ENVISIONING THE FUTURE: THE 2008 PRESIDENTIAL CANDIDATES' HEALTH REFORM PROPOSALS

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The Commonwealth Fund

January 2008

ABSTRACT: This report analyzes the health care proposals of eight Democratic and Republican 2008 presidential candidates—Hillary Clinton, John Edwards, Rudolph Giuliani, Mike Huckabee, Dennis Kucinich, John McCain, Barack Obama, and Mitt Romney. Their approaches to health insurance reform fall into three categories: 1) proposals that emphasize tax incentives for obtaining insurance through the individual market (Giuliani, Huckabee, McCain, Romney); 2) proposals that build on existing private and public group insurance with shared responsibility for financing coverage (Clinton, Edwards, Obama); and 3) proposals that aim to cover everyone through publicly sponsored insurance systems like Medicare (Kucinich). The report examines differences among the proposals, and evaluates them against key principles like affordability, provision of essential services, financial protection, streamlined administration, and fair financing.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1092.

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ACKNOWLEDGMENTS

The authors thank The Commonwealth Fund's Karen Davis, Cathy Schoen, Stephen C. Schoenbaum, M.D., and Anne Gauthier for helpful comments.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

INTRODUCTION

With the 2008 presidential election well under way, health care reform has jumped to the top of the nation's domestic policy priorities. The reasons are clear and numerous. The number of Americans without health insurance has continued to climb: 47 million people were uninsured in 2006, an increase of 8.6 million from 2000. In addition, an estimated 16 million nonelderly adults are underinsured as a result of high out-of-pocket health costs relative to income. And although employer-provided health insurance remains the predominant form of coverage for U.S. workers and their families, rapid growth in health care costs and premiums has weakened the ability of many firms to offer comprehensive coverage and for many families to afford it. Employers—particularly small companies—are passing more costs to their employees or eliminating coverage altogether.

The Commonwealth Fund Commission on a High Performance Health System released a report in October 2007 that examined how our current health insurance system impedes a high performance health system overall. The report, *A Roadmap to Health Insurance for All: Principles for Reform*, then outlined a set of key principles to help guide policymakers in reforming the health insurance system and to help the public ask the right questions when evaluating the health care reform proposals of their elected representatives and political candidates.

Eight presidential candidates—Senator Hillary Clinton (D–N.Y.), former senator John Edwards (D–N.C.), former New York City mayor Rudolph Giuliani (R), former Arkansas governor Mike Huckabee (R), Representative Dennis Kucinich (D–Ohio), Senator John McCain (R–Ariz.), Senator Barack Obama (D–Ill.), and former Massachusetts governor Mitt Romney (R)—have proposed plans for the future direction of the health insurance system in the United States that range from simple ideas and philosophies to more concrete strategies for reform. They have also put forth ideas to improve quality and efficiency, and to control costs. 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 the set of key principles laid out in the *Roadmap* report.

PROPOSALS OF THE 2008 PRESIDENTIAL CANDIDATES

Three Distinct Approaches to Health Care Reform

The health care reform proposals of the eight presidential candidates offer fundamentally different visions of the future of health insurance in the United States and fall into three

distinct categories: 1) strategies that emphasize tax incentives for obtaining insurance through the individual market; 2) proposals that build on existing private and public group insurance with shared responsibility for financing coverage; and 3) proposals that aim to cover everyone through publicly sponsored insurance programs like Medicare.

Tax Incentives for Individual Market Insurance. Four Republican presidential candidates—former New York City mayor Rudolph Giuliani, former Arkansas governor Mike Huckabee, Senator John McCain (R–Ariz.), and former Massachusetts governor Mitt Romney—have proposed to increase insurance coverage through the individual insurance market with new tax incentives and deregulation of state markets (Figure ES-1).

Figure ES-1. Features of Leading Candidates' Approaches to Health Care Reform

	Clinton	Edwards	Obama	Giuliani	Huckabee	McCain	Romney
Individual Mandate	Yes	Yes	Children only	No	No	No	No
Employer Shared Responsibility	Large firms offer or contribute X% of payroll	Offer or contribute 6% of payroll	Offer or contribute X% of payroll	No	No	No	No
Medicaid/ SCHIP Expansion	Yes	Parents/children up to 250% FPL; childless adults up to 100% FPL	Yes	No	No	No	No
Private Insurance Markets	New group Health Choices Menu through FEHBP with private & public plan options	New group regional Health Care Markets with private & public plan options	New group National Health Insurance Exchange with private & public plan options	Purchase private individual insurance in any state	States as laboratories for market-based approaches	Purchase private individual insurance in any state	Emphasis on private individual markets
Subsidies for Low to Moderate Income	Tax credit for premium >X% of income	Refundable sliding scale tax credit up to 400% FPL	Sliding scale premium subsidies	Health insurance credit for low-income	Tax credits for low-income families	Tax credit $2,500 for individuals, $5,000 for families	Premium subsidies
Quality and Efficiency Measures	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, Prevention, Malpractice reform	HIT, Prevention, Malpractice reform	HIT, Transparency, P4P, Prevention, Chronic disease management, Malpractice reform	HIT, Transparency, Malpractice reform

Source: Authors' analysis of presidential candidates' health reform proposals.

Mixed Private–Public Group Insurance with Shared Responsibility for Financing. Three Democratic presidential candidates, Senator Hillary Clinton (D–N.Y.), former Senator John Edwards (D–N.C.), and Senator Barack Obama (D–Ill.), have proposed plans for universal coverage that would maintain and build on the current mixed private and public insurance system. Most include a new group insurance market arrangement

often referred to as "connectors" or "exchanges" that would provide people with a choice of private and public group plans. These proposals include consumer protections, financial support for premiums for lower- and moderate-income households, expansions in state Medicaid and the State Children's Health Insurance Program (SCHIP), and requirements for individuals to purchase coverage and for employers to offer or help pay for coverage. These proposals are similar in structure to the new Massachusetts universal coverage law that includes a private–public group "Insurance Connector." In California, Governor Arnold Schwarzenegger and the state legislature have also proposed such a plan.

Public Insurance. Presidential candidate and Representative Dennis Kucinich (D–Ohio) has proposed a plan for universal coverage in which everyone becomes insured through a public insurance program like Medicare.

ENVISIONING THE FUTURE: KEY DIFFERENCES IN THE CANDIDATES' APPROACHES

Overall the candidates' views of a future health insurance system are fundamentally the same within the two parties but fundamentally different between the two parties in the following key areas (Figure ES-2):

Figure ES-2. Where Leading Candidates Stand on Health Care Reform Features

	Clinton	Edwards	Obama	Giuliani	Huckabee	McCain	Romney
Most Candidates from Both Parties Agree							
Expand coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Health IT	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Transparency	Yes	Yes	Yes	Yes	No	Yes	Yes
Malpractice reform	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevention	Yes	Yes	Yes	Yes	Yes	Yes	No
Some Candidates Agree							
Pay for performance	Yes	Yes	Yes	No	No	Yes	No
Candidates Differ							
Universal coverage	Yes	Yes	Yes	No	No	No	No
Individual mandate	Yes	Yes	Children only	No	No	No	No
Employer pay or play	Yes	Yes	Yes	No	No	No	No
Changes to employer benefit tax exemption	Yes	No	No	Yes	Unclear	Unclear	Yes
Regulation of insurance markets	Yes	Yes	Yes	No	No	No	No
Financing source	Yes	Yes	Yes	No	No	No	No

Source: Authors' analysis of presidential candidates' health reform proposals.

- **The goal of universal coverage.** The candidates differ markedly on the goal of providing coverage to everyone. All the Democratic candidates support universal coverage as a goal. While the Republican candidates discuss expanding access to health insurance coverage, none to date has said that covering everyone is a goal.

- **Insurance markets.** Both Republican and Democratic candidates, with the exception of Kucinich, envision a health insurance system that continues to be structured around private insurance markets with a supporting role played by public insurance programs. The candidates diverge significantly, however, on the way this system should operate. The Democrats see the health insurance system based primarily on broad private and public group risk pools with regulations that prevent insurers from selecting against individuals with serious health risks, while Republicans see a health insurance system that would rely nearly exclusively on individual insurance markets without consumer protections. The Democratic candidates propose to replace the individual insurance market with new group insurance "exchanges" or "connectors," with a choice of private and public health plans. These markets would be regulated by ground rules designed to ensure that anyone—even older people or those with health problems—can obtain an affordable health plan with a standard set of benefits. In contrast, most of the Republican candidates propose plans to encourage more people to buy individual market insurance through the provision of new tax incentives and changes in the tax code. Most Republican candidates' proposals could have the effect of reducing existing consumer protections that states like New York and New Jersey have put in place, such as requiring insurers to write a policy for anyone who applies and restricting carriers from charging premiums based on health risk or age. None of the Republican candidates has discussed how they would address adverse selection issues and the considerable difficulties that people with higher health risks face in securing affordable coverage.

- **The role of employers.** Republican and Democratic candidates have fundamentally different views of the role employers will play in the health insurance system. The Democratic proposals would retain and strengthen employers' role in the system by requiring that all large employers offer coverage or pay part of the coverage costs of their employees. This would allow people to keep the coverage they have and maintain the significant financial support provided by employers. In 2005, employers contributed approximately $420 billion—over one-fifth of total U.S. health care expenditures in that year—for premiums for active employees and their dependents. In contrast, most of the

Republican candidates propose changes in the tax code that could significantly alter the role employers play. Under current federal law, health benefits that employees receive from their employers are excluded from taxable income. Most of the Republican candidates have proposed eliminating or changing this special tax treatment and replacing it with a new standard income tax deduction that would apply to anyone with private insurance, either employer-based or individual market. This change has the potential to weaken the incentive of some employers, particularly small employers, to continue providing health coverage to their employees if they knew their employees could gain an equivalent tax deduction if they purchased coverage in the individual market. The Republican candidates have not addressed how they would replace any lost employer financing. Clinton is the only Democratic presidential candidate who has proposed changing the tax treatment of employer-based health benefits, suggesting capping the amount of employer contributions that are excluded from taxable income for households earning $250,000 or more to the value of the standard plan offered through the Federal Employees Health Benefits Program (FEHBP).

- **Requirements that individuals have coverage.** The candidates diverge on whether they would require everyone to have health insurance. Clinton would require coverage at the start of her plan, while Edwards would require that everyone have coverage when his plan was fully implemented. Obama would require coverage only for children, though he would consider an individual mandate for adults if substantial numbers of people do not buy coverage that is deemed affordable. None of the Republican candidates requires that people have health insurance.

