141 b	(29.6 m)	$160 b
2018	(2.0 m)	$64 b	(33.9 m)	$237 b
Total Cost (2009–2018)	—	$1,311 b	—	$1,630 b
Total Uninsured Not Covered, 2018 (Out of an Estimated 66.8 m)	64.8 m	—	32.9 m	—

* 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, *Bending the Curve*, 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.

Figure 12. Policy Options and Distribution of 10-Year Impact on Spending Across Payer Groups (in billions)

	Total NHE*	Federal Government	State/Local Government	Private Payer	Households
Producing and Using Better Information					
1. Promoting Health Information Technology	–$88	–$41	–$19	$0	–$27
2. Center for Medical Effectiveness and Health Care Decision-Making	–$368	–$114	–$49	–$98	–$107
3. Patient Shared Decision-Making	–$9	–$8	$0	$0	–$1
Promoting Health and Disease Prevention					
4. Public Health: Reducing Tobacco Use	–$191	–$68	–$35	–$39	–$49
5. Public Health: Reducing Obesity	–$283	–$101	–$52	–$57	–$73
6. Positive Incentives for Health	–$19	$2	–$12	–$4	–$5
Aligning Incentives with Quality and Efficiency					
7. Hospital Pay-for-Performance	–$34	–$27	–$1	–$2	–$4
8. Episode-of-Care Payment	–$229	–$377	$18	$90	$40
9. Strengthening Primary Care and Care Coordination	–$194	–$157	–$4	–$9	–$23
10. Limit Federal Tax Exemptions for Premium Contributions	–$131	–$186	–$19	–$55	$130
Correcting Price Signals in the Health Market					
11. Reset Benchmark Rates for Medicare Advantage Plans	–$50	–$124	$0	$0	$74
12. Competitive Bidding	–$104	–$283	$0	$0	$178
13. Negotiated Prescription Drug Prices	–$43	–$72	$4	$17	$8
14. All-Payer Provider Payment Methods and Rates	–$122	$0	$0	–$105	–$18
15. Limit Payment Updates in High-Cost Areas	–$158	–$260	$13	$62	$27

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).

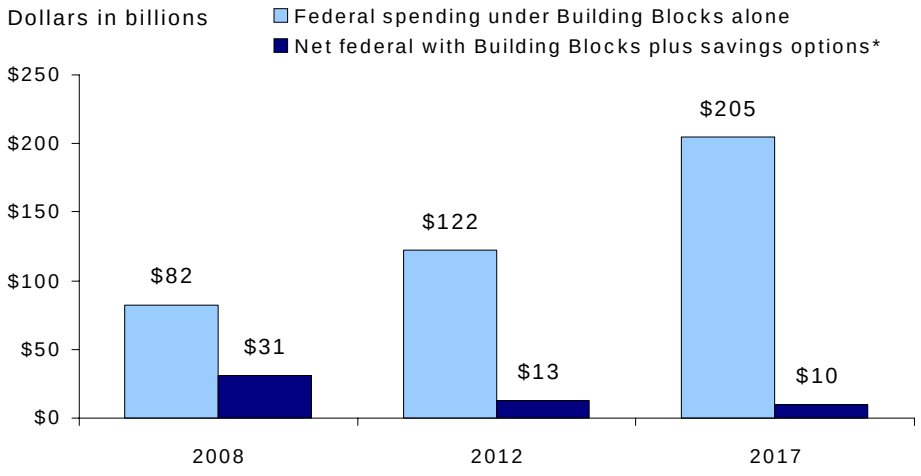
The Lewin Group estimated what impact these strategies would have on national health expenditures and spending by major stakeholders over a 10-year period. Many of

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 could result in savings of up to $194 billion over 10 years. The potential savings associated with resetting the benchmark payment rates for Medicare Advantage plans closer to the per-capita costs of people enrolled in the traditional Medicare program would be an estimated $50 billion over 10 years. Allowing the federal government to directly negotiate prescription drug prices available through the Medicare program with pharmaceutical companies could result in savings of $43 billion over 10 years (although without provisions to prevent cost-shifting, payers other than the federal government could experience a net increase in spending).

