

ELECTION 2008

## The Partisan Divide — The McCain and Obama Plans for U.S. Health Care Reform

Jonathan Oberlander, Ph.D.

In the face of escalating costs, uneven quality of care, and the growth of the uninsured population, there is broad agreement that the U.S. health care system requires reform. However, Democrats and Republicans remain sharply divided over how to reform it, as evidenced by the health care plans offered by the parties' presidential candidates. The ambitious reform agendas of Senators John McCain (R-AZ) and Barack Obama (D-IL) would take the U.S. health care system in very different directions.

McCain's plan embraces market forces and promotes individually purchased insurance (see red box). Its centerpiece is a change in the tax treatment of health insurance. Currently, workers do not pay taxes on health insurance premiums paid by their employers. The McCain plan would eliminate this tax exclusion and use the revenue generated — projected to be \$3.6 trillion over 10 years — to pay for refundable tax credits for Americans obtaining private insurance (\$2,500 for individuals, \$5,000 for families). Uninsured Americans could use their credits to help buy insurance coverage on the individual market, and workers with employer-sponsored insurance could use theirs to offset the cost of paying taxes on their employers' premium contributions or to purchase coverage on their own.

The McCain campaign emphasizes key advantages of this ap-

proach. First, the current tax exclusion disproportionately benefits higher-income Americans, since its value depends on a worker's tax bracket.<sup>1</sup> Providing an equal credit to all Americans is a fairer allocation of federal revenues, and since the credit is refundable, even those who do not pay taxes would qualify for federal payments. Second, the tax exclusion benefits only persons with employer-sponsored insurance, whereas under the McCain plan everyone, including the unemployed and workers whose employers do not offer coverage, would receive a credit to purchase insurance regardless of where they obtained it.

In terms of cost control, the McCain plan offers several initia-

tives aimed at spurring competition and changing the status quo in health insurance and medical practice. It would deregulate the insurance market to allow insurers to sell policies across state lines; residents of states that extensively regulate insurance (for example, by mandating covered benefits) would be able to shop nationwide for less comprehensive, less costly health insurance policies than those available in their home states.

McCain's plan also calls for changing the way Medicare pays for medical services — moving away from fee-for-service reimbursement and toward bundled payment for episodes of care and payments based on outcomes. The

### Key Elements of John McCain's Plan for Health Care Reform.

- Elimination of current tax exclusion for employer-paid health insurance premiums
- Using revenues generated from eliminating tax exclusion, provision of refundable tax credits (\$2,500 for individuals, \$5,000 for families) for all persons obtaining private health insurance; if insurance costs less than the value of the credit, remaining funds can be deposited into health savings accounts
- Creation of guaranteed access plan to provide insurance pool for persons who are medically uninsurable on the individual market
- Promotion of individually purchased insurance and less comprehensive insurance policies
- Deregulation of insurance markets
- Reform of Medicare to make bundled payments for episodes of care and to pay on the basis of outcomes
- Other proposed measures to control costs and improve quality:
  - Enhanced competition
  - Faster introduction of generic drugs
  - Emphasis on prevention and better management of chronic conditions
  - Greater use of health information technology
  - Medical malpractice reform

hope is that Medicare payment reform would drive broader changes in the health care system.

In addition, replacing the invisible, unlimited tax exclusion with a visible, limited tax credit could slow health care spending. Making employer premium payments taxable income would make insurance costs more transparent to workers, many of whom are unaware how much their employers are paying for their insurance. And since Americans would receive a fixed credit, the expectation is that they would seek out lower-cost, less comprehensive insurance plans, fostering competition among insurers. Other cost-control provisions include speeding up generic-drug development, encouraging prevention, improving care for chronic diseases, and adopting medical malpractice reform.

How the McCain plan would affect costs and coverage is uncertain. Nobody knows how effective repealing the tax exclusion would be in controlling costs, but if it turns out not to be a magic bullet, the plan lacks other mechanisms for reliably slowing spending. Prevention, better care for chronic conditions, and enhanced competition represent aspirations rather than concrete policies for controlling costs.

In addition, most uninsured Americans would probably remain uninsured under the McCain plan. Given the high price of health insurance, even with the new tax credits, many lower-income people would still not be able to afford coverage. And if the credits are not indexed to the rate of growth in health care spending, that affordability gap would grow over time (as would the number

of Americans who would pay higher taxes for employer-sponsored health insurance). Indeed, with the proposed credits, many Americans could afford only high-deductible insurance policies. The McCain plan could consequently trigger a move from comprehensive insurance toward thinner coverage policies that shift costs onto sicker patients. Moreover, some employers, particularly smaller businesses, might stop offering insurance if the tax benefits of employer-sponsored insurance were eliminated. As a result, some currently insured workers could lose coverage.