- **Affordability and enforcement.** With the presence of an individual mandate, it will be critical that health plans are affordable and that the mandate is enforceable. Even the ability of the Republican proposals to expand coverage will depend on whether people have access to affordable health plans. Edwards is the only candidate who has stated how he would enforce an individual requirement to have health insurance. With respect to affordability, all the leading Democrats (Clinton, Edwards, and Obama) have said that enrollees would pay a set percentage of their income on premiums, but have not specified the percentage or what would happen if affordable plans are not available. They have also focused exclusively on premiums when determining affordability, despite the fact that out-of-pocket costs can and do comprise a substantial share of family incomes, particularly in low- and moderate-income households. The Republican candidates have suggested subsidies

and tax credits to help low- and moderate-income people buy coverage on the individual market but have not specified the amount of the subsidies. McCain has proposed a specific refundable tax credit for everyone that would not vary by income. The Republican candidates have not discussed how they will address the considerable variation in the value of tax credits or subsidies for health coverage purchased in the individual market when premiums can vary substantially based on health risk and age.

- **Ease of enrollment.** The complexity and fragmentation of the current health insurance system often makes obtaining and retaining insurance difficult. Kucinich's National Health Insurance program would provide the most seamless enrollment of the current proposals. The Democratic candidates that have proposed mixed private–public approaches would fill the gap in the current system with new group insurance "connectors." However, these proposals would not make enrollment easier or more seamless and would retain the complexity in the system. To address this problem, Edwards has proposed requiring proof of insurance at tax filing and upon receipt of health services. Enrolling people through the tax system would help reduce the "churning" in and out of coverage that now characterizes the current system. Neither would the Republican proposals to provide tax incentives for individual market coverage make enrollment easier or more seamless. In theory, by separating coverage from employment, these proposals would make coverage portable, with people able to retain their health plans from job to job. But the candidates have not addressed serious problems in the individual market. Many people, especially those with health risks, have trouble obtaining coverage and staying covered over time, if the terms of their coverage change. Shifting the insurance system away from the relatively greater security of employer group coverage could ultimately exacerbate the complexity of the system, making access to insurance more uncertain and the potential for churning greater.

- **Quality and efficiency improvement.** Many candidates from both parties have proposed strategies to improve quality and efficiency in the health care system. There is broader agreement—at least on basic concepts—across candidates from both parties on improving quality and efficiency than on the issue of health insurance coverage. The candidates' support for quality and efficiency improvement often amounts to a "laundry list" of features, compared with many of the candidates' more structured proposals regarding the health insurance system. In addition, while the candidates all discuss health care cost growth as a major

problem, none has developed a comprehensive strategy for tackling it. If elected, it will be important for a candidate to incorporate these often disparate ideas—quality and efficiency improvement and cost control—into a broader vision of health system improvement.

- **Financing.** Achieving universal coverage or expanded health insurance coverage will require a significant financial investment by federal and state governments, employers, households, and other stakeholders. Such a shared responsibility among stakeholders should be fair, based on ability to pay. None of the Republican candidates has identified a source of financing. The leading Democratic candidates would either roll back the tax cuts of the past few years or allow them to expire for households with incomes above $200,000 (Edwards) and $250,000 (Clinton and Obama). They have also identified other more minor sources of financing, as well as savings achieved through improved efficiency. The lack of details in their proposals on many key features—the size of the premium subsidies for low- and moderate-income families, the employer contribution, the increase in Medicaid and SCHIP income eligibility standards—means it is unclear whether the amount of identified financing will be sufficient.

WHICH PROPOSALS HOLD THE GREATEST PROMISE?

To evaluate these new policies, The Commonwealth Fund Commission on a High Performance Health System, identified several key principles to 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 should be 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 stay in the coverage they have if desired
- Financing would need to be adequate, fair, shared across stakeholders.

Measured against these principles, the mixed private–public group insurance with a shared responsibility for financing proposed by the leading Democratic candidates and the public insurance reform proposals put forward by Kucinich have the greatest potential to move the health care system toward high performance (Figure ES-3). Both approaches have the potential to provide everyone with comprehensive and affordable health insurance, 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. However, from a pragmatic perspective, the mixed public–private approach, which allows the more than 160 million people who now have employer-based health coverage to retain it—and does not require them to enroll in a new program as in the public insurance models—would cause far less dislocation.

Figure ES-3. Design Matters: How Well Do Different Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Incentives and Deregulation of Individual Insurance Markets	Mixed Private-Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum 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	–	+	++
Work to 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).

The Republican candidates' proposals for reform that rely on tax incentives and voluntary purchase of coverage in an unregulated individual insurance market are, on their own, 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, minimum benefit standards, regulations against risk selection, and premium and out-of-

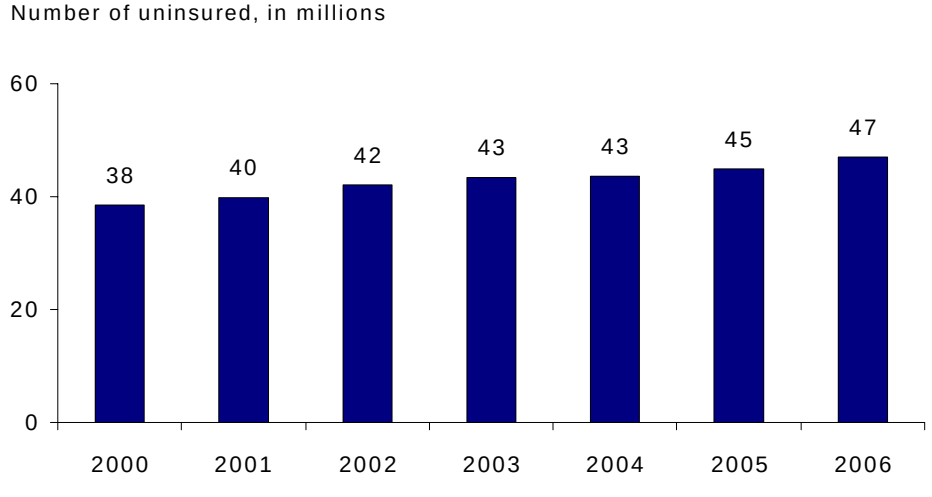
pocket spending limits as a share of income. Providing incentives for coverage in the individual market without an individual mandate or regulations against risk selection would not pool risks. Insurers would still write individual policies rather than policies for a broad group of people. Moreover, because of the substantially higher administrative costs in the individual market, covering more people this way will only increase U.S. annual spending on insurance administration.

ENVISIONING THE FUTURE: THE 2008 PRESIDENTIAL CANDIDATES' HEALTH REFORM PROPOSALS

INTRODUCTION

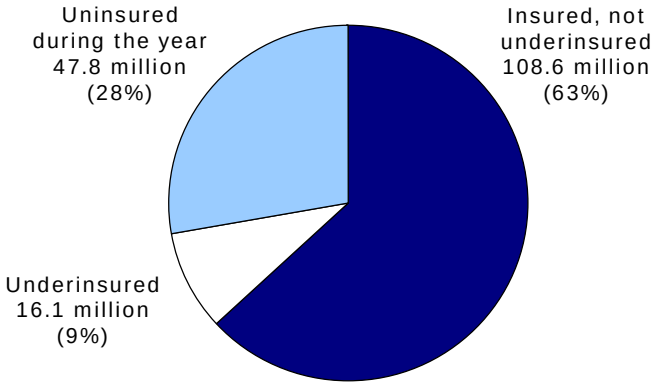
With the 2008 presidential election well under way, health care reform has jumped to the top of the nation's domestic policy priorities, driven by people's concerns about the rising costs of health insurance and health care, and their ability to maintain both their health and their financial security. Their concern is well-founded. The number of Americans without health insurance has continued to climb steadily: 47 million people were uninsured in 2006, an increase of 8.6 million from 2000 (Figure 1).[1] In addition, in 2005, an estimated 16 million nonelderly adults were underinsured, as indicated by their high out-of-pocket health costs relative to income (Figure 2).[2] And while employer-provided health insurance remains the predominant form of health insurance for U.S. workers and their families, rapid growth in health care costs and premiums has weakened the ability of many firms to offer comprehensive coverage and for many families to afford it (Figure 3).[3] Employers—particularly small companies—are passing more costs to their employees or eliminating coverage altogether.

Figure 1. 47 Million Uninsured in 2006; Increase of 8.6 Million Since 2000



Source: U.S. Census Bureau, March Current Population Survey, 2001–2007.

Figure 2. 16 Million Adults Under Age 65 Were Underinsured in 2005

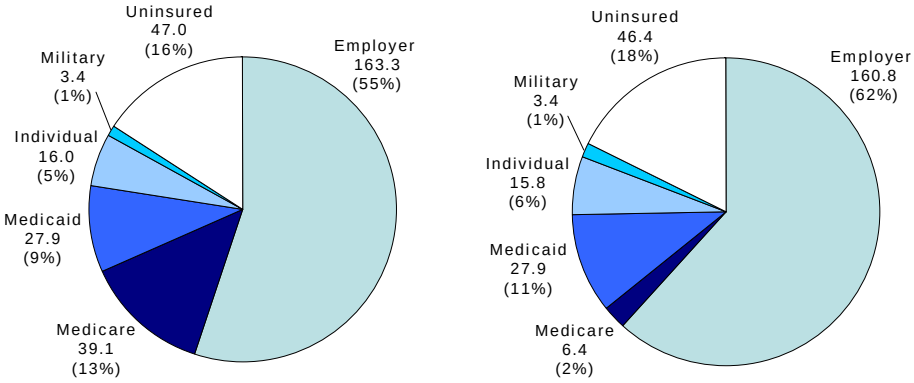


Adults Ages 19–64

Note: Underinsured defined as having any of three conditions: 1) annual out-of-pocket medical expenses are 10% or more of income; 2) among low-income adults, out-of-pocket medical expenses are 5% or more of income; 3) health plan deductibles are 5% or more of income.
Source: Analysis of the Commonwealth Fund Biennial Health Insurance Survey (2005).

Figure 3. Employers Provide Health Benefits to More than 160 Million Working Americans and Family Members

Numbers in millions, 2006



Total population = 296.7

Under-65 population = 260.7

Data: U.S. Census Bureau, Current Population Survey, Mar. 2007.
Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).

The Commonwealth Fund Commission on a High Performance Health System released a report in October 2007 that examined how our current health insurance system impedes a high performance health system overall.[4] The report, *A Roadmap to Health Insurance for All: Principles for Reform*, then outlined a set of key principles to help guide

policymakers in reforming the health insurance system and to help the public ask the right questions when evaluating the health care reform proposals of their elected representatives and political candidates.

Eight presidential candidates—Senator Hillary Clinton (D–N.Y.), former senator John Edwards (D–N.C.), former New York City mayor Rudolph Giuliani (R), former Arkansas governor Mike Huckabee (R), Representative Dennis Kucinich (D–Ohio), Senator John McCain (R–Ariz.), Senator Barack Obama (D–Ill.), and former Massachusetts governor Mitt Romney (R)—have proposed plans for the future direction of the health insurance system in the United States that range from simple ideas and philosophies to more concrete strategies for reform. They have also put forth ideas to improve quality and efficiency, and to control costs. 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 the set of key principles laid out in the *Roadmap* report.