These cost-saving strategies could potentially offset some of the costs of expanding health coverage. For example, in the Schoen et al. *Building Blocks* proposal to expand health coverage in ways similar to those proposed by Obama (though with an individual requirement to have insurance), the estimated federal costs in 2008 would be just over $82 billion.[54] The Lewin Group modeled how some of the savings options outlined in *Bending the Curve* would affect the costs of the *Building Blocks* coverage proposal. Specifically, they modeled the effects on costs of: increasing the use of health information technology; creating a center on medical effectiveness; reforming provider payment; increasing the tobacco tax; and allowing Medicare to negotiate prescription drug prices with pharmaceutical companies.[55] With these cost-saving strategies in place, Lewin finds that net federal spending on the *Building Blocks* proposal would fall to $31 billion in the first year (Figure 13). Savings from the initiatives increase over time, so that spending offsets are estimated to be even larger in future years. By 2017, the federal costs of expanding coverage according to the *Building Blocks* proposal—without the savings strategies in place—would climb to $205 billion. The savings strategies would reduce that cost to just $10 billion. Including savings to state governments, businesses, and households, the nation could actually *save* $1.6 trillion over 10 years if health expansions

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.

Figure 13. Savings Can Offset Federal Costs of Insurance for All: Federal Spending Under Two Scenarios



* 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).

FINANCING

Is Financing Adequate, Shared Across Stakeholders, and Fair Based on Ability to Pay?

Achieving universal coverage will require a serious financial investment by federal and state governments, employers, households, and other stakeholders. Such a shared responsibility among stakeholders should be fair and based on the ability to pay.

Obama has proposed financing his proposal in part through repeal or expiration of the tax cuts implemented over the past few years for households with incomes of $250,000 or higher. Another key source of financing in Obama's plan is the requirement that employers offer coverage to their employees or contribute to the cost of their coverage through a payroll tax. In 2005, employer premium contributions for coverage of active employees and their dependents totaled approximately $420 billion, over one-fifth of total U.S. health expenditures that year.[56]

McCain has not offered details on how he would finance the cost of his proposal.

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):

Figure 14. Key Differences Between the Presidential Candidates' Health Reform Plans

	McCain	Obama
Aims to Cover Everyone	Not a Goal	Goal
Rules for Individual Insurance Market	Minimum State Rules	Uniform National Rules
Employer Role in Providing Health Benefits	Reduce	Expand
Medicaid/SCHIP	Reduce	Expand
Families' Exposure to Health Care Costs	More	Less
Requirements to Have Coverage	None	Children Only
Leverage to Stimulate Improvement in Quality and Efficiency	No change from current system	More
Uninsured Covered After 10 Years*	2 million	34 million

* 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.

Figure 15. How Well Do the Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Credits and Minimum State Rules for Individual Insurance Market	Mixed Private–Public Group Insurance with Premium Subsidies and Consumer Protections
Covers Everyone	0	+
Standard Benefit Floor	–	+
Premium/Deductible/ Out-of-Pocket Costs Affordable Relative to Income	–	+
Easy, Seamless Enrollment	0	+
Choice	+	+
Pool Health Care Risks Broadly	–	+
Minimize Dislocation, Ability to Keep Current Coverage	+	++
Administratively Simple	–	+
Improve Health Care Quality and Efficiency	0	+

0 = Minimal or no change from current system; — = Worse than current system;
+ = Better than current system; ++ = Much better than current system
Source: S. R. Collins, C. Schoen, K. Davis et al., *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund Commission on a High Performance Health System, Oct. 2007).

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 an individual mandate, benefit standards, regulations against risk selection by carriers, 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. Moreover, because of the substantially higher administrative costs in the individual market, covering more people this way would increase annual 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 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, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).

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