Perhaps the most serious problem with McCain's plan is its reliance on the individual insurance market. Individual insurance policies are administratively expensive, typically involve medical underwriting so that sick persons and those with preexisting conditions are charged higher premiums (premiums also increase with age) or are denied coverage altogether, and generally offer less comprehensive benefits than employer-sponsored insurance.<sup>2</sup>

The McCain campaign has proposed a "guaranteed access plan," whereby the federal government would work with states to create insurance alternatives for those unable to afford coverage on the individual market. The plan builds on the experiences of the 34 states that operate high-risk pools for residents who are deemed to be medically uninsurable. Yet such a program is unlikely to remedy problems inherent in the individual market. State high-risk pools ironically suffer from the same problems (high costs, limited benefits, preexisting-condition exclusions) that plague the insurance

markets from which they are supposed to offer refuge.<sup>3</sup> Furthermore, the McCain plan for interstate insurance markets could weaken regulatory protections in some states.

In contrast to John McCain's emphasis on markets and deregulation, Barack Obama's reform plan relies on an employer mandate, new public and private insurance programs, and insurance-market regulation (see blue box). The core of the Obama plan is a requirement that employers either offer their workers insurance or pay a tax to help finance coverage for the uninsured (some small businesses would be exempt, and others would be subsidized). The Obama plan would also create two new options for obtaining health insurance: a new government health plan (similar to Medicare) and a national health insurance exchange (a purchasing pool analogous to the Massachusetts Connector) that would offer a choice of private insurance options. Both would be open to persons without access to group health insurance or other public insurance, as well as to small businesses that wanted to purchase coverage for their workers. Income-related subsidies would be provided to help lower-income persons afford coverage. And private insurers could not deny coverage because of preexisting conditions or charge substantially higher premiums to sick enrollees: the Obama plan would end medical underwriting according to health status.

The Obama campaign emphasizes that its plan offers a choice of insurance options. Rather than deciding whether public or private insurance is a better model, the plan would allow people to

choose between them. In addition, the new national health plan and insurance exchange would provide insurance pooling and purchasing power that, along with insurance-market regulation, would effectively address the problems that Americans without group coverage encounter when trying to purchase affordable insurance on the individual market.

The Obama campaign says that the insurance exchange, by providing broader pooling and cutting marketing expenses, can reduce administrative expenses in private insurance and promote competition. The plan also calls for a new system of reinsurance, whereby the federal government would reimburse employers for a portion of the costs they incur for employees with high-cost, catastrophic medical cases — theoretically enabling businesses to reduce insurance premiums and particularly benefiting smaller businesses whose risk pools are too small to spread the costs of expensive cases.

Other cost-control measures include accelerated adoption of electronic medical records, promoting disease management and better coordination of long-term care, paying providers on the basis of performance and outcomes, strengthening prevention, permitting the federal government to negotiate prescription-drug prices for Medicare patients, cutting excessive payments to private health plans contracting with Medicare, and establishing an institute for comparative-effectiveness research to generate information about effective treatments.

The Obama plan's precise impact on coverage is impossible to gauge. If the payroll tax is set low,

Key Elements of Barack Obama's Plan for Health Care Reform.
"Play or pay" employer mandate requiring businesses either to offer workers insurance or to pay a tax (very small businesses would be exempt)
Creation of a new national health plan (similar to Medicare) for the uninsured and small businesses
Establishment of new national health insurance exchange that would offer choice of private insurance options for the uninsured and small businesses
Mandate that all children must have coverage
Subsidies for lower-income Americans to help them afford coverage
Expanded coverage financed through the payroll tax, letting tax cuts for families making over \$250,000 expire, and savings from electronic medical records, disease management, and other system reforms
Regulation of all private insurance plans to end risk rating based on health status
Establishment of federal reinsurance program to insure businesses against the costs of workers' expensive medical episodes
Other proposed measures to control costs and improve quality:
Reduction in the administrative costs of private insurance
Accelerated adoption of electronic medical records
Promotion of disease management
Emphasis on prevention and public health
Payment of providers on the basis of performance and outcomes
Reduction in excessive payments to private plans contracting with Medicare
Allowing Medicare to negotiate with drug companies
Establishment of a comparative-effectiveness research institute

many businesses would choose to pay it rather than offer coverage, and enrollment in a new national health plan could be substantial. The capacity of the Obama plan to expand insurance coverage depends on the scope of subsidies, premium prices, and the effectiveness of automatic enrollment or other participation-boosting policies, but details of those policies are not clear. Since the plan lacks an individual mandate for adults (coverage is mandated for children), it would not cover all the uninsured and therefore would provide universal access to insurance rather than universal coverage. However, most Americans without insurance would gain coverage through the new public and private insurance options, and Obama has not ruled out adopt-

ing an individual mandate in the future if the plan does not produce universal coverage.