DESIGN MATTERS: KEY PRINCIPLES TO CONSIDER IN EVALUATING HEALTH REFORM PROPOSALS

The 2008 presidential candidates have put forth proposals to address the critical weaknesses in our health insurance system. To help the public evaluate these new policies, the Commission has identified the following key principles of health care reform essential to moving the overall health system towards high performance:

PRINCIPLES FOR HEALTH INSURANCE REFORM

Access to Care

- Provides equitable and comprehensive insurance for all.
- Insures the population in a way that leads to full and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Coverage is automatic and stable with seamless transitions to maintain enrollment.
- Provides a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Fosters efficiency by reducing complexity for patients and providers, and reducing transaction and administrative costs as a share of premiums.

- Works 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.
- Minimizes dislocation; people can maintain current coverage if desired.
- Is simple to administer.
- Health risks are pooled across broad groups and lifespans; insurance practices designed to avoid individuals with poor health risks are eliminated.
- Has the potential to lower overall health care cost growth.

Financing

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

PROPOSALS OF THE 2008 PRESIDENTIAL CANDIDATES

Three Distinct Approaches to Health Care Reform

The health care reform proposals of the eight presidential candidates offer fundamentally different visions of the future of health insurance in the United States and fall into three distinct categories: 1) strategies that emphasize tax incentives for obtaining insurance through the individual market; 2) proposals that build on existing private and public group insurance with a shared responsibility for financing coverage; and 3) proposals that aim to cover everyone through publicly sponsored insurance programs, like Medicare.

Tax Incentives for Individual Market Insurance. Four Republican presidential candidates—former New York City mayor Rudolph Giuliani, former Arkansas governor Mike Huckabee, Senator John McCain (R–Ariz.), and former Massachusetts governor Mitt Romney—have proposed to increase insurance coverage through the individual insurance market with new tax incentives and deregulation of state markets.

Mixed Private–Public Group Insurance with Shared Responsibility for Financing. Three Democratic presidential candidates—Senator Hillary Clinton (D–N.Y.), former Senator John Edwards (D–N.C.), and Senator Barack Obama (D–Ill.)—have proposed plans for universal coverage that maintain and build on the current mixed private and public group insurance system. Most include new group insurance market arrangements often referred to as "connectors" or "exchanges" that would provide people with choice of private and public group plans. These proposals include consumer protections, financial support for premiums for lower- and moderate-income households, expansions in state

Medicaid and the State Children's Health Insurance Program (SCHIP), and requirements for individuals to purchase coverage and for employers to offer or help pay for coverage. These proposals are similar in structure to the new Massachusetts universal coverage law that includes a private–public group "Insurance Connector." In California, Governor Arnold Schwarzenegger and the state legislature have also has proposed such a plan.

Public Insurance. Presidential candidate and Representative Dennis Kucinich (D–Ohio) has proposed a plan for universal coverage in which everyone becomes insured through a public insurance program like Medicare.

The Plans

The following are summaries of the candidates' proposals and ideas about health care reform abstracted from documents posted on their campaign Web sites, as well as from public comments reported in the press. For more detailed descriptions of the candidates' health reform proposals, a link to each campaign Web site is provided.

Senator Hillary Clinton

The American Health Choices Plan

(www.hillaryclinton.com)

Overall approach: Mixed private–public group insurance with a shared responsibility for financing, with individual and employer mandates

Special focus: Choice, cost-consciousness

Individual mandate: All Americans would be required to have health insurance.

Employer mandate: Large employers would be required to either provide coverage to their workers or contribute to the cost of the system. The contribution of employers would take into account firm size and average wages.

Public program expansions: Strengthen Medicaid and SCHIP to serve all low-income people, including childless adults. The safety net will continue to receive support to serve vulnerable populations.

New group insurance option: Business, employees, and uninsured people will have the option of buying group coverage through a new Health Choices Menu. The Menu will be part of the existing Federal Employees Health Benefits Program (FEHBP) and have a full range of private options. Benefits will be equivalent to those offered to members of Congress, including mental health, dental, and high priority preventive services. It will include a public plan option that could be modeled on the traditional Medicare program, but would cover the same benefits as private plan options in the Menu. The public plan option will not be funded through the Medicare Trust Fund. In order to participate in the Menu, health plans will be required to adopt practices to improve quality and efficiency. In addition, states will also have option of banding together to offer the same type of Health Choices Menu in a region of the country.

Tax credits/subsidies: A new refundable tax credit would be provided to offset the cost of premiums above a certain percentage of family income. The tax credit would be indexed over time, and designed to encourage consumers to be price conscious when choosing health plans. Small businesses would be offered tax incentives to continue or begin to offer coverage. For example, a tax credit could be 50 percent of premium for firms with 25 or fewer employees. The tax credit would be refundable and take into account firm size, average wages, and tax credits received by individuals. Reinsurance would be available for private and public employers with retiree health plans. This reinsurance would offset catastrophic expenditures over a defined threshold. The reinsurance support would be time limited.

Change in tax code: The federal income tax exclusion of employer contributions for health benefits would be capped for households with incomes over $250,000 to the value of a standard plan, like that available through FEHBP.

Insurance market regulation: Health plans would compete on cost and quality and not risk. Requirements for health plans include: guaranteed issue, automatic renewal, modified community rating, and minimum stop–loss ratios.

Prevention and chronic disease management: Would require coverage of preventive services that are known to be effective, in FEHBP and Medicare, and promote chronic care management programs and innovative models such as medical homes. Would promote a broad-based prevention commitment based on recommendations from the U.S. Prevention Services Task Force and would require all insurers participating in federal programs to cover prevention services. Would coordinate public spending on prevention across federal programs in the Department of Health and Human Services to maximize high-priority prevention. A public–private collaboration would provide free prevention services in schools, workplaces, supermarkets, and communities. Chronic care coordination models would be implemented within federally funded programs, including the Health Choices Menu, to provide coordinated care for people with chronic conditions such as cardiovascular disease and diabetes. Services would include care coordination between providers, drug management, diet and exercise counseling, lifestyle management, and promotion of patient responsibility for self-management. Medicare beneficiaries and federal employees could choose to opt-in to the program, and physicians providing services in these programs would receive management bonus payments.

Comparative effectiveness/quality improvement: Would fund and disseminate research information to patients, doctors, and other health professionals about best medical practices in a partnership between the Agency for Healthcare Research and Quality and the private sector.

Health information technology: Providers participating in federal programs would be required to adopt private, secure, and interoperable technology. An up-front and phased-out $3 billion per year investment fund would be provided to help providers adopt and implement a health information technology system.

Transparency: Would develop a Web-based tool to make provider information available to consumers, and provide access to information and tools to help consumers understand their treatment options and make decisions regarding treatment. Would implement Smart Purchasing Initiatives to constrain excess expenditures on prescription drugs and managed care.

Pay-for-performance: Physicians who participate in certified programs and demonstrate improved patient outcomes would receive higher reimbursement in federal programs including Medicare and FEHBP. Increased reimbursement would also be provided for models of care that treat patients as whole individuals, as opposed to treating individual illnesses.

Prescription drugs: Would allow Medicare to negotiate lower drug prices. Would implement Smart Purchasing Initiatives to constrain expenditures on prescription drugs. Would remove barriers to generic drugs entering the market including creation of a regulatory pathway for biogeneric drug competition, allow imports of cheaper drugs, limit direct-to-consumer advertising, and institute reporting requirements regarding financial arrangements between providers and pharmaceutical manufacturers.

Disparities: Would require development and testing of quality measures targeted at racial and ethnic disparities in health care for providers. Would develop a uniform reporting format for the collection of quality information on race and ethnicity. Federal government would provide $50 million annually over five years to develop culturally and linguistically competent clinical care programs.

Malpractice: Would include medical malpractice reforms that would support the development of systems that eliminate medical errors, protect appropriate reporting data by physicians and other health personnel, and provide incentives for alternative dispute mechanisms.

Financing: Would repeal tax cuts for those with annual incomes over $250,000 and cap the amount of employer contributions to health benefits that are excluded from federal income taxes for households with incomes over $250,000. Has identified other potential sources of savings, including those from the quality and efficiency initiatives described above, reallocation of disproportionate share funds to new uses, after everyone is covered, and phasing out Medicare overpayments to HMOs and other managed care plans.

Former Senator John Edwards

Universal Health Care Through Shared Responsibility

(www.johnedwards.com)

Overall approach: Mixed private–public group insurance with a shared responsibility for financing, with individual and employer mandates

Special focus: Autoenrollment

Individual mandate: Everyone would be required to have health insurance by 2012, when the plan is fully implemented. Proof of health insurance would be required when income taxes are paid and when health care is provided. Uninsured U.S. residents would be automatically enrolled in health plans when they use the health care system or public services, such as schools or libraries. Those who can afford to pay for health insurance but decide not to purchase it would face penalties, including having their wages garnished. Families without insurance will be enrolled in Medicare, Medicaid, SCHIP or another targeted plan or be assigned a plan within the new Health Care Markets [defined below].

Employer mandate: Employers would be required to either provide coverage to their workers or pay up to 6 percent of wages into a pool to cover workers through regional Health Care Markets.

Public program expansions: Medicaid and SCHIP would be expanded to cover parents and children with household income up to 250 percent of the federal poverty level, and childless adults with household income up to 100 percent of the federal poverty level.

New group insurance option: With assistance from the federal government, states or groups of states would be encouraged to create regional "Health Care Market" purchasing pools. These markets would comprise pools of competing private plans and a public plan option based on—but separate from—Medicare. People without access to comparable coverage through an employer or public program would be able to purchase coverage through these markets. All businesses could also opt to offer coverage through the markets, paying the cost of coverage for their employees. All plans offered through the markets would include comprehensive benefits, including full mental health benefits. The markets would be nonprofit and would negotiate premiums with health plans.

Tax credits/subsidies: Refundable tax credits would provide sliding-scale premium subsidies based on income, for families with incomes up to 400 percent of the federal poverty level to purchase health plans through the Health Care Markets. Low-income families would not pay premiums.

Insurance market regulation: Health insurers would be required to keep health plans open to everyone regardless of preexisting conditions, medical history, age, job, and other characteristics. Insurers would also be required to spend at least 85 percent of premiums directly on patient care.

Prevention and chronic disease management: New national standards would ensure that health plans cover preventive, chronic, and long-term care (including dental and vision care) with minimal cost-sharing. People who enroll in "healthy living programs" and have free physical exams would be rewarded with lower premiums. The Health Care Markets would encourage plans to cover chronic disease management such as nutrition counseling for diabetic patients, and would encourage plans to monitor patients' health to keep them out of the emergency room. Medicare reimbursement will be increased to promote primary care and creation of medical homes.

Comparative effectiveness/quality improvement: Would establish a nonprofit organization within IOM to research the best methods of providing care, to support new technologies, and to develop partnerships among medical centers and federal agencies to disseminate information about and encourage adoption of high quality medical care.

Health information technology: Would provide resources hospitals need to implement health information technology with an aim of improving patient safety and hospital efficiency. Subsidies would be provided to rural and public providers. Supports implementation of electronic medical records.

Transparency: A new "Consumer Reports" for health care would provide people with information to enable them to evaluate hospitals' effectiveness.

Pay-for-performance: Medicare and the Health Care Markets would lead the way in paying providers based on results to reward quality and efficiency. Plans that fail to meet critical, easily quantifiable goals such as childhood immunization would be penalized. Would support public–private collaborations to prevent medical errors through reorganizing patient care, improving internal communications, reducing errors through electronic prescribing, and establishing basic quality benchmarks.

Prescription drugs: To encourage research on breakthrough drugs, an expert panel would be convened to examine the idea of providing prizes to researchers as an incentive to develop breakthrough drugs for certain health problems. Would eliminate barriers, such as trade obstacles, that prevent use of generic drugs, and allow the FDA to approve biogenerics. Would restrict direct-to-consumer advertising for new drugs.

Disparities: Would support medical research into disparities.

Malpractice: Would limit medical malpractice lawsuits without merit by requiring attorneys who seek to file malpractice lawsuits to obtain certification by an expert to prove that their cases have merit.

Financing: Would finance with a repeal of tax cuts for those with annual incomes over $200,000, enforcement of the capital gains tax, and a 6 percent employer payroll contribution.

Former Mayor Rudolph Giuliani

(www.joinrudy2008.com)

Overall approach: Tax incentives for individual market insurance

Special focus: Elimination of the employer health benefits tax exemption

Tax credits/subsidies: Would provide a health insurance credit for low-income U.S. residents to purchase coverage in individual market.

Change in tax code: A $15,000 personal tax deduction for families would replace the current employer health benefits tax exemption for both employer and individual market insurance to help families buy private health insurance, with vouchers for those who do not pay taxes. Would expand access to health savings accounts by simplifying regulations.

Insurance market regulation: Would allow people to buy insurance coverage from any insurer in any state.

States: Would offer block grants to states to encourage innovation, reduce health costs, enroll eligible uninsured, and solve adverse selection issues.

Prevention and chronic disease management: Would propose new initiatives to promote healthy lifestyles and wellness programs. Would tie Medicaid payments to a state's success in promoting preventive care and tracking obesity for children.

Health information technology: Would promote public–private partnerships to improve and set standards for health information technology.

Transparency: Would create visibility of price, provider qualification, and risk-adjusted procedure outcomes.

Prescription drugs: Would bring greater accountability and efficiency to the evaluation process for new drugs.

Malpractice: Committed to ending frivolous lawsuits.

Financing: None specified.

Former Governor Mike Huckabee

(www.mikehuckabee.com)

Overall approach: Tax incentives for individual market insurance

Special focus: Private markets

Change in tax code: Would make health insurance tax deductible for individuals and families. Would encourage shift from employer-based to consumer-based health insurance system. Low-income families would receive tax credits instead of deductions. Would make health savings accounts available to everyone, even those without a high-deductible health plan.

States: Supports states' role as laboratories for new market-based approaches. Would support policies to encourage the private sector to seek innovative ways to reduce health care costs.

Prevention: Supports preventive health care.

Health information technology: Adopt electronic medical record keeping.

Malpractice: Reform medical liability.

Financing: None specified.

Congressman Dennis Kucinich

United States National Health Insurance Act
(or the Expanded and Improved Medicare for All Act) [H.R. 676]
(www.dennis4president.com)

Overall approach: Public Insurance

Special focus: All participating providers would be nonprofit or public

Public program expansion: All U.S. residents would be entitled to health care under the United States National Health Insurance (USNHI) program. Individuals who receive health care would be presumed to be eligible for USNHI benefits, and would be asked to complete an application if not already enrolled. Each individual would receive a USHNI card with a unique number. Covered benefits would be available through any licensed health care clinician in the United States who is legally qualified to provide the benefits. Benefits would include primary care and prevention, inpatient care, outpatient

care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health services, dental services other than cosmetic, substance abuse treatment services, chiropractic services, and basic vision care and vision correction other than laser surgery for cosmetic purposes. All participating providers would be nonprofit or public. For-profit institutions who want to participate must convert to nonprofit status; owners would be compensated for the appraised value of converted facilities for the delivery of health care. This transition would take place over a 15-year period. Providers could be paid on a fee-for-service basis or by salary if employed by hospital, health maintenance organization, clinic, or group practice that elected to be paid through a global budget.

Tax credits/subsidies: There would be no deductibles, copayments, coinsurance, or other cost-sharing.

Insurance market regulation: Private health insurers would be prohibited from selling health insurance that duplicates covered benefits. However, private carriers would be able to sell insurance for benefits not covered under the program. Nonprofit health maintenance organizations that deliver care in their own facilities and employ physicians on a salaried basis may participate in the USNHI program and receive global budgets or capitation payments. Selective enrollment policies would be prohibited.

Prevention and chronic disease management: Benefits would cover primary care and prevention, dental services, and a full scope of other care.

Comparative effectiveness/quality improvement: An Office of Quality Control would be created to provide annual recommendations to Congress, the President, the Secretary, and other program officials on how to maintain the highest quality health care delivery.

Health information technology: The Secretary of Health and Human Services and the Director of the USNHI program would create an electronic patient record and billing system to be used by all participating providers.

Transparency: Participating health care facilities must meet regional and state quality and licensing requirements, including guidelines regarding safe staffing and quality of care.

Prescription drugs: Prices for covered pharmaceuticals, medical supplies, and medically necessary equipment would be negotiated annually by USNHI. USHNI would establish a formulary system to encourage best practices and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available. The formulary would promote the use of generics, when possible.

Disparities: Would aim to reduce health disparities by race, ethnicity, income, and geographic region. Would provide culturally appropriate care to all individuals.

Financing: A USNHI Trust Fund would be established to fund the new program. The trust fund would be financed from existing sources of federal government revenues for health care, an increased personal income tax on the top 5 percent of income earners, a new excise tax on payroll and self-employment income, and a new small tax on stock and bond transactions. Additional savings could accrue through reduced paperwork and bulk procurement of medications.

Senator John McCain

(www.johnmccain.com)

Overall approach: Tax incentives for individual market insurance

Special focus: Provider payment reform

Public program expansion: Provide electronic card or other device to veterans so they can receive health care from local non-Veterans Administration providers.

Tax credits/subsidies: Individuals and families with private health insurance will receive refundable tax credits: $2,500 for individuals, $5,000 for families. Individuals with multi-year policies that cost less than the full credit could deposit the remainder in expanded HSAs. Parents would be responsible for ensuring that their children have health insurance when options are available to them.

Change in tax code: Reform the tax code to eliminate the bias toward employer-sponsored health insurance.

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

States: Would allow states to use Medicaid funds to enable purchase of private insurance by eligible families. States could use tax credits for families to purchase private coverage; a financial risk-adjustment bonus would be provided to high-cost, low-income families. Would allow doctors to practice across state lines.

Prevention and chronic disease management: Would promote coverage of preventive services. Would make patients the center of care and give them a larger role in both prevention and care, putting more decisions and responsibility in their hands. Promote care alternatives such as walk-in clinics in retail outlets. 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. Parents would be responsible for insuring children are taught about health, nutrition, and exercise. Children should be provided healthy dietary choices in schools. Public health leadership, including the next President, must promote lower rates of obesity. In Medicaid, would promote care management for the disabled and elderly.

Comparative effectiveness/quality improvement: Federally sponsored research should focus on the care and cure of chronic disease and the treatment of patients with multiple chronic conditions. Facilitate the development of national standards for measuring and recording treatments and outcomes. Government programs such as Medicare and Medicaid should lead the way in health care reforms that improve quality and lower costs:

Health information technology: Promote rapid deployment of modern information systems. Use telemedicine to connect community health clinics in areas where services and providers are limited.

Transparency: All health care providers (including clinics, hospitals, doctors, medical technology producers, and drug companies) must make their transactions transparent and must be accountable. Information on treatment options, medical outcomes, quality of care, costs, and prices would be made available.

Pay-for-performance: Pay only for quality care that is the right care: care intended to improve a patient's health. Medicare and Medicaid should be leaders on changing the way providers are paid to focus their attention more on chronic disease and managing treatment. Reform the payment systems in Medicare to compensate providers for diagnosis, prevention, and care coordination. Medicare could pay a single bill for high-quality coordinated care in which providers collaborate to produce the best health outcome for a patient. Medicare should not pay for preventable medical errors or mismanagement.

Prescription drugs: Allow safe re-importation of drugs, faster introduction of generic drugs, publication of drug prices.

Malpractice: Pass tort reform to eliminate frivolous lawsuits and excessive damage awards. Medical liability reform would eliminate lawsuits for doctors that follow clinical guidelines and adhere to patient safety protocols.

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, with an employer mandate and individual mandate for children

Special focus: Reducing disparities

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

Employer mandate: Employers would be required to provide "meaningful" coverage with a "meaningful contribution" to workers or contribute a percentage of payroll toward the costs of the national plan. 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 group insurance option: A new National Health Insurance Exchange would allow anyone to purchase an approved private plan. A new public health insurance plan, with benefits similar to a standard plan in FEHBP, would be available to small businesses and individuals who do not have access to group coverage. The Exchange would require that all plans offered are at least as generous as the new public plan. It would evaluate plans and make differences transparent among the plans, including cost of services.

Tax credits/subsidies: Sliding-scale premium subsidies based on income would be provided for families and could be used to buy into the new public plan or purchase a private plan.

Insurance market regulation: All insurers would have to issue all applicants a policy, and charge fair and stable premiums that do not depend on health status. Would require health plans to pay out a reasonable share of their premiums for patient care and report the amount.

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

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

Prevention and chronic disease management: Participating plans in the new public plan, the National Health Insurance Exchange, Medicare, and FEHPB would be required to utilize proven disease management programs. Support would be given to providers to implement medical home models of care management and team care to improve coordination and integration of care for people with chronic conditions. Disease prevention would be promoted.

Comparative effectiveness: An independent institute would be established to guide reviews and research on comparative effectiveness.

Health information technology: Would invest $10 billion per year over five years for nationwide adoption of standards-based health information technology systems, including electronic medical records. Requirements for full implementation of health information technology would be phased in with the necessary federal resources.

Transparency: Would require hospitals and other providers to collect and publicly report measures of health care costs and quality, including data on medical errors, nurse staffing ratios, hospital-acquired infections, and disparities in care.

Pay-for-performance: 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 medications from Canada and other developed countries, and increase use of generic treatments in public health care programs. Would address the problem of prescription drug companies using their market power to prevent generic drugs from entering the market.

Disparities: Hospitals would be held accountable for disparities in care. Would aim to diversify the workforce, implement and fund evidence-based programs to reduce care disparities, and expand 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.

Former Governor Mitt Romney

(www.mittromney.com)

Overall approach: Tax incentives for individual market insurance

Special focus: Deregulation of private insurance markets

Change in tax code: Would make all qualified health care expenses tax deductible, eliminate the special tax treatment afforded employer-provided health plans. Would expand the use of health savings accounts.

Insurance market regulation: Would encourage states to deregulate their private insurance markets.