Although the Obama plan would substantially expand access to insurance, it lacks reliable cost-control mechanisms and a viable financing source. Reinsurance would shift private-sector costs for catastrophic cases to the government but would not reduce total health care expenditures. The plan also assumes that substantial savings will be achieved by increasing the use of electronic medical records, improving the management of chronic conditions, and strengthening prevention, but none of these worthwhile measures is likely to control costs in the short run. The new national health plan could control costs, but its effectiveness in slowing

spending would depend on its enrollment and the political willingness to restrain provider payments.

The Obama campaign says it would finance the \$50 billion to \$65 billion in new federal spending for its health plan by allowing tax cuts adopted in 2001 and 2003 for families making over \$250,000 to expire. However, the Congressional Budget Office (CBO) already assumes in its projections that these tax cuts will end after 2010, so their expiration will not generate new revenues to satisfy congressional budget rules.<sup>4</sup> And if savings from prevention, disease management, and electronic medical records are not realized — or if the CBO does not validate them as an acceptable financing

source — then the Obama plan would need substantial additional revenues to fund expanded coverage.

The McCain and Obama health plans are best viewed as sketches rather than finished portraits, with many important details yet to be revealed. Still, the 2008 presidential election clearly offers voters dramatically different alternatives. The candidates' opposing visions of health care reform reflect fundamentally different assumptions about the virtues and vices of markets and government. With the debate over how to reform U.S. health care far from settled, whoever wins the presidency can expect fierce opposition to any attempt at comprehensive reform.

No potential conflict of interest relevant to this article was reported.

Dr. Oberlander is an associate professor of social medicine and of health policy and administration at the University of North Carolina, Chapel Hill.

1. Reischauer RD. Benefits with risks — Bush's tax-based health care proposals. *N Engl J Med* 2007;356:1393-5.
2. Pollitz K, Soriano R. Ensuring health security: is the individual market ready for prime time? *Health Aff (Millwood)* 2002;Suppl Web Exclusives:W372-W376.
3. Chollet D. Expanding individual health insurance coverage: are high-risk pools the answer? *Health Aff (Millwood)* 2002;Suppl Web Exclusives:W349-W352.
4. The budget and economic outlook: fiscal years 2008 to 2018. Washington, DC: Congressional Budget Office, January 2008. (Accessed August 1, 2008, at [http://www.cbo.gov/ftpdocs/89xx/doc8917/01-23-2008\\_BudgetOutlook.pdf](http://www.cbo.gov/ftpdocs/89xx/doc8917/01-23-2008_BudgetOutlook.pdf))

Copyright © 2008 Massachusetts Medical Society.

## GLOBAL HEALTH

# Talking Dirty — The Politics of Clean Water and Sanitation

Michele Barry, M.D., and James M. Hughes, M.D.

In the wake of Cyclone Nargis, which devastated the Myanmar delta in early May, and the seismic earthquake that shook China shortly thereafter, access to safe drinking water and proper sanitation have become top priorities among those attempting to prevent epidemic diseases. But even without catastrophic disasters, the lack of access to clean water and basic sanitation represents a silent crisis affecting more than a third of the world's population.<sup>1</sup> Some 443 million school days are lost annually to water-related illness, millions of women and girls spend up to 2 hours a day collecting water, and every day in Bangladesh alone 28 million to 35 million people consume drinking

water containing dangerously elevated levels of arsenic.<sup>2</sup> Given that the United Nations has de-



**Keratosis from Arsenic Poisoning, Bangladesh.**

clared 2008 the International Year of Sanitation — and that in the United States this year marks the 100th anniversary of the first chlorination of a public water supply — this seems an appropriate time to reengage in an ancient conversation about safe water and sanitation.

The first documented attempts to treat drinking water, which may date back to 4000 B.C., were recorded in Greek and Sanskrit writings that describe the boiling and filtering of water, primarily to make it smell and taste better, although reducing visible particles and turbidity was also a goal. Hippocrates invented the cloth-bag filter (or Hippocratic sleeve) and was among the first to be-