States: Through block grants, give states flexibility to spend their Medicaid dollars in whatever way they choose. Use some of the money currently spent on "free care" for the uninsured at emergency rooms to help people buy private insurance.

Health information technology: Enhance the use of information technology.

Transparency: Establish cost and quality transparency.

Malpractice: Would implement medical liability reform including caps on noneconomic and punitive damage awards. Encourage states to engage in additional medical liability reforms.

Financing: None specified.

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

Assessing the presidential candidates' health insurance reform proposals against the key principles described earlier in this report helps to illustrate their strengths and weaknesses. The proposals, which broadly reflect three different visions of the future, use a range of mechanisms to address health system issues of inadequate access to care, variable quality, and high cost (Figure 4). The inclusion or omission of key design features has significant implications for the number of people who would ultimately become covered, the cost to stakeholders and the overall health system, equity in access and financing, and improvements in efficiency and quality. Raising the right questions and weighing the evidence will help shape consensus.

Figure 4. Features of Leading Candidates' Approaches to Health Care Reform

	Clinton	Edwards	Obama	Giuliani	Huckabee	McCain	Romney
Individual Mandate	Yes	Yes	Children only	No	No	No	No
Employer Shared Responsibility	Large firms offer or contribute X% of payroll	Offer or contribute 6% of payroll	Offer or contribute X% of payroll	No	No	No	No
Medicaid/ SCHIP Expansion	Yes	Parents/children up to 250% FPL; childless adults up to 100% FPL	Yes	No	No	No	No
Private Insurance Markets	New group Health Choices Menu through FEHBP with private & public plan options	New group regional Health Care Markets with private & public plan options	New group National Health Insurance Exchange with private & public plan options	Purchase private individual insurance in any state	States as laboratories for market-based approaches	Purchase private individual insurance in any state	Emphasis on private individual markets
Subsidies for Low to Moderate Income	Tax credit for premium >X% of income	Refundable sliding scale tax credit up to 400% FPL	Sliding scale premium subsidies	Health insurance credit for low-income	Tax credits for low-income families	Tax credit $2,500 for individuals, $5,000 for families	Premium subsidies
Quality and Efficiency Measures	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, P4P, Prevention, Comparative effectiveness, Chronic disease management, Disparities, Malpractice reform	HIT, Transparency, Prevention, Malpractice reform	HIT, Prevention, Malpractice reform	HIT, Transparency, P4P, Prevention, Chronic disease management, Malpractice reform	HIT, Transparency, Malpractice reform

Source: Authors' analysis of presidential candidates' health reform proposals.

Access to Care

Do the Proposals Have the Potential to Cover Everyone?

The candidates differ markedly on the goal of providing coverage to everyone. All the Democratic candidates support universal coverage as a goal (Figure 5). While the Republican candidates discuss expanding access to health insurance coverage, none to date has said that covering everyone is a goal.

Figure 5. Where Leading Candidates Stand on Health Care Reform Features

	Clinton	Edwards	Obama	Giuliani	Huckabee	McCain	Romney
Most Candidates from Both Parties Agree							
Expand coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Health IT	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Transparency	Yes	Yes	Yes	Yes	No	Yes	Yes
Malpractice reform	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevention	Yes	Yes	Yes	Yes	Yes	Yes	No
Some Candidates Agree							
Pay for performance	Yes	Yes	Yes	No	No	Yes	No
Candidates Differ							
Universal coverage	Yes	Yes	Yes	No	No	No	No
Individual mandate	Yes	Yes	Children only	No	No	No	No
Employer pay or play	Yes	Yes	Yes	No	No	No	No
Changes to employer benefit tax exemption	Yes	No	No	Yes	Unclear	Unclear	Yes
Regulation of insurance markets	Yes	Yes	Yes	No	No	No	No
Financing source	Yes	Yes	Yes	No	No	No	No

Source: Authors' analysis of presidential candidates' health reform proposals.

The Democratic candidates, with the exception of Kucinich, and the Republican candidates envision a health system that continues to be structured around private insurance markets with a supporting role played by public insurance programs. The candidates diverge significantly, however, on the way this system should operate. The Democratic candidates see the health insurance system based primarily on broad private and public group risk pools with regulations that prevent insurers from selecting against individuals with serious health risks, while the Republican candidates see a health insurance system that would rely nearly exclusively on individual insurance markets without consumer protections. They also differ dramatically on requirements for employers and households to participate in the health system. They also have significantly different views of state discretion over Medicaid and SCHIP.

Democrats' vision: private group insurance markets. The most gaping hole in the current system occurs when people do not have access to employer coverage and have incomes that are too high to qualify for Medicaid or SCHIP. The individual insurance market—where 6 percent of the under-65 population buys coverage—has proven largely inadequate to stem the rising tide of uninsured people. 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 who buy coverage in the individual insurance markets has stayed relatively constant over time. The Democratic candidates propose to fill this gap with new group insurance options referred to as "exchanges" or "connectors." This model is similar to the new Massachusetts plan, where the "Commonwealth Care Connector" has merged and organized the individual and small-group markets. Clinton is proposing a new menu of private and public insurance plan options, like Medicare, within FEHBP. In Edwards' plan, it would be regional markets with both private and public plan options like Medicare; and for Obama, it would be a national insurance exchange with both private and public plan options. Offering a public plan option like Medicare in these new health insurance exchanges would give individuals and businesses the option to choose between private and public health plans.

The Democrats propose to regulate the new private group insurance markets 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). All the Democratic candidates are proposing regulations to protect consumers in their new group insurance markets and throughout the health insurance system.

To broaden the risk pools in these new markets, both Clinton and Edwards would eventually require all people to have health insurance. They, along with the other Democratic candidates, would provide subsidies for lower-income households to offset the cost of insurance.

Republicans' vision: building on the private individual market. In contrast to the Democratic plans, most Republican candidates featured in this report view the individual insurance market as central to the health insurance system of the future. Most of the Republican candidates propose encouraging more people to buy individual market insurance through the provision of new tax incentives and changes in the tax code. Most Republican candidates' proposals would potentially have the effect of reducing existing

consumer protections that states have put in place, either by encouraging states to deregulate their markets or allowing people to buy health insurance in any state.

Unlike the Democratic health proposals in which employer-provided health insurance would remain a central feature of the health insurance system through an employer mandate, the Republican candidates propose changes in the tax code that could significantly alter the employer role in the system. Under current federal law, health benefits that employees receive from their employers are excluded from taxable income. Giuliani and Romney have proposed eliminating this special tax treatment and replacing it with a new standard income tax deduction for anyone with private insurance, whether received from an employer or purchased in the individual market. With this change, health benefits provided through employers would be taxed and an equivalent new tax deduction for health insurance would apply to both employer-based and privately purchased health plans. The proposals of Huckabee and McCain would also encourage a shift away from employer-based coverage.

While the Democratic plans propose to increase insurance regulations, many of the Republican candidates are proposing the opposite. They would encourage states that have regulated their markets with consumer protections like guaranteed issue and community rating to remove those protections. Giuliani and McCain have proposed plans to allow people to purchase an insurance policy in any state. People electing to buy coverage would likely select states with the most favorable rates—people with health problems would seek out states with community rating and healthier individuals would seek coverage in less regulated states. Such fragmentation of health risks could ultimately drive carriers away from regulated states and would increase premiums in those states. In the end, it would be very difficult for people with health problems or health risks to gain access to health insurance.

While all the Republican candidates propose expanding coverage through the individual market, none has discussed how they would address the adverse selection issues that characterize the market and the considerable difficulties that people with health risks have in securing coverage. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that 48 percent of adults with health problems who 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 one-third said they were turned down or charged a higher price because of a pre-existing condition.[5] Ninety-two percent said they never bought a plan. In the absence of regulations against risk selection, a mandate requiring that

everyone have insurance, and the imposition of minimum benefit standards, the value of the candidates' proposed tax credits or standard income tax deductions would vary significantly, based on age, health status, gender, and even work industry. Nor do the candidates address the issue of people with severe health problems for whom no insurer will write a policy. Indeed, their vision of an insurance market unfettered by any federal or state oversight is radical even in the context of other U.S. markets. The stock market, for example, is regulated and overseen by the Securities and Exchange Commission.

The candidates have also not addressed how to contain costs in the individual market, which has considerably higher administrative costs than group insurance. 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.[6] Covering more people through the individual market could fuel growth in administrative costs over time.

Expanding health insurance coverage. The Democratic proposals all share the goal of universal coverage. Prior analyses have shown that an individual mandate will help move the system to near-universal coverage.[7] But the ability of any proposal to expand coverage will depend critically on key factors, including the presence of an employer mandate, the generosity of subsidies to offset premium and out-of-pocket costs, the expansion of Medicaid and SCHIP eligibility, how easy it is for people to become enrolled, and compliance with an individual mandate.[8] An employer mandate alone, even with generous subsidies, is expected to fall short of universal coverage because it fails to reach those with weak connections to the labor force and those for whom the subsidies are not sufficient incentive to enroll. Employer mandates that exclude small firms would cover even fewer uninsured people.[9] Alternatively, subsidies for individuals and small firms to voluntarily buy into a new group option are estimated to fall short of achieving universal coverage, although it would depend on the generosity of the subsidies. Moreover, this may contribute to individuals with employer-based coverage becoming uninsured because some small firms with lower-wage workers might drop coverage if they knew their employees had a new option.

Clinton and Edwards would require that all people have coverage. While Clinton would require coverage at the start of her new plan, Edwards would require coverage when his plan was fully implemented in 2012. Obama would require coverage only for children, but would consider an individual mandate for adults if substantial numbers of people do not purchase coverage that is deemed affordable.

The effectiveness of an individual requirement to have health insurance will depend on whether the mandate is enforceable and that health plans are affordable. Edwards has proposed requiring proof of insurance at tax filing and upon receipt of health services, as well as imposing penalties on those who do not enroll, including garnishment of wages. With respect to affordability, all the leading Democrats (Clinton, Edwards, and Obama) have said that enrollees would pay only a set percentage of their income on premiums, but have not specified the percentage or what would happen if people do not have affordable plans available to them. They have also focused exclusively on premiums when discussing affordability, despite the fact that out-of-pocket costs can and do comprise a substantial share of family incomes, particularly in low- and moderate-income households.

The proposals of the Republican candidates are expected to fall far short of universal coverage; indeed, none of the candidates has stated universal coverage as a goal. The ability of the Republican candidates' approaches to expand coverage would depend on the generosity of their tax credits or deductions, whether they would replace the current tax exemption for employer health benefits, and whether the new tax incentives would retain their value over time.

President Bush proposed replacing the current employer tax exemption for health benefits with a new standard income tax deduction of $7,500 for individuals and $15,000 for families. A prior analysis of the President's proposal finds that it would cover only about one of five previously uninsured people in the first year.[10] Under the President's proposal, the tax deduction would be a standard amount that would rise annually by the rate of consumer price inflation, which is projected to rise more slowly than premiums. This means the proposal is likely to cover more uninsured people in the first years of the proposal than in future years, when premiums are more likely to exceed the standard deduction. In addition, providing an equivalent capped income tax deduction for insurance gained through the individual market would provide some employers—particularly small employers—with an incentive to drop coverage because employees would receive the same tax deduction for coverage in the individual market. As a result, the number of people with employer-based coverage might fall and the number covered in the individual insurance market would rise.

A public insurance approach, such as the one proposed by Kucinich, would likely cover everyone. Individuals could not opt out. Prior analyses of proposals that would open Medicare to the full population but would allow employers to opt out, such as Representative Pete Stark's (D–Calif.) AmeriCare bill, find that most employers would

not opt out, as it is unlikely that firms could negotiate premiums with rates more favorable than those the government could offer in Medicare's fee-for-service plan, its self-insured product.[11] Thus, it is anticipated that most people would have coverage through Medicare, even under proposals that include an employer opt-out provision.

Do the Proposals Provide a Minimum, Standard Benefit Floor for Essential Coverage with Financial Protection?

Proposals that define a minimum health benefit package including cost-sharing would improve coverage for millions whose current health insurance provides inadequate protection and 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, as well as programs to manage chronic health conditions.

By expanding access to Medicaid and SCHIP, all the Democratic mixed private–public proposals would improve existing benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults with low-to-moderate incomes.

The proposals of Clinton, Edwards, and Obama all include some guidelines regarding benefits. Clinton does not specify what employers must offer to comply with the employer requirement to offer or contribute to the cost of coverage, but does say that plans offered through her new "Health Choices Menu" would include benefits that would be as good as those available to members of Congress through FEHBP. Similarly, Edwards does not specify the benefit package that employers would be required to offer, but under his new regional "Health Care Markets," private and public plans would offer comprehensive benefits including full mental health benefits. People who did not have equivalent benefits offered through their jobs could purchase a plan through the Health Care Markets. Under Senator Obama's 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.

Kucinich's proposal is the most explicit about covered services that would be available to everyone at all participating providers in the U.S. Benefits would include primary care and prevention, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health services, dental services other than cosmetic, substance abuse treatment services, chiropractic services, and basic vision care and vision correction other than laser surgery for cosmetic purposes. There

would be no deductibles, copayments, coinsurance, or other cost-sharing. Private insurance carriers could sell coverage for benefits not covered by the program. The risk in this plan is the ability of revenues to keep pace with medical cost inflation. If, in the future, revenues for the program lagged behind cost growth, the benefit package might have to be reduced to contain growth in program costs.

In contrast, none of the Republican candidates proposes a minimum set of covered benefits. People could continue to get coverage through their employers if offered or buy coverage on the individual insurance market. People opting to apply their new tax incentive to purchasing coverage on the individual market coverage could choose between more comprehensive plans with higher premiums and less comprehensive plans with lower premiums. But for many people, the availability of benefits would be beyond their control. Depending on the state in which a plan is offered, benefit packages and premiums could be determined by preexisting conditions, gender, and age. In states that allow underwriting, 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.

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

The design and size of new premium subsidies, tax credits, or tax deductions will have a significant impact on the share of income that families will spend out-of-pocket on health care. The Democratic candidates with mixed private–public group insurance reform proposals have said they would make premiums affordable by providing sliding-scale refundable tax credits or premium subsidies based on income. But the candidates are mostly vague on the specifics of the subsidies including the size of the credits or subsidies, the percentage of income people would be required to pay, and the income levels of households eligible for the tax credits or subsidies. Edwards has provided the most detail, indicating that people in low-income households would be subsidized 100 percent and the premium subsidy would phase out gradually up to households earning 400 percent of the federal poverty level. The Democratic candidates have focused exclusively on premiums when determining affordability, despite the fact that out-of-pocket costs can and do comprise a substantial share of family incomes, particularly in low- and moderate-income households, and for people in poor health.[12] Under Kucinich's proposal, people would not pay premiums and there would be no deductibles, copayments, coinsurance, or other cost-sharing.

Blumberg and colleagues examined the affordability issue in the context of the new Massachusetts law that requires all individuals to have health insurance if an affordable option is available.[13] Because federal data show that people in low- and moderate-income households with individual market coverage spend a large percentage of their income on premiums and out-of-pocket costs, it would be inappropriate to simply define as affordable what people currently spend on health care across all income groups. A more appropriate standard, they argue, is applying the share of income currently spent by higher-income households on both premiums and out-of-pocket spending across income groups. Including out-of-pocket spending in addition to premiums reflects the fact that plans purchased in the individual insurance market can have low premiums but high deductibles or other cost-sharing that can lead to high out-of-pocket spending. Mandating coverage without taking into account out-of-pocket spending could prove burdensome for people with lower incomes or poor health. Massachusetts ultimately settled on using premiums alone in defining affordable plans and determined that people with incomes under 150 percent of the poverty level would pay no premiums; those with incomes up to 200 percent of poverty would pay, on average, 2.4 percent of income on premiums; those with incomes up to 300 percent would pay, on average, 4.5 percent; and those with incomes up to 500 percent of poverty would pay, on average, 8 percent.[14] Blumberg and colleagues point out that these standards are in the range that people with incomes of 300 percent to 500 percent of the poverty level spend on employer and individual market premiums: 2.1 percent for employer-based coverage and 7.9 percent for coverage purchase in the individual market.

All the Republican candidates have proposed new tax credits or income tax deductions for people purchasing private health plans. Giuliani and Romney propose replacing the tax exemption for employer contributions to health benefits with a new standard income tax deduction for anyone with private insurance, whether received through an employer or purchased in the individual market. Giuliani has proposed a new standard income tax deduction of $15,000 for families. Because the deduction does not vary with income, it would be most valuable to those in higher income tax brackets. Prior analyses of a similar proposal by the Bush Administration has shown that because of the greater value of the tax deduction to higher-income families, its greatest impact on reducing the number of uninsured would be among higher-income families, even though more than 60 percent of the nonelderly uninsured are in families with incomes under 200 percent of the poverty level.[15] For those who purchase coverage in the individual insurance market, the value of the deduction would potentially vary by state of residence, health status, gender, and age. Giuliani and Romney would provide tax credits or premium subsidies to offset the costs for lower-income families, as would Huckabee. Like

the Democrats, none of these three candidates has provided specific detail, including the amount of the tax credits or subsidies or the income ranges for households eligible for the subsidies.

McCain has proposed reforming the tax code to eliminate the bias toward employer-sponsored health insurance, though he has not offered details on the type of reform he would seek. He would provide refundable tax credits of $2,500 for individuals and $5,000 for families with private health insurance. Compared with tax deductions, 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 they do not favor people in higher-income tax brackets. Still, McCain's proposed tax credits fall short of the average premium in employer-based health plans, which was about $12,106 in 2007.[16] Making up the difference between the tax credit and the premium would pose a great burden for lower- and moderate-income households. And, similar to the income tax deduction, 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.

Other health care reform proposals would fundamentally alter the tax treatment of employer-based health benefits but would also provide greater protection for lower-income households. Clinton is the only Democratic presidential candidate who has proposed changing the tax treatment of employer-based health benefits, suggesting capping the amount of employer contributions that are excluded from taxable income for households earning $250,000 or more at the actuarial value of the standard plan offered through FEHBP. Senator Ron Wyden's (D–Ore.) Healthy Americans Act would end the tax exemption for employer-provided health benefits and replace it with a standard personal income tax deduction, as in Giuliani and Romney's proposals.[17] But the Wyden bill differs in several ways including: the creation of large regional purchasing pools where people would buy coverage and progressively structuring a new personal income tax deduction and combining it with premium subsidies for lower-income households. A prior analysis of the Wyden bill estimates it would result in a decline in household spending on health care for lower-income families and increases for higher-income families.[18]

Do the Proposals Make Enrollment Easy and Seamless to Get and Stay Enrolled? Proposals that would enroll people automatically through the tax system or at birth are the most likely to ensure that people become and remain enrolled. Kucinich's National Health Insurance program would provide the most seamless enrollment of the current proposals. Anyone who receives health care from a licensed provider would be presumed eligible for health benefits and would fill out an application if not already enrolled. This approach

would ensure that people remain enrolled, regardless of changes in income, age, health, or employment status.

The Democratic candidates that have proposed mixed private–public group insurance approaches would fill a major gap in the current system through new group insurance mechanisms. But, on their own, these proposals would not make enrollment easier or more seamless, even with the inclusion of an individual mandate. They would also retain the complexity of the current system. To address this problem, Edwards has proposed requiring proof of insurance at tax filing and upon receipt of health services. Enrolling people through the tax system would help reduce the churning in and out of coverage that characterizes the current system. The tax system might also provide an administrative mechanism for income-related premium assistance and ceilings on out-of-pocket costs as a percent of income.

The Republican proposals to provide tax incentives for individual market coverage would not make enrollment easier or more seamless. In theory, by separating coverage from employers, these proposals would make coverage portable, with people able to take their health plans from job to job. But the candidates have not addressed serious problems in the individual market. Many people, especially those with health risks, have trouble obtaining coverage and staying covered over time, if the terms of their coverage change. Shifting the insurance system away from the relatively greater security of employer group coverage could ultimately exacerbate the complexity of the system, making access to insurance more uncertain, and the potential for churning greater.

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. Nearly three of five adults under age 65 with employer-based coverage surveyed in the Commonwealth Fund Biennial Health Insurance Survey said it was very important that their employer offer a choice of health plans.[19] Lambrew found that having a choice of provider was an even more important factor in overall satisfaction with health care than having a choice of health plan.[20]

Reflecting this tenet of public opinion, most candidates' proposals emphasize a choice of health plans. The new group insurance markets proposed by many of the Democratic candidates would include a range of private health plans in addition to a public health plan option, similar to Medicare, but with the same set of covered benefits. Indeed, Clinton refers to her new group insurance option as the "Health Choices Menu."

These proposals emphasize that people would not be forced to change plans. They could choose to stay in their current employer-based coverage if their employer continues to offer coverage.

The proposals that would provide tax incentives for people to gain coverage through the individual market would also 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 Giuliani and McCain have proposed, would also provide a greater range of choices. However, older people or those in poor health might have less choice and flexibility in the individual market than those who are young and in good health. This proposal could also destabilize the affordability of coverage in states that attract individuals who are poor health risks.

Kucinich's plan could offer people the broadest choice of provider: services provided by any licensed provider in the U.S. would be covered under the U.S. National Health Insurance program.

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 others who are experiencing poor health; the young support the higher costs of the old; able-bodied individuals support accident victims, and so forth across the life span. Life is notoriously uncertain and insurance coverage, whether for material items 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, the individual cost of the premiums will be lower.

Insurance carriers sell polices in three different markets—large employer group, small employer group (i.e., firms of fewer than 50 employees), and individual—in each of the 50 states and the District of Columbia.[21] 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 or individuals may 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 adverse selection 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 that sold in the small- and large-group markets.[22]

From an efficiency and equity perspective, the advantages of group insurance like employer-based coverage, Medicare, and Medicaid and SCHIP are considerable. Employer coverage forms natural risk pools: people enroll in coverage when they take a job rather than when they are sick, reducing the potential for adverse selection. In the absence of individual underwriting and other activities designed to protect against health risks, premiums in the employer group market are more in line with actual medical expenditures than are those in the individual market. Administrative costs in the individual market coverage consume from 25 percent to 40 percent of each premium dollar and 15 percent to 25 percent of small-group premiums, compared with 5 percent to 15 percent for large-group coverage.[23] 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.[24] The lack of underwriting in the employer group market also ensures that workers are not excluded from coverage, or charged different premiums, on the basis of health status or age.

Prior estimates have shown that the costs of insurance administration can vary significantly, depending on the size of the risk pool.[25] 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 with lifetime coverage once eligible—have the potential to significantly lower overall administrative costs.

Most of the Democratic proposals would retain and build on the strength of large employer risk pools by requiring that employers either offer coverage or help finance coverage. They would also retain and expand the large risk pools of public insurance, most notably Medicare. They would also expand eligibility for Medicaid and SCHIP, both of which operate with lower overhead than either individual or small group insurance markets. Notably, in many states Medicaid and SCHIP contract with private insurance carriers to provide coverage.

The challenge these mixed private–public health reform plans face is creating a new viable group insurance market that would replace the inefficiencies and inequities inherent in the current individual market. Key to the viability of these new group options is a broad risk pool and requiring that everyone be included in the pool. Prior experience and analysis has demonstrated that simply offering people a premium subsidy will not guarantee that everyone will become insured. But, under a universal requirement that everyone have coverage, people would have to be in the pool regardless of their age or health needs. Both Clinton and Edwards support an individual requirement to have insurance. Obama would require that children have coverage, but has expressed concern about imposing a broader mandate on families due to affordability concerns. Premiums would have to be made affordable before he would support an individual mandate. The Clinton campaign has argued, alternatively, that the only way to achieve affordable premiums is to have everyone in the risk pool. None of the campaigns has put forth guidelines about what would constitute an affordable health plan.

Another major challenge to the viability of the new group insurance markets is whether individual and small group markets will continue to exist. If so, will the rules that apply to carriers in the new group markets apply to those selling in the individual and small group markets? To ensure that healthy individuals do not leave the new group insurance markets, it will be important that similar rules apply to carriers selling in the individual and small group markets, if they are not incorporated into the new group options.

For his part, Kucinich would avoid the issues that arise from individual mandates, affordability, and adverse selection by automatically enrolling everyone in one health plan and not requiring a premium payment for coverage. The program would be financed through tax contributions by families and companies, and providers would be paid through federal revenues, largely eliminating the role of insurance carriers in the health system.

Most of the Republican candidates propose 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 an individual mandate, minimum 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 will only increase annual spending on insurance administration. An analysis of federal data on premiums and benefits in the individual market shows that 43 percent of premiums were spent on nonmedical activities, including marketing.[26] Supporters of these proposals, however, argue that when consumers spend more of their own money on health insurance and health care they will be more cost-conscious, seek out lower-cost providers, and avoid marginal or unnecessary care. These proposals would allow substantial choice of covered benefits and financial protection, within the limits of people's budgets. However, they could limit options and increase costs for those with health risks who depend on existing consumer protections, which vary by state. People with preexisting conditions might face very high premiums, not be able to get their health needs covered, or might not be offered a policy at all.

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 their premium.[27]

From a pragmatic perspective, it might be simpler to allow people to remain with their current coverage, as long as it met minimum benefit and affordability standards, than to move everyone to new forms of coverage at the outset of a reformed system. With more than 60 percent of the under-65 population enrolled in employer-based plans, it would be far less disruptive to allow people to stay in their plans. Moreover, by maintaining employer coverage, the system would continue to reap the efficiency benefits of the large-employer risk pools. Finally, allowing people to remain covered by employers would retain a critical and substantial source of financing.

Most health care reform proposals by Democratic candidates would allow people with employer-based health insurance to retain their coverage, if they are so inclined and if their employers chose to continue offering coverage. They would not have to move to a new type of insurance coverage or change providers. Under Kucinich's proposal, people would no longer receive health benefits through their jobs but would be covered under a

new public insurance plan like Medicare. However, it is unlikely that people would have to change their current providers under this type of approach.

Neither would the Republican candidates' reform proposals lead to a large-scale movement out of employer-based coverage. People would not to have to move to a new type of insurance or change providers, as long as their employers continued to offer health insurance. But the proposals do emphasize a shift away from employer-based coverage by changes in the tax code regarding employer benefit contributions. This would represent a significant departure from the current system and would provide an incentive for some employers to drop coverage.

Would the Proposals Be Simple to Administer?

The current insurance system is highly fragmented and complex, with people receiving coverage through multiple, competing insurance carriers. By building on the current structure of the health insurance system, most of the Democratic candidates' proposals would retain much of the complexity of the current system. However, these proposals would retain and expand group coverage, like large employer insurance and Medicaid and SCHIP, and retain the Medicare program, which all have lower administrative costs than individual and small group insurance.[28] The proposals would also replace the individual and small-group insurance markets with new group insurance connectors or exchanges, which would reduce the comparatively higher insurance administrative costs associated with those markets. In addition, the three leading Democratic candidates all would include a choice of a public plan, like Medicare, in their new group markets. In prior analyses of a similar model, researchers estimate that two-thirds of new enrollees in a connector program would select the Medicare option because its premiums are likely to be more affordable than the private plan options.[29] As a result, administrative costs overall would be estimated to decline by $15.4 billion in the first year of implementation.

Kucinich's proposal to insure everyone through a public program would substantially reduce complexity in the health care system. A prior analysis of Stark's AmeriCare Act of 2007, which would open Medicare to the full population, estimates a net savings in administrative costs of $56.5 billion in the first year.[30]

The Republican candidates' proposals to expand insurance coverage in the individual insurance market through tax incentives and deregulation have 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 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.[31] Prior research also suggests that there could also be high costs associated with administering tax credits for use in the individual insurance market. Dorn examined the costs of administering Health Coverage Tax Credits, which are refundable tax credits to subsidize 65 percent of the private insurance premiums of certain workers who lose their jobs through international trade under the Trade Act of 2002.[32] 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?

A significant barrier to improving the quality and efficiency of health care nationally is the substantial number of people who lack health insurance coverage and are therefore, largely outside the system. Proposals that aim for covering everyone with comprehensive benefit packages would help ensure the entire population has access to preventive care and timely, essential medical care across their lifespan.

But other significant changes are also needed to improve quality and efficiency in a systematic, sustainable way. In addition to the goal of universal coverage, The Commonwealth Fund Commission on a High Performance Health System recommended four key strategies the next president and Congress should pursue:[33]

- Aligned incentives and effective cost control through provider payment reform including rewarding high quality care and minimizing waste, payment based on total episodes of care for patients rather than a fee-for-service approach, and correcting the imbalance in payments between specialty and primary/preventive care;
- Accountable, coordinated care that allows patients and families to effectively navigate the health system;
- Investment in public reporting of quality and efficiency, evidence-based medicine, healthy lifestyles, and an infrastructure that supports the health system, including universal implementation of electronic information systems within five years;
- National leadership with collaboration between the private and public sectors, to include the creation of a new national entity, to establish and achieve national targets and goals for health system improvement.

Many of the presidential candidates from both parties have proposed strategies to improve quality and efficiency. The ideas range greatly in specificity, with some candidates simply voicing support for a particular idea. In this arena, there is broader agreement—at least on basic concepts—across candidates from both parties than there is on the issue of expanding health insurance coverage (Figure 5).

The candidates' support for quality and efficiency improvement often amounts to a "laundry list" of features, compared with their more structured proposals regarding the health insurance system. If elected, it will be important for a candidate to incorporate these often disparate ideas on quality and efficiency improvement into a broader vision of health system improvement. The four key strategic areas outlined by the Commission above provided a focused agenda, and can help voters view the candidates' proposals in a more systematic way as follows (see candidates' proposals for more details):

1. **Aligned incentives and effective cost control**
    - Pay-for-performance (Clinton, Edwards, McCain, Obama)
    - Preventive health services (Clinton, Edwards, Giuliani, Huckabee, McCain, Obama)
    - Chronic disease management (Clinton, Edwards, McCain, Obama)
    - Transparency of health care information (Clinton, Edwards, Giuliani, McCain, Obama, Romney)

2. **Accountable, coordinated care**
    - Chronic care coordination (Clinton, McCain, Obama)
    - Reducing disparities (Clinton, Edwards, Obama)
    - Health information technology (Clinton, Edwards, Giuliani, Huckabee, McCain, Obama, Romney)

3. **Investment in public reporting, evidence-based medicine**
    - Comparative effectiveness and evidence-based medicine (Clinton, Edwards, McCain, Obama)

4. **Accountable national leadership**
    - No candidates

Do the Proposals Have the Potential to Achieve Overall System Savings?
The details of whatever approach or proposal is employed will have implications in terms of costs borne by employers, individuals, the government, and other stakeholders, as well as for overall health system expenditures.[34] Key features that will have significant implications for stakeholder and health system costs include:

- the extent of participation of employers, including of the presence of an employer mandate;
- the extent of participation by individuals, including the presence of an individual mandate;
- the generosity of the benefit package;
- the contributions by employers, individuals, and other stakeholders;
- the degree to which risks are pooled;
- the choice of a public plan option, like Medicare, in new group insurance connectors or exchanges;
- the extent to which private insurers are regulated, including restrictions against risk selection and regulations 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 who receives them; and
- the new income eligibility limits in Medicaid and SCHIP, spending requirements for states; and changes in provider reimbursement rates.

But many of the candidates' proposals for quality and efficiency improvement, as outlined above, above will also have implications for costs and long-term health system savings. A new report by the Commission examined several of the candidates' ideas to improve quality and efficiency.[35] For example, the report found that 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, as some of the candidates have proposed, along with the creation of payment and cost-sharing incentives for providers and consumers to use the results of medical effectiveness research, could result in estimated savings of up to $368 billion over ten 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 ten years.

In addition, several of the candidates have proposed measures specifically aimed at reducing costs. For example, both Clinton and Obama propose reducing excess payments to Medicare Advantage health plans. The potential savings associated with resetting the benchmark payment rates for Medicare Advantage plans closer to per capita spending costs of people enrolled in the traditional Medicare program is an estimated $124 billion over 10 years.[36] In another approach to cost saving, McCain has recommended greater use of walk-in clinics in retail outlets.

Several of the candidates have proposed measures to reduce spending on prescription drugs. Clinton and Obama would allow the federal government to directly negotiate prescription drug prices available through the Medicare program with pharmaceutical companies, something it is not allowed to do now. The Commission estimates this new authority 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.[37]

Clinton, Obama and McCain would allow U.S. residents to purchase drugs from other countries and, along with Edwards, would promote increased use of generic drugs. Clinton and Edwards would limit direct-to-consumer advertising. Clinton would institute reporting requirements for financial arrangements between providers and pharmaceutical manufacturers. Giuliani would bring greater accountability and efficiency to the evaluation process for new drugs.

Nearly all the candidates support malpractice reform of some sort. Clinton would support the development of systems that eliminate medical errors and provide incentives for alternative dispute resolution mechanisms. Edwards would limit medical malpractice lawsuits without merit by requiring attorneys who seek to file malpractice lawsuits to obtain certification by an expert to prove their cases have merit. Giuliani is committed to ending frivolous lawsuits. Obama would strengthen antitrust laws to prevent insurers from overcharging physicians for malpractice insurance. He 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. Romney would impose caps on noneconomic and punitive damage awards. McCain would pass tort reform to eliminate frivolous lawsuits and excessive damage awards, and eliminate lawsuits for doctors that follow clinical guidelines and adhere to patient-safety protocols.

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, based on ability to pay.

The three leading Democratic candidates, Clinton, Edwards and Obama, would directly finance their proposals through repeal or expiration of the tax cuts of the past few years for households with incomes of $200,000 or higher (Edwards) or $250,000 or higher (Clinton and Obama). Clinton has proposed other potential sources of revenue: capping the amount of employer contributions to health benefits that are excluded from federal taxes for households with incomes over $250,000 and reinvesting a share of federal disproportionate share payments to safety-net providers once all Americans are covered. Clinton also points to potential savings from quality and efficiency improvement proposals, many of which are included in the plans of the other candidates: reduced payments to Medicare Advantage plans, savings from allowing Medicare to negotiate prescription drug prices, increasing the use of health information technology, comparative effectiveness, and better chronic disease management.

Another key source of financing in the leading Democratic plans is the continuing participation of employers in the health system. In 2005, total employer premium contributions for coverage of active employees and their dependents totaled approximately $420 billion, over one-fifth of total U.S. health expenditures in that year.[38] The Democratic candidates would keep that financial commitment through their play-or-pay mandates. All the Republican presidential candidates are suggesting a shift away from reliance on employers through a change in the tax treatment of employer-based health benefits, but they have not addressed how they would replace lost employer contributions to employee coverage. This could be a factor if employers decide to stop offering coverage if their employees can qualify for an equivalent tax benefit through the individual insurance market.

Kucinich's proposal would remove employers, along with most private insurance carriers, from the health insurance system altogether. He would establish a new trust fund to be financed from existing revenues, along with an increase in the personal income tax on the top 5 percent of earners, a new excise tax on payroll and self-employment income, and a new small tax on stock and bond transactions.

The degree of risk pooling, as well as insurance market regulations on carrier behavior, will have significant implications for the cost of the proposals, particularly on the

size of subsidies needed to help low- and moderate-income people access health insurance. Broader risk pooling will help keep the cost of premiums affordable for families and lower the amount of federal or state subsidies required.

Another critical factor that will affect financing needs over time is the rate of growth in national health expenditures. Growth in health care costs and premiums has contributed significantly to loss of coverage for many people over the past several years and, combined with sluggish household income growth, is the reason families are spending increasing amounts of their income on health care expenditures.[39] Therefore, the cost-saving provisions of the candidates' proposals are critical—both those implicit in the design of their health insurance expansions and those explicitly aimed at improving quality and efficiency and reducing the rate of growth in health care costs over time.

ENVISIONING THE FUTURE: KEY DIFFERENCES IN THE CANDIDATES' VIEWS

Overall, the candidates' views of a future health insurance system are fundamentally the same within the two parties, but are fundamentally different between the two parties (Figure 5).

The goal of universal coverage. The candidates differ markedly on the goal of providing coverage to everyone. All the Democratic candidates support universal coverage as a goal. While the Republican candidates discuss expanding access to health insurance coverage, none to date has said that covering everyone is a goal.

Insurance markets. Both Republican and Democratic candidates, with the exception of Kucinich, envision a health insurance system that continues to be structured around private insurance markets, with a supporting role played by public insurance programs. The candidates diverge significantly, however, on the way this system should operate. The Democrats see the health insurance system based primarily on broad private and public group risk pools with regulations that prevent insurers from selecting against individuals with serious health risks, while Republicans see a health insurance system that would rely nearly exclusively on individual insurance markets without consumer protections. The Democratic candidates propose to replace the individual insurance market with new group insurance "exchanges" or "connectors," with a choice of private and public group health plans. These markets would be regulated by ground rules designed to ensure that anyone—even older people or those with health problems—can gain access to an affordable health plan with a standard set of benefits. In contrast, most Republican candidates would encourage more people to buy individual market insurance through the provision of new tax incentives and changes in the tax code. Most Republican candidates'

proposals could have the effect of reducing existing consumer protections that states like New York and New Jersey have put in place, such as requiring insurers to write a policy for anyone who applies and restricting carriers from charging premiums based on health risk or age. None of the Republican candidates has discussed how they would address the adverse selection issues that characterize the market and the considerable difficulties that people with higher health risks have in securing affordable coverage.

The role of employers. Republican and Democratic candidates have fundamentally different views of the role employers will play in the health insurance system. The Democratic proposals would retain and strengthen the employer role by requiring that all large employers offer coverage or pay part of the coverage costs of their employees. This would allow people to keep the coverage they have, and would also maintain the significant financial support employers provide. In 2005, employers contributed approximately $420 billion—over one-fifth of total U.S. health expenditures in that year—for premiums for active employees and their dependents. In contrast, most of the Republican candidates propose changes in the tax code that could significantly alter the employer role. Under current federal law, health benefits employees receive from their employers are excluded from taxable income. Giuliani and Romney have proposed eliminating this special tax treatment and replacing it with a new standard income tax deduction for anyone with private insurance, whether received through an employer or purchased in the individual market. Some employers might have less incentive to continue providing health coverage to employees, if these employees could gain an equivalent tax deduction if they purchased coverage in the individual market. The Republican candidates have not addressed how they would replace lost employer financing. Clinton is the only Democratic presidential candidate who has proposed changing the tax treatment of employer-based health benefits, suggesting capping the amount of employer contributions that are excluded from taxable income for households earning $250,000 or more at the actuarial value of the standard plan offered through FEHBP.

Requirements that individuals have coverage. The candidates diverge on whether they would require everyone to have health insurance. Clinton and Edwards would require that all people eventually have coverage. While Clinton would require coverage at the start of her plan, Edwards would require that everyone have coverage by 2012, when his plan is fully implemented. Obama would mandate coverage only for children, but would consider an individual mandate for adults if substantial numbers of people do not purchase coverage that is deemed affordable. None of the Republican candidates would require that people have health insurance.

Affordability and enforcement. With universal coverage relying on the presence of an individual mandate, it will be critical that health plans are affordable and the mandate is enforceable. Even the ability of the Republican proposals to increase coverage will depend on whether people have access to affordable health plans. Edwards is the only candidate who has discussed how he would enforce an individual requirement to have health insurance. With respect to affordability, all the leading Democrats (Clinton, Edwards, and Obama) have said that enrollees would pay only a set percentage of their income on premiums, but have not specified this percentage, or what would happen if people do not have affordable plans available to them. They have also focused exclusively on premiums when determining affordability, despite the fact that out-of-pocket costs can and do comprise a substantial share of family incomes, particularly in low- and moderate-income households. The Republican candidates have suggested subsidies and tax credits to help low- and moderate-income people buy coverage on the individual market, but have not specified the amount of the subsidies. McCain has proposed a specific refundable tax credit for everyone but it would not vary by income. The Republican candidates have not discussed how they will address the considerable variation in the value of tax credits or subsidies for health coverage purchased in the individual market when premiums can vary substantially based on health risk and age.

Ease of enrollment. The complexity and fragmentation of the current health insurance system makes obtaining and retaining insurance difficult. Of the current proposals, Kucinich's National Health Insurance program would provide the most seamless enrollment. The Democratic candidates that have proposed mixed private–public approaches to health system reform would fill the gap in the current system through their new group insurance "Exchanges," "Menus," and "Health Care Markets." But by building on multiple forms of existing group coverage and adding a new group insurance option, the Democratic proposals would not make enrollment easier or more seamless and would retain the complexity in the system. To address this problem, Edwards has proposed requiring proof of insurance at tax filing and upon receipt of health services. Enrolling people through the tax system would help reduce the "churning" in and out of coverage that now characterizes the current system. In theory, by separating coverage from employers, the Republican proposals would make coverage portable, with people able retain their health plans from job to job. But the Republican candidates have not addressed the problems that people with health risks have in both obtaining coverage in the individual market and staying covered over time. Shifting the insurance system away from the relatively greater security of employer group coverage could ultimately exacerbate the complexity of the system, making access to insurance more uncertain, and the potential for churning greater.

Quality and efficiency improvement. Candidates from both parties have proposed strategies to improve quality and efficiency. The ideas range greatly in specificity. However, there is broader agreement—at least on basic concepts—across candidates from both parties on improving quality and efficiency than on the issue of expanding health insurance coverage. The candidates' support for quality and efficiency improvement often amounts to a "laundry list" of features, compared with their more structured proposals regarding the health insurance system. In addition, while the candidates all discuss health care cost growth as a major problem, none has developed a comprehensive strategy for tackling it. If elected, it will be important for the candidates to incorporate these often disparate ideas—quality and efficiency improvement and cost control—into a broader vision of health system improvement.

Financing. Achieving universal or expanded 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, based on ability to pay. None of the Republican candidates has identified a source of financing. The leading Democratic candidates would either roll back the tax cuts of the past few years or allow them to expire for households with incomes above $200,000 (Edwards) and $250,000 (Clinton and Obama). They have also identified other minor sources of financing, and savings through improved efficiency in the system. The lack of details in their proposals on many key features—the size of the premium subsidies for low- and moderate-income families, the employer contribution, the increase in Medicaid and SCHIP income eligibility standards—means it is unclear whether the amount of financing they have identified is sufficient.

WHICH PROPOSALS HOLD THE GREATEST PROMISE?

Measured against the broad principles of reform laid out by The Commonwealth Fund Commission on a High Performance Health System, both the mixed private–public group insurance with a shared responsibility for financing proposed by the leading Democratic candidates and the public insurance program proposed by Kucinich have the greatest potential to move the health care system toward high performance (Figure 6). Depending on the specifics of proposals, both approaches have the potential to provide everyone with comprehensive and affordable health insurance, 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. However, from a pragmatic perspective, allowing the more than 160 million people who now have employer-based health coverage to retain it as in the mixed—public private approach—and not asking them to enroll in a new program as in Kucinich's public insurance model—would cause far less dislocation.

Figure 6. Design Matters: How Well Do Different Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Incentives and Deregulation of Individual Insurance Markets	Mixed Private-Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum 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	–	+	++
Work to 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).

The Republican candidates' proposals to reform the health insurance system by relying on tax incentives and voluntary purchase of coverage in an unregulated individual insurance market are, by themselves, 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, minimum 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. Moreover, because of the substantially higher administrative costs in the individual market, covering more people this way will only increase U.S. annual spending on insurance administration.